

African Health Policy Network

Policy briefing

14 March 2014

Migrant access to the NHS: the health impact of the Immigration Bill and changes to NHS charging policies

This policy briefing addresses the changes planned to migrant access to NHS services, as proposed in the Department of Health's consultation documents 'Sustaining services, ensuring fairness' and subsequent implementation plans. These changes raise a number of concerns for Africans in the UK, as well as posing far reaching implications for all NHS users. The African Health Policy Network (AHPN) has prepared this briefing to highlight the key issues raised by these changes.

AHPN is a national policy organisation committed to improving the health and wellbeing of African people in the UK through policy, research, campaigns and community engagement. We work to reduce health inequalities, improve prevention of ill-health and to improve patient experience for African people in the UK.

The key issues raised by these changes are:

- The new 'integrated IT system' capable of linking patient data to immigration status and national insurance will be a large-scale and costly project that is very difficult to implement.
- There is a lack of evidence regarding 'health tourism' and unconvincing data on i) how much migrants currently cost the NHS and ii) how much will be saved by the changes.
- There will be an added burden placed on NHS staff, and potential issues in determining what constitutes 'immediately necessary care', with particular implications for patients using mental health services and with long-term conditions.
- Redefining the eligibility criteria of 'ordinary resident' to mean indefinite leave to remain unfairly targets many long term migrants who work, study and pay taxes which contribute to the running of NHS services as well as other public services.
- The changes will make it more difficult for everyone to access the NHS and place a particular barrier to access to healthcare for vulnerable migrant groups.
- There are significant public health risks caused by creating barriers to primary health care.

Background

The Department of Health's proposed changes to migrant access to the NHS were outlined in July 2013 in the consultation 'Sustaining services, ensuring fairness.' AHPN responded to the consultation and raised a number of concerns about the proposed measures.¹ The Department of Health response to the consultation and detailed implementation plans were published in December last year. The changes will be introduced in phases. Currently, the government is looking into improving the current system of cost recovery from chargeable patients. Then in April, it will begin testing the new registration system before implementing the health levy and extended charging from November 2014 onwards. Full implementation is expected to begin from April 2015. More details on the timings of implementation will be published in March this year.

Some of the changes are also linked to the Immigration Bill, which is currently being considered in the House of Lords and involves much wider measures that will impact migrants living in the UK.

What's changing?

NHS services have previously been free of charge to anyone considered an 'ordinary resident', but the government now feels that the NHS is 'overly generous to those who have only a temporary relationship with the UK'.² Under clause 34 of the Immigration Bill, 'ordinary residency' will be redefined to mean permanent residency, or indefinite leave to remain, meaning anyone subject to immigration controls will now be chargeable.

A new health levy will be introduced under clause 33 of the Immigration Bill to any non-EEA (European Economic Area) migrants subject to immigration controls. The charge is currently proposed at £150 for students and £200 for other migrants and will be payable at the point of visa application. Further, changes will be introduced that will impact expatriates and former UK citizens, who will be required to provide evidence of National Insurance (NI) contributions of at least 7 years to receive free healthcare.

Under the changes, there will be an extension to which NHS services are chargeable. Currently, some short-term visitors are charged for using secondary services (hospital care), but primary care (GP services), are free to all. Under the changes, initial consultations by a nurse or GP will remain free for all, but everything else: follow up GP appointments, community care, dental, pharmacy and optical care will be subject to charges to anyone without indefinite leave to remain. Accident and Emergency (A&E) will also be subject to charges for the first time. It is unclear as yet how much patients will be charged, but it is likely that anyone not covered by the levy will have to pay the full cost of treatment.

Some provision of care will remain exempt from charges, such as treatment for infectious diseases, as well as all care for specific groups such as asylum seekers, refugees and victims of trafficking. The government will continue to apply EU legislation which governs health care provision to recover costs for treating EEA migrants from their home countries. As such, health services will remain free for EEA migrants at the point of access.

The changes will involve creating a new 'integrated IT system' of NHS registration to gather information on an individuals' residency and immigration status. This will mean creating a legal gateway for the Home Office to share residency information with the NHS. Before accessing services, all NHS users will have to register with the system.

AHPN strongly opposes the proposed changes, which will have far-reaching implications for the NHS as a whole, as well as particularly negative impacts on migrants and other affected groups.

Financial and administrative burden

Implementation of the changes will involve a significant financial and administrative burden, and may be unworkable in practice by adding an additional administrative burden to an already over-stretched health system. The new, 'more rigorous' registration system will involve linking NHS and Home Office systems and sharing data. This will be of concern to many, that such large scale data sharing will affect

Timeline of events

- From November 2013: Phase 1: focus on reviewing the current system of charging.
- March 2014: Committee stage of Immigration Bill in the House of Lords.
- March 2014: Publication of revised guidance to the NHS and full implementation plan.
- From April 2014: Phase 2: Testing and eventual introduction of new registration system.
- 2014/2015: Phase 3: Introduction of health levy.
- From April 2015: extension of charging to A&E and primary care.

confidentiality and data protection, as well as patient trust. The new 'integrated IT system' would involve a major and costly reform to NHS administration. Immigration status changes regularly for individuals and so the new system would need to be capable of keeping up to date with this. In order to establish expatriate access to services, the system will also have to link to national insurance data. Integrating all of this would be a major project. The challenges involved in major NHS IT projects were amply demonstrated by the 'National Programme for IT in the NHS' (NPfIT), eventually cancelled after failing in 2011 and now estimated to have cost the taxpayer £10billion.³ Furthermore, the problems with the Universal Credit System rollout highlights that implementing the new IT system by April next year may be unrealistic.⁴

The proposals intend to link the new registration system with patient NHS numbers. There are several issues with this. Firstly, not all patients currently know or can prove their NHS number, and this number is not associated with photo identification. Concerns were acknowledged in the consultation response over creating an 'NHS card' to identify patient chargeability, as this would impact the resident population. However, the government has not yet made it clear how identification will work in practice. Immigration checking will certainly affect all NHS users and the additional administrative burden placed upon GP services and A&E to check everyone's residency status will affect already overstretched and understaffed services. As the Department of Health noted itself in its 2012 review: **"although there may be good policy reasons, and potentially significant income opportunities in extending the scope of charging, the NHS is not currently set up structurally, operationally or culturally to identifying a small subset of patients and charging them for their NHS treatment."**⁵

A closer look at the figures

Health Secretary Jeremy Hunt's widely cited figure that migrants cost the NHS £1.9-2 billion a year can paint a misleading picture of the financial burden migrants place on UK health services.⁶ As stated in an external assessment of the data in October 2013, the estimate is only "50% likely to be in the range of £1.53 billion to £1.94 billion", hardly concrete evidence on which to base reform.⁷ The Department of Health commissioned both qualitative and quantitative research studies into migrant use of the NHS, published in October 2013. Both reports of the research state that there has been no properly collected data on migrant use of the NHS. Overseas visitors and migrants (both EEA and non-EEA) account for 4.5% of the population served by the NHS and only around 2% of total NHS expenditure.⁸ As the report admits, most of the £2billion figure is covered by those who are here to 'work or study,' and so already contribute financially to health services. Of the estimated figure, approximately £328m is potentially recoverable and the proposed changes would mean only an additional £94m in potentially chargeable income.⁹ Given that the NHS had a budget of £95.6 billion in 2013/14, the migrant 'problem' can actually be seen as a drop in the ocean.¹⁰ On the other hand, migrants have been estimated to contribute £16.3 billion to the UK economy a year (1.02% of GDP), according to the OECD.¹¹ The figures on 'health tourism' misrepresent the true impact on the NHS and fail to represent a fair picture of the economic value of migration in the UK.

Despite aiming to improve fairness to those who contribute to the NHS through taxes, the changes will impact many long term migrants who already pay tax and contribute to services just as British residents do. Furthermore, as Lord Dholakia stated in the House of Lords reading of the Immigration Bill, the NHS is reliant on migrant workers, constituting 1 in 4 doctors in the UK.¹² As the British Medical Association has warned, charging migrant doctors a health levy might "deter them from seeking employment in the UK which would have a negative impact on patient care", particularly affecting A&E staffing.¹³

There has been a huge amount of media coverage on the issue of 'health tourism,' referring to those who come to the UK for the expressed purpose of receiving free NHS treatment, but there is far from concrete evidence of the practice. For example, the Department of Health's diary exercise report, based on collected data from the Overseas Visitors Advisory Group members, found that only 4 of 997 patients sampled in 15 Trusts fitted the 'fly in and fly out' category. In addition, this figure was based on a highly limited survey of only 9% of NHS trusts, and those in regions 'with a relatively high inflow of

international migrants.’ The report then attempted to identify ‘health tourists’ by considering data from one trust on how soon patients accessed services after arriving in the UK. This evidence does not take into account motives for accessing services, nor is it sufficient; only 156 patients were included in the study.¹⁴ Many of the government’s claims are therefore based on occasional examples and anecdotal evidence. With ‘health tourism’ a largely subjective category to establish, the measures proposed are based largely on suspicion and subjectivity. As the data analysis states: **“the estimates for health tourism, as for any unlawful activity, are impossible to estimate with confidence.”**¹⁵

The actual groups of people who will be affected by these changes are far broader than that covered by the ‘health tourist’ label, which represents a very small number of those using NHS services. Yet the narrative of ‘health tourism’ is used as the political justification for these far-reaching changes.

Impact of the proposed changes

Migrants, including many African people, already face major problems accessing health services in the UK, even when they are entitled to use them without charge. A Doctors of the World report found that 73% of the 1449 migrant patients surveyed in London in 2012 were eligible for free health care but were not registered with a GP. Over 50% lacked an understanding of how the system worked and 40% had trouble obtaining the correct documentation they needed to access services.¹⁶ In addition, despite entitlement to free services, a study in Brixton found that 54% of asylum seekers were turned away from GP services more than once.¹⁷ This is indicative of the huge barriers migrants already face. With added immigration checks, a hostile healthcare environment will be created, adding further barriers to vulnerable communities. The extended charging rules will act as a deterrent for vulnerable people seeking healthcare and will likely increase the burden at the acute end of health services.

In addition, any individual without a permanent address or who does not have official photo ID, whether they are a British national or not, will face challenges identifying themselves and accessing services. This is likely to impact people from groups such as undocumented migrants, destitute and homeless people, and may lead to their outright exclusion from services. The proposed measures will worsen the health of already marginalised sections of the population, when the Government should instead be focussing on measures to reduce health inequalities.

The changes will impact many migrants, who may have resided in the UK for a number of years and who pay taxes that contribute to the NHS. In order to be exempt from the charges under the new definition of ‘ordinary residency’, these individuals will have to apply for indefinite leave to remain in the UK (ILR). IRL status requires individuals to have been a resident in the UK, for anything from 2 up to 14 years; based on the type of visa they have been issued. The process is complicated and time-consuming, and involves a language and ‘Life in the UK’ test. If an individual then spends more than 2 years outside the UK, they also can then lose their ILR status.

Key Messages

- The changes are likely to be expensive and complicated to implement. They will create administrative burdens on overstretched services and intrusive identification checks for all NHS users.
- There is a fundamental lack of evidence to justify reform or indicate the benefits that it will bring.
- African and other non-EEA migrants contribute financially to health services already and the changes unfairly target many people who work, study and pay taxes.
- The changes will exacerbate health inequalities and endanger both individual and public health.
- The changes are likely to cause discrimination of non-white patients and create a hostile healthcare environment.
- We must preserve a fair and effective NHS, with access based on need, not the ability to pay.

- **Discrimination**

The administrative measures that the changes would introduce mean that NHS users must prove their eligibility upon registering for services and reconfirm it during subsequent visits. To ensure this is a non-discriminatory practice, staff should ensure that they check every individual. However, the added administrative pressures may well cause staff to cut corners, potentially leading to racial 'profiling'. Although the measures are not explicitly discriminatory, there is a real danger that they could become so in practice. Antonio Guterres, the UN High Commissioner for refugees has stated that the UK's immigration reforms 'could contribute toward a climate of misunderstanding and ethnic profiling, which in the long term could prove detrimental to social cohesion.'¹⁸ There is real risk that the changes will create a discriminatory healthcare environment, impacting upon non-white patients.

- **HIV and other public health concerns**

Identifying and treating infectious diseases depends on patients easily accessing health services. Although treatments for communicable diseases such as HIV and TB will remain exempt from charges, there are various ways in which the proposed changes will impact public health. Although GP consultations will remain free, the changes are likely to deter migrant patients seeking services, knowing that they may be charged for any subsequent services and for certain treatments they might be recommended. Diagnoses of HIV are often the result of several visits to a doctor and the chance for patients to present multiple health issues. Further, migrants may not be aware that treatments for HIV or other diseases are exempt from charges and so might refrain from accessing care on this basis.

Free, universal primary healthcare is vital for the identification and prevention of infectious diseases in order to protect public health. With 21% of HIV cases undiagnosed, deterring someone with HIV from seeking medical advice increases the risk of the disease being passed on and therefore presents a wider threat to public health. In Greece it has been demonstrated that austerity measures can affect HIV transmission, where rates have increased 60% in just two years.¹⁹ Protecting public health must be prioritised over any potential financial incentive that charging for healthcare might involve.

As Africans in the UK account for 35% of new HIV diagnoses each year, the impact of the changes will fall heavily on these communities, impacting those most in need of HIV-related services.²⁰ There is also evidence that African people are less likely to get tested for HIV and are diagnosed with it later than the wider population.²¹ This will mean it will be even harder to identify and prevent HIV cases amongst those most likely to be affected. In addition, the rate of TB is 20 times higher in non-UK born populations than UK born, and Black Africans represent a high proportion (18%) of cases in the UK.²² The charges introduced will have a negative effect on public health.

- **Mental health**

The implementation plan published by the Department of Health indicates that charging for 'elective mental health services' beyond the hospital setting is under consideration. Mental health was not mentioned in the consultation and the Department of Health has not discussed how the changes will relate to mental health in any detail, despite the potentially huge implications.

