Scottish Refugee Council

Consultation Response

Department of Health consultation on migrant access and their financial contribution to NHS provision in England

Response submitted by
Scottish Refugee Council

August 2013

About Scottish Refugee Council

Since 1985 Scottish Refugee Council has provided help and advice to those who have fled human rights abuses or other persecution in their homeland and now seek refuge in Scotland. We are a membership organisation which works independently and in partnership with others to provide support to refugees from arrival to settlement and integration into Scottish society. We campaign to ensure that the UK Government meets its international, legal and humanitarian obligations and to raise awareness of refugee issues. We are also an active member of the European Council on Refugees and Exiles (ECRE), a network of over 80 refugee-assisting organisations across Europe.

Introduction

Scottish Refugee Council welcomes the opportunity to submit a response to this consultation. As a member of the *Still Human Still Here* coalition, we fully endorse the submission on behalf of the coalition and we will not repeat the points made there.[1] Rather, we will endeavour to provide general comments on the proposals contained in the consultation document as they relate to our work with people seeking refuge in Scotland. Although the consultation focuses on the provision of services and implementation of regulations specific to England, the proposals infer an impact on migrant populations across the UK and we consider it crucial to ensure the voices of migrants and refugees and the organisations representing them in other parts of the UK are heard.

[1] http://stillhumanstillhere.files.wordpress.com/2009/01/still-human-still-here-consultation-response.doc

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We have not sought to answer all of the consultation questions, but will focus our comments on the issues of evidence, government competency in the area of health, the approach of the Scottish Government and its responsibility for developing health policy in Scotland, and some of the key reasons why we strongly believe the current proposals are ill thought through and unworkable.

Comments

Evidence

As the evidence presented by our colleagues at the Still Human Still Here coalition suggests, it is our view that the proposals outlined in this consultation are ill thought through and constitute an apparent knee-jerk reaction to public (mis)perceptions around migration and migrants' use and financial contribution to National Health Services across the UK. The consultation document itself acknowledges the "*limited detailed information available*" (1.13) to back up its own proposals and provide a reliable evidence base for accusations of 'health tourism' or lack of contribution to NHS services by migrant populations. The Migration Observatory at the University of Oxford has clearly stated that:

> "*There is … **very limited systematic data and analysis** about migrants' use of public services, **especially health** and education, and **even less information about the value of migrants' contributions to the provision of public services** in the UK."* [2]

Competency

At paragraphs 1.23 and 2.25, the Department of Health suggests that the proposals it outlines will 'benefit' parts of the UK for which it has no competency to be recommending or developing health policy in relation to overseas visitors. There is no mention, let alone evidence presented, in the consultation that any of the issues discussed are of concern to health authorities in Scotland, Wales or Northern Ireland. A recent parliamentary question revealed that "*the devolved authorities **have been made aware** of Government intentions to take forward actions in these areas* [health and housing]"[3] suggesting not only a lack of any meaningful discussion or evidencing of the benefits or otherwise of the UK Government's proposals for other parts of the UK, but also a complete lack of regard for the competency of devolved administrations 'in these areas'. In order to legislate on devolved matters the Westminster government is required not only to discuss and agree proposals with the Scottish Government, but to seek formal legislative consent from the Scottish Parliament. The timescales for these proposals further highlight a lack of regard for due process, as the consultation period takes place whilst the Scottish Parliament is in summer recess.

[2] http://www.migrationobservatory.ox.ac.uk/top-ten/7-impacts
[3] Hansard Ref: HC Deb, 16 July 2013, c604W

Scottish Government approach

The Scottish Government approach to the provision of healthcare *"is based on a principle of collective responsibility by the state for the provision of comprehensive health services free at the point of use… funded from central taxation and …based on need"*[4], not on a concept of direct contributions-based access for certain categories of people deemed to be 'contributing' directly through income-based taxation, as the Department of Health is proposing. The proposals being put forward in this consultation are inconsistent with the strategic aims of the Scottish Government on healthcare, which are grounded in a human rights based approach and reflected in the legislation and guidance currently in force in Scotland.

