Sustaining services, ensuring fairness

A consultation on migrant access and their financial contribution to NHS provision in England

Please send your completed response to
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Response template

We have responded only to those questions which directly relate to Refugee Council clients, in line with our remit.

Overarching principles

Question 1: Are there any other principles you think we should take into consideration?
Response: We would like to see more analysis regarding how the four overarching principles will be protected under the different proposals in the consultation document. There are inherent tensions between the ambition of regulating migrant access to health service (the title of the Home Office consultation), while ensuring that the system is efficient and protects the needs of vulnerable patients. This is particularly the case with any system that links eligibility to demonstrably flawed decision making systems such as the asylum determination system, the asylum support system and the National Referral Mechanism. We will explore this in further detail in our response. Ultimately, we fear that if implemented, these proposals will result in some of the most vulnerable in our society being refused essential care, thereby inevitably undermining the principle of ***a system that does not increase inequalities***. While we welcome the exemption of asylum seekers, refugees and victims of trafficking, we know from experience that this will not be sufficient to guarantee their access. As we will explore in our response to these proposals, Refugee Council clients already experience significant barriers to NHS care regardless of the fact they are, in the main, currently entitled to free care.

Nor do these proposals include provision for those at the beginning of the asylum process: for newly arrived refugees that have not yet claimed asylum or trafficking victims yet to make themselves known to the authorities, perhaps still under the control of their traffickers (see answer to question 16). Moreover, refused asylum seekers are specifically cited as 'fully chargeable'. Not allowed to work, not entitled to support, it is impossible for the vast majority to make a direct financial contribution to the NHS (they will however pay VAT whenever they pay for goods or services). This is despite the fact it is explicitly acknowledged in the consultation paper that this is a group that is "likely to be vulnerable, living in conditions typically associated with greater individual health needs. They may also be destitute with no means to pay" (para. 3.60).

Denying access to early, preventative care to a group not able to pay, not only results in significant human cost, it also results in costly and unnecessary emergency treatment, also acknowledged in the paper: "Failure to identify and treat early symptoms promptly risks delayed emergency hospital admission as well public health risks. In the main, this group are unable to pay charges levied for urgent treatment and figure significantly in debts to Trusts" (para. 3.62). Pursuing payment from individuals who are known to be destitute is highly unlikely to result in costs ever being recovered. On the contrary, chasing payment will simply incur further expense for the NHS through administrative costs and charges from debt-recovery agencies, undermining the principle of ***a system that is workable and efficient***.

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

Response:

The experience of our clients under the present system suggests that that any extension of charging to primary care services will have a disproportionate negative impact on protected characteristic groups, including race, pregnancy and maternity as well as the most vulnerable members of society. Refugee Council clients already encounter significant barriers to accessing GP services. Despite clear guidance from the Department of Health that GPs can accept any patient, asylum seekers often face difficulties when registering for primary care including being asked for identification and proof of address. Further changes will exacerbate existing confusion amongst health professionals resulting in people who are entitled to free healthcare being denied or wrongly charged.

The Refugee Council Health Access team monitored the experiences of 56 clients attempting to register with GP surgeries. Only 6 did not ask for any form of ID or proof of address and a further 3 accepted a letter from the Home Office as ID. Contrary to guidance, the rest (47) required 1 or 2 documents to prove address or some form of identification that was not a letter from the Home Office. 14 required a passport. These are documents that asylum seekers are unlikely to have.

[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

Case study: Karim is an asylum seeker from Afghanistan. He is a victim of sustained torture and imprisonment and as a result suffers from a host of mental and physical health issues. He tried to register with GP surgeries in the area he was living but was told that the Home Office letter detailing his address was not enough, and that he needed to produce photographic ID and another proof of address. As an asylum seeker, he had no national passport and did not pay any utility bills. The Home Office had not provided him with photographic ID.

After his failed attempts at registering he approached the Health Access team at the Refugee Council, he was concerned about a number of health conditions he suffered from. The team negotiated with the practice manager of a surgery in his area who agreed that he could register. He was referred to a walk-in clinic for immediate treatment. He was provided with a letter addressed to the practice detailing the agreement and advised to approach the surgery in person. He attempted this three times unsuccessfully; he was told he must have photographic ID to register. In the meantime, one of his conditions he suffered from deteriorated, an infection in his finger spread to his heart and he fell ill. He was admitted to hospital through A&E for treatment. When he was discharged he had no GP to follow-up his treatment, as a result he did not continue his medication and his finger became infected again.

The difficulties Karim has experienced in accessing care has not only resulted in huge personal cost, but will also have resulted in significantly higher costs to the NHS.

Due to misinformation and anxiety, some people who are entitled will not seek healthcare even when in need because they may not realise their entitlement or for fear of the authorities. The proposal to extend charging will act as a further deterrent to people trying to access primary health care and will extenuate their existing problems.

There is a particular risk that **the proposal to extend charging to primary services will impact disproportionately on pregnant women**. While antenatal care is considered immediately necessary, the proposals risk exacerbating the existing barriers that women with insecure immigration status experience, given that GPs are by far the most common referral route to maternity services. Current policy is for the booking appointment to take place by 12 weeks and NICE guidelines advocate first booking at 10 weeks. 14 of 20 women we interviewed for *When maternity doesn't matter* had first contact with a midwife after 12 weeks of pregnancy. Delays in obtaining maternity care resulted from women arriving in the UK late in pregnancy, their fears of accessing health services because of their own or their partner's or family's immigration status, and barriers to accessing GP services. Several of the women reported that they had been refused registration by GPs.[2]

This is particularly concerning given the inequalities experienced between different ethnic groups in maternal mortality and the importance of reaching disadvantaged

[2] Maternity Action & Refugee Council, 2013, *When maternity doesn't matter: Dispersing pregnant women seeking asylum*, available at http://www.refugeecouncil.org.uk/policy_research/research, p.42

women early. A midwife interviewed for the study said that most asylum seekers come early to maternity services if they make contact through the GP.[3] Delays in maternity care increases the risk to both mother and baby and may increase the costs to the NHS.

Case study: Josephine, a refused asylum seeker from Zimbabwe did not register with a GP for fear of being forcibly removed. When she became ill in 2002, she felt she had no option. The GP discovered she was pregnant.

19 years old, pregnant for the first time and with no family in the UK, Josephine saw a midwife when she was 28 weeks pregnant. At 32 weeks, on her second visit to the midwife, she was told to go to hospital immediately. Diagnosed with preeclampsia, Josephine was given an emergency caesarean. Three days after the birth, the baby developed an infection and was operated on. She did not survive.

Josephine accessed maternity care via her GP. Under the new proposals, she would not be entitled to free primary care services until she became entitled to asylum support (section 4) when she was six weeks before her due date (if there were no delays in processing her asylum support application – see q.14). We cannot know if her baby would have survived if she had accessed maternity care earlier in her pregnancy but, aside from the terrible human cost, the additional costs to the NHS will have been significant.

In 2009, eight years after arriving in the UK, Josephine was finally granted leave to remain. She is now doing a BSc in Health and Social Care and is a Health Befriender for the Refugee Council, supporting other women with insecure immigration status to access maternity care.

The same is also true for the diagnosis and treatment of infectious diseases. In 2011, 47 per cent of people newly diagnosed with HIV were diagnosed late. The problem of undiagnosed and late diagnosed HIV is most severe in migrant communities. For example, in 2011 over 60 per cent of African-born men and women were diagnosed with HIV late, meaning after they should have already started treatment.[4]

The proposed introduction of charges is likely to increase the late diagnosis and treatment problems amongst the groups most at risk as GP surgeries are a key place where HIV awareness-raising, testing and treatment takes place. NICE guidelines instruct GPs to offer an HIV test to all patients from high prevalence countries and all new registrants living in parts of the UK with elevated HIV prevalence, in addition to those who are showing symptoms of potential HIV infection. The routine offer of a test from a GP is extremely important because people from BME communities, in particular, are unlikely to seek an HIV test from a sexual health clinic. Increasing offers and uptake of HIV testing to migrants within a primary care setting is therefore vital to decreasing rates of late HIV diagnosis and the related costs to the NHS.

Case study: Susan, from Zimbabwe, was trafficked to the UK on a false passport and forced to work as a domestic servant. When she became ill she was no longer any use

[3] Ibid.
[4] Health Protection Agency, *HIV in the United Kingdom*, 2011

to the people who brought her here so they threw her out. She was brave enough to seek medical advice and was diagnosed HIV+ but was too fearful to return to the clinic for the recommended regular monitoring because of her insecure immigration status, as well as the shame and stigma that surrounds HIV in her community.

Despite being advised she has a strong case, Susan has not claimed asylum as she is afraid to give any information about what has happened to her to the authorities as her family in Zimbabwe have received threats

It has now been two years since she was diagnosed HIV+ and she has just been discharged from hospital after nine months on an acute ward after contracting meningitis. She has been left with brain damage due to an entirely preventable opportunistic infection.

Like the case study above, under the new proposals Susan would face additional barriers to accessing NHS care. Aside from the obvious tragic human cost, this case study illustrates the impact on public health in increased transmission of infectious diseases and the increased cost to the NHS when patients require long term acute care for a condition that could have been treated with antibiotics for the cost of a prescription.

The evidence above shows that asylum seekers are already encountering significant barriers to accessing GP services despite their current entitlement. For those that are HIV+, this may result in late treatment endangering their health and that of the wider community, and greatly increasing the costs to the NHS. The extension of charging to primary care services will only exacerbate these problems.

The Health and Social Care Act 2012 makes reducing health inequalities a requirement, but all the available evidence indicates that the proposals to extend charging into primary healthcare will have the opposite effect and further exclude already marginalised groups.

Who should be charged?

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

Response:

The proposal to link the definition of ‘ordinarily resident’ to indefinite leave to remain (ILR) is ill-advised as it will not include newly recognised refugees. While we welcome the inclusion of refugees in the list of exemptions, this suggests that they will need to evidence their eligibility. This is not in the spirit of the 1951 UN Refugee Convention which declares that recognised refugees should enjoy the same access to services as nationals (British citizens).

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)

Response:

No.

As mentioned above, we are particularly concerned that newly recognised refugees will not be automatically entitled to free healthcare. In addition to the point above, any system that requires newly recognised refugees to prove their eligibility for NHS care risks contravening the EU Directive 2004/83/EC (the Refugee Qualification Directive). The directive guarantees the content of international protection (such as equal access to education, healthcare, etc.) on the same terms as nationals to recognised refugees and those granted subsidiary protection.

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?

Response:

No comment.

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?

Response:

No comment.

Question 7: Which would make the most effective means of ensuring temporary migrants make a financial contribution to the health service?

a) A health levy paid as part of the entry clearance process

b) Health insurance (for NHS treatment)

c) Other – do you have any other proposals on how the costs of their healthcare could be covered?

Response:

No comment.

Question 8: If we were to establish a health levy at what level should this be set?

a) **£200 per year**

b) **£500 per year**

c) **Other amount (please specify)?**

Response:

No comment.

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**

Response:

No comment.

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)

Response:

No comment.

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)

Response:

No comment.

Question 12: Do you agree that non-EEA visitors should continue to be liable for the full costs of their NHS healthcare? How should these costs be calculated?

Response:

No comment.

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?

Response:

No. This group includes a significant proportion of people who are extremely vulnerable and who fall under the remit of the Refugee Council.

In recent years a high number of our destitute clients have been from countries like Democratic Republic of Congo, Eritrea, Somalia, Sudan and Zimbabwe,[5] countries where there are on-going human rights violations and instability. They are refused asylum seekers who are expected to return home voluntarily, either by arranging it themselves, or through the Assisted Voluntary Returns programme. Many feel they cannot return because they fear they will be in danger if they return, they have been wrongly refused protection by the UK government or they have been unable to access good quality legal advice from the outset.

The Refugee Council and other organisations working on behalf of asylum seekers have consistently **raised the issue of the variable quality of Home Office decision making on asylum applications and it has been well documented**.[6] Recent research by UNHCR found that the current procedures do not provide sufficient safeguards to ensure that dependant family members are able to present their protection needs[7] and a report by Asylum Aid detailed the particular problems with decision making on women's claims.[8] There are also serious concerns about the National Referral Mechanism for potential victims of trafficking which has been described as 'flawed' and 'possibly discriminatory', and operated by 'minimally-trained' Home Office staff who 'put more emphasis on the immigration status of the presumed trafficked persons, rather than the alleged crime against them'.[9] A coalition of organisations including Anti-Slavery

[5] Refugee Council, 2012, *Between a rock and a hard place: The dilemma facing refused asylum seekers*, available at http://www.refugeecouncil.org.uk/policy_research/research

[6] Amnesty International & Still Human Still Here, 2013, *A question of credibility: Why so many initial asylum decisions are overturned on appeal in the UK*, available at http://www.amnesty.org.uk/news_details.asp?NewsID=20736

[7] UNHCR, 2013, *Untold stories… families in the asylum process*, available at http://www.unhcr.org.uk/news-and-views/news-list/news-detail/article/unhcr-calls-for-a-more-family-friendly-asylum-process.html

[8] Asylum Aid, 2011, *Unsustainable: The quality of initial decision-making in women's asylum claims*, available at http://www.asylumaid.org.uk/pages/unsustainable.html

[9] Anti-Trafficking Monitoring Group, 2010, *Wrong kind of victim? One year on: an analysis of UK measures to protect trafficked persons*. Available at http://www.amnesty.org.uk/uploads/documents/doc_20461.pdf

International, Amnesty International UK and ECPAT UK has described the system for identifying those who have been trafficked as 'unfit for purpose'.[10]

Moreover, asylum seekers and victims of trafficking may not have been able to present their stories due to trauma symptoms or because of feelings of guilt and shame. One effect of Post Traumatic Stress Disorder (PTSD) is repressed memories or forgetting which adversely reflects on credibility and people are wrongly refused.

Case study: Jade, aged 43, was trafficked to the UK from Uganda in 2002 for the purpose of domestic servitude. She was kept locked in the house and was not allowed to leave, slept in the living room and was given left overs to eat. After 6 months she managed to get help from a woman who supported her escape.

After her escape she applied for asylum however her trafficking background was never formally recognised and she was not referred to the appropriate support provider. In May 2013, approximately a decade later, Jade was referred to us for therapeutic support. With the help of a specialist caseworker, she was able to disclose her experiences and the caseworker identified her as a victim of trafficking. We referred her to the appropriate organisation to make a referral to the National Referral Mechanism.

Without therapeutic specialist support, Jade may not have been able to disclose that she had been trafficked. Jade has had significant health problems since arriving in the UK. She has been diagnosed with and recovered from breast cancer and she is also diabetic.

While the UK's criminal courts have recognised that the trauma of rape can cause feelings of shame and guilt which might inhibit a woman from going to the police, an asylum seeker is obliged to immediately tell a stranger, in the form of a Home Office official, of any sexual violence that might form the basis of her asylum claim. If she does not, she risks her credibility being questioned at a later stage and being refused. Nor are women always able to access female interviewers and interpreters.

The high number of initial negative asylum decisions that were overturned by the courts on appeal, give an indication of the on-going problems with Home Office decision-making. Others will have been correctly refused asylum under the very limited definition of the 1951 UN Refugee Convention, but will still face risk of persecution, torture or death if they return. Some may be persecuted simply for having left the country and claimed asylum elsewhere.[11]

It is clear that **charging this group seriously conflicts with the overarching principle of ensuring that "the needs and interests of vulnerable or disadvantaged patients are protected"**. Furthermore, it is not financially viable to do so as this group are generally unable to pay. The inability to pay or fear of enormous debts prevents many refused asylum seekers from getting medical treatment until their condition becomes critical and medical care is provided by the NHS on an emergency basis. Costs for such treatment – usually much more expensive than treatment would have

[10] Ibid.
[11] Refugee Council, 2012, *Between a rock and a hard place: The dilemma facing refused asylum seekers*, available at http://www.refugeecouncil.org.uk/policy_research/research

been at an earlier stage – are still formally levied against the patient, despite their inability to pay.

We particularly want to highlight the impact of charging for maternity care. While maternity care is considered 'immediately necessary treatment' and therefore cannot be refused for any reason, **it is extremely distressing for women to receive bills that they cannot pay and may deter them from accessing care for the remainder of their pregnancy** – increasing the risks to mother and baby. One woman we supported showed us a 'final demand for payment' letter dated 31 May 2013 – her due date was 6 June 2013. She was extremely distressed until we contacted the NHS Trust that had written to her to advocate on her behalf, explaining that, as an asylum seeker waiting for a decision on her claim, she had been wrongly charged. Chasing payment from individuals that are destitute (as well as individuals who are in fact entitled to free care) can only result in further expense for the NHS through administrative costs and charges from debt-recovery agencies.

The Refugee Council believes that all asylum seekers and refused asylum seekers should receive free healthcare on the basis of need until they receive permission to remain in the UK, or return to their country of origin. **Charging refused asylum seekers for secondary NHS healthcare is unethical, uneconomical and impractical**. In its report on the treatment of asylum seekers, the Joint Committee on Human Rights found that "No evidence has been provided to us to justify the charging policy, whether on the grounds of costs saving or of encouraging refused asylum seekers to leave the UK. We recommend that free primary and secondary healthcare be provided for all those who have made a claim for asylum or under the ECHR whilst they are in the UK, in order to comply with the laws of common humanity and the UK's international human rights obligations, and to protect the health of the nation."[12]

Please see our detailed response to question 14 for further reasons why we believe that it is imperative that refused asylum seekers are exempt from charging for both primary and secondary healthcare.

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

Response:

We welcome the exemption of those seeking asylum, temporary protection or humanitarian protection, refugees, children in Local Authority care, victims and suspected victims of trafficking, and refused asylum seekers receiving section 4 or section 95 support.

We would like further information on how individuals will evidence their eligibility. Given the difficulties that Refugee Council clients currently experience in accessing the NHS (see answer to question 2) despite their entitlement, **we fear that making them exempt**

[12] Joint Committee on Human Rights, 2007, *The treatment of asylum seekers* [Tenth report], available at http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/jtrights.htm

will not be sufficient to ensure their access.

Furthermore, given the complexities of the asylum and immigration systems, it is difficult to see how these exemptions can be effectively implemented without placing "undue burdens on staff" (one of the overarching principles of these proposed changes). For example, the documentation that asylum seekers and newly qualified refugees have available to them varies. Not all asylum seekers have an ARC (Asylum Registration Card) and not all refugees have a Biometric Residence Permit. All staff involved in decisions around eligibility would need to be familiar with the different immigration documentation that someone might present with in addition to understanding the different forms of leave and immigration status cited above.

Further exemptions required

Temporary protection, humanitarian protection, UASC leave and discretionary leave

We agree with the current exemptions listed, but further exemptions are required for those asylum seekers granted Humanitarian Protection (HP), Discretionary Leave to Remain (DLR) and UASC leave. HP, DLR and UASC leave provide temporary protection, which may well become permanent protection, to people who have not proved that they are individually being targeted for persecution, but where the Government has found that they would be at serious risk of harm if returned to their own countries due to conflict and widespread human rights violations, or that there are other exceptional and compassionate reasons for allowing them to stay in the UK. The vast majority of these people will be unable to pay for their healthcare if they are charged.

Refused ('failed') asylum seekers

While we welcome the exemption of refused asylum seekers receiving section 95 and section 4, **we cannot support any system that links entitlement to the NHS to the asylum support system which is complex, inefficient and often unfair.**

In the experience of our front line services, many refused asylum seekers are wrongly denied asylum support, due to the demanding level of evidence applicants are required to produce in support of their applications. The unfairness of these decisions is evidenced by the large number of applicants who are denied support by the Home Office but subsequently have their claims approved on appeal at the Asylum Support Tribunal. The Asylum Support Appeals Project's biennial analysis of Home Office decision making found that of the files surveyed, 80% were overturned by the Asylum Support Tribunal.[13] ASAP also found an unusually high number of women amongst the files surveyed: Most women were either pregnant or single parents.[14]

Completing the asylum support appeals process creates further delays and leaves applicants ineligible for medical treatment in the interim. Moreover, not all applicants will

[13] Asylum Support Appeals Project (ASAP), 2013, *UKBA Decision-making Audit: One year on – still 'no credibility'*, http://www.asaproject.org/research-publications/asap-reports/
[14] Asylum Support Appeals Project (ASAP), 2011, *No credibility: UKBA decision-making and section 4 support*, http://www.asaproject.org/research-publications/asap-reports/, p.3

be able or aware of their right to appeal a negative decision. Further research by ASAP has identified that women experience a number of key barriers to asylum support appeals. These include health: More than three-quarters (17) of the appellants had mental or physical health problems covering a wide range of ailments, including HIV, renal failure, post-traumatic stress disorder, depression, high blood pressure, vitamin deficiency and back pain. Fourteen women said health problems made it more difficult to appeal.[15] Under the new proposals, until these women begin receiving section 4 support, they would be unable to access free primary healthcare. Other barriers included childcare responsibilities and pregnancy: Eight women had dependent children in the UK – mostly young children under the age of 5 – and all were lone parents.[16]

In the Refugee Council's experience, there are significant delays in processing applications for section 4 support. It is not uncommon for these delays to exceed several months. Some groups are more likely to experience delays in the decision-making on their asylum application: An analysis of 42 pregnant women helped by the Refugee Council to apply for section 4 support revealed that single pregnant women are more likely to face delays in receiving support. This is because the majority will be required to submit information about the paternity of the baby. This administrative hurdle creates further delays: Those single pregnant women that were sent a paternity questionnaire had to wait on average 57 days before receiving support.[17] It will be difficult if not impossible for refused asylum seekers waiting for asylum support to demonstrate to medical staff that they are eligible for treatment.

Case study: Nicole applied for section 4 support at the beginning of January 2012 but it was not until June that her application was accepted. During these five months, she and her two children aged 6 and 3 were sleeping on the floor of a mosque and surviving on hand-outs from people attending the mosque.

Under the new proposals, during the time she was waiting for a decision, Nicole and her children would not be entitled to free primary care. She was eventually granted section 4 support but this would not have helped her if, during her five month wait, she or one of her children had needed medical help.

Furthermore, in some cases, healthcare professionals themselves have a role in helping destitute refused asylum seekers who cannot return to their home country (and who are therefore effectively trapped in the UK) access accommodation and support in the UK. Section 4 of the Immigration and Asylum Act 1999 allows for the provision of support to refused asylum seekers who are destitute if they meet a narrow set of criteria. One of these criteria is that they are unable to leave the UK on account of a physical impediment to travel or some other medical reason.[18] The burden of proof is on the applicant, to show that they meet the section 4 criteria on the balance of probabilities. In

[15] Asylum Support Appeals Project (ASAP), 2011*, Barriers to support appeals for asylum seeking women*, http://www.asaproject.org/research-publications/asap-reports/ p.5
[16] ibid.
[17] Refugee Council, 2012, *The Refugee Council submission to the parliamentary inquiry into asylum support for children and young people*, available at http://www.refugeecouncil.org.uk/policy_research/policy_work/briefings
[18] See http://www.ukba.homeoffice.gov.uk/asylum/support/apply/section4/ for further information

order for someone to apply for section 4 on the basis of having a medical impediment to travel they must submit a Section 4 Medical Declaration Form[19] completed by a GP or NHS consultant and / or a recent letter on headed notepaper from the most relevant medical practitioner. We fear that these proposals will make it more difficult for a refused asylum seeker entitled to section 4 support to provide the evidence they need to prove their entitlement.

Applicants for section 4 support must also prove that they are destitute or likely to be destitute within the next 14 days. If they have been staying with friends or family, they will be asked to provide a letter from their friend / family member detailing why they can no longer support them. In the case of women seeking to escape a violent partner or abusive situation, Refugee Council client advisers report that an application for section 4 support will be routinely refused unless evidence of the violence is submitted with the application – evidence such as a letter from a GP or police report. It is highly unlikely that a woman with insecure immigration status will go to the police to report the abuse she is experiencing and under these proposals, women will face additional barriers in accessing their GP.

We are keen to underline **the potential unintended consequences of these proposals**: Charging refused asylum seekers for access to the NHS may prevent individuals who are living street homeless, sofa surfing or in other vulnerable situations from accessing the accommodation and subsistence they are entitled to. It may also trap women in violent relationships or exploitative situations as section 4 support is often the only escape route available to this group who have no recourse to public funds.

For these reasons (in addition to those cited in response to question 13), we strongly believe that all refused asylum seekers should be exempt from charges.

Pregnant women and children

The Refugee Council believes that *all* maternity services and *all* children should have free access to NHS care and therefore should be exempt.

As illustrated above, refused asylum seekers who are not receiving section 4 or section 95 asylum support include families with babies and young children, who are also denied free healthcare under the current and proposed regulations. As noted above, this may be a result of poor decision making on both the substantive asylum application and asylum support applications and women (and their children) may face key barriers in accessing the asylum support appeals process. Under the new proposals, women and children in these circumstances would remain indefinitely unable to access free essential care. Inadequate healthcare at a young age may have life-long consequences. Exempting children would be consistent with the UK's obligations under the UN Convention on the Rights of the Child.

Pregnant women seeking asylum (including those who have been refused asylum) have extremely poor maternal health outcomes. The most recent report by the Centre for Maternal and Child Enquiries (CMACE) showed that black and Asian women were up to

[19] Available at http://www.ukba.homeoffice.gov.uk/asylum/support/apply/section4/

2.4 times more likely to have a stillbirth or a neonatal death than white mothers, while the Royal College of Obstetricians and Gynaecologists noted that pregnant asylum seeking women are seven times more likely to develop complications during childbirth and three times more likely to die than the general population.[20] In response to an earlier CEMACH report, in evidence to the House of Commons Health Committee, the Department of Health acknowledged that "pregnant asylum applicants may be in a particularly vulnerable condition."[21]

The National Institute for Health and Clinical Excellence (NICE) Guidance and other policy documents draw attention to the need for special efforts and service provision for disadvantaged and vulnerable pregnant women in order to reduce levels of maternal and infant mortality. Proposals for strategies to achieve this have consistently emphasised **identifying and reaching disadvantaged women early** in order to facilitate early booking, continuity of midwifery care, inter-agency collaboration and provision of language services.[22] The introduction of charging for primary care risks undermining these strategies as GPs are by far the most common referral route to maternity services. As described above (Q2) it also risks increasing the confusion amongst health professionals, and women who are exempt from charges such as asylum seekers or victims of trafficking may also find it more difficult to access maternity care due to problems registering with a GP.

Case study: Taiwo, a refused asylum seeker from Nigeria, who was pregnant and had left her partner due to domestic abuse, attempted to register with three GPs in Leeds but was refused each time because she did not have a passport or fixed address. She persevered and on her fourth attempt successfully managed to register with a GP. Due to the difficulties she experienced in registering with a GP, it was not until she was eight months pregnant that she managed to see a midwife.

A very vulnerable woman with clear complex social factors who was likely to have a high risk pregnancy was almost at full term before receiving antenatal care.

What services should we charge for?

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?

Response:

We support the right of any person to register for free GP services (see Q16 for details).

[20] Centre for Maternal and Child Enquiries (CMACE), 2011, *Perinatal Mortality 2009: United Kingdom*, London CMACE

[21] House of Commons Health Committee, 2003*, Inequalities in Access to Maternity Services: Eighth Report of Session 2002–03*, available at http://www.parliament.the-stationery-office.co.uk/pa/cm200203/cmselect/cmhealth/696/696.pdf

[22] Maternity Action & Refugee Council, 2013, *When maternity doesn't matter: Dispersing pregnant women seeking asylum*, available at http://www.refugeecouncil.org.uk/policy_research/research

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)

Response:

No. We are very concerned about the implications of this proposal. This will leave extremely vulnerable individuals unable to access free NHS care. As discussed above, we strongly advocate for refused asylum seekers to be exempt from charges. However, this alone would not be sufficient to ensure that all individuals with protection needs in the UK have access to healthcare. Perhaps the most vulnerable are those at the beginning of the process, those that are yet to be identified, or to self-identify, as in need of protection or support. There are any number of reasons why someone may not claim asylum upon arrival, not least because they may not understand the system or their rights.

Case study: Katrine, a 37 year old woman from east Africa, fled to the UK after being raped and to avoid FGM and a forced marriage. She was brought here by her boyfriend on a false passport and lived with him in London for over three years. He became abusive when she tried to legalise her status as his partner – he had kept her a virtual prisoner ostensibly to avoid her lack of valid immigration documents becoming known. After she became pregnant, the abuse increased and when she refused to have an abortion he threw her out.

Katrine went on to claim asylum. Under the new proposals when Katrine was at her most vulnerable, imprisoned by her partner and unaware of her rights during a 3-year period, she would have faced additional barriers in accessing healthcare.

Most worryingly, victims of trafficking may not immediately understand that they can seek protection if they manage to escape their traffickers. In such circumstance, the exemption of "victims (or suspected victims) of trafficking" will not help them. Still worse, there is no provision for victims trying to access essential care who are still under the control of their traffickers.

Please see our response to questions 13 and 14 for our concerns for refused asylum seekers. There is no evidence that refused asylum seekers are "health tourists" seeking to take advantage of free medical treatment in the UK, so restricting entitlement to healthcare does not affect the number of asylum applications made each year. A study published in January 2010 found that less than a third of asylum seekers and refugees interviewed had specifically chosen the UK as their destination for claiming asylum, and in many cases asylum seekers did not know they were going to the UK until they arrived as their travel was arranged by someone else. Around 75 per cent of those interviewed had no prior knowledge of the UK asylum or welfare system, including the health system.[23]

[23] Crawley, H., 2010, *Chance or choice? Understanding why asylum seekers come to the UK*, available at http://www.refugeecouncil.org.uk/policy_research/research

There is no evidence that restricting access to healthcare encourages refused asylum seekers to leave the UK. A comprehensive survey conducted in 2009 found that 31 per cent of refused asylum seekers had remained in the UK, destitute, for over two years.[24] Seventy-eight per cent of refused asylum seekers who had been destitute in the UK for over six months came from Afghanistan, China, Congo-Brazzaville, Democratic Republic of Congo, Eritrea, Iran, Iraq, Somalia, Sudan and Zimbabwe. Lack of access to healthcare is unlikely to motivate these individuals to return home to countries suffering active conflict or widespread human rights violations.

Lack of access to healthcare may actually prevent refused asylum seekers from leaving the UK as they are too unwell to focus on decisions, make arrangements for travel, attend appointments, etc. Furthermore, lack of medical treatment may cause the individual's health to deteriorate to such an extent that they are no longer able to travel.

