women's resource centre

Consultation response

'Sustaining services, Ensuring fairness'

Consultation by Department of Health

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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Response

Women's Resource Centre welcomes the opportunity to comment as part of the Department of Health's consultation 'Sustaining services, ensuring fairness: a consultation on migrant access and their financial contribution to NHS provision in England'. However, we are concerned that these proposals could have a disproportionately negative impact on migrant women in the UK when they are at their most vulnerable. We urge the Department of Health to analyse these proposals carefully for their potential impact on minority groups, including pregnant and disabled migrant women.

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 this consultation response. We urge the Home Office to work with the women's voluntary and community sector and other equalities organisations to consider the long term financial and social impact of introducing these proposals rather than the possible short-term financial gains.

We would like to highlight a number of concerns the proposals raise and would like further clarity on:

- The safeguards that will be put in place for women and girls experiencing violence and abuse (including domestic violence, rape and sexual violence, forced marriage, 'honor-based' violence and Female Genital Mutilation (FGM))

- How will the review of evidence as to the extent of the problem of health care 'tourism' impact the proposals outlined in this consultation
- How these proposals will not increase the risk of groups facing barriers to accessing care earlier on.

Overarching Principles

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

There are some welcome inclusions in the list of overarching principles, but other very important guiding principles have not been stated. These include:

- Human rights under the Human Rights Act 1997, including the right to life, health and a family life. Also a commitment to upholding the UK's obligations to advancing women's rights, as described in the Convention on the Elimination of Discrimination Against Women (CEDAW).[1]
- Ethical obligations on doctors to provide care to people who are in need, including the Hippocratic Oath.
- Existing services standards and guidelines (e.g. NICE guidance) which must not be undermined by restrictions on healthcare access.

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

There is already extensive evidence that current charging policies 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.

Migrant women are more likