National Voices

People shaping health and social care

NATIONAL VOICES' RESPONSE TO THE CONSULTATION:

Sustaining services, ensuring fairness: a consultation on migrant access and their financial contribution to NHS provision in England

SUMMARY

This response is submitted by National Voices and was coordinated by National Voices' member, the African Health Policy Network.

The main points of this response can be summarised as:

- There are significant process and procedure challenges thrown up by these proposals which are not addressed sufficiently. Primarily, it is unclear who will hold decision-making powers over: what treatment is necessary "to prevent risks to their life or permanent health"; at what point this decision will be made; how disputes over such decisions will be arbitrated and settled; and how the process can be undertaken without compromising timely access to treatment, patient flow and the moral and medical obligations of clinical staff.
- The proposals will not only impact on migrants but may have negative consequences for certain groups (e.g. the homeless, Travellers and Gypsies etc) and all people accessing NHS services due to the impact of an additional administrative burden and additional identification requirements.
- The proposals will create barriers and delay to accessing health care, yet to safeguard individual and public health, early detection, diagnosis and treatment is essential. Delays increase treatment costs and risk an increase in the transmission of infectious diseases.
- The NHS is not a contributory system, and nor is it paid for by National Insurance. To establish access based on contributions paid by NI is to undermine the principle of a universal health service, and effectively creates barriers to access for specific groups not applicable to others, and is therefore discriminatory.
- Further, the definitions of 'tourist' and 'temporary migrant' used in the consultation paper are unduly broad, covering people who have in fact lived in the UK for many years (e.g. those with limited leave to remain) who are paying towards the health system in exactly the same way as others paying any form of tax.
- There is a fundamental lack of evidence of the scale or financial impact of 'health tourism', undermining the need for any proposals to be brought forward at all. Doctors of the World UK have recently published evidence on this issue showing that "seven years of data from walk-in clinics in east London illustrated that service users had, on average, been living in the UK for three years before they tried to access healthcare. Only 1.6% of people using the service had left their country of origin for personal health reasons."
- The consultation fails to provide specific evidence of the actual costs of migrant access to the NHS. Systems are already in place, though under-utilised, for charging EEA migrants through their countries of origin. Improving the collection of these costs would have a far more significant impact than imposing individual-level charges on people who are likely to either be already contributing through the taxation system, or in the case of irregular migrants, unable to pay the charges imposed.

The proposals represent an expensive, far-reaching re-design of the NHS with implications for all patients, and no evidence that savings will be made as a result.

1. NATIONAL VOICES

National Voices is the national coalition of health and social care charities in England. We work together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them. We have more than 150 members with 130 charity members and 20 professional and associate members. Our broad membership, rooted in people's experience, represents millions of individuals, and covers a diverse range of health conditions and communities.

Our policy position on health inclusion can be found here: http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/policy_position_health_inclusion_v1.1_0.pdf

2. RESPONSE TO THE CONSULTATION

Question 1: Are there any other principles you think we should take into consideration?

Additional principles to be considered should include:

- The NHS constitution
- Human rights and legal obligations
- Medical ethics and the duties of professionals
- Public health principles
- Clinical guidelines, such as NICE guidance
- The Equality Act 2010

These principles, which underpin fair, safe, effective and timely healthcare, should be upheld for all patients.

Question 2: Do you have any evidence of how our proposals may impact disproportionately on any of the protected characteristic groups[1]?

The proposals contained within the consultation document may specifically and/or disproportionately impact on many people with protected characteristics and exacerbate health inequalities.

National Voices' policy position on health inclusion outlines the barriers to primary care access already experienced by socially excluded groups including homeless people, sex workers, vulnerable migrants and Gypsies and Travellers who experience poorer health outcomes as a result. The initial NHS registration policy and residency requirements outlined in the consultation document will exacerbate these barriers and consequently increase health inequalities for these groups.

Age: particularly babies, if maternity care is not exempted, as suggested in the proposals.

Disability: people with disabilities and long-term conditions, whether migrant or permanent residents, are likely to be disproportionately impacted by these proposals – especially the need to prove eligibility when accessing different services, and by increased information-sharing between services, including non-health services as proposed, leading to a potential loss of confidentiality.

Race: the proposals as outlined indicate that people accessing healthcare, including primary and emergency care, will be asked to prove entitlement on registration, and to confirm eligibility before gaining access to services once registered. In theory, this means everyone accessing primary and secondary care should have their eligibility queried, however

[1] As defined in the Equality Act 2010: age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity

imposing this significant administrative burden on already stretched services may lead to corners being cut, and patients being 'profiled' for eligibility checks. This may have a disproportionate impact on people of non-white ethnicities.

