



# Patients Not Passports



Challenging healthcare charging in the NHS

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Citation: Medact (2019) *Patients Not Passports: Challenging healthcare charging in the NHS*. Medact. London. UK

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Special thanks to the Joint Council for the Welfare of Immigrants for their work on gathering the data analysed in this report and to Docs Not Cops for their image archive.

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This briefing is designed to be used as a tool and reference guide for anyone working to improve access to healthcare. It has been written with this in mind and expects readers to take the information they need to use without having to read the entire briefing.

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About Medact

Medact's mission is to support health professionals from all disciplines to work together towards a world in which everyone can truly achieve and exercise their human right to health.

We do this through research and evidence-based campaigning for solutions to the social, political and economic conditions which damage health, deepen health inequalities and threaten peace and security.



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Registered charity 1081097 Company reg no 2267125

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# 1 - Introduction



The NHS was conceived as a universal service, a project designed to guarantee the right to health, available to all who need it, regardless of ability to pay. However it has long been under threat from the forces of privatisation and the market logic of neo-liberalism. This has manifested in political decisions to restrain the budget, to open up procurement to the free market, and increasingly to treat care delivery as a service to be earned, not a right guaranteed to all. The Hostile Environment facilitates this process, increasingly restricting care by embedding the mechanisms of immigration enforcement in the framework of the NHS. In 2017, new charging regulations introduced upfront charging for NHS services, accompanied by a trial of ID checks on patients in order to determine their eligibility for care. Behind this, NHS Trusts engage in the sharing of patient data and reporting of patient debt to the Home Office, information which is then used by immigration teams to track, detain, and deport people. These policy changes are the culmination of years of successive Governments eroding migrants' rights to access the NHS and represent a drastic step backwards from the vision of the NHS as a truly universal service.

Healthcare workers themselves have been leading the push back against these harmful policies. Since 2014 Docs Not Cops has worked to challenge the expansion of border controls and charging in the NHS, initially focusing on the Immigration Health Surcharge and increased fees for migrants brought in under the Immigration Act 2014. In 2017 they launched the Patients Not Passports campaign focusing on the introduction of ID checks and upfront charging. Medact and Migrants Organise joined the campaign and together the three groups support opposition to the policy from frontline healthcare workers and communities impacted by charging. At the same time the Medact Migrant Solidarity group, a volunteer group of healthcare workers supported by Medact, started delivering trainings in NHS Trusts to raise awareness of the policy, and worked to get a number of Royal Colleges to speak out against charging.

This briefing is designed to be a tool to support people in campaigning against the Hostile Environment in the NHS. It sets out the policy and ideological background to NHS charging; reframes and challenges some of the arguments used to justify the policies; and presents evidence and analysis of the likely impact of restricting access to the NHS. It also includes new data on NHS Trusts' response to the policy and reveals how little has been done to mitigate or monitor the harm it will cause.

This document sits alongside the *Patients Not Passports Toolkit*. Together they offer resources and information that should support healthcare workers and people affected by charging to launch campaigns in their Trusts and in their communities. You can find the toolkit at [www.PatientsNotPassports.co.uk](http://www.PatientsNotPassports.co.uk).



## 2 - Why Does the NHS Charge for Care?



*Immigration Enforcement Logo - Licenced under CC BY-SA 4.0*

## 2.1 - History of Charging in the NHS

The NHS is built on the principle that healthcare should be free at the point of use to all who need it. It is a mantra that is deeply embedded in our understanding of healthcare delivery in the UK. To fully grasp the significance of the changes brought about by the Immigration Act 2014<sup>1</sup> and the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2015<sup>2</sup> and 2017<sup>3</sup> we need to understand how and when the NHS started charging overseas visitors.

Since its inception the NHS has been able to charge for some services. In 1946 Aneurin Bevan introduced the National Health Services Act<sup>4</sup> which placed on the Secretary of State for Health the responsibility to provide a comprehensive health service for the people of England and Wales leading to the creation of the NHS. Although the Act enshrined in law that the vast majority of services would be provided free of charge it did allow charging in a few areas including dental and optician services, aftercare and domestic help, and for some of the more expensive medical devices. It did not make any provision about particular categories of people that would be required to pay or would be excluded from services.

It was not until 1977 that the concept of entitlement based on 'ordinary residence' entered the NHS in the National Health Service Act<sup>5</sup>, through a provision that allowed for the Secretary of State to levy charges for NHS services on people who are not 'ordinarily resident' in Great Britain. 'Ordinary residence' is a loosely defined category derived from case law that we will discuss in detail in section 3.1 [p14]. The ordinary residence requirement was restated and remained unchanged in the National Health Services Act 2006<sup>6</sup>. It was the Immigration Act 2014 that made the next significant change in who was able to access NHS care, modifying the definition of 'ordinary residence' to make it reliant on the person having indefinite leave to remain in the UK<sup>7</sup> (we explain different types of immigration status in section 3.2 [p15]). This change excluded vast numbers of people from NHS care and allowed for the application of the Immigration Health Surcharge to those people applying for temporary visas (discussed in detail in section 2.4 [p9]).

The provisions in the National Health Services Act 2006 and the Immigration Act 2014 that allow for charging for NHS care are enacted through regulations made by the Secretary of State for Health and Social Care. These regulations are not subject to parliamentary scrutiny in the way acts of parliament are, instead they are made and modified unilaterally by the Department of Health and Social Care (DHSC).

## 2.2 - Current Charging Policy

The current regulations that govern charging for NHS care, the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2015<sup>8</sup> and 2017<sup>9</sup>, introduced a number of significant changes to the ways in which people are charged for NHS care. Together they have fundamentally altered the principles that underpin the delivery of healthcare in England.

**The information in this briefing applies only to England. Scotland, Wales, and Northern Ireland all have devolved power over their healthcare systems and do not have policies that mirror the NHS charging regulations in England**

The 2015 regulations placed a statutory requirement on NHS Trusts to identify and charge people not eligible for free NHS care<sup>10</sup>; increased the amount people could be charged to 150% of the national tariff<sup>11</sup>; and introduced the Immigration Health Surcharge<sup>12</sup>. The 2017 regulations placed a statutory duty on NHS Trusts to charge people upfront for treatment if they were found to be ineligible for free NHS care<sup>13</sup>; increased the range of services that were chargeable to include some community and mental health services<sup>14</sup>; and mandated that NHS Trusts record people's chargeable status on their patient record<sup>15</sup>.

Never before have Trusts been required to charge people upfront for routine NHS care. Prior to 2017, Trusts had been required to charge people retrospectively, a policy that still led to people facing large bills as a result of accessing the NHS, however the 2017 regulations represent a particularly drastic shift in charging practices. It is clear that the principle policy objective of the NHS, to improve people's health and wellbeing<sup>16</sup>, is now secondary to determining a person's eligibility for care.

The 2017 regulations extended charging beyond secondary care and into areas of community care that had never previously been chargeable. Initially this had included a requirement for school nurses to check and charge school children however, following widespread criticism, the DHSC modified the guidance to exempt this service<sup>17</sup>. Many other services are now chargeable including: termination of pregnancy, community mental health services, and some district nursing services<sup>18</sup>. The DHSC had originally planned to extend charges to A&E and GP services by 2016<sup>19</sup> but have delayed this process following outcry from the healthcare community and civil society<sup>20</sup>. The intention to extend charging still remains and the 2017 regulations should be understood in the context of Government plans to extend charging to all NHS services.

## 2.3 - The Government's Attempt to Justify A Charging Regime

The Government claims these new charging measures are necessary to meet their target to recover £500m a year from use of the NHS by overseas visitors<sup>21</sup>. This section will explore the myths that underpin these figures and detail why the policy will never achieve the Government's cost recovery targets.

### The Myth of 'Health Tourism'

So-called 'health tourism' is a political concept that is almost ubiquitous in the media<sup>22,23</sup> and is often pointed to as a major drain on NHS resources<sup>24</sup>. In reality however there is very little evidence to substantiate the existence of the phenomenon, with some studies even suggesting that migrants are more likely to return to their home country to access treatment when they need it<sup>25</sup>. On the other hand, there is robust evidence to show that on the whole migrant populations are healthier and use health resources less than host populations<sup>26</sup>.