Charging refused asylum seekers for secondary NHS healthcare is unethical, uneconomical and impractical – **to charge them for primary services is still more so**. Those responsible for providing primary healthcare will not be experienced in reviewing an individual's immigration status, which is undeniably complex and often requires a comprehensive understanding of immigration legislation, making it extremely likely that some people will be wrongly refused healthcare. It will further undermine the efficient, cost effective and safe delivery of healthcare and place an undue burden on staff as well as increasing health inequalities.

In particular, it is likely to discourage vulnerable groups from accessing primary healthcare, because they are concerned about their immigration status or because they cannot afford to pay for a consultation. Creating obstacles to primary health care fundamentally undermines the objective of providing an efficient and effective healthcare system. The consultation document itself recognises that:

"Immediate access and ongoing doctor/patient relationships provide for effective management of chronic and other existing conditions and prompt diagnosis and treatment of new health problems. This provides obvious health benefits for the patient, potential cost savings for the NHS, and supports population centred public health protection, including preventing the spread of disease." (para. 4.13)

The Department of Health already found in 2012 that "there is some evidence of higher and sometimes inappropriate use of A&E by short term visitors and others who may experience barriers to registering with a GP."[25] As charging is extended, more patients will be deterred or prevented from seeking timely treatment, risking their long term health and significantly increasing the costs of treatment to the NHS (see also Q2). Furthermore, the costs of immediately necessary treatment through A&E, which cannot be denied, are likely to increase dramatically as individuals are unable to access free primary healthcare where preventive or early treatment is much more cost effective. For example, GP consultations on average cost £20 compared with £110 for an average A&E attendance.[26] Forcing people to use A&E as their first point of access to health

[24] Asylum Support Partnership, 2009, *The Second Destitution Tally: An indication of the extent of destitution among asylum seekers, refused asylum seekers, and refugees*, p.17
[25] Department of Health, 2012, *Review of overseas visitors charging policy*, Summary report, para.28
[26] Yates, T.; Crane, J; Rushby, M., 2007, "Charging vulnerable migrants for healthcare", *Student British Medical Journal*; 15:427-470

care, not only vastly increases the costs to the system, but threatens the efficiency and effectiveness of A&E care for the general population.

Question 17: Do you have any comments or ideas on whether, and if so how, the principle of fair contribution can best be extended to the provision of prescribing, ophthalmic or dental services to visitors and other migrants?

Response:

For the reasons cited above, we do not believe that charging should be extended to these services.

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

Response:

No. Charging for emergency treatment is unethical and would seriously undermine the principle that "no person should be denied timely treatment necessary to prevent risks to their life or permanent health." It would be impossible to implement as it would be extremely difficult to obtain detailed information on a patient's immigration status during an emergency or when they are acutely ill, even if NHS staff had the specialist knowledge required and the patient spoke adequate English.

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

Response:

We do not believe that charging can be introduced without having an adverse impact on patient flow and staff. Staff are unlikely to have the level of immigration expertise required to correctly assess entitlement and this may lead to people being wrongly charged or discriminated against as staff seek to make quick decisions because of time and resource pressures.

Question 20: Do you agree we should extend charges to include care outside hospitals and hospital care provided by non-NHS providers?

Response:

No comment.

Question 21: How can charging be applied for treatment provided by all other healthcare providers without expensive administration burden?
Response: No comment.

Making the system work in the NHS

Question 22: How else could current hospital processes be improved in advance of more significant rules changes and structural redesign?
Response: No comment.

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?
Response: As outlined above, we do not believe the current proposals are consistent with the overarching principles and we are particularly concerned that they will **increase health inequalities** by creating additional barriers to essential care for some of the most vulnerable in the UK. Neither do we think the proposals will be efficient or cost-effective as they are extremely likely to place undue burdens on staff thereby compromising the safe delivery of quality healthcare.

Question 24: Where should initial NHS registration be located and how should it operate?
Response: No comment.

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?
Response: We believe that the challenges involved in introducing charges for primary care services

make the proposals unworkable – see in particular our answers to Qs 2, 13, 14 and 16.

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?

Response:

No. We are very concerned that that protection principles will be contravened and sensitive personal data will not be protected.

Recovering Healthcare Costs from the European Economic Area (EEA)

Question 27: Do you agree that we should stop issuing S1 forms to early retirees and stop refunding co-payments and if not, why?

Response:

No comment