Mental illness continues to be stigmatised, which makes it difficult for individuals to take steps to accessing medical help. Charging and obtrusive residency checks for individuals struggling with mental health problems may act as a deterrent to them seeking help and lead to an increased burden at the acute end of mental health services. In addition, the new charges for A&E services will mean that NHS staff will have to identify what is considered 'immediately necessary treatment' in emergency situations. How this will be determined for mental health cases is unclear.

Changes that restrict access to NHS services for mental health must consider the potential impact on people who already find it difficult to access help for mental health problems. This is especially the case for migrants, who are also more likely to suffer mental illness, particularly depression, after arrival to a new country.²³ For African people in particular, there is already evidence of barriers to access to support at earlier stages of mental illness and over-representation in acute services.²⁴ Any potential charging for

mental health services would impact the mental health of many people and further increase mental health inequalities. The government's 2011 mental health strategy 'No Health without Mental Health' addressed stigma and underlying inequalities as key priorities. Proposed charging for mental health services would undermine this acknowledgement of mental health inequalities in the UK and much of the work done so far to help African people address barriers to accessing mental health services.

- **Pregnant women**

Currently, while migrant women should not be denied care, those without 'ordinary residency' status are chargeable for using maternity services. Under the new system, maternity care will continue to be chargeable, but due to the redefining of 'ordinary residence' many more women will be affected. The Department of Health highlights 'maternal health tourism' as a particular concern: the practice of migrant women travelling to the UK with the specific intention of using NHS maternity services. There has also been a great deal of media coverage on this topic, with some prejudicial references to West African women who come to the UK to give birth, referred to as the 'Lagos Shuttle'.²⁵ However, as with general 'health tourism', evidence for this practice is far from substantial, the qualitative assessment report citing only occasional anecdotal examples.

Not exempting maternity care will have an adverse effect on pregnant women and new-born babies. These charges unfairly target migrant women, risking poor standards of maternity care, increasing chances of emergency cases and potentially leading to an increase in post and neonatal deaths. Maternity Action has found evidence that pregnant migrants are already avoiding antenatal care and risking their lives to avoid NHS maternity charges, for example by running away from antenatal units. Those who face charges are more likely to only seek help in emergency circumstances, risking the life and health of themselves and their babies.²⁶ As GPs are the most common referral route for such services, the additional charges for primary care will also risk worsening maternal health amongst migrants. Furthermore, the potential that charges will be extended to 'services for pre-existing pregnancies', even if patients have paid the levy, would be unworkable in practice and is likely to create discriminatory practice against migrant women.

- **Family planning services**

The implementation plan noted that there would be consideration of charging for some "family planning services (e.g. termination of pregnancy, IUDs and oral contraceptives)."²⁷ As with mental health, this was not initially mentioned in the consultation and will not be open to further public consultation.

These proposals would be devastating to the sexual and reproductive health of migrant women. Not only would charging for termination of pregnancy create a significant barrier for migrant women accessing abortions but it would also be likely to lead to an increase in unsafe abortion practices. Charging for contraception would be hugely detrimental to migrant women's freedom and control over their reproductive health. Such charging would place a financial burden on women and would likely lead to more unplanned pregnancies and more abortions. Furthermore, contraception has been shown to be 'critical' in helping women become more economically independent.²⁸ As such, these additional proposals present a very real threat to migrant women's health, as well as their reproductive rights.

- **Children**

The changes do not exempt children from charges to NHS services, because the Department of Health feels that doing so would be a 'draw' to illegal migrant families and families with ill children.²⁹ This will negatively impact on child health in migrant families in the UK and create a deterrent for families seeking vital healthcare for their children. These reforms are therefore likely to worsen the health and welfare of migrant children living in the UK. In addition, parents may be less likely to take their children to the GP for regular checks or immunisations, fearing charges, or they may not even be aware of the importance of vaccinations if they are not registered with a GP. As such, the further barrier to these groups accessing primary health care will also affect public health.

Policy Recommendations

AHPN recommends that the Department of Health review the changes proposed. Specifically we recommend:

- ❖ Not redefining ‘ordinary residency’ under the Immigration Bill, so that long term migrants living in the UK on a settled basis and contributing through taxation are not charged for their care.
- ❖ Expanding exemptions from charges, to include all mental health services, family planning services, maternity care, long term conditions and all services for children.
- ❖ Focussing on recovering costs under the current charging system, rather than creating new charges that will be a financial and administrative burden to implement.
- ❖ Ensuring that access to necessary treatment is available for all patients regardless of their residency or immigration status.

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Further Reading: Department of Health consultation documents can be found at

<https://www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs>

Disclaimer: please note this briefing is prepared for information purposes only, and does not necessarily constitute official AHPN policy

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