Generally, 'health tourism' refers to the idea that people travel deliberately to the UK to seek free treatment for a pre-existing condition. It is a term usually reserved for people that are not citizens of the UK but in practice, under the rules that base access to the NHS on 'ordinary residence', it would also extend to British migrants who live abroad but return to the UK to access healthcare<sup>27</sup>. Research commissioned by the Department of Health into the categories of overseas visitors that use the NHS noted that while overseas visitor managers in hospitals recognised the category of 'health tourist' they were largely unable to prove that people they grouped into this category were actually travelling to the UK for the express purpose of accessing care<sup>28</sup>.

### The Economic Justification

The Government's own estimate puts the cost of deliberate misuse of the NHS by overseas visitors at £300m, at most, equating to roughly 0.3% of the NHS budget<sup>29</sup>; the majority of which is attributed to British migrants that live overseas and return to the UK to use the NHS. This figure does not represent what could be considered recoverable through charging these people for care. It includes the use of primary care and A&E services and does not take into account an assessment of the likelihood of the people charged being able to pay the bill. The Government itself admits that these figures are a very rough estimate, and even if it did extend charging to all services it would still be unable to recoup the total costs of this supposed 0.3%. This estimate also obscures the concomitant cost of deterring people from care that arises from the policy,

and the cost of implementing and administering ID checks and invoicing patients. A concerning indication of the numbers of people that have been unable to pay the bills they owe to the NHS is the number of Trusts that have resorted to using bailiffs to chase down unpaid debt<sup>30</sup>. The fact that three quarters of Trusts are now using private firms to pursue patients to repay debts suggests that not only are Trusts failing to use their discretion to write off debts owed by people that have no means to pay; but also that private companies are now profiting from exclusionary Hostile Environment policies.

The financial impact of restricting care has been investigated by three recent studies across Europe that found providing universal access to preventative healthcare, including access for undocumented migrants, is more cost effective than restricting access to certain migration statuses to focus on emergency care<sup>31,32,33</sup>.

The European Agency for Fundamental Rights (FRA) performed a cost analysis study on hypertension and prenatal care, and applied their findings to models representing three European countries' healthcare systems<sup>34</sup>. The FRA only calculated the cost incurred by the health service and did not account for the cost to the individual or to society as a whole, and so it is likely to have underestimated the impact. Nevertheless, they found significant savings in providing preventative care as opposed to emergency care alone. Additionally, a German study used quasi-experimental methods to evaluate recorded health system expenditure on asylum seekers and refugees with full access to healthcare compared to those without. They found that the health system expenditure was greater for asylum seekers and refugees excluded from care, compared to those with regular access<sup>35</sup>. Lastly, a study from the Centre for Health and Migration analysed four EU countries for the direct (to the individual) and indirect (to wider societies due to disability and disease burden) costs of restriction to healthcare access. The results show that primary health care provision was always cost saving when compared to hospital treatment; and that, between 49%, and 99% of medical and non-medical costs of hospitalisation that could be saved if timely primary care is provided<sup>36</sup>.

The Government's often used refrain "the NHS is a national, not an international, health service"<sup>37,38</sup> mobilises the myth of 'health tourism' to justify a policy that is based on unreliable evidence and, as we will detail in section 4 [p19], causes harm and leads to discrimination. This is not a new phenomenon, in 1952 Aneurin Bevan addressed this problem with a clarity that remains relevant today, as the quote overleaf shows.<sup>39</sup>

## 2.4 - Creating a Hostile Environment

The expansion of charging, and subsequent immigration checks in the NHS is not an isolated policy development. These measures form part of what is known as the Hostile Environment; the name Theresa May, as Home Secretary, gave to a range of policies designed to make life in the UK difficult for migrants<sup>40</sup>. Other policies include immigration checks on bank account holders, the sharing of school children's nationality data with the Home Office, and passport checks on renters conducted by landlords<sup>41</sup>. A concerted effort among civil society groups and professional associations have attempted to address the inherent discrimination that comes when implementing these policies. In early 2019, the Joint Council for the Welfare of Immigrants won a High Court victory that deemed the Right to Rent scheme discrimination under racial and nationality grounds<sup>42</sup>. Alongside ID checks and upfront charging the Hostile Environment impacts people's ability to access the NHS through a number of different but overlapping policies.

### The Immigration Health Surcharge

The 2014 Immigration Act introduced the Immigration Health Surcharge (IHS)<sup>43</sup>, an additional fee people pay as part of their visa application in order to access NHS services. The IHS is designed in a way that prices people out of being able to regularise their immigration status and prevents them from moving to or staying in the UK. The fee is levied per person per year and is not adjusted by income. In December 2018 the fee was increased from £200 to £400<sup>44</sup> meaning a family of 4 would need to pay an extra £3,200 on the cost of an application for two years leave to remain. We know this has led people to separate their families, including the



*"One of the consequences of the universality of the British Health Service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill-informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues? So the argument goes.*

*No doubt a little of this objection is still based on the confusion about contributions... The fact is, of course, that visitors to Britain subscribe to the national revenues as soon as they start consuming certain commodities, drink and tobacco for example, and entertainment. They make no direct contribution to the cost of the Health Service any more than does a British citizen.*

*However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain.*

*How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats both must be classified. What began as an attempt to keep the Health Service for ourselves would end by being a nuisance to everybody.*

*Happily, this is one of those occasions when generosity and convenience march together. The cost of looking after the visitor who falls ill cannot amount to more than a negligible fraction of £399,000,000, the total cost of the Health Service. It is not difficult to arrive at an approximate estimate. All we have to do is look up the number of visitors to Great Britain during one year and assume they would make the same use of the Health Service as a similar number of Britishers. Divide the total cost of the Service by the population and you get the answer. I had the estimate taken out and it amounted to about £200,000 a year. Obviously this is an overestimate because people who go for holidays are not likely to need a doctor's attention as much as others. However, there it is. for what it is worth and you will see it does not justify the fuss that has been made about it.*

*The whole agitation has a nasty taste. Instead of rejoicing at the opportunity to practice a civilized principle, Conservatives have tried to exploit the most disreputable emotions in this among many other attempts to discredit socialized medicine."*

Aneurin Bevan. In Place of Fear. 1952

case of a nurse forced to send her children back to Kenya because she could not afford to pay for her whole family<sup>45</sup>. This fee is imposed despite what individuals pay in through their tax contributions and essentially amounts to double taxation of migrants for use of the NHS.

## Sharing Patient Data

The Home Office has been encouraging other Government departments to share with them the personal data of people that use public services, which is then used by Home Office Immigration Enforcement teams. These practices are widespread and can be seen in the Department for Education<sup>46</sup> and more recently in the Department of Work and Pensions<sup>47</sup>. NHS data is shared with the Home Office in three main ways.

## NHS Trusts Making Enquiries to the Home Office

As part of the process of determining a person's eligibility for free NHS care, Trusts can utilise the Home Office's checking service to access information about their immigration status<sup>48</sup>, this service includes a hotline to the Home Office at a cost of 8 pence per minute to the NHS<sup>49</sup>. Trusts send non-clinical information about the person to the Home Office which they can then use to update their records and potentially take enforcement action. The Trust does not need to gain the consent of the person in order to share their information in this way. Recently it was revealed that the Home Office offered to embed immigration officials in NHS Trusts and Local Authorities to help them identify people eligible for charging, these offices available at a cost to the Trust of £60 an hour<sup>50</sup>.

## NHS Trusts Reporting Patient Debt to the Home Office

When a person has unpaid debt to the NHS of more than £500 for longer than two months the Trust is encouraged to share this information with the Home Office. The Home Office is then able to use the presence of the debt to refuse that person's application for leave to remain<sup>51</sup>. A recent report from the Independent Chief Inspector of Borders and Immigration revealed that the Home Office runs a program called Operation DINTel that uses the information supplied by NHS Trusts to aid the work of their Immigration Enforcement Teams<sup>52</sup>. These brutal policies place individuals at risk of arrest, deportation, and destitution when they seek care. Burdened by unmanageable healthcare debts, individuals become trapped; unable to regularise their immigration status because of the costs this involves and any immigration application or appeal threatened by their outstanding debt with the NHS<sup>53</sup>. Sharing of debt information is not mandatory and at present most Trusts do not share this information however the Home Office is working to make the practice more widespread<sup>54</sup>.

## Bulk Data Sharing with the Home Office

In 2017 it was revealed that NHS Digital had signed a Memorandum of Understanding (MoU) with the Home Office that allowed for bulk sharing of non-clinical patient data for the purposes of Immigration Enforcement<sup>55</sup>. The MoU was the formalisation of data sharing practices that had seen NHS Digital share over 5000 patient records with the Home Office in 2016 alone<sup>56</sup>. Following campaigning from Doctors of the World, the National Aids Trust, and grass roots group Voice of Domestic Workers, alongside calls to halt data sharing from the Health and Social Care Select Committee<sup>57</sup> the MoU was eventually scrapped<sup>58</sup>. However, NHS Digital have already entered negotiations with the Home Office for a revised MoU<sup>59</sup> that is likely to try and replicate the arrangement that was previously in place.

To ensure the NHS remains a safe space for all who need it we echo calls from the European Agency for Fundamental Rights<sup>60</sup>, the ECRI<sup>61</sup>, Liberty<sup>62</sup>, and PICUM<sup>63</sup> for a 'firewall' between the data held by vital public services and Immigration Enforcement.

## 2.5 - Commitments to Universal Healthcare

Medact works to promote the function of the health system as a foundation for societal well-being and a platform for the expression of ethical behaviour. In spite of some improvements in healthcare coverage across the world, hundreds of millions of people still lack adequate access to healthcare and protection from the costs of illness, disease and injury<sup>64</sup>. Health systems have long been commercialised and marketised through structural adjustment programmes, resulting in greater inefficiency and inequity<sup>65</sup>. Though there is a global movement, buoyed by the World Health Organisation's commitment to Universal Healthcare, this principle is being reinterpreted so that certain groups continue to feel alienated, demonised and neglected.

In the UK, we are rightly proud that our NHS was founded on a principle of treating everyone in the country regardless of status, wealth or origin. It has consistently demonstrated the effectiveness and efficiency of Universal Health Coverage since its inception in 1948, and is one of the most equitable and cost-effective health systems in the world.<sup>66</sup> However, the removal of the Secretary of State's duty to secure or provide comprehensive health services in the Health and Social Care Act 2012 set in motion changes to the health system that have jeopardised this standing<sup>67</sup>. The idea that people can be either eligible or ineligible to access care contradicts the central reasoning behind collective provision, in which pooling finances through general taxation shares risks and ensures equity in healthcare for all. In addition, the way a society supports and cares for refugees, asylum seekers and migrants is often a demonstration of its commitment to equality and fairness in society more broadly. The 2015 and 2017 charging regulations represent a significant step backwards in the UK's attempt to provide truly universal healthcare and moves us away from a fair and equitable healthcare system.

The charging system also contradicts a global commitment to Universal Healthcare Coverage (UHC)<sup>68</sup>. UHC is defined by the World Health Organisation (WHO) as 'ensuring that all people have access to needed health services (prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship'<sup>69</sup>. The UK is obliged to work towards this ambitious target by adhering to the EU's commitments to the Sustainable Development Goals (which include UHC in SDG 3<sup>70</sup>), as well as through commitments to reduce health inequalities and protect public health enshrined in UK law by the Health and Social Care Act 2012<sup>71,72</sup>. Furthermore, the UK is a signatory of several human right treaties, including the International Convention on Economic, Social and Cultural Rights in which Article 12 explicitly lays out a human right to the highest attainable standard of physical and mental health<sup>73</sup>. This right is not dependent on migration status, but rather applies equally to all people<sup>74</sup>.

# 3 - Who is Entitled to NHS Care?



The image shows a red suitcase standing upright against a light green wall. The suitcase has a black handle and a black strap. On the front of the suitcase, there is a white rectangular area with a credit card design. The card has a chip icon on the left, a card number '1234 0000 0000 5678', an expiration date '03/11', and the name 'MR A SMITH' at the bottom.

**NHS healthcare is not free for everyone**

If you are visiting England or not living here on a lawful and settled basis, you may have to pay for your hospital treatment.

For more information go to  
[www.nhs.uk/visitingengland](http://www.nhs.uk/visitingengland)

## 3.1 - Ordinary Residence

Entitlement to free NHS care in England is currently reliant on a person being 'ordinarily resident' in the country. DHSC guidance states that a *"person will be 'ordinarily resident' in the UK when that residence is lawful, adopted voluntarily [sic], and for settled purposes as part of the regular order of their life for the time being, whether of short or long duration"*<sup>75</sup>. The definition is derived from case law, principally the case of *Shah vs London Borough of Barnet*<sup>76</sup> and has since been modified in the NHS context to include a requirement for non-EEA citizens to also have indefinite leave to remain<sup>77</sup>. The concept of 'ordinary residence' is problematic for a number of reasons; it is difficult to demonstrate; the assertion that it is reliant on lawful residence ignores the reality of many people's difficult journey through the immigration system; and it is a complicated legal term that NHS practitioners are poorly placed to judge. It is important to note that access to the NHS is not reliant on an individual's tax contribution, a common misconception that underpins many people's understanding of entitlement to NHS services.

### Proving Ordinary Residence

One of the major problems faced by people whose entitlement to care is challenged is that there is no single document that can demonstrate that they are 'ordinarily resident'. It is often based on the person's ability to provide a series of documents, usually a photo ID (often a passport) and proof of address, along with a decision letter from the overseas visitor manager in the Trust that the person is settled in the UK for the time being. This means the policy is likely to have a disproportionate impact on people who do not have documentation or who are unable to provide proof of address. When considering the scale of the impact this policy will have it is worth remembering that 16.5% of people living in the UK hold no passport at all<sup>78</sup>. This is further complicated by the standard question recommended by the DHSC, which requires Trusts to ask if a person has lived in the UK for the last 6 months<sup>79</sup>. This gives the false impression that someone has to have been living in the UK for a specified period of time to be ordinarily resident.

### The Windrush Scandal

The problems people face when they can no longer access vital public services are exemplified by what happened to people from the Windrush Generation as a result of changes in the Immigration Act 2014<sup>80</sup> and the ensuing Hostile Environment policies. Many people that had migrated to the UK before 1973 had no official documentation to prove they had indefinite leave to remain and as a result of the changes could no longer demonstrate their entitlement to free NHS care. This led to people being denied access to care<sup>81</sup>, people deterred from accessing care<sup>82</sup>, and left many homeless and destitute<sup>83</sup>. There was widespread outrage about the situation, including from the High Commissioners of Caribbean Commonwealth Nations<sup>84</sup>, eventually leading to the resignation of then Home Secretary, Amber Rudd<sup>85</sup>.

### ID Checking Pilots

To support Trusts in meeting their requirement to identify and charge patients upfront, the Department of Health and Social Care (DHSC) launched a pilot scheme in 2016 that trialled a requirement for patients to bring two forms of identification document (ID) with them to their appointments<sup>86</sup>. The pilot ran in 18 Trusts for a year prior to the commencement of upfront charging in October 2017. Previous studies show being asked to provide identification to access healthcare deters people from seeking help when they are unwell<sup>87</sup>. The DHSC is yet to publish any evaluation of the result<sup>88</sup>. With data obtained via freedom of information (FOI) requests we do know that the pilot scheme had been largely ineffective at identifying people for charging, finding only 50 people that were ineligible for free care out of 8,900 ID checks<sup>89</sup>. There has been no formal conclusion of the pilot and it remains unclear how many of the Trusts are still running the ID checking scheme.



## 3.2 - The Transient Nature of Immigration Status

The immigration system in the UK is complex. In this section we try and breakdown some of the basic concepts that underpin the system, if you want to get a more detailed understanding, we highly recommend Corporate Watch's 'The UK Border Regime: A Critical Guide'<sup>90</sup> which we draw from heavily for this section.

### How Does the UK Immigration System Categorise People?

Immigration systems are designed to sort people into categories based on their entitlement to live, work, or visit a particular geographic space. In the UK migrants are sorted into these four main categories:

#### EEA Citizens

People who are citizens of EU countries and other countries within the European Economic Area (EEA). Generally, they have a right to live and work in the UK, however this is reliant on them exercising their 'treaty rights' which generally means they are self-sufficient<sup>91</sup>.

#### Non-EEA Citizens

People from countries outside the EEA who usually need to apply for a visa to enter the UK, this will include payment of the Immigration Health Surcharge mentioned earlier.

#### Refugees and Asylum Seekers

People granted or seeking protection from the state as a result of fleeing persecution in their own country. Asylum seekers are people who are in the process of making a claim for asylum and have not yet had their claim approved or refused. As we will discuss later, this category does not indicate whether a person is a refugee, but whether or not the Home Office recognises them as such.

#### So-called 'Undocumented migrants'

This is a very broad category that essentially includes any person that is in breach of immigration rules. It can include: refused asylum seekers, EEA citizens who are not exercising their 'treaty rights', people that previously had leave to remain which has now run out (often known as 'overstayers'), people working outside the terms of their visa - a student working too many hours per week for example, the children of people without leave to remain that are born into 'illegality', and people that are entitled to citizenship but have no papers - many of the Windrush generation for example<sup>92</sup>. This category of migrants are also sometimes referred to as 'irregular' or 'illegal' migrants. We do not use this term in solidarity with other campaigns which have drawn attention to the idea that 'no person is illegal'. Illegality is not a characteristic of an individual but a status produced by policies and legislation<sup>93</sup>.

A person's immigration status can change easily and quickly, with them one day being entitled to NHS care and the next being chargeable. The rules change frequently and have doubled in length since 2010<sup>94</sup>, this complexity coupled with cuts to legal aid support<sup>95</sup> mean people are increasingly unable to navigate the system. When the Home Office makes a decision to refuse a person's application for asylum or for leave to remain that person is able to appeal the Home Office's decision. Just under half of these decisions are overturned at appeal stage<sup>96</sup> suggesting serious flaws in the way the Home Office handle immigration

applications. The average waiting time for an appeal is now around 52 weeks<sup>97</sup>, during this time appellants do not have leave to remain in the UK, they are unable to lawfully work and unable to access free NHS care while they wait for their case to be heard. They may also be subject to immigration enforcement measures like detention or deportation.

The spectre of the 'illegal migrant' is mentioned repeatedly in the British media, migrants are referred to as 'illegal' more frequently than any other qualifier, and 'illegal migrants' are vastly more likely to be talked about in relation to rule breaking and crime<sup>98</sup>. The charging regulations rely on this depiction of 'illegal migrants' to justify the harm the policy causes. It is clear however that in reality people end up breaching immigration rules in a multitude of ways, often as a result of laborious appeals procedures or lack of access to legal representation.

## 3.3 - Who and What is Exempt from Charging?

Exemptions from the charging system include certain services and treatment, as well as certain groups of people. Broadly the exempted services cover all A&E and primary care; infectious and sexually transmitted disease services; and other community services like school nursing (depending whether they are funded by NHS Trusts or by Clinical Commissioning Groups). Certain groups of people excluded from charging include vulnerable people (survivors of torture, trafficking or domestic abuse), people with certain communicable diseases, or people in the care of the State<sup>99</sup>. The complex nature of the policy and poorly communicated information about people's entitlement to care deters people from seeking treatment as a result of fear and confusion about facing potential charges<sup>100</sup>, we discuss the deterrent effect of the policy in detail in section 4 [p19].

### Why Don't the Exemptions Work?

While the guidance aims to exclude from the charging system groups that have increased vulnerability to health inequalities, in reality it is difficult for many people to demonstrate that they qualify for the exemptions. Health problems arising from domestic abuse, sexual violence and torture are exempt from charging, but it is well known that people find it difficult to disclose historic or current abuse<sup>101,102</sup>; and that in general healthcare practitioners are not well trained in handling disclosures<sup>103,104</sup>. To qualify for many of the exemptions people are required to present written confirmation from their GP or a charity to substantiate their experiences<sup>105</sup>, a process that in itself can be traumatising and difficult for people to do. Similarly, to meet the exemption covering survivors of trafficking and modern slavery the person has to have been referred to the National Referral Mechanism (NRM)<sup>106</sup>. This is something that many survivors are unwilling or unprepared to do, not least because around half of claims submitted to the NRM are refused<sup>107</sup> leaving that person vulnerable to detention or deportation. These exemptions from charging only apply to treatment directly related to the exempt condition, this is often a subjective decision taken by healthcare workers leaving many people uncertain what charges they may face, especially in the context of survivors of trauma that may have long standing mental and physical health needs.<sup>108</sup>

Services provided for the treatment of many infectious diseases, including the diagnostic tests required to identify them, are also exempt from the charges. The problem is that people do not present with a diagnosis, they present with symptoms and so for many the fear of incurring charges will still prevent them from seeking care<sup>109</sup>. The exemption only applies to the diagnostic tests and treatment for the specific condition, so people will still risk charges for other tests and any other comorbidities even if one of their healthcare problems is exempt. The policy is still too recent for there to be much data about the impact of charging on people with exempt conditions. However, concerns have been raised by the Faculty of Public Health about underdiagnosis

and undertreatment of infectious diseases arising from charging policy<sup>110</sup> and by a coalition of HIV charities about the prevention of HIV positive migrants from accessing the care they need<sup>111</sup>. A recent study revealed an increase in delayed diagnosis of TB in non-UK born populations in East London following the commencement of the Migrant Visitor Cost Recovery Program in 2014<sup>112</sup>. Whilst this study does not show the impact of the introduction of upfront charging in 2017, it does give an indication of the deterrent impact of the Hostile Environment in the NHS. In addition, there is evidence the broader 'hostile environment' deters individuals with tuberculosis from accessing care<sup>113</sup>.

Although A&E and GP services are exempt from charging, we know that they are sites at which people face questions about their entitlement to care and are identified for charging later. It is increasingly common practice for people to be issued with pre-attendance forms in A&E asking people to demonstrate their eligibility for free care, a process that can lead to delays in care or deter people from seeking treatment altogether<sup>114</sup>. Similarly, people are often inappropriately required to present a passport and proof of address to register with their GP<sup>115</sup> despite Government guidance clearly stating this is not required<sup>116</sup>. These practices undermine the exemptions that are supposed to ensure vital services remain open and accessible to all and are another example of prioritising immigration control over the provision of healthcare.

Refugees and people seeking asylum are also exempt from NHS charges, an exemption designed to stop this very marginalised group being made destitute or excluded from care altogether. This is particularly important as refugees and asylum seekers are known to have a higher prevalence of mental and physical health problems compared to the host population<sup>117</sup>. Many refugees and asylum seekers have limited knowledge of the health systems in their host country and experience fear and mistrust of services<sup>118</sup>, as such it often falls to healthcare workers to identify and support people to access care<sup>119</sup>. Refused asylum seekers, on the other hand, are not exempt from charging under the 2017 regulations, section 3.2 [p15] gives more detail on the difference between asylum seekers and refused asylum seekers and explains how transient these immigration status' can be. Research conducted by Medact Manchester revealed that healthcare workers had a limited understanding of different immigration statuses and the impact these statuses had on a person's entitlement to care. Only 1 in 5 felt comfortable defining the terms 'asylum seeker', 'refugee' and 'economic migrant', while 1 in 3 failed to identify refused asylum seekers as being eligible for free emergency care<sup>120</sup>. Not only is it inappropriate for healthcare workers to interrogate people's immigration status prior to or during treatment, but it is also clear that healthcare workers are poorly placed to apply the exemptions designed to ensure vulnerable people are not denied care. Moreover, this exemption fails to recognise the transient nature of immigration status' and that a person's status can often shift from asylum seeker to refused asylum seeker and back again depending on the progress of their application or appeal to the Home Office.

## 3.4 - Urgent & Immediately Necessary Treatment

The 2017 Guidance groups NHS treatment into 3 categories of urgency, in order of severity they are: immediately necessary, urgent, and non-urgent treatment<sup>121</sup>. The assessment of the person's condition and a determination as to which category applies to them is conducted by a clinician and is supposed to be recorded on a specific form<sup>122</sup>. The Guidance explains in each category in detail, but in brief they are:

<b><u>Immediately Necessary</u></b>	Treatment that needs to be delivered promptly in order to save a person's life, prevent their condition from becoming life threatening, or prevent permanent and serious damage occurring.
<b><u>Urgent</u></b>	Not immediately necessary but cannot wait for the person to be reasonably expected to leave the UK.
<b><u>Non-Urgent</u></b>	Routine treatment that can wait until the person has left the UK.

If a person's condition is determined to be urgent or immediately necessary then care cannot be withheld regardless of that person's ability to pay. This does not exempt them from charging altogether, but instead means that charges will be collected retrospectively, after the treatment is delivered. People are also liable for the cost of the clinician's assessment of urgency.

The definition of 'Urgent' treatment is both complicated and highly subjective. Clinicians are required to judge both the severity of the condition and the impact it has on a person's life, alongside making a judgement about the timescale within which the person is likely to leave the UK; taking into account their immigration status and their ties to the UK. In Immigration hearings, such a decision would be made through the courts by an immigration judge, whereas in healthcare this burden falls on healthcare workers who are ill equipped to make judgments about the nature and impact a person's immigration status has on their entitlement to care<sup>123</sup>. For a healthcare worker to fully understand the likelihood of a person leaving the UK they would need to undertake detailed investigation of the person's circumstances and have a thorough understanding of the processes of the Immigration System, something they cannot and should not be expected to do. The complexity of making decisions about urgency and the harm caused when these decisions are made poorly can be seen in two recent incidents. Elfreda Spencer<sup>124</sup> and Nasar Ullah Khan<sup>125</sup> were unable to pay upfront for their care, their treatment was deemed to be non-urgent and as such was withheld pending payment. Both had been declared not medically fit to fly, yet despite clearly being unable to leave the UK their treatment was still deemed to be 'non-urgent'. Elfreda Spencer died in January 2018 without receiving treatment, the type of cancer she had normally responds well to treatment. Nasar's case was further complicated by recent changes to way in which people are prioritised for organ donation. In 2018 following a decision in the Court of Appeal the practice of de-prioritising people who were not 'ordinarily resident' in the UK<sup>126</sup> was deemed to be lawful. This means that only people with indefinite leave to remain will make it to the top of the transplant list. Nasar was unable to get the transplant he needed He died in February 2019.

## The Special Case of Maternity Care

All maternity treatment is deemed to be 'immediately necessary' and as such can never be withheld as a result of the person's ability to pay<sup>127</sup>. Despite this a number of Trusts involved in the ID checking pilot used their maternity departments to trial the scheme<sup>128,129</sup>. There is ample evidence to suggest that as a result of the charging policy many women are deterred from seeking care<sup>130</sup> and that the confusing way charges are communicated by Trusts often leads women to withdraw from care<sup>131</sup>. In reality it does not matter whether charges are demanded upfront or pursued after care is given, for many women the prospect of being charged at all is enough to stop them accessing maternity services<sup>132</sup>.

# 4 - The Impact of Charging Policy





## 4.1 - Deterrence and Delay

One of the widest ranging and devastating impacts of charging policy is the role it plays in deterring people from seeking care. The Hostile Environment works in a way that embeds the practices of immigration enforcement in the working of vital public services by using a range of behind the scenes data sharing systems and reporting mechanisms. This makes these systems difficult to identify, and can leave people uncertain about whether they will come into contact with immigration enforcement mechanisms when they access a health service. The invisible threat is then bolstered by active publicity campaigns in NHS Trusts using posters supplied by the DHSC<sup>133</sup> that warn people of the likelihood that they will face charging. Although many of the most hostile posters were removed from the DHSC site in August 2018, Trusts still have them on display, including in A&E waiting rooms.

### Health Seeking Behaviour

An effective healthcare system relies on proper and appropriate use of each service provision, with correct and efficient signposting and a focus on preventative care. The impact of restrictive regulations on deterring people from care has been found to change health seeking behaviour, with people more likely to use emergency care instead of primary care. In the UK, Doctors of the World found undocumented migrants reported to use A&E above GP services, and were more likely to use emergency services than planned care<sup>134</sup>. Additionally, Maternity Action found that women in the UK were likely to avoid care until a point of crisis<sup>135</sup>. A number of studies on the effect of policy on the health of migrant populations found that when barriers to care exist people will resort to using A&E instead of primary care; or will pursue unconventional options such as self-treatment, borrowing their friends ID, or discharging themselves before treatment is complete<sup>136,137</sup>.

Delaying seeking care until emergency treatment is required is incentivised if it is the only service that is free to access. Not only is this behaviour risky for individual health but it also puts additional pressure on the health system through increasing demand on an already stretched emergency service, shifting utilisation away from cheaper preventative care, to expensive emergency treatment<sup>138,139</sup>. Although primary care remains free in theory, in reality migrants find it difficult to access<sup>140</sup> and GP registration is known to be lower among people that have recently migrated to the UK<sup>141</sup>. The Hostile Environment is likely to increase inappropriate use of NHS emergency services and, by creating a culture of suspicion and refusal of migrant's right to healthcare, is also likely to further hinder people's ability to register with and access a GP. This will lead to worse health outcomes for migrants and to increased strain on NHS resources that face continuing cuts to funding<sup>142</sup>.

### How the Policy Generates Fear

ID checking and charging policies are enacted with wide variability both between and within Trusts<sup>143</sup>, with patient experience often relying on the knowledge, seniority, and willingness of the healthcare worker advocating on their behalf. An analysis of data obtained by the Joint Commission for the Welfare of Immigrants under the Freedom of Information Act 2005 and analysed by Medact supports this fact.

#### **Our Research:**

The data revealed that of the 99 Trusts that responded 32% had no policy to cover the implementation of the charging regulations and of the remaining Trusts 22% used only the standard DHSC guidance. 28% of Trusts did report having local policies, however of these only 7% had policy specifically relating to the charging regulations, with the rest relying on their general overseas visitors' policy<sup>144</sup>.

The combination of a visible threat of being charged with the invisible and unpredictable mechanisms of identifying chargeable individuals makes these policies even more damaging to the patient and healthcare worker relationship. They rely on the fear of accruing insurmountable debt as a means to deter people from using the health services altogether. The barriers migrants, and particularly undocumented migrants, already face in accessing healthcare are well evidenced<sup>145,146</sup>, and this policy is likely to make the situation worse. There remains relatively limited research into the specific impact of the charging regulations in the UK, however Doctors of the World found that 1 in 5 of the patients of their London clinic did not access mainstream NHS services due to fear of the Home Office or of facing unaffordable bills. They found this deterrence to be the case even for people with urgent health needs such as heavily pregnant women, people with cancer, people with kidney failure and those suffering from post-stroke complications<sup>147</sup>. Additionally, a recent study revealed an increase in delayed diagnosis of TB in non-UK born people living in East London following the launch of the Migrant Visitor Cost Recovery Program in 2014<sup>148</sup>. Supporting these UK based studies, a systematic review into the impact of European immigration policies on the health status of undocumented people, found that although the policies of healthcare restriction for undocumented people varied greatly, being deterred from using services due to the fear of deportation, harassment, and not knowing what they were entitled to was common throughout<sup>149</sup>.

## Comparison with the Spanish Healthcare System

The 2012 Spanish health care reform known as the Royal Decree Law 16 (RDL 16/2012)<sup>150</sup> introduced similar restrictions to healthcare to the 2017 NHS regulations and has been found to reduce access to healthcare for undocumented migrants. The Centre for Research in Health and Economics (Centre de Recerca en Economia I Salut, CRES) analysed data on use of services, satisfaction and self-reported health, before and after the reforms were introduced. The research outcomes demonstrated a sharp decrease in utilisation of primary and secondary care by undocumented people following the reforms<sup>151</sup>. REDER, a network of charities and civil society organisations, have collated evidence on those affected by the reforms, documenting 3,340 cases of people being denied access to healthcare. REDER has found that people officially exempt from charging have wrongly been excluded from care, including 146 pregnant women, 243 minors<sup>152</sup>, and 26 asylum seekers. Sweden has a healthcare policy that restricts healthcare on the basis of migration status, however primary care remains free for all. Despite this blanket exemption, MSF Sweden has found that primary health care is often denied<sup>153</sup>, a finding in keeping with the experience of people without proof of address in the UK<sup>154</sup>.