The Scottish Government *2020 Vision* for the delivery of health and social care in Scotland states as priorities: early intervention, anticipation and the reduction of health inequalities.[5] In line with the findings of the Christie Commission, which called for a focus on prevention, tackling inequalities and promoting equality in the delivery of public services, the Scottish Government has committed to a drive to:

- *accelerate progress in building prevention into the design and delivery of all our public services;*
- *focus support in the first few years of life where we know it can have the biggest impact in improving life chances for the most vulnerable in society;*
- *unlock resources currently invested in dealing with acute problems;*
- *tackle inter-generational cycles of inequality and pockets of disadvantage that blight the life chances of some of our people;*
- *and better utilise the talents, capacities and potential of our people and communities.*[6]

As clearly demonstrated in the submission by the *Still Human Still Here* coalition, the proposals outlined in this consultation are completely inconsistent with these fundamental principles of the provision of public services in Scotland and the derived cost benefits of early intervention.

Legislative variation across the UK

The consultation document states at paragraph 2.25:

> "*The devolved administrations currently retain substantially the same legislative framework and almost all regulations on charging visitors.*"

This is in fact not the case. In Scotland, statutory legislation and government guidance in the area of overseas visitors' access and charging for healthcare differ from those in force in England. The legislation in force in Scotland is The National Health Service (Charges to Overseas Visitors)

[4] Robson, K. (2011) *The National Health Service in Scotland: Subject Profile*, Scottish Parliament Information Centre (SPICe)
[5] www.scotland.gov.uk/Topics/Health/Policy/2020-Vision
[6] The Scottish Government (2011), *Renewing Scotland's Public Services: Priorities for reform in response to the Christie Commission*, Edinburgh, p.6

(Scotland) Regulations 1989[7] and in England, it is The National Health Service (Charges to Overseas Visitors) Regulations 2011.[8] An example of a significant difference between the legislative frameworks of England and Scotland are the regulations governing exemptions from charging for NHS services for asylum claimants. The Department of Health states its intention to retain the current exemptions but these already differ substantially across the devolved health authorities and already cause confusion, which, in turn, are often a barrier to access.

For example, in Scotland:

> "*Anyone who has made a formal application for asylum,* ***whether pending or unsuccessful****, is entitled to treatment* ***on the same basis as a UK national*** *who is ordinarily resident in Scotland* ***while they remain in the country***".[9]

In England, the equivalent exemption is limited to anyone who "*has made an application,* ***which has not yet been determined****, to be granted temporary protection, asylum or humanitarian protection under those rules…*" or, "***is currently supported*** *under section 4 or 95 of the Immigration and Asylum Act 1999(13)*". The English regulations thus make liable to charging, an extremely vulnerable group of people, refused asylum but in England without access to public funds, who are likely to have healthcare needs and very unlikely to be able to pay for them.[10] This example highlights a fundamental difference in approach between England and Scotland, which is inconsistent with the inference in the consultation document that a uniform policy of further restrictions is workable or in anyone's best interests. A useful comparison of the entitlements of refused asylum seekers to free secondary healthcare in the different health administrations is available on the Northern Ireland Law Centre website for further evidence of differing regulations across the UK.[11]

Despite these clear differences in entitlement, there is ***no evidence*** of any intra-UK movement of people seeking more favourable or free access to healthcare. In fact, we know from our own experience that even in Scotland where entitlement to both primary and secondary healthcare for all those who have made an application for asylum is clear, a fear of authority can make vulnerable people at any stage of the asylum process reluctant to access care until their condition becomes critical. Our experience has shown that the differentiation in regulations already causes

[7] The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989/364 www.legislation.gov.uk/uksi/1989/364/made

[8] The National Health Service (Charges to Overseas Visitors) Regulations 2011/1556 www.legislation.gov.uk/uksi/2011/1556/made

[9] Scottish Government Health Directorate, CEL 09 (2010) Overseas Visitors' Liability to Pay Charges for NHS Care and Services www.sehd.scot.nhs.uk/mels/CEL2010_09.pdf

[10] See for example: Crawley et al (2011) *Coping with Destitution: Survival and livelihood strategies of refused asylum seekers living in the UK*, Centre for Migration Policy Research (CMPR), Swansea University; Gillespie, M (2012) *Trapped: Destitution and Asylum in Scotland*, Scottish Poverty Information Unit, Institute for Society and Social Justice Research, Glasgow Caledonian University

