women's resource centre

Consultation response

'Controlling Immigration – Regulating Migrant Access to Health Services in the UK'

Consultation by Home Office

28 August 2013

Understanding and supporting women and their organisations

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About the Women's Resource Centre

WRC is a unique charity which supports women's organisations to be more effective and sustainable. We provide training, information, resources and one-to-one support on a range of organisational development issues. We also lobby decision makers on behalf of the women's not-for-profit sector for improved representation and funding.

Our members work in a wide range of fields including health, violence against women, employment, education, rights and equality, the criminal justice system and the environment. They deliver services to and campaign on behalf of some of the most marginalised communities of women.

There are over ten thousand people working or volunteering for our members who support almost half a million individuals each year.

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Introduction

Women's Resource Centre welcomes the opportunity to comment on the proposals for a migrant health levy as part of the Home Office's consultation 'Controlling Immigration – Regulating migrant access to health services in the UK'.

There is extensive evidence that current charging policies already have a disproportionate effect on vulnerable groups, particularly on women migrants. Women migrants may have not have access to public funds and can be vulnerable to high levels of depression and anxiety as a result of experiences of trauma, violence, lost social support and discrimination in the UK. Financial barriers, in addition to fear of the authorities, mean that many destitute migrant women are not seeking healthcare at all. If further barriers to healthcare are created, the negative impact of these policies on vulnerable women will increase.

Women's Resource Centre is also very concerned at the impact assessment that has been conducted for this consultation, which we believe is inadequate and does not consider the issues which we raise in our consultation response. We urge the Home Office to work with the equalities voluntary and community sector to consider the long term financial and social impact of introducing these proposals rather than the possible short-term financial gains.

Response

1. Should all temporary migrants, and any dependants who accompany them, make a direct contribution to the costs of their healthcare? (Yes / No / Don't know)

No.

Migrants who come to live in the UK for an extended period of time (more than six months) already contribute to the NHS through their regular taxation (VAT, income tax and National Insurance Contributions). They also contribute to revenue through their visa fees prior to entering the UK.

2. Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK? (Yes / No / Don't know)

No.

Linking NHS entitlement to permanent residence does not reflect either the commitment or contribution of the migrants who will be affected by these proposals. Although most immigration routes leading to settlement should render migrants eligible for permanent residence after five years, additional requirements to apply for ILR (such as the Life in the UK Test or the minimum income requirement for partners) means that in practice many migrants take much longer to acquire permanent residence. There will be migrants who have lived in the UK for many years and contributed greatly, without having qualified for completely free NHS access.

Women who have experienced violence including domestic and sexual violence, forced marriage and female genital mutilation (FGM), are particularly vulnerable to the impact of this proposed change. Their route to permanent residence and access to healthcare may be reliant on their sponsorship by the perpetrator of the abuse, such as a partner or relative, who could prolong the process of acquiring permanent residency, or use this dependency to threaten the victim of abuse.

Experiencing violence either in the UK or abroad can cause significant long-term physical and mental health issues for migrant women[1], which they may not be able to receive treatment for under the proposed system. Furthermore, for many women, particularly pregnant women, receiving treatment for health problems caused by violence is their first opportunity to disclose the violence they have experienced in a safe place. Restricting access to free healthcare would mean that the most vulnerable migrant women, who are in an abusive relationship and could not afford to pay a health levy or insurance, would lose another opportunity to disclose their experiences in a safe place and flee their abusive partner.

3. What would be the most effective means of ensuring temporary migrants make a financial contribution to public health services?
a) A health levy paid as part of the entry clearance process
b) Health insurance
c) Other option (please detail your proposals)

The consultation documentation does not provide sufficient evidence to indicate that a greater financial contribution from resident non-EEA migrants is needed. A health insurance requirement is unlikely to address the situation of vulnerable women living in the UK as they are unlikely to have the funds to maintain insurance. These include women who are destitute, who have insecure immigration status, who are

[1] http://www.whec.org.uk/wordpress/wp-content/uploads/downloads/2011/11/WhyWomensHealth11.pdf

dependent on partners or relatives for financial support, or who are working in low paid jobs.

A mandatory health levy will unfairly impact on women seeking to visit the UK. Worldwide, women are more likely to live in poverty than men and are more likely to be in lower paid work than men. Imposing an additional cost penalty on entering the UK will impact most heavily on women.

A better initial focus would be on recouping costs from other EEA nations, for the treatment of their citizens, as this is a more straight-forward matter of implementation that does not require a change in law.

4. If a health levy were established, at what level should it be set?
a) £200 per year
b) £500 per year
c) Other amount (please specify)

We do not think a levy should be introduced.

5. Should some or all categories of migrant be granted the flexibility to opt out of paying a migrant health levy, for example where they hold medical insurance for privately provided healthcare? (Yes, some categories / Yes, all categories / No / Don't know)

If you responded with 'Yes, some categories', please specify.

We do not think a levy should be introduced.

6. Should a migrant health levy be set at a fixed level for all temporary migrants, or varied (for example according to the age of the migrant)?
a) Fixed level
b) Varied level
c) Don't know

We do not think a levy should be introduced.

7. Should temporary migrants already in the UK be required to pay a health levy as part of any application to extend their leave? (Yes / No / Don't know)

No.

We do not support a health levy charge in the case of migrants entering the UK; therefore we believe that it is unreasonable to expect a health levy to be paid as part of an application to extend leave for migrants already in the UK. Migrants applying to extend leave will have been living in the UK for a considerable period, during which time they have contributed to the NHS through everyday taxation. In addition, applying for extension of leave clearly indicates that the migrant does not consider his/her stay 'temporary', but considers the UK his/her country of residence. It is only reasonable that s/he can access healthcare as a UK resident at this point. It would also be unfair to implement any levy which would affect migrants who arrived in the

UK under different entry rules, mid-way through their journey to permanent residence.

