Scottish Refugee Council
Consultation Response

Home Office Consultation Controlling Immigration – Regulating Migrant Access to Health Services in the UK

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 made to the Department of Health's parallel consultation and we will not repeat the substantive 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.

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

Scottish Refugee Council
5 Cadogan Square, (170 Blythswood Court), Glasgow G2 7PH
Tel: 0141 248 9799 Fax: 0141 243 2499 **www.scottishrefugeecouncil.org.uk**
Registered charity no: SC008639

Summary

We have not sought to answer all of the consultation questions and we will not be submitting a response through the online Survey Monkey questionnaire as we do not feel this provides an appropriate space for us to voice our wider concerns. Our response focuses on the following fundamental issues:

- the absence of evidence to back up proposals contained in the consultation document;
- government competency in the area of health;
- the lack of engagement with devolved administrations;
- the UK's international obligations to ensure access to healthcare; and
- the practical implications of the Home Office's proposals.

General Comments

1. Absence of evidence

1.1 As the submission to the Department of Health by our colleagues at the Still Human Still Here coalition suggests, it is our view that the proposals outlined by the UK Government are ill thought through, unworkable and constitute an apparent knee-jerk reaction to pubic (mis)perceptions around migration and migrants' use and financial contribution to National Health Services across the UK.

1.2 The Home Office consultation document provides ***no evidence*** whatsoever to back up its claim that the UK has a "*significant problem with health tourism*" (paragraph 5.3; also 1.5, 1.7, 1.15) nor does it provide any evidence for the alleged lack of financial contribution to NHS services across the UK by migrant populations. In its parallel consultation document, the Department of Health acknowledges the "*limited detailed information available*"[2] to back up the proposals being put forward. The 'evidence' presented in Annex B of the Home Office consultation document is limited to speculative assumptions for which no quantitative cost-benefit analysis is available. In the Introduction to Annex B, the Home Office recognises that "*it is not possible to fully monetise the impacts due to gaps in the available data*". Furthermore, 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."* [3]

2. Government Competency

2.1 Despite not having competency to be recommending or developing health policy in relation to overseas visitors in the devolved administrations, at paragraph 1.7, the Home Office states that the proposals it outlines "*should apply across the whole of the UK".* There is no mention, let alone evidence presented in the consultation that any of the issues discussed

[2] Department of Health, Sustaining services, ensuring fairness: a consultation on migrant access and their financial contribution to NHS provision in England, July 2013, para. 1.13

[3] http://www.migrationobservatory.ox.ac.uk/top-ten/7-impacts

are of concern to health authorities in Scotland, Wales or Northern Ireland. There is no recognition within the consultation document of the different approaches to the provision of healthcare in the devolved administrations. There is no acknowledgement of the different legislation currently governing charging regimes for overseas visitors in the devolved nations (pages 5 & 6)[4], and no recognition of the different interpretations of ordinary residence and exemptions from charging for the purpose of access to NHS services (page 30)[5].

2.2 Despite clear differences in entitlement in relation to refused asylum seekers, there is ***no evidence*** of any intra-UK movement of people seeking more favourable or free access to healthcare. On the contrary, we know from our own experience that even in Scotland where entitlement to both primary and secondary healthcare is clear for all those who have applied for asylum until they leave the country, 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 confusion and barriers to access among statutory authorities, health practitioners and those in need of care.[6]

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.

2.3 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]"[7] confirming, not only a lack of any meaningful discussion or evidencing of the

[4] For example, the legislation in force in Scotland is The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 and in England, it is The National Health Service (Charges to Overseas Visitors) Regulations 2011.

[5] For example, the Scottish Government Health Directorate, CEL 09 (2010) Overseas Visitors' Liability to Pay Charges for NHS Care and Services Guidance (www.sehd.scot.nhs.uk/mels/CEL2010_09.pdf) states that 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**. For a further analysis of differences in this particular area across all four of the UK's health authorities see www.lawcentreni.org/component/content/article/63-policy-briefings/865-refused-asylum-seekers-and-access-to-free-secondary-healthcare.html.

[6] 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).

[7] Hansard Ref: HC Deb, 16 July 2013, c604W

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 the UK Government has set further highlight a lack of regard for due process, as the consultation period takes place whilst the Scottish Parliament is in summer recess.

3. The Scottish Government approach

3.1 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"*[8], 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 Home Office 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.

3.2 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.[9] 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.*[10]

3.3 The Still Human Still Here submission to the Department of Health contains detailed examples of how 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.

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

4. International obligations

4.1 Not only are the proposals contained in the consultation inconsistent with the principles of public service provision in Scotland, but also, fundamentally, they are inconsistent with the UK's legal obligations under international law. As demonstrated in the case study above, the complexity of the existing charging regulations and the differing degrees of restriction across the UK already present a barrier to access and the provision of healthcare to vulnerable groups of people. Under international human rights law, the right to healthcare is core to the right to health recognised in various international conventions, which are legally binding in the UK.[11]

4.2 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 asylum seekers, until their return to their countries of origin*".[12] Thus, in the United Nations' view, the UK Government's current policies are already in contravention of international human rights law, even before the far-reaching proposals contained in this consultation document are taken into account.

5. Practicalities of the Home Office proposals

5.1 If the UK Government cannot be clear about current regulations, practices and principles in the provision of healthcare across the United Kingdom, nor provide any meaningful evidence to back up its proposals, it is not at all clear how it intends to implement the sweeping reforms proposed. Fundamentally, it is unclear how the proposals will save money or how they will be implemented in practice. For example, given that healthcare is a devolved matter administered by four separate national health authorities across the UK, it is not clear how the Home Office intends to administer the proposed migrant health levy. How would money levied through visa fees at the UK border then be distributed to the appropriate health authority in one of the four devolved nations potentially providing care to the migrant? There would surely need to be consideration factored into the proposals to take account of this. Would this process be administered through the Barnett Formula?

5.2 As the Home Office is well aware, immigration and asylum legislation is extremely complex and not only are people frequently moved around the United Kingdom by the government (for example in the asylum support system) or indeed move themselves for work, study or

[11] 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) (Article 12); 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (Article 12); 1989 Convention on the Rights of the Child (CRC) (Article 24)

[12] 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)

family reasons, their immigration status can also be fluid. From our experience, people are often unclear about the immigration category they fall into. Many women in particular have no control over their immigration status as dependents on the status of a partner or spouse. A person who has been working or studying in the UK with one form of 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 for healthcare 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.

5.3 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.

5.4 Overall, the likely outcomes of the proposals being put forward by the Home Office and Department of Health for England are an increase in health inequalities as people become even more reluctant to access healthcare at the point of need; a significant increase in cost both administratively to implement such impractical proposals and in the provision of care as conditions become critical through lack of access to appropriate treatment early on; an increased risk to public health as communicable diseases go untreated; an increase in statutory discrimination in the provision of public services; and a significant reduction in the quality of care overall as healthcare staff face additional pressure to act as immigration officials on top of their already extremely pressured workloads.

5.5 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.

For further information please contact:

Nina Murray
Women's Policy Development Officer
Scottish Refugee Council
nina.murray@scottishrefugeecouncil.org.uk