This comparison paints a concerning picture of the likely long-term impact of these policies in England.

## 4.2 - Maternal Health

The impact of targeted charging on health outcomes can be evaluated in more detail with regards to maternal health due to the availability of several comprehensive reports on the experiences of women facing charges for NHS care. The National Institute for Health and Care Excellence (NICE) make clear recommendations for best practice in antenatal care with evidence showing that having an early booking appointment, regular midwife reviews and prompt referral to a consultant led team or hospital care, is required for optimum health outcomes<sup>155</sup>. NICE have also recognised that migrant women face additional barriers to care and are at increased risk of poor outcomes in pregnancy and in response they have released specialist guidance aiming to address this disparity<sup>156</sup>.

Maternity Action conducted interviews with health professionals and women affected by charging and found that despite the exemption from upfront payment the prospect of retrospective charging meant that migrant women were more likely to: present later than the NICE recommended time of 10 weeks; miss appointments and discharge early from hospital for the fear of large bills; and feel stressed throughout the pregnancy<sup>157,158</sup>. In addition to the fear of charging exposing women to unacceptable risks for health outcomes, Maternity Action added to a growing body of evidence that found stress in pregnancy has long term negative impacts on the

child's emotional and cognitive development<sup>159</sup>. Similarly, Doctors of the World found that many pregnant women were being denied care due to inability to pay despite their entitlement, as staff did not understand the charging rules<sup>160</sup>.

Furthermore, Maternity Action found a concerning impact of targeted healthcare charges on survivors of domestic violence. Their research highlighted a case in which the addition of unaffordable NHS bills to a woman with a newly born baby increased her vulnerability to exploitation and violence from her partner, on whom she was financially dependent<sup>161</sup>. This not only highlights the way in which multiple circumstances can combine to magnify the harmful impact of the charging policy, but also shows the limitations of the exemptions from charging. Treatment for conditions that are directly attributable to domestic violence are exempt from the policy<sup>162</sup>, however it makes no allowance for circumstances in which vulnerability to violence can be increased as a result of the debt incurred.

## 4.3 - Mental Health

Refugees, asylum seekers and undocumented migrants are likely to suffer from worse mental health than host populations<sup>163,164</sup> and are more likely to have been exposed to specific risks that negatively impact mental health, such as detention and conflict<sup>165</sup>. A study on the health of asylum seekers by Médecins Sans Frontières Sweden found that despite being more likely to be younger and healthier than the host population on arrival; asylum seekers were at higher risk of deteriorating health due to poor living conditions, poor access to healthcare, and social isolation<sup>166</sup>. It is well documented that anti-immigration policies restrict access to healthcare and have a negative impact on the mental health of migrant populations causing anxiety and depression<sup>167</sup>. By restricting access to care the recent changes to NHS charging policy under the Hostile Environment will further disadvantage this already marginalised group.

## 4.4 - Child Health

Under the current charging regulations undocumented children are not eligible for free NHS care, placing England among some of the most restrictive healthcare systems in Europe<sup>168</sup>. There are many reasons a child may be undocumented including: children that have an irregular immigration status due to the status of their parents<sup>169</sup>; unrecognised survivors of modern slavery and trafficking; and those who are in the process of seeking asylum<sup>170</sup>. The charging restrictions are thought to affect an estimate of 120,000 children, 65,000 of which are thought to be born in the UK<sup>171</sup>. There are already cases of children being denied or deterred from care<sup>172</sup> but paediatricians are urging health professionals in the UK to independently and systematically collect evidence on the harm of restricting children's access to healthcare<sup>173</sup>.

The available research suggests that undocumented children's engagement with healthcare follows the trend of adults - decreased use and worse outcomes compared to the host populations<sup>174,175,176</sup>. Charging for secondary services is feared to make it less likely for children to be referred to paediatric services or to visit any health professional<sup>177</sup>. Reduced access to health services is also detrimental to a children's safety due to reduced opportunity for health services to come into contact with at risk children, exacerbating their vulnerability. Meaning children that are current or potential victims of slavery, trafficking, child abuse and sexual exploitation are less visible, undermining the prevention and identification strategies in place to protect these children<sup>178</sup>.

The NHS charging regulations pose a risk to the health of undocumented children. This is contradictory to the government's stated commitment and obligation to child health as outlined under the United Nations Convention on the Rights of the Child (Article 24), and the UN Global Compact for Migration which was signed by the UK in December 2018<sup>179</sup>. It is therefore no surprise that the Royal College of Paediatrics and Child Health (RCPCH) was amongst a number of medical colleges that have called for a suspension of the NHS overseas visitor charges<sup>180</sup>.

## 4.5 - Increasing Mortality

Currently there are no quantitative assessments of the impact of NHS charging policy on mortality. This is, at least in part, because the 2017 regulations were introduced too recently to be able to produce a meaningful picture. To get an idea of the possible impact of the regulations we can look to research from Spain following the introduction of Royal Decree Law 16 (RDL 16/2012) a policy similar to the 2017 regulations that restricted access to care for migrants<sup>181</sup>. The Centre for Research in Health and Economics (Centre de Recerca en Economia i Salut, CRES) produced two studies, one looking at the impact on health accessing behaviours<sup>182</sup>, and the other at mortality rates<sup>183</sup>. They found that monthly mortality rates in the undocumented migrant population increased by 15% during the first three years of the policy, equating to about 70 more deaths a year. The study also noted that the mortality rate increased year by year, recording a 22.6% increase from baseline in the third year of the policy. Finally, the research shows that mortality rates are higher still for amenable mortality<sup>184</sup> - deaths that should not occur in the presence of timely and effective interventions - suggesting that restricted access to care is likely to be the cause of the increase.

This research is novel in its approach to quantify the impact of charging regulations. Innovation in research methodology is necessary in this field due to the current lack of data and challenges in assessing impact on undocumented people. The data used did not include migration status on the death certificate, instead they used nationality as a proxy measure of migration, utilising an average percentage of undocumented migration from each country to guide their estimates. Despite these limitations, the results show a significant increase in mortality that is consistent across different age ranges, and across migrant groups from Africa, Asia, and Central & South-America after the introduction of the regulations<sup>185</sup>.

### Our Research:

The assessment of the impact and long-term consequences to health and wellbeing of those affected by the new charging policies is concerning low. Of the 99 trusts that responded, only 3% were able to provide evidence of having conducted an equality impact assessment of this change in policy. Furthermore, no Trust had a system in place to monitor the discriminatory impact of this policy or the potentially devastating effect charging could have on the health of the patients they serve.<sup>186</sup>

### Inherent Discrimination

Given that no Trust has a system in place to monitor the implementation of the charging policy, it is unsurprising that there is limited evidence available that demonstrates its discriminatory impact. We have heard anecdotal evidence suggesting that patients are selectively asked for ID based on their appearance and that it is common for overseas visitor managers to scan patient lists for names that 'look foreign', a claim that is supported by a number of stories that came to light in the media. Shortly after the policy was introduced there were two separate incidents, one of a woman and one of a baby, being billed for care seemingly on the basis of their surname alone<sup>187,188</sup>. In both cases the Trusts sent threatening letters demanding proof of ID or payment for care causing undue distress. In both cases the threat of charging was eventually withdrawn. The presence of structural racism in the NHS is well documented, with members of staff from Black and Minority Ethnic (BAME) backgrounds less likely to be in more senior positions and more likely to report discrimination or face disciplinary proceedings than their white colleagues<sup>189,190</sup>. There is also evidence that people from BAME backgrounds experience different approaches to care and different treatment outcomes compared to white patients<sup>191,192</sup>. The systemic biases that disadvantage people from BAME backgrounds are likely to be worsened by the new charging regulations leading to increasing health inequality and worse outcomes for BAME patients.