Pregnancy and maternity: by proposing additional charges for maternity care for migrant women, the proposals both unfairly target those women, and risk standards of maternity care for all pregnant women, by increasing the risk of women affected by charging presenting late and/or as emergency cases.

Gypsy and Travellers: will be negatively impacted by the requirements to provide proof of permanent residency, as there are currently 25,000 Gypsies and Travellers with nowhere legal or safe to stop, who will be unable to provide a fixed address. This group already experiences significant challenges in accessing primary healthcare. They is also the risk that these proposals will result in discrimination towards non-white people and non-native English speakers, who will be more likely to be suspected of being migrants and have their right to healthcare challenged.

Question 3: Do you have any views on how to improve the ordinary residence qualification?

The current qualification is understood as:

"living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, [who has]…an identifiable purpose for their residence here and [where]…that purpose has a sufficient degree of continuity to be properly described as 'settled'."

This is useful, but potentially difficult for some patients to prove, and may be burdensome and cause delays in accessing healthcare. Indeed without more detailed information on *how* an individual could prove their ability to satisfy these requirements the qualification may be unworkable.

Question 4: Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK? (Yes / No / Don't know)

No – permanent residence is a specific legal status that requires time and financial inputs to achieve. People can legally live in the UK for many years without permanent status, but with no viable alternative access to healthcare. Further, these people are paying taxes just as other UK residents and given the founding principles of the NHS ought to be equally entitled to access it. Their contributions through the tax system will be equivalent to other UK residents so their access ought to be the same in order for fairness to be upheld. Testing for permanent residence in the UK is likely to discriminate against population groups including indigenous Gypsies and Travellers, those in the care of the state, the homeless population and others without permanent or fixed addresses, who already face numerous barriers to accessing primary healthcare.

Question 5: Do you agree with the principle of exempting those with a long term relationship with the UK (evidenced by National Insurance contributions)? How long should this have been for? Are there any relevant circumstances under which this simple rule will lead to the unfair exclusion of any groups?

We do not agree with the use of National Insurance contributions as a measure of contribution to the NHS, because:

- This creates an association between NHS access and National Insurance payments, which is erroneous given that it is not the case that NI pays exclusively or directly for the NHS.
- This suggestion fundamentally re-defines the NHS as a system that is contributory, and based on one form of taxation contribution. Whilst this is currently tied to years of contributions for one defined group, it is not clear that this can be enacted without

discrimination, first of all, and secondly creates a real risk that this principle could be extended to affect other groups.

This proposal also has particular impact on certain social groups less likely or less able to pay NI, including those with disabilities and long term conditions or those with caring responsibilities.

Question 6: Do you support the principle that all temporary non-EEA migrants, and any dependants who accompany them, should make a direct contribution to the costs of their healthcare?

Some National Voices members do support the principle of contribution. The challenges to this principle though are significant in terms of the definitions used.

- The NHS is not a contributory system. This proposal fundamentally changes the nature of the NHS.
- The definition of 'temporary' is also too broad, and so these charges will affect people who in fact live and work in the UK, paying taxes to contribute to the NHS just as all British residents do.

Question 9: Should a migrant health levy be set at a fixed level for all temporary migrants? Or vary according to the age of the individual migrant?

a) Fixed

b) Varied

Any variance based on the characteristics of individual migrants has the potential to be discriminatory.

Question 10: Should some or all categories of temporary migrant (Visa Tiers) be granted the flexibility to opt out of paying the migrant levy, for example where they hold medical insurance for privately provided healthcare? (Yes / No / Don't know)

Monitoring such a system would be a huge administrative burden – the systems required to allow individual healthcare providers to ascertain whether a migrant had paid the levy would potentially be both expensive to set up and time-consuming to administer, as well as having implications in terms of information sharing between government agencies and the impact this would have on patient confidentiality

Question 11: Should temporary migrants already in the UK be required to pay any health levy as part of any application to extend their leave? (Yes / No / Don't know)

No. This would be both unfairly moving the goalposts retrospectively, and unfair on the basis of the other tax-based contributions this group are already making

Question 13: Do you agree we should continue to charge illegal migrants who present for treatment in the same way as we charge non-EEA visitors?

- Such charging, applied to people who have no means to pay, results not in increased funds for the NHS but in increased ill health.
- It also increases the likelihood of people presenting as emergency cases. This has serious implications for public health and impacts on the wider population, not just individuals.

The use of the terminology 'illegal migrants' is also unhelpful as the category is ill-defined and contains diverse groups within it.

Question 14: Do you agree with the proposed changes to individual exemptions? Are any further specific exemptions required?

Maternity services should also be exempted.

Question 15: Do you agree with the continued right of any person to register for GP services, as long as their registration records their chargeable status?

