Sustaining services, ensuring fairness

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

Response from The Children's Society

Overarching principles

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

Our response is based on our extensive experience of working directly with approximately 1,500 migrant and refugee children and young people each year across England for over 15 years. Our response focuses on the proposals affecting migrant children and families already in the UK.

We oppose the proposals within this consultation in their entirety and have particular concerns about how these proposals, if implemented, would impact on children, young people and families who fall outside of the exempt groups.

Key messages

- We believe that all children, young people and families should be able to access free primary and secondary health care regardless of their immigration status.
- These proposals are a breach of the UN Convention on the Rights of the Child (UNCRC) which state that every child without discrimination has a right to the highest standard of health and medical care attainable.
- Irregular migrant children and young people should be recognised as a particularly vulnerable group, already at risk of destitution, exploitation and social exclusion, and their rights should not be breached for the purpose of immigration control.
- Charging for primary healthcare for parents and children will create a barrier to promoting the health and well-being of children and also presents a public health risk.
- Obstacles to accessing primary care can have knock on effects on emergency services in terms of increased attendance and could also reduce the use of preventative treatments such as immunisations. This will create increased costs for the NHS.
- The lack of free access to primary care services will affect the ability of healthcare professionals to identify factors which raise child protection concerns.
- If the proposals did go ahead, we believe the list of exemptions would need further consideration. This is particularly relating to children whose families have been refused asylum, care-leavers, potential victims of trafficking, children and families supported under Section 17 of the Children Act 1989 and children in private fostering arrangements.

We have addressed the specific principles in the consultation document in turn:

1) "A system that ensures access for all in need"

We strongly believe that immigration status should never be a barrier to good health for anyone and particularly for children given the government's obligations to promote every child's right to the enjoyment of the highest attainable standard of health (see details below). We believe that

this principle is undermined by the current proposals since access to health care would be restricted according to immigration status and contribution rather than need. The proposals do not take into account the government's obligations to address the health needs of all children or its obligations not to discriminate based on a child's nationality, ethnicity, social group or other status or their parents' status. This is outlined in Article 2 of the UNCRC[1] as well as in the Home Office guidance 'Every Child Matters'[2]. We also notice that this first principle only covers 'immediately necessary treatment' but should in our view at least include 'urgent treatment' as well[3].

2) "***A system where everybody makes a fair contribution to the NHS".***

We think that this principle is problematic and would argue that the NHS was born out of the notion that "*good healthcare should be available to all, regardless of wealth*"[4] Suggesting that everybody makes a fair contribution fails to take into account the particular circumstances and capacities of some members of society, such as children, who cannot be expected to make a contribution to the running of the NHS, whatever their nationality or immigration status.

3) **"*A system that is workable and efficient***"

We agree with this principle but in fact, we feel that the proposals outlined are in direct conflict with it (also see our answer to question 25). The proposals are unworkable and will place heavy burdens on the NHS. They also present contradictions with current guidelines and strategies relating to healthcare. They are also inefficient because they seek to discourage access to primary care and preventative services, the first point of call for most people seeking help or advice. This will inevitably lead to an increased burden on A&E and more expensive treatment if children, young people or parents develop serious illnesses which could have been prevented with early intervention or diagnosis via a GP or health clinic. An example of this is the need to vaccinate all children to provide herd immunity against a number of infectious diseases.

4) ***"A system that does not increase inequalities***"

Although we certainly agree with the need for a system that does not increase inequalities, we find this principle problematic and would argue that it is not sufficient to halt an increase, but that we should be trying to actively reduce health inequalities. The Marmot Report, Fair Society, Healthy Lives[5], stressed that "*tackling health inequalities was a matter of social justice, with real economic benefits and savings*". Yet research shows that child health inequalities are increasing. Over the last ten years, the difference between rich and poor children's health has grown almost seven times greater[6]. The Secretary of State for Education, NHS England and Clinical Commissioning Groups all have a legal duty, under the Health and Social Care Act

[1] This states that all rights apply to all children without exception. It is the State's obligation to protect children from any form of discrimination and to take positive action to promote their rights.
[2] Every Child Matters: Change for Children: Statutory guidance to the UK Border Agency on making arrangements to safeguard and promote the welfare of children, Home Office: http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/legislation/bci-act1/change-for-children.pdf?view=Binary
[3] 'Immediately necessary treatment' is needed to save a life, or to prevent a condition from becoming immediately life-threatening, or to prevent permanent serious damage from occurring. Urgent treatment would cover situations where treatment is not immediately necessary, but cannot wait until the patient returns home.
[4] NHS Choices. The Principles and Values of the NHS in England. http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx (accessed 20th July 2013).
[5] Marmot, M. Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010. Marmot Review. 2010. http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthy
[6] Growing up in the UK – Ensuring a healthy future for our children (2013) British Medical Association

2012, to reduce inequalities by improving the health outcomes of groups including the marginalised and vulnerable[7]. The system proposed is likely to further increase inequalities by charging the vulnerable, excluding them from certain treatments and by increasing barriers to accessing care.

<u>We would also propose that several other fundamental principles need to be taken into consideration.</u>

- ***A child's right to health:***
  The right of the child to receive the highest attainable standard of health is outlined in Article 24 of the UNCRC: "*States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services"*.

  In addition, General Comment No. 15 (2013) adopts a comprehensive approach to guide States Parties in understanding and implementing their obligations under article 24. It also reiterates that States Parties have an obligation under Article 2 to ensure that children's health is not undermined as a result of discrimination because of the child's, parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status[8].

- **Child first, migrant second[9]** - The importance of not allowing immigration status to take precedence over any child's well-being is summarised by the European Council: "*A child is first, foremost and only, a child. This is the starting point for any discussion about undocumented migrant children. The status of the child is secondary and arguably, irrelevant*."[10][11]

- **A system which promotes Public Health and does not negatively impact on it -** Public Health being defined as: "The *science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society*." [12]

- **A system where existing services standards and guidelines are not being undermined** - This includes NICE guidance, obligations under the Children Act 1989, Health and Social Care Act and Equalities legislation among others.

[7] Sections 1C, 13G, 14T of the NHS Act 2006 and 62(4) of the Health and Social Care Act 2012
[8] General comment No. 15 (2013) The right of the child to the enjoyment of the highest attainable standard of health (Article. 24) : http://www2.ohchr.org/english/bodies/crc/docs/GC/CRC-C-GC-15_en.doc
[9] Crawley, H. Child First, Migrant Second: Ensuring that Every Child Matters. Immigration Law Practitioners' Association, London, 2006 http://www.ilpa.org.uk/data/resources/13270/ilpa_child_first.pdf (accessed 23rd July 2013)
[10] Lengar, S and LeVoy, M. (2013) Children First and Foremost - A guide to realising the rights of children and families in an irregular migration situation. Platform for International Cooperation on Undocumented Migrants. http://picum.org/picum.org/uploads/publication/Children%20First%20and%20Foremost.pdf
[11] Council of Europe. (2011) Undocumented migrant children in an irregular situation: a real cause for concern. Council of Europe committee on migration, Refugees and Population, Doc. 12718, Strasbourg, 16 September 2011, page 5. http://www.refworld.org/docid/5138386f2.html
[12] UK Faculty of Public Health. What is public health? http://www.fph.org.uk/what_is_public_health

Question 2: Do you have any evidence of how our proposals may impact disproportionately on any of the protected characteristic groups[13]?

Response:

These proposals will impact disproportionately on migrants, which is the policy's stated purpose. In addition, we believe these proposals will impact disproportionately on several protected characteristic groups: age, race and gender.

Age:

From our direct practice experience of supporting young refugees and migrants, many of whom already have significant difficulties accessing vital services like healthcare, we are very concerned about the proposals to limit access to primary care for children falling within the non-exempt categories. Children have a range of age-specific health needs which are met by primary care and we would strongly recommend an exemption for all children up to 18 years of age, regardless of their immigration status or that of their parents or guardians. This is for a number of reasons:

- **International and national legal obligations**

The government has made a clear commitment to "*give due consideration to the UNCRC Articles when making new policy and legislation*".[14] However, the consultation documents do not demonstrate that such consideration has been given to the government's obligations to all children under international and domestic legislation. Under the UNCRC every child has a right to the enjoyment of the highest attainable standard of health (Article 24) regardless of their status (Article 2) and the government must ensure to the maximum extent possible the survival and development of the child (Article 6). More recently, in considering the rights of children within the context of international migration, the UN Committee urged governments to "*make clear in their legislation, policy, and practice that the principle of the child's best interests takes priority over migration and policy or other administrative considerations*"[15].

General Comment No. 15 on health[16] reiterates that States Parties have an obligation under Article 2 to ensure that children's health is not undermined as a result of discrimination including on the basis of the child's or parent's status. This point was specifically stressed in the Committee's General Comment No. 6[17] in relation to migrant children: *"The enjoyment of rights stipulated in the Convention are not limited to children who are citizens of a State Party and must therefore, if not explicitly stated otherwise in the Convention, also be available to all children – including asylum-seeking, refugee and migrant children – irrespective of their nationality, immigration status or statelessness."*

The NHS has a specific duty to safeguard and promote the welfare of children, as outlined in UK law in Section 11(4) of the Children Act 2004, carrying on from the duties first enshrined in the

[13] 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

[14] Written Ministerial Statement on 6 December 2010 - Publication of the independent review of the Children's Commissioner: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm101206/wmstext/101206m0001.htm

[15] UN Committee on the Rights of the Child (2012) Day of General Discussion on the rights of all children in the context of international migration: http://www2.ohchr.org/english/bodies/crc/discussion2012.htm

[16] General comment No. 15 (2013) The right of the child to the enjoyment of the highest attainable standard of health (Article. 24) http://www.crin.org/docs/CRC-C-GC-15_en-1.pdf

[17] Paragraph 12 General Comment No. 6 (2005) *Treatment of unaccompanied and separated children outside their country of origin* http://www2.ohchr.org/english/bodies/crc/docs/GC6.pdf : http://www2.ohchr.org/english/bodies/crc/docs/GC6.pdf

Children Act 1989. The Home Office is under the same duty by virtue of section 55 of the Borders, Citizenship and Immigration Act 2009 set out in the '*Every Child Matters'* guidance[18].

- **Age-specific health needs**

Children have age-specific health needs, and charging for primary care would create a barrier to promoting the health and well-being of children. Health protection is normally afforded to children, via surveillance, screening and immunisation in the primary care setting, in the form of the Healthy Child Programme[19]. Barriers to screening and surveillance can result in delays in diagnosis and cause a lack of intervention for other conditions. GPs are one of the key providers/facilitators of early intervention programmes and the evidence of the benefits of this are well documented[20] Any barriers to access to primary care, such as charging, impacts on child morbidity and well-being.

Case study: Baby Adeela[21] diagnosed with life-threatening genetic disorder

Five-month-old Adeela was screened for five serious conditions. Results of the screening showed that she had Maple Syrup Urine disease (MSUD), a genetic disorder which stops the body breaking down proteins. Adeela was rushed to hospital where they discovered she was close to death. The test identified high levels of the amino acid leucine in her blood, a condition which can lead to coma, brain damage and death if not treated. The symptoms of this disease are so broad it is difficult to detect and diagnose. Adeela and her mother had 24 hour access to the hospital and the doctor.

Adeela's mother is from Pakistan and had no recourse to public funds due to her immigration status. Adeela's father was a French national but had very little contact with her and did not help. Adeela and her mother were living above a shop in poor conditions. The hospital was unsure what could be done about this due to her immigration status but they were desperate to get her appropriate accommodation especially as she was being chased by the landlord due to rent arrears. The hospital referred her to The Children's Society. We helped her to access appropriate accommodation through social services, regular financial support and access to a legal aid solicitor.

IMPACT: Adeela was an undocumented child and without being registered with the NHS and receiving free screening and emergency treatment Adeela most likely would have died.

- **Public Health**

Charging for primary care would undermine the government's commitment to an effective childhood immunisation programme with an aim to reduce the incidence of childhood infections.[22] NICE recommends how to reduce differences in uptake and highlights several groups as being at particular risk of not being immunised including "*those from some minority*

[18] Every Child Matters: Change for Children: Statutory guidance to the UK Border Agency on making arrangements to safeguard and promote the welfare of children, Home Office: http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/legislation/bci-act1/change-for-children.pdf?view=Binary

[19] Department of Health (2013) *Healthy Child programme: pregnancy and the first five years of life*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf

[20] Allen G. Early Intervention (2011): *The Next Steps; an Independent Report to Her Majesty's Government by Graham Allen MP*: The Stationery Office: http://www.dwp.gov.uk/docs/early-intervention-next-steps.pdf

[21] Not real name

[22] This commitment is emphasised in the *Improving Children and Young People's Health Outcomes: a system wide response* (2013) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214928/9328-TSO-2900598-DH-SystemWideResponse.pdf and the *National Service Framework for Children, Young People and Maternity services* (2004)

ethnic groups, those from non-English speaking families, and vulnerable children, such as those whose families are travellers, asylum seekers or are homeless"[23]. Charging could have an impact on immunisation up-take within these groups. NICE has stressed that reduced immunisation up-take could also have an impact on herd immunity[24]. From a public health perspective, it is important that the proportion of people vaccinated reaches a certain percentage. For example, measles target vaccine coverage is over 95%.[25] In Northern Ireland there is a considerable lack of legal clarity about entitlement to primary care. In 2012-2013, 15 cases of measles affected a migrant community, many of whom had no access to a GP and therefore had not been vaccinated[26]. Several required hospital admittance for several days at significant cost to the NHS. Proposals to limit access to primary care for some children are detrimental to the health of both individual children and the population as a whole.

- **Parental access and impact on children**

Charging for healthcare and the fear of detection will have an impact on parents and children, even if children were exempt. Research has shown that the cost of a service impacts on how accessible it is perceived to be by parents and paying for services often acts as a disincentive for parents and consequently affects their children[27]. Doctors of the World found that in their London clinic, one in five (20%) feared arrest if they sought help for illness and more than 40% did not even try accessing mainstream healthcare services before asking for help[28]. Research in the Netherlands found that parents who were undocumented were afraid that hospitals had the duty to report them to the police and that they would not be able to pay hospital bills. These concerns caused parents to delay going to hospital when their child was unwell.[29] Research in the UK has highlighted the particular situation of pregnant women who, to avoid debt and out of fear of being reported to the authorities, do not benefit from antenatal and postnatal care services, putting the life of their newborns and themselves at risk[30]. It must therefore be acknowledged by the government that any policy of charging for adults would also have a detrimental impact on their children.

- **Trafficked children**

We note the consultation proposes to exempt 'those identified, or suspected as being, victims of human trafficking'. Children who are suspected of having been trafficked can be referred by agencies to competent authorities through the National Referral Mechanism (NRM)[31]. However, research has shown that there are significant obstacles to get a referral to the NRM process. The UKHTC reports over half (54%) of all potential victims of trafficking were not referred to the NRM in 2011.[32] This shortcoming was even acknowledged recently in new guidance issued to

[23] NICE (2009) Reducing differences in the uptake of immunisations (including targeted vaccines) among children and young people aged under 19 years http://www.nice.org.uk/nicemedia/pdf/ph21guidance.pdf
[24] Ibid.
[25] Department of Health (2013) *MMR catch-up programme* https://www.gov.uk/government/organisations/public-health-england/series/mmr-catch-up-programme-2013
[26] Northern Ireland Law Centre Policy Briefing (2013) A*ccessing healthcare for migrants in Northern Ireland: problems and solutions*: http://www.lawcentreni.org/Publications/Policy-Briefings/Policy-Briefing-Migrants-and-health-care-Law-Centre-NI-2013.pdf
[27] Joseph Rowntree Foundation (2007): *Barriers to inclusion and successful engagement of parents in mainstream services:* http://www.jrf.org.uk/sites/files/jrf/barriers-inclusion-parents.pdf
[28] Doctors of the World (2013) *The importance of equitable access to healthcare for people in England: a policy briefing* http://www.appgmigration.org.uk/sites/default/files/Doctors%20of%20the%20World%20-%20access%20policy%20briefing%2009072013.pdf
[29] Mensinga, M. (2010) *Undocumented children and the access to healthcare at the hospital*. http://lastradainternational.org/lsidocs/Summary_Study-acces_of_illegal_children_in_NL_at_hospitals.pdf
[30] Sigona, N and Hughes, V (2012) No Way Out, No Way in, *Irregular migrant children and families in the UK* http://www.compas.ox.ac.uk/fileadmin/files/Publications/Reports/NO_WAY_OUT_NO_WAY_IN_FINAL.pdf
[31] Agencies who identify children who they think have been trafficked provide information and make referrals to a system known as the National Referral Mechanism (NRM). This is a central system managed by the UK Human Trafficking Centre (UKHTC) which is responsible for identifying, monitoring and protecting all victims of trafficking and also referring them for support. The NRM is also the mechanism through which the UKHTC collects data about all victims of human trafficking.
[32] UKHTC: A Baseline Assessment on the Nature and Scale of Human Trafficking in 2011 – published by the Serious and Organised Crime Agency – August 2012: http://www.soca.gov.uk/news/462-human-trafficking-assessment-published

NHS staff in an attempt to increase identification of trafficked victims and subsequent referrals to the NRM.[33] The Public Health Minster here acknowledged that: "*In many cases, victims need treatment for health problems so NHS staffs are uniquely placed to spot, treat and support victims of trafficking*". Whilst we welcome the exemption for trafficking victims we therefore wish to highlight that this category is very limited and will mean many victims of trafficking will remain outside the scope of these proposals.

- **Separated children**

In addition to trafficking, there are many other reasons why a young person can find themselves without a legal status in the UK. For example, our research on separated children at risk[34] highlights many cases of children who did not have documents to prove their identity. This may be because they were smuggled into the country, came here on false documents, or came here on a visa but overstayed without knowing there was anything wrong. These children will be considered undocumented or irregular (or 'illegal' as referred to in the government's documents), falling outside the scope of entitlement proposed in this consultation.

For example, Victoria Climbié who died in 2000 was brought into the UK from the Ivory Coast by her aunt on false documents to live in private fostering arrangements. Under these proposals she may have been denied access to primary care. This exemption as it stands therefore undermines attempts by the Department of Health to make progress in facilitating support to trafficked and abused children. This example gives even greater emphasis for the need to ensure that all children and young people are able to access free healthcare.

- **Child protection**

The lack of free access to primary care services affects the ability of services to assess for factors relating to child protection in order to make an early intervention relating to their safety. Primary health care professionals such as GPs, midwives and health visitors are in an advantageous position to notice early signs of parental abuse or neglect[3536]. By removing primary care access for irregular migrant children the government will be reducing the number of professionals who could potentially identify and intervene in a case such as that of Victoria Climbié.

Race:

- **Impact on vulnerable families who are entitled**

We are concerned that these proposals will disproportionately impact on asylum-seeking, refugee and migrant children and families as well as those from black and minority ethnic backgrounds, because the process of checking entitlement might lead to a greater propensity for discrimination. Refugees and asylum seekers already experience barriers in accessing healthcare[37]. This includes language barriers, concerns about confidentiality, discrimination by

[33] Department of Health (2013) *Help for NHS staff to spot and support trafficking victims:* https://www.gov.uk/government/news/help-for-nhs-staff-to-spot-and-support-trafficking-victims
[34] The Children's Society (2009) *Hidden Children – separated at risk:* http://www.childrenssociety.org.uk/sites/default/files/tcs/research_docs/Hidden_children_full_report.pdf
[35] Davies, C and Ward, H (2011) *Safeguarding Children Across Services: Messages from research on identifying and responding to child maltreatment* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184882/DFE-RBX-10-09.pdf
[36] Department of education (2013) *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children
[37] Hargreaves S et al (2006) The identification and charging of Overseas Visitors at NHS services in Newham: a Consultation: http://www.lho.org.uk/Download/Public/11948/1/IHU%20Entitlement%20Report%2006.pdf

members of staff, concerns about authority and their lack of knowledge about the UK health system, and what they are entitled to, have all been cited as pre-existing barriers[38]. The proposed policies will only exacerbate this trend among vulnerable groups and healthcare professionals for those who will still be entitled to access free healthcare.

Case study: Young carer, Riyya[39] refused by GP and children's services

Riyya was 11 when she and her disabled mother claimed asylum in the UK. Her mother could not walk, so it fell to Riyya to take care of her as well as do all the shopping and cleaning. She often had to take days off school to take her mother to appointments and was asked to interpret for her mother, including by solicitors and doctors. '*My mum couldn't go [sign in] every single week because of her disability, and if we don't go we can't get the money which meant a lot of the times we didn't have any money…it took around three or four months for them to realise*.' Her support worker made a number of referrals to children's services and adult social care but they were consistently refused. Despite being on Section 95 asylum support during this time and entitled to primary care, they tried to register with a number of different GPs but were wrongly turned away for being asylum seekers. Riyya said: *'I felt as if we were wrong, or as if we were not equal*.'

- **Poor health and inability to pay for those no longer entitled**

While the government has noted that asylum seekers on section 4 and section 95 support will be exempt, some asylum seeking children and families will not be protected because they will not be receiving support from the Home Office. This includes families who are unable to return, are destitute and have no means to pay for health care. Research has consistently highlighted that many of those applying for asylum support from the Home Office are wrongly refused because Home Office decision-makers are not applying the correct legal test in relation to destitution: out of the cases surveyed by the Asylum Support Appeals Project, 80% were overturned on appeal and the majority of these were section 4 cases[40].

Research available on the health needs of refused asylum seekers suggests that they are a particularly vulnerable group which could impact on their health status both on arrival and in the future[41]. Many will have come from countries in which there is a poor infrastructure, including disrupted/minimal healthcare systems, they may have passed through refugee camps, or made long and difficult journeys to the UK.

Current charging for secondary care results in children not getting the treatment they need and sometimes means families are forced into significant debt. Refused asylum seekers are not allowed to work and earn money, therefore denial of access to free health care will arguably encourage informal and exploitative working to pay for their healthcare. There is evidence that NHS trusts have pursued asylum seekers for debt, often in an aggressive manner, even when they have no means of paying these substantial hospital bills[42]. This has resulted in a great deal of distress to the children and parents, despite this approach being time consuming and expensive.

[38] Ibid.
[39] Not her real name
[40] ASAP (2013) 'UKBA decision making audit: One year on, still 'no credibility'': http://www.asaproject.org/wp-content/uploads/2013/05/ASAP-Audit-on-decision-making-2013.pdf
[41] Williams, P.D (2005) *Failed asylum seekers and access to free health care in the UK* http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)66576-2/fulltext
[42] Independent Asylum Commission: Evidence from the National AIDS Trust (2007) http://www.nat.org.uk/Media%20library/Files/PDF%20Documents/NAT-submission-Independent-Asylum-Commission-29Nov2007-FINAL.pdf

In addition, refused asylum seekers who cannot register or are de-registered from their GP surgery will not be able to obtain the appropriate medical verification that they are too sick to travel or that they are in poor health and should have their reporting requirements to the Home Office reduced or temporarily suspended. Charging will therefore create a further barrier to their access of section 4 support.

- **Legal limbo for those who will lack entitlement**

The division of migrants into two mutually exclusive and exhaustive categories as either 'legal' or 'illegal' is not clear in practice or legal terms, nor does it conform to children and young people's own experiences and conceptions of their status. From our perspective, the term 'illegal immigrant' does little to promote an understanding of why different individuals and vulnerable groups, such as children and young people, refugees and victims of human trafficking, might find themselves in this country without documentation or a legal status[43]. Research has consistently highlighted problems with the quality of decision-making by the Home Office in asylum claims generally[44], as well as in family[45] and children's[46] cases specifically. The first report of the Independent Family Returns Panel highlighted that of the families that the UK Border Agency (UKBA) had considered to have 'no right to be in the UK' and should return, 41% (77 out of 186) were subsequently granted leave to remain in the UK[47].

It is evident from our own work with children and families that many have real fears about returning and do not believe they have had a chance to have their case fairly considered. Often this is due to inadequate legal advice and representation early on in their case, a lack of adherence to guidance by Home Office decision-makers[48] as well as a 'culture of disbelief' within the Home Office[49]. Furthermore, there are a number of countries which are internationally recognised as too unsafe to return to or where the courts have ruled that it is unsafe to return for a period of time. This is frequently not acknowledged in UK asylum policy and decision-making[50]. These barriers to return will therefore not be reflected in the immigration status of children and families but will prevent removal or voluntary return. In addition, some families will be unable to obtain documentation in order to return. For example, we work with young people from Iran, who are refused international protection, however; they cannot get documentation to return as there is currently no embassy in the UK. This leaves them in limbo without a regular immigration status or access to services, but unable to leave the UK.

The assumption that charging for primary healthcare will encourage people to leave the UK, as cited in the consultation document, is substantially flawed. If anything, this approach would simply further undermine the position of these vulnerable groups who are unable or unwilling to return home.

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[43] For example see recent letter to the editor: http://www.theguardian.com/world/2013/aug/08/van-campaign-turning-back-clock

[44] Amnesty International (2013) *A Question of Credibility: Why so many initial asylum decisions are overturned on appeal in the UK* : http://www.amnesty.org.uk/uploads/documents/doc_23149.pdf

[45] UNHCR (2013) *Untold Stories; Families in the asylum process*: http://www.unhcr.org.uk/fileadmin/user_upload/pdf/aUNHCR_Report_Untold_Stories.pdf

[46] UNHCR (2009*) Sixth Report of the Quality Initiative Project*: http://www.unhcr.org.uk/fileadmin/user_upload/pdf/6_QI_Key_Observations_Recommendations6.pdf

[47] p8, Independent Family Returns Panel Annual Report, 2011/12

[48] Amnesty International (2013) *Question of Credibility: Why so many initial asylum decisions are overturned on appeal in the UK* http://www.amnesty.org.uk/uploads/documents/doc_23149.pdf

[49] The Children's Society (2012) *Into the Unknown: Children's journeys through the asylum process* http://www.childrenssociety.org.uk/news-views/press-release/children-seeking-safety-uk-face-damaging-culture-doubt

[50] The UN Committee Against Torture for example recently criticised the UK for not amending its asylum policy on Sri Lanka despite the High Court ruling earlier this year suspending removals of Tamil refused asylum seekers to Sri Lanka. 5th periodic report – May 2013: http://www2.ohchr.org/english/bodies/cat/cats50.htm The Refugee Council (2012) *Between a Rock and a Hard Place* recently illustrated other examples of the protection gap for nationals from the Democratic Republic of Congo, Eritrea, Somalia, Sudan, and Zimbabwe who have been refused asylum but may still have a well-founded fear of return.

Gender

- **Pregnancy and maternity**

We are concerned about the impact these proposals will have on pregnant women and newborns who may experience follow-on effects from any restriction on maternity services, which are vital to their healthy start in life. Charging for primary care services in particular will impact on pregnant women as 83% of women first seek maternity care through their GP[51]. There is clear evidence that current charging policy has negatively impacted on pregnant women's health and well-being. The outlined proposals are only going to make this situation worse, especially as the consultation specifically targets maternity services for additional charges, even when non-EEA migrants have paid the levy.

One factor in poor maternal health outcomes for vulnerable migrants is poor general health.[52] Women may arrive in the UK with undiagnosed conditions such as congenital heart disease, HIV/AIDS or tuberculosis, or have undergone female genital mutilation (FGM) in their country of origin. Some women may have psychological and physical problems secondary to their experiences in their country of origin and en route to the UK, such as physical injuries and rape.

However, as highlighted in the recent parliamentary inquiry supported by The Children's Society on asylum support for children and young people, the lack of consistent and adequate support and access to vital services for women in the asylum system also has implications for their health needs[53]. For example, the inquiry highlighted that refugee and asylum seeking women make up 12% of all maternal deaths, but only 0.3% of the population in the UK.[54] Pregnant asylum seeking women are also seven times more likely to develop complications and three times more likely to die during childbirth than the general population.[55] In the UK, 46% of stillbirths and deaths in the first year of a child's life are due to low birth weight; there are clear links to malnourishment, poor accommodation and a lack of cash-support, all of which are far more likely to be experienced by an asylum seeker.

Research has found that the current charging system results in pregnant women being denied access to care because they are not able to pay for their treatment upfront, because staff are unaware of entitlements, or because they have been deterred from accessing treatment due to a fear of incurring large debts[56]. In some cases women experienced rude and aggressive treatment by Overseas Visitor Managers, and threats to bring in debt collectors prior to giving birth[57].

Similarly charging for GP services may then result in vulnerable pregnant women delaying the commencement of maternity care or not seeking it at all. If access to free healthcare is further curtailed, both through changing the definition of ordinary resident and through charging for primary care, this will most likely result in more mothers not engaging with services putting both them and their children at risk.

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[51] M. Redshaw, R. Rowe, C. Hockley, & P. Brocklehurst (2006) *Recorded delivery: a national survey of women's experience of maternity care*. National Perinatal Epidemiology Unit Available online: www.npeu.ox.ac.uk

[52] Maternity Action (2012) *Guidance for commissioning health services for vulnerable migrant women* http://www.maternityaction.org.uk/sitebuildercontent/sitebuilderfiles/guidancecommissioninghealthservvulnmigrantwomen2012.pdf

[53] Dr. Jenny Phillimore, University of Birmingham, Evidence Session 1, 20 November 2012 – Parliamentary Inquiry in Asylum Support for Children and Young People: http://www.childrenssociety.org.uk/parliamentary-inquiry-asylum-support-children

[54] Lewis, G. (2007) The Confidential Enquiry into Maternal and Child Health (CEMACH). *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer*, 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH

[55] Faculty for Public Health (2008) *The health needs of asylum seekers:* http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf

[56] Maternity Action and Medact (2009) *Money and Maternity: charging vulnerable pregnant women for NHS care* UK Public Health Association Conference, Brighton http://www.maternityaction.org.uk/sitebuildercontent/sitebuilderfiles/phapresentation2009.pdf

[57] Joint Committee on Human Rights (2007), *The treatment of asylum seekers: Tenth report of session 2006-07*, London: The Stationery Office: http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf

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

Response:
N/A

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

Access should be based on clinical need and charging will act as a barrier to this as already highlighted in the previous sections.

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:
We disagree that a long-term relationship with the UK should be defined through National Insurance contributions. We believe this approach would unfairly exclude people who have been living permanently in the UK but have not been able to contribute for a variety of reasons. In particular, children, people with disabilities, those with long-term illness or those with caring responsibilities cannot be expected to have made National Insurance contributions.

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
Whilst we have highlighted a specific subset of migrants to the UK who are particularly vulnerable, in general, as the Department of Health itself notes, evidence suggests that immigrants are younger than the native-born population as a whole and use the health care services less than those born in the UK[58]. Not only are temporary migrants generally healthier than the native population, but they will often return to their home countries for elective treatment.

[58] Department of Health (2013) *Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment*, page 14.

This approach also fails to recognise that migrants who come to the UK to work or study are already making a full and fair contribution to the UK's economy and society, including their healthcare, through income tax, VAT and National Insurance contributions and through visa fees.

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:

(c) We do not support any of these proposals.

We find the definition of 'health tourism' used problematic. The use of the term 'health tourists' as 'people who take advantage of our current generous entitlements and are able to avoid detection or payment'[59] is extremely broad and misleading. When previous charging has been introduced, the Joint Committee on Human Rights (JCHR) has noted that "*the Government has not produced any evidence to demonstrate the extent of what it describes as 'health tourism' in the UK*"[60] and the House of Commons Health Select Committee (HCHSC) "*were astonished that by the Department [of Health]'s own admission, these changes [were] introduced without any attempt at a cost-benefit analysis*".[61] We cannot see any new evidence that has come to light to warrant the current proposals, particularly given that a full cost-benefit analysis was not produced before the consultation started.

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:

A health levy should not be introduced.

[59] Page 5 of consultation document
[60] Joint Committee on Human Rights (2007) *Tenth Report: The Treatment of Asylum Seekers.* London: Stationary Office
[61] House of Commons Health Select Committee (2006) *NHS Charges: Third Report of Session 2005-2006,* HC 815-I, London: The Stationary Office Limited

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:

Fixed: We do not believe there should be a levy.

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. We have concerns that insurance policies will not cover all services (e.g. maternity services and pre-existing illnesses etc) and that this will either lead to gaps in healthcare and/or mean that migrant children and families accrue large debts in order to cover costs.

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.

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:

The current system of charging is not cost effective. The available evidence provided by the Department of Health indicates that hospitals identify approximately 40% of those who are currently chargeable and only recover 40% of the costs that they invoice for (roughly £20m out of £45m). The total cost of Overseas Visitors Managers and screening by NHS staff is estimated at £18m. This does not include other administrative costs (e.g. translation etc.) or the costs of pursuing payments, including using debt recovery agencies – some of which charge up to half of the value of the debt as a fee for recovery.

The '*2012 review of overseas visitors charging policy*'[62] identifies that the largest category of chargeable 'visitors' affected by the current charging system are those migrants living in the UK without the required immigration documentation. These include many refused asylum seekers families, young victims of trafficking, children in private fostering arrangements who have

[62] International Policy Team. *2012 review of overseas visitors charging policy.* Summary Report. Department of Health, 2013.

overstayed their visa and other vulnerable groups. As the review makes clear, these groups are in the main unable to pay charges for healthcare they access. This means that money spent on trying to recoup costs is a waste and causes significant distress, whilst it will also simultaneously deter people from accessing healthcare until they are seriously ill as evidenced in question 2 and arrive in A&E for emergency treatment at significantly increased cost to the NHS.

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. We strongly oppose this proposal because it is detrimental to both individual children and families as well as the population at large.

As highlighted under question 2 ('legal limbo') we find the use of the term 'illegal' misleading and inaccurate.

Groups falling into this category nevertheless, tend to be unable to pay for treatment which therefore results in delays in presentation, diagnosis and treatment. It encourages individuals to only therefore present when their condition is serious and nearing the threshold of urgent treatment. The Department of Health itself concluded that recovering charges from illegal migrants is difficult and "in most cases the burden falls on the state"[63]. Additionally, this approach is also extremely distressing for the children and families concerned.

This group of individuals are generally extremely vulnerable. For example, a survey of 20 destitute refused asylum seekers who were represented by the Asylum Support Appeals Project between July 2011 and January 2012 found that a total of 45% were suffering from mental or physical health problems[64].

Similar risks exist around infectious diseases and the protection of public health. Data collected from 112 asylum seekers at a specialist clinic in Brixton found that more than half had not been able to register at GP surgeries in the UK, but after testing the patients they discovered that 18% had at least one serious communicable disease (five were HIV positive, six had acute hepatitis B, two were infectious for hepatitis C and three had active tuberculosis).[65]

An approach that aims to prevent illness and enable early diagnosis and treatment is the best course of action and more cost-effective.

Charging this group contradicts many of the principles laid out in the consultation in that it is not cost effective, places undue burden on NHS staff, does not protect the interests of vulnerable patients and presents a public health risk to the wider population.

[63] Department of Health (2013) *Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessmen*t, page 11.
[64] ASAP (2012) *UKBA decision making audit – One Year on, Still no Credibility*
[65] Nyiri, P (2012) *A specialist clinic for destitute asylum seekers and refugees in London*, BJGP

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

Response:

We oppose the proposals in their entirety, but if they did go ahead, we believe the list of exemptions would need further consideration. We are particularly concerned that all children and many vulnerable young people and families are not protected. This includes but is not limited to:

a. Children whose families have been refused asylum: these will include families who are not on asylum support, but are unable to return and have no means to pay for health services. For example, research has consistently highlighted that many of those applying for asylum support from the Home Office are wrongly refused because Home Office decision-makers are not applying the correct legal test in relation to destitution: out of the cases surveyed by the majority of these were Section 4 cases[66]

b. 'Former relevant children' or care leavers: despite being very vulnerable and still supported by local authorities, these young people are not covered

c. Potential victims of trafficking: although it is right that 'those identified, or suspected as being, victims of human trafficking' are exempt it is unclear how this will be determined. For example, if this will depend on referrals to the NRM, its unlikely to capture many young victims of trafficking as few are referred to the NRM. The government's own baseline assessment report last year highlighted that over half of trafficking victims identified by agencies were not referred to the NRM[67].

d. Children, young people and families who have been granted Discretionary Leave to Remain and Humanitarian Protection[68]

e. Children and families supported under Section 17 of the Children Act 1989: these are families where children have been accepted as being 'in need' and are only receiving minimal amounts of support so will not be able to pay for health services.

f. Children and young people who have an irregular immigration status and are in private fostering arrangements.

We believe that all children, young people and families should be able to access free primary and secondary health care regardless of their immigration status. We believe that irregular migrant children and young people should be recognised as a particularly vulnerable group, already at risk of destitution, exploitation and social exclusion, and that their rights should not be breached for the purpose of immigration control.

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[66] ASAP (2013) *UKBA decision making audit: One year on, still 'no credibility'*: http://www.asaproject.org/wp-content/uploads/2013/05/ASAP-Audit-on-decision-making-2013.pdf

[67] UKHTC (2012) A Baseline Assessment on the Nature and Scale of Human Trafficking in 2011: http://www.soca.gov.uk/news/462-human-trafficking-assessment-published

[68] This includes unaccompanied children who have been granted Discretionary Leave for Unaccompanied Asylum Seeking Children or 'UASC-leave' as set out under paragraph 352ZE of the immigration rules.

Comparisons with other European countries

Comparisons with Europe provide a compelling case to indicate that these proposals for the UK are far too restrictive for undocumented migrant children[6970].

The level of care available to undocumented or 'illegal' migrant children in many parts of Europe is varied. However, in almost all cases where research has been undertaken, it is much more comprehensive than that available in the UK now for this group, even without the restrictive proposals being put forward in this consultation.

Spain[71], Romania[72] and France[73] for example offer the same access to healthcare for undocumented children up to 18 as national children. This same rule applies to children up to 14 in Greece[74]. In Belgium[75] and Italy[76], all children under the age of 6 can access a wide range of essential and preventative treatments free of charge. In the Netherlands[77], if children cannot afford to pay their healthcare costs, there is a system in place to reimburse health care providers for 80-100% of their costs. In Estonia[78], children attending school under 19 years of age and students of up to 24 years of age are treated in the same way as insured persons, regardless of their legal status.

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 healthcare being accessible based on clinical need and support the right of any person to register for free GP services. We believe this should not be dependent on their immigration or nationality.

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: Primary healthcare plays a vital role in an effective healthcare system and creating a barrier to accessing primary healthcare will result in vulnerable groups being prevented from accessing health services altogether until they become so ill they present in A&E.

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[69] PICUM (2013) *Children First and Foremost: A guide to realising the rights of children and families in an irregular migrant situation*. See page 27: Comparison of National Legal Protections http://picum.org/picum.org/uploads/publication/Children%20First%20and%20Foremost.pdf

[70] European Union Agency for Fundamental Rights (2011) *Fundamental rights of migrants in an irregular situation* http://fra.europa.eu/sites/default/files/fra_uploads/1827 FRA_2011_Migrants_in_an_irregular_situation_EN.pdf

[71] Article 1 of the Royal Decree 16/2012 (2012)

[72] Romanian Law on the protection and promotion of the rights of the child/ 272/2004, Article 43; Romania, Law 95/2006 on healthcare reform, Article 213, and Cuadra, C. B. (2010) Policies on Health Care for Undocumented Migrants in EU27: Country Report Romania, April 2010, available at: http://files.nowhereland.info/670.pdf

[73] Article L 251-1 of the Code on Social Action and Families

[74] Greece, Law No. 3386/2005 (2005), Article 84(1)

[75] Royal Decree of 12 December 1996 on State Medical Assistance

[76] Article 35(3) National Immigration Law T.U. 286/98 (1998)

[77] Article 10 Immigration Act (2000)

[78] Estonia, Health Insurance Act § 5(4)s

We believe this policy is very concerning on a number of levels:

Child Health

As stated in question 2 and 14 we believe all children should be exempt from any charging schemes including in the primary care setting. The proposed polices raise considerable risks to the health and well-being of irregular migrant children, on ethical, legal and public health grounds.

Particular vulnerable groups

As identified in question 2, restricting access to a GP for refused asylum seekers looking for support under section 4 under the Immigration and Asylum Act 1999 on health grounds will mean they are unable to access a doctor's report as part of this evidence.

Victims of domestic violence, in particular single women with children will be unable to access a medical report to provide evidence for an application for permission to stay in the UK if they cannot access a GP or hospital doctor.

Mental Health

As identified in our answer to question 13, the groups who will be predominantly affected by this policy suffer from disproportionality high levels of mental health problems. This may be as a result of the particular difficult experiences this group has faced often having experienced exploitation, persecution and destitution. Lacking access to primary care will further isolate this group which could create a risk to themselves or others in society. There is a is a much greater cost if a condition becomes worse and culminates in a person being detained under the Mental Health Act or admitted to hospital.

Preventative treatments

Open primary care services are vital for public health. It is not in the best interests of the population to be creating obstacles to immunisation particularly in light of the recent measles crisis in Wales.[79]

Preventative health care and screening for conditions such as diabetes and hypertension is just as important in migrant populations as the UK born population and barriers to accessing them for this population are considered not cost-effective.[80]

Impact on Emergency Services

Research highlights that obstacles to accessing primary care can create increased attendance at A&E.[81] There is evidence from the UK that migrants unable to access primary care services

[79] BBC News. (2013) *Swansea measles epidemic: Worries over MMR uptake after outbreak*. BBC News. 10 July 2013.
[80] Lu, MC et al.(2000) *Elimination of public funding of prenatal care for undocumented immigrants in California: a cost/benefit analysis*. Am J Obstet Gynecol 2000; 182: 233-39.
[81] Norredam M, Krasnik A, Moller Sorensen T, et al. (2004) *Emergency room utilization in Copenhagen: a comparison of immigrant groups and Danish-born residents*. Scand J Public Health; 32: 53-59

look to A&E to meet their health needs. This is despite the fact that some ailments would have been more appropriately treated in primary care.[8283]

Increased use of A&E is very concerning on several levels. Firstly the cost, GP consultations on average cost £20 compared with your average A&E attendance on average costs £110[84]. Secondly, following the charging regime introduced in 2004 for secondary care, even those that are fully entitled to access healthcare free of charge, such as asylum seekers and British Citizens, have been denied access, sometimes with catastrophic consequences[85].

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: We do not think 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

It is not ethical or feasible to undertake charging in this setting. It would be impractical to obtain detailed information about immigration status in an emergency, particularly as NHS staff will not have the detailed knowledge required to do this. Patients are also unlikely to be able to provide evidence of Indefinite Leave to Remain (ILR) at such short notice.

Charging for A&E will create delays in an already overstretched system, many people will be wrongly charged or follow up checks will waste NHS resources.

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

Response:

No system will make charging workable. A new system would be administratively burdensome and encourages discrimination whereby people from black or minority ethnic backgrounds or those with a language barrier could be wrongly charged when NHS staff are under pressure to make quick decisions.