## 4.6 - Public Health

The stigma and suspicion surrounding migrant populations posing a threat to the public health of the host population has been prevalent for some time<sup>193</sup>, however it has been shown that in reality the health problems of migrants and refugees are similar to those of the general population and there is no association between migration and importation of infectious disease<sup>194</sup>. Conditions such as HIV and TB pose little threat of transmission to the host population<sup>195</sup>, instead it is the restriction of access to healthcare for individuals with an infectious condition that poses a potential for increased risk to public health. This risk will only increase as at-risk populations are marginalised by exclusionary policies<sup>196</sup>.

For this reason, many infectious diseases including HIV and TB are exempt from charging<sup>197</sup>. Despite this, concern remains among leading clinicians across Europe that the charging policies will deter patients and hinder early detection and diagnosis. They fear that this dis-engagement could give rise to avoidable disease progression, an increase in mother to child transmission of HIV; and increase the opportunity for the spread of disease<sup>198,199,200,201</sup>.

In Spain there is already evidence that exemptions for infectious diseases are failing to protect patients. REDER reported the case of a man who presented critically unwell with HIV; confusion about the regulations meant that his treatment was severely delayed and exposed the patient to a high risk of worse outcomes<sup>202</sup>. In another case Alpha Pam, an undocumented migrant, was turned away from treatment on several occasions for his undiagnosed TB, despite investigation for TB being exempt<sup>203</sup>. He later died as a result of being unable to access the care he needed<sup>204</sup>. These failings are likely to be replicated in the UK. During the ID checking pilot scheme, a Newcastle NHS Trust asked patients to provide two forms of ID when attending appointments in their infectious diseases department, despite many of the conditions treated there being exempt from charging<sup>205</sup>. These barriers prevent marginalised populations engaging in essential care can not only lead to disease progression in the individual, but to increased opportunity for disease spread to the wider population<sup>206</sup>.

With regards to non-communicable diseases (NCDs) prevalent in migrant communities, most are common conditions that can be treated effectively, such as cardiovascular disease, diabetes and hypertensive issues<sup>207</sup>. NCDs are best treated early; simple preventative measures can ensure symptoms are controlled and more severe and costly complications avoided. This is supported by evidence which shows that rather than providing emergency care alone, access to preventative and non-urgent routine care for migrants is in fact cost-saving for health systems<sup>208</sup>. Furthermore, individuals who face barriers to healthcare such as those associated with charging suffer further harm in the form of anxiety, an additional mental health burden contributes to even more cases of preventable ill-health. Below an NHS doctor talks about the impact on one of her patients.

***“I know another who was pursued relentlessly by a debt collection agency for an erroneous bill for something he was entitled to for free. He had two extra consultations with me in primary care to manage the anxiety it created - this would have cost the NHS more than the £60 for which they were hounding him.”*** <sup>209</sup>



## 4.7 - How Does the Policy Impact NHS Staff

The Hostile Environment presents a significant challenge to the ethical frameworks that underpin the work of healthcare practitioners. The policies that require staff to check a person's immigration status; the data sharing systems that send patient information to the Home Office; the decisions made about what care a person can afford, or how much pain they can bare before being expected to leave the UK; these policies make healthcare workers complicit in a system that causes harm to patients by default. Alongside our own personal moral frameworks, all healthcare workers are also governed by standards and codes of practice set out by our regulatory bodies<sup>210,211</sup>; however, neither the General Medical Council nor the Nursing and Midwifery Council have provided further guidance for practitioners about how to manage the ethical contradictions inherent in the administration of charging. This is despite concerns being repeatedly raised by healthcare workers about the implications of the policy, both on their own practice and on the NHS more broadly<sup>212,213,214,215</sup>, and motions passed at the British Medical Association Conference<sup>216</sup>.

### **Our Research:**

Our analysis of FOI data from NHS Trusts revealed that a concerning 67% of Trusts provided no specific training for staff. 40% of Trusts either gave no training or did not specify which training they gave, while 27% gave only standard Equality and Diversity training. Of the 99 Trusts that responded to the FOI requests only 1 in 5 offered staff specific training on the charging regulations<sup>217</sup>.

The long-term impact of the Hostile Environment on people's trust in healthcare workers is yet to be properly evaluated, however we know that across Europe anti-migrant policies have a direct and negative impact on people's trust in the healthcare providers<sup>218</sup>.

Following the introduction of similar restrictions to care in Spain in 2012 healthcare workers across the country with Yo Sí Sanidad and the REDER Network began conscientiously objecting to the policy by refusing to charge patients for care<sup>219</sup>. The required response is necessarily more complicated in the UK context as a result of the interconnected way in which patient data is monitored by overseas visitor managers in Trusts and shared with the Home Office. These mechanisms mean people risk being identified for charging at many different points in the system, not just in their interaction with a healthcare worker. Although advocacy remains a vitally important role for healthcare workers when supporting people who face charges for NHS care, trying to 'hide' patients from the system is likely to be a less effective tactic than it was in Spain. In the next section we'll look at responses from the healthcare community, both in the UK and across Europe.

# 5 - Responses from the Healthcare Community



## 5.1 - Opposition from Healthcare Institutions

The expansion of NHS charges and introduction of ID checks have drawn widespread criticism from the healthcare community, civil society, and politicians. In December 2018 the Royal College of Physicians, the Royal College of Paediatrics and Child Health, the Royal College of Obstetricians and Gynaecologists, and the Faculty of Public Health released a statement calling on the DHSC to scrap both the 2015 and 2017 regulations and conduct an independent review into NHS charging policy<sup>220,221</sup>. This was followed shortly after by a statement from the Academy of Medical Royal Colleges, the umbrella body representing all medical royal colleges in the UK, also calling for the regulations to be scrapped and calling for clear separation between the NHS and Immigration Enforcement<sup>222</sup>. Shadow Health Secretary Jon Ashworth has called for a scrapping of the policy<sup>223</sup> and a motion of regret was tabled in the House of Lords<sup>224</sup>, but was withdrawn before being put to vote. There have been statements warning about the harmful impact of the policy from both the British Medical Association<sup>225</sup> and from ex-NHS Chief Executive David Nicholson<sup>226</sup> but these did not go as far as calling for an end to the policy.

A number of healthcare and migrants' rights focused civil society organisations have also called for the policy to be scrapped or launched campaigns against the charges, they include: Medact, the Joint Council for the Welfare of Immigrants<sup>227</sup>, Doctors of the World<sup>228</sup>, Maternity Action<sup>229</sup>, Asylum Matters<sup>230</sup>, and the National Aids Trust<sup>231</sup>. This work is supported by reports that detail the harmful impact of the policy from the Equality and Human Rights Commission<sup>232</sup> and The Lancet Commission on Migration<sup>233</sup>.

## 5.2 - Patients Not Passports - Resistance from the Grassroots

Docs Not Cops, a grassroots campaigning group, emerged in response to the introduction of the Immigration Act 2014. They held protests and took direct action focusing on the expansion of charging and borders in the NHS and erected fake border checkpoints outside hospitals in London to raise awareness of the harms of the policy amongst staff and the local community. They also mobilised junior doctors to bring a motion to the BMA in 2016 that called on the union to denounce the 2014 Immigration Act<sup>234</sup>. With the introduction of upfront charging and ID checks in 2017, Docs Not Cops created the now well-known Patients Not Passports campaign and throughout 2017 led a series of direct actions aiming to raise awareness about the policy and force the DHSC to abandon their plans to introduce the policy. This saw Docs Not Cops erect fake border checkpoints outside the DHSC<sup>235,236,237</sup> and hold a mass demonstration outside a central London hospital<sup>238</sup>. This was then followed by a number of protests by other groups throughout 2018 and into 2019 in which doctors returned medals earned during the Ebola crisis<sup>239</sup>, actions were targeted at specific NHS Trusts<sup>240,241</sup>, and attention was focused on particular patient groups<sup>242</sup>.