8. Are there any categories of migrant that you believe should be exempt from paying the health levy or other methods of charging (over and above those already exempt on humanitarian grounds or as a result of our international obligations)? (Yes / No / Don't know). If yes, please specify.

We believe that the consultation document has made some omissions regarding groups that should be exempt from these proposals, including:

Asylum seeking women - Asylum seeking women have poor health outcomes and should be actively encouraged to make effective use of health services. They are less likely than their UK counterparts to have received vaccinations against common communicable diseases, and may be more likely to present with diseases such as tuberculosis, and hepatitis. Poor healthcare in their country of origin may also mean that women arrive with other undetected or untreated problems such as congenital or rheumatic heart disease, sickle cell anaemia or beta thasselemia.[2] Many may still bear the physical and mental scars of the violence they experienced in the country they have fled, such as injuries sustained through torture, imprisonment, rape or female genital mutilation (FGM) (BMA 2002, CEMACH 2007, Refugee Council 2009).

There is evidence of extremely poor mental health amongst asylum seeking women. A recent study by the Scottish Refugee Council (2009) found that of the 46 women interviewed, 57 percent were above the cut-point for Post Traumatic Stress Disorder (PTSD); 20 percent reported thoughts of ending their life within the past seven days. The women were in the upper 90th percentile for depression and anxiety compared to an average adult female population.[3]

Women accessing maternity care - Introducing charges without exemptions for pregnant migrant women would exacerbate the problems that migrant women already face when accessing maternity care. Research has shown that compared to white women born in the UK, BME women born outside the UK booked for antenatal care later, had poorer information provision and were less likely to be treated with respect by staff.[4] In 2011, the majority of pregnant women who attended the Project: London's clinic in East London, established for migrants, the homeless, and female sex workers, were already in the second trimester of their pregnancy or beyond, without having yet accessed antenatal care.[5] Refugee and asylum seeking women make up 12 percent all maternal deaths yet less than 0.3 percent of the population.[6]

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[2] Lewis, G (2007) 'The Confidential Enquiry into maternal and child health (CEMACH). Saving mothers lives: reviewing maternal deaths to make motherhood safer 2003-2005. The seventh report on confidential enquires into maternal deaths in the UK' London

[3] Scottish Refugee Council (2009) Asylum-seeking Women, Violence and Health. Glasgow http://tinyurl.com/k8agbpe

[4] Redshaw, M. and Heikilla, K. (2010) Delivered with care: A national survey of women's experiences of maternity care in 2010. National Perinatal Epidemiology Unit https://www.npeu.ox.ac.uk/files/downloads/reports/Maternity-Survey-Report-2010.pdf

[5] Ramaswami, R. (2012) 'Why migrants mothers die in childbirth in the UK', Open Democracy, 12th January 2012 http://www.opendemocracy.net/5050/ramya-ramaswami/why-migrant-mothers-die-in-childbirth-inuk

[6] Lewis, G (2007) 'The Confidential Enquiry into maternal and child health (CEMACH). Saving mothers lives: reviewing maternal deaths to make motherhood safer 2003-2005. The seventh report on confidential enquires into maternal deaths in the UK' London

Women who have experienced violence - Domestic and sexual violence, forced marriage and other forms of violence against women have long-term physical and mental health implications for migrant women. Restricting access to healthcare by introducing charges will mean that women with temporary or irregular immigration status will be unable to receive the support they need to recover from the violence that they have experienced. For example, women who experience domestic violence require twice the level of general medical services and three to eight times the level of mental health services.[7] Primary healthcare services are likely to be the first and possibly the only professional contact for many women suffering domestic abuse, and groups such as vulnerable migrant women may have very little idea of where else to turn.

9. Should any requirement to hold health insurance be a mandatory condition of entry to the UK (as determined by the Home Office)? (Yes / No / Don't know)

No.

10. Should chargeable migrants pay for all healthcare services, including primary medical care provided by GPs? (Yes / No / Don't know)

Maintaining universal access to primary care is vital to both individual and public health. Anything which deters people living in the UK from seeking medical advice early, through primary care will cost the NHS more when they eventually become seriously ill or develop complications. This is particularly concerning when one considers the importance of early treatment for:

- **Maternity care:** Women who commence antenatal care early in their pregnancy have better maternal and child health outcomes that those commencing care later. Accessing primary care early also reduces the need for costly interventions.
- **Progressive conditions:** There are considerable efforts to improve the ability of GPs to diagnose cancer early, when it can be treated more effectively. When detected early, diabetes can also be treated inexpensively, compared to treating complications arising from unmanaged diabetes.

Furthermore, access to primary care is a lynch pin for a number of health-related rules within the asylum and immigration system. For example:

- Victims of domestic violence who are seeking permission to remain in the UK after the breakdown of the relationship with a partner who was sponsoring them must provide proof of the domestic violence. GPs are an important source of evidence.
- Refused asylum seekers applying for Section 4 support on health grounds must be assessed by a doctor (usually a GP). Asylum seekers asking for an exemption from reporting requirements on health grounds must also provide evidence from their doctor.

Therefore, it is essential that all migrants can access primary care services without charge, irrespective of their immigration status.

[7] Women's National Commission (2010) A Bitter Pill To Swallow: Report from WNC Focus Groups to inform the Department of Health Taskforce on the Health Aspects of Violence Against Women and Girls. WNC: London http://wnc.equalities.gov.uk/work-of-the-wnc/violence-against-women/newsand-updates/309-a-bitter-pill-to-swallow-report-from-the-wnc-focus-groups.html