[11] www.lawcentreni.org/component/content/article/63-policy-briefings/865-refused-asylum-seekers-and-access-to-free-secondary-healthcare.html

confusion among statutory authorities, health practitioners and those in need of care.[12] The case studies below are reflective of the common issues of vulnerable people facing barriers to care and wrongly being considered liable to charging with which clients regularly present to our frontline advice service:

Case Study - Ali

Ali is a refused asylum seeker who has no further right of appeal. Ali has been in the UK for 10 years, his sister and family have refugee status in the UK, but his claim was refused and he is now destitute. Ali has long-term mental health problems and is diabetic. Ali's mental health deteriorated, he was involved in an altercation with the receptionist at his GP surgery and subsequently removed from their patient list. His family sought assistance from Scottish Refugee Council to register with another GP as he had been turned away from another local practice and required urgent treatment. He was eventually re-registered but in the meantime had to access costly emergency care.

Case Study – The Abdullah Family

Mr and Mrs Abdullah and their two young children are awaiting a decision on their asylum claim in Glasgow. They receive asylum support from the Home Office and have been issued with an HC2 certificate entitling them to exemption from additional charges for NHS services such as dental care and assistance with travel costs to hospital appointments. Mrs Abdullah attended her local GP practice with her young family and subsequently received a bill charging them for the primary care they had received. They came to Scottish Refugee Council very concerned about their apparent liability to charging for healthcare. We were able to advocate on their behalf for the bill to be revoked.

International obligations

It is clear that the complexity of the existing regulations and the fact that they already differ across the UK present a barrier to the provision of healthcare and the UK government's legal obligations under international law. In a recent examination of the UK, the United Nations Committee on the Elimination of all forms of Discrimination Against Women noted in its Concluding Observations that it was "*concerned about reports…that …asylum seeking women … face obstacles in accessing medical healthcare*" and repeated its recommendation from 2008 that the UK "*provide access to justice and healthcare* ***to all women with insecure immigration status****, including*

[12] Scottish Refugee Council correspondence with the former Regional Director of UK Border Agency Scotland and Northern Ireland (June 2011); Scottish Refugee Council correspondence with British Medical Association (Dec 2011 & Feb 2013).

asylum seekers, until their return to their countries of origin".[13] The Department of Health for England's current policies are already in contravention of this recommendation, even before the far-reaching proposals contained in this consultation are taken into account.

Complexity of immigration and asylum law

Immigration and asylum legislation is extremely complex and people frequently move between immigration 'categories'. From our experience, people are often unclear themselves about the category they fall into. Many women in particular have no control over their immigration status as dependents on the cases of a partner or spouse. A person who has been working or studying in the UK with one form of immigration status may find themselves unable to return home and move into the asylum system, for example, a Syrian university student who finds their country in turmoil and faces a real risk of persecution on return. An asylum seeker whose case has been refused but then secures new evidence to make further submissions would move between eligibility and charging categories in England. Someone who has been granted Discretionary Leave for three years would have to wait up to 10 years to be entitled to Indefinite Leave to Remain and become entitled to healthcare under the new proposals. In the meantime, their leave may lapse if they fail to renew their application for continued leave within each three year period, causing them to move between different categories.

Health professionals cannot and should not be expected to become immigration officers. Establishing someone's immigration status requires extensive knowledge of asylum and immigration law and to suggest a health professional already working under considerable pressure to deliver a non-discriminatory public service should be expected to assess the immigration status of their patients is completely inappropriate.

The likely outcomes of further categorisation of entitlement and restrictions on eligibility are an increase in health inequalities as people become even more reluctant to access healthcare at the point of need, an increased risk to public health as communicable diseases go untreated, and an increase in statutory discrimination in the provision of public services. As acknowledged by the Scottish Government in its approach to public service provision and evidenced in the Still Human Still Here coalition's response, the cost of *not* providing care is far greater in the long-term than ensuring full access at the point of need.

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[13] United Nations Committee on the Elimination of Discrimination against Women, *Concluding observations on the seventh periodic report of the United Kingdom of Great Britain and Northern Ireland*, 26 July 2013 (CEDAW/C/GBR/CO/7)