Resistance to the policy is now being led by frontline healthcare workers organising locally to call on individual NHS Trusts to scrap the policy, often supported by groups like Docs Not Cops<sup>243</sup>, Migrants Organise<sup>244</sup> and the Medact Migrant Solidarity Group<sup>245</sup>. These campaigns are spreading across the country and see healthcare workers joining forces with community groups, long-standing NHS campaign organisations like Keep Our NHS Public<sup>246</sup>, and people affected by charging to call on Trusts to support patients to access the care they need<sup>247,248</sup>.

## A Toolkit for Action

Together with Docs Not Cops and Migrants Organise we have produced a toolkit designed to: support health care and community workers to advocate for people facing or impacted by charging; provide a framework to help people start localised campaigns; and give some context to the Hostile Environment in the NHS. The toolkit works alongside our other resources for healthcare workers organising in NHS Trusts - Patients Not Passports Lanyards, Patients Not Passports Advocacy Cards, and this briefing. The lanyards are designed to bring together healthcare workers who oppose the policy in a Trust and provide a talking point for people who do not yet know about the charging regime. The lanyards' advocacy cards provide a condensed version of the advocacy advice in the toolkit, alongside some of the key arguments against the charging policy and a link to main the toolkit, designed to be a quick access resource for healthcare workers. The toolkit itself contains advice, information and resources and can be accessed at [www.PatientsNotPassports.co.uk](http://www.PatientsNotPassports.co.uk).

## 5.3 - Stories of Resistance from Around the World

The UK is not alone in restricting access to care for those with precarious or no immigration status<sup>249</sup>. Wherever policies that restrict care emerge they are met with strategies of resistance whether from healthcare workers, healthcare providers, or municipal governments<sup>250</sup>. PICUM have detailed a range of innovative city level responses to restrictive healthcare policies, demonstrating that with political will these policies can be challenged<sup>251</sup>.

In Spain, following the introduction of Royal Decree Law 16 (RDL 16/2012)<sup>252</sup>, a policy with some similarities to the 2017 NHS charging regulations, a mass movement of healthcare workers formed as Yo Sí Sanidad Universal<sup>253</sup>. They organised conscientious objection from healthcare workers, accompanying schemes to support people to access care, and a national case study reporting mechanism to track the impacts of the policy<sup>254</sup>. Alongside the grassroots mobilisation from Yo Sí Sanidad Universal, a network of civil society organisations collectively known as REDER worked to challenge the policy by monitoring the harm caused<sup>255</sup> and by challenging the human rights impact of the policy through the Committee on Economic and Social Rights (CESR)<sup>256</sup>. The CESR found that the policy contravened Spain's obligations to Article 12, citing that denying healthcare on the basis of migration status represented unacceptable discrimination<sup>257</sup>. These campaigns eventually led to the Spanish Government repealing RDL 16/2012 and restoring undocumented migrants right to access healthcare<sup>258</sup>.

Following investigation of the case of Nell Toussaint the United Nations Human Rights Committee made the landmark decision to condemn the Canadian Government for denying healthcare to people based on their immigration status<sup>259,260</sup>. This led to a national day of action<sup>261</sup> and an open letter signed by over 1,500 healthcare workers and organisations calling on the Government to provide universal and equitable access to healthcare<sup>262</sup>.



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# 6 - Recommendations

## 6.1 - For the Department of Health and Social Care

1. Suspend the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2015 and 2017.
2. Publish in full the Department's internal review of the 2017 Charging Regulations
3. Commission a full independent inquiry into the impact of the Regulations on individual and public health

## 6.2 - For NHS Trusts

1. Suspend upfront charging in the Trust -
  - a. Suspend upfront charging for overseas visitors with immediate effect, and undertake and publish a full public health impact assessment of the charging regulations.
2. Suspend ID checks in the Trust -
  - a. Stop using the appointment pre-attendance form to ask patients to provide unnecessary demographic information which can then be passed to the Home Office. These forms act as a deterrent and stop people attending appointments.
  - b. *[if the Trust has a pilot scheme still running]* Suspend the pilot scheme requiring patients to bring two forms of ID to their appointment.



## For NHS Trusts (cont'd)

3. Call on Government to suspend charging in the NHS -
  - a. Represent the serious concerns of healthcare workers and patients to Government. The impact of charging on patient care and public health must be properly evaluated, nationwide.
4. Properly evaluate the impact of charging on patient care -
  - a. Undertake detailed research into the impact of both charging and ID checks on patients' health and on the Trust's ability to meet its equality duty, and other legal obligations including professional duties of care staff have towards their patients.
5. Stop sharing patient data with the Home Office
  - a. Do not use the Home Office checking service to check patients immigration status
  - b. Stop reporting patient debt to the Home Office, it is known the Home Office then uses this information to aid Immigration Enforcement Teams
  - c. Refuse to share any data with the Home Office
6. Stop collaborating with the Government's Hostile Environment -
  - a. *[If the Trust has them]* Remove all posters and display boards threatening people with charges for their care. They are designed to instil fear and deter people from accessing services.
  - b. Promote a welcoming environment in the Trust with posters reassuring patients their immigration status will not be challenged when seeking healthcare.
  - c. Work with community, faith and voluntary sector organisations to ensure that the Trust is a welcoming environment for all who need to access healthcare.

## 6.3 - For Unions & Royal Colleges

1. Call on the Department of Health and Social Care to suspend both the 2015 and 2017 NHS Charging Regulations
2. Call on the Department of Health to commission a full independent inquiry into the impact of the Regulations on individual and public health; and publish their own internal review of the 2017 Charging Regulations.
3. Call on NHS Trusts to stop sharing patient data with the Home Office and clearly separate the roles of the health care sector and migration authorities.
4. Engage and educate your membership on the impacts of NHS Charging Regulations and support them to challenge the policy.
5. Endorse the 5 Key recommendations put forward by the UCL-Lancet Commission on Migration and Health:
  - a. Dedicate political capital, financial, and human resources to fulfil global commitments to secure healthy migration and improve the security and well-being of mobile groups, especially the most marginalised.
  - b. Re-balance policy making in migration, trade and environment, and foreign affairs to give greater prominence to health. Foster cross-sector, complementary decision making that integrates health considerations across policies and services that determine the health of migrants.
  - c. Confront urgently, vigorously, and persistently divisive myths and discriminatory rhetoric about migrants.
  - d. Advocate for and improve the rights of migrants to ensure safe and healthy educational and working conditions that includes freedom of movement with no arbitrary arrest.
  - e. There is an urgent need to ensure adequate monitoring, evaluation, and research to support the implementation of the Global Compacts.

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**Equality and Human Rights Commission (2018). The lived experiences of access to healthcare for people seeking and refused asylum**

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**PICUM (2018) Firewall and Health: Creating Safe Spaces, Addressing Health Inequalities**

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**UCL–Lancet Commission on Migration and Health (2018) The health of a world on the move.**

[https://doi.org/10.1016/S0140-6736\(18\)32114-7](https://doi.org/10.1016/S0140-6736(18)32114-7)

# 8 - Resources

## Patients Not Passports Toolkit

[www.PatientsNotPassports.co.uk](http://www.PatientsNotPassports.co.uk)

Produced by Docs Not Cops, Medact, and Migrants Organise.

A toolkit designed to support you in advocating for people facing charges for NHS care, and in taking action to end immigration checks and upfront charging in the NHS.

## Safe Surgeries Toolkit

[www.doctorsoftheworld.org.uk/what-we-stand-for/supporting-medics/safe-surgeries-initiative](http://www.doctorsoftheworld.org.uk/what-we-stand-for/supporting-medics/safe-surgeries-initiative)

Produced by Doctors of the World UK

This is a toolkit for healthcare professionals and GP practices who want to provide confidential and welcoming services for all their patients including refugees, asylum seekers and undocumented migrants

## NHS Charging Toolkit

[www.jcwi.org.uk/nhs-charging-toolkits](http://www.jcwi.org.uk/nhs-charging-toolkits)

Produced by the Joint Council for the Welfare of Immigrants

This short guide is for anyone in England who has been refused NHS healthcare, or told that they will have to pay for it. It is also for people working in frontline charities and advice services, MPs' caseworkers, volunteers, mental health advocates, or anyone else trying to help a person who's been put in that situation.

# 9 - Endnotes

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