Everyone should have the right to register with a GP. This protects both individual and public health, and is vital to the effective running of the NHS, where access is determined through primary care. Including the need to prove chargeable status is a barrier to this access, not just for migrants but for all patients (e.g. how will a British citizen without a passport and without a copy of their birth certificate prove their status?). This is a risk for groups such as the elderly, homeless population and those without permanent or fixed addresses including some part of the Gypsy and Traveller population. This proposal creates an administrative burden for GP surgeries and the potential to delay or even prevent access to those actually entitled to free care.

If the residence/payment threshold shifts to the primary care gateway, we will undoubtedly deter people with uncertain status from registering with GPs and seeking medical advice, creating a barrier to detecting disease in local populations (e.g. TB).

Question 16: Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs? (Yes / No / Don't know)

No. Primary care also serves a public health function (e.g. flu jabs, HIV testing). Introducing charging in these settings therefore undermines the principles of protecting public health. It would also be enormously difficult to implement if the principle of maintaining access to immediately necessary treatment without delay or denial is to be actually upheld, as people will be required to access a chargeable service in order to have their clinical needs assessed to find out if their treatment is chargeable. This proposal would make the process of determining if treatment is immediately necessary, and therefore charge-exempt, both complex and retrospective in the risk of charges would be incurred before the decision on charging could be made.

This risks dissuading people from accessing healthcare, and creating additional pressures on emergency care as potentially chargeable individuals are more likely to either delay seeking treatment or to present at A&E as an emergency.

Question 18: Should non-EEA visitors and other chargeable migrants be charged for access to emergency treatment in A&E or emergency GP settings?

Introducing charging in emergency settings implies that patients presenting for emergency care will be forced to undergo administrative checks, potentially delaying treatment. At a practical level, the implementation of charging should not negatively impact on the treatment or access of the general population, but implementing charging in these settings will inevitably do so. A&Es are already struggling to cope with the level of demand and this extra responsibility is likely to impact on patient care more broadly.

Question 19: What systems and processes would be needed to enable charging in A&E without adversely impacting on patient flow and staff?

Additional staffing and funding would be needed – but this could be far better diverted to improving patient care.

Question 21: How can charging be applied for treatment provided by all other healthcare providers without expensive administration burden?

There is no feasible way to apply charging for treatment to all other healthcare providers without creating an extensive administrative both on non-NHS providers and the NHS as a whole. As well, such a system would create further difficulties as it requires the sharing of patient information to a wide variety of providers. Such large-scale sharing of information will be extremely difficult to implement without compromising data protection principles.

Question 22: How else could current hospital processes be improved in advance of more significant rules changes and structural redesign?

The focus should be on improving hospitals for patients, not another structural redesign with no perceivable patient benefit.

Question 23: How could the outline design proposal be improved? Do you have any alternative ideas? Are there any other challenges and issues that need to be incorporated?

There are a number of significant challenges:

- To avoid being discriminatory, full implementation of the proposals would in time require all patients accessing the NHS to prove their entitlement and have their chargeable status recorded – requiring every single patient to re-register. This is a huge burden on individual patients, who would receive no benefit from it, as well as on the health service.
- There would also be particular challenges for some people in proving their status. Registration would require both prove of citizenship and of regular residence, requiring significant paperwork that many individuals may simply not have.

Patients would subsequently be required to prove their entitlement at every NHS use – this would be a significant departure from the current system

Question 24: Where should initial NHS registration be located and how should it operate?

To set this up as an independent system would be costly and involve significant infrastructure. To include it in primary care risks compromising the ability of primary care services to provide timely access to necessary care.

Question 25: How can charges for primary care services best be applied to those who need to pay in the future? What are the challenges for implementing a system of charging in primary care and how can these be overcome?

There are a number of challenges with this proposal: who will set the charges, where and how will they be collected, will they be national or vary between areas, how will fairness be maintained and so on.

In particular, everyone will continue to have the right to immediately necessary and emergency care but this assessment can only be made by a medical professional – and in primary care the only way to access a medical professional is after registration. The risks here are: reception staff assessing emergency care needs without due qualifications; people actually entitled to treatment being denied access; people accessing treatment without knowing if and how much they may be charged for it – which is both unfair and likely to discourage people from accessing treatment.

Implementing charging to access GP services is a backward step with implications for a wide range of excluded or vulnerable groups including not just migrants but also the homeless population, gypsies and travellers and others. It would impose significant additional administrative burdens and poses a threat to population and public health.

Question 26: Do you agree with the proposal to establish a legal gateway for information sharing to administer the charging regime? What safeguards would be needed in such a gateway?

Sharing this information on such a large scale risks confidentiality, data protection and patient trust.

Further information about this response

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