[82] House of Commons Health Select Committee (2006). *NHS Charges: Third Report of Session 2005-2006*, HC 815-I, London: The Stationary Office Limited

[83] Blog, I. (2000) *Inappropriate attendance at an accident and emergency department by adults registered in local general practices: how is it related to their use of primary care*? Journal of health services research & policy; 7 (3): 160.

[84] Yates, T; Crane, J; Rushby, (2007) M. *Charging Vulnerable migrants for healthcare*. Student British Medical Journal, 15:427-470

[85] Morris, S; Allison, E (2008) *Hospital defends treatment in asylum seeker death*. The Guardian: 13 February 2008 http://www.guardian.co.uk/society/2008/feb/13/nhs.immigrationandpublicservices

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

Response:

No. Many of these services are set up to meet the needs of vulnerable and hard to reach groups such as homeless people including destitute asylum seekers. Charging would undermine this work making people even less likely to engage with these services.

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

Response:

Inevitably extending charging will create an expensive administrative burden for the NHS and sharing data across a number of agencies could be at odds with data protection principles. The government should take note of The Department for Education's guidance on when and how to share information legally and professionally when dealing with services for children, young people and families[86]. For example, if an organisation wants to share information about a family with other agencies, this should only be done with the knowledge and consent of the family unless child protection issues make it impossible to respect a parent/carer's wish for information not to be disclosed. From our experience, sharing information about a child's or family's immigration status would pose serious issues when taking into account the best interests of the child and would create considerable fear and distress in gaining consent and cooperation.

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:

The government should focus on recouping costs from existing agreements and pre-existing insurance before considering the new proposals.

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 already outlined, we do not believe the current proposals are workable or consistent with the overarching principles proposed. We also do not think the proposals will be efficient, cost-effective or ensure the safe delivery of quality healthcare. They are instead extremely likely to place undue burdens on staff and increase health inequalities.

[86] Department of Education; *Information Sharing*: http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/a0072915/information-sharing

Evidence suggests that policies which limit or deter people from accessing primary healthcare will not be cost effective. Research, including from the National Audit Office shows that early diagnosis and intervention provide positive social and economic outcomes and significant long term savings stating that '*A concerted shift away from reactive spending towards early action can result in better outcomes and greater value for money'.*[87]

A system based on charging will require the registration of all patients in order to adhere to equality duties. This will ultimately require the issuing of ID cards. This will be a hugely expensive system to implement and will require all existing patients to re-register with the NHS.

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

Response:

N/A

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:

As already outlined, we do not believe charges can be effectively applied. The proposals set out by the government are unethical, discriminatory, administratively burdensome, not cost effective and are entirely unworkable.

Unworkable

The only person that should be deciding if a treatment is 'immediately necessary' is the doctor after they have seen the patient. This is not something that administrative staff can or should be expected to judge. Doctors via the British Medical Association[88] have voiced their opposition to acting as the intermediaries in determining if patients are eligible to receive NHS care. They believe trust between doctor and patient is crucial for the effective delivery of health services and charging could clearly undermine this.

It is also unclear from the documentation provided how much patients will be charged for primary care access and how these rates will be set and managed. We believe that any system would indirectly discriminate based on race, nationality and ethnicity. Article 2 of the UNCRC makes clear the State's obligation to protect children from any form of discrimination and to take positive action to promote their rights irrespective of the child's or his or her parent's race, nationality or other status. More recently the UN Committee has urged governments to ensure that adequate measures are in place to "combat discrimination on any grounds". It specifically stated that efforts to combat xenophobia, racism and discrimination and promote the integration of families affected by migration into society should be strengthened[89]. It is difficult to see how

[87] National Audit Office: *Early Action: Landscape Review*: http://www.nao.org.uk/wp-content/uploads/2013/03/Early-Action-full-report.pdf
[88] BMA. *Overseas visitor NHS charges require more thought, warn doctors leaders.* British Medical Association, UK, 2013
[89] UN Committee on the Rights of the Child (2012) *Day of General Discussion on the rights of all children in the context of international migration*: http://www2.ohchr.org/english/bodies/crc/discussion2012.htm

this policy will have the effect of better integrating migrant children and families as children will be adversely affected by the way their parents are treated in any healthcare setting. If parents are refused treatment this will likely have an adverse effect on the children's access. In addition, we must also consider those in the NHS workforce who will be responsible for implementing the system who may themselves be subject to the same rules.

It is not yet clear how the government intends to ensure that those accessing NHS services are eligible to do so, and that those who are not eligible are prevented from seeing a doctor if they do not have the means to pay. We know from our own work that families are already fearful of approaching health services and these proposals will make that fear considerably worse. Media reports have suggested that an individual's immigration status will be checked by the health service with the immigration authorities before care is provided. This will prove difficult for doctors bound by medical confidentiality and professional ethics as well as additional burdens on already stretched staff.

Ineffective and expensive

As outlined in question 16, barriers to primary care access will inevitably force children and young people to attend A&E. Those denied access to primary care will eventually present to emergency health services with advanced illnesses that are more complicated and take longer, and cost much more to treat.

Restricted access to preventative health care and screening, for example diabetes treatment or high blood pressure, is not considered a cost-effective approach to delivering health-care to migrant groups. A Doctors of the World study into diabetes showed that providing irregular migrants with entitlement to primary healthcare would lead to earlier diagnosis and prevent diabetes-related complications, saving the NHS at least £1.2 million.[90]

Consequently, no one should be barred from primary healthcare. GPs are the frontline defence against poor public and personal ill-health. They save the NHS money by treating patients early and well. Vulnerable, excluded people should be provided with the care they need if they are living here, regardless of their income or immigration status. The Marmot Review reported that health inequalities may cost the NHS more than £5.5 billion per year, not including the broader economic costs to society.[91]

We believe these proposals, if implemented, could have a severe impact on the children and families we work with. They will increase health inequalities in many areas, and impact negatively on public health more broadly.

[90] Doctors of the World UK (2013)*The importance of equitable access to healthcare for people in England*: a policy briefing http://www.appgmigration.org.uk/sites/default/files/Doctors%20of%20the%20World%20-%20access%20policy%20briefing%2009072013.pdf

[91] *Fair Society, Healthy Lives*: the Marmot review: http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf

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: N/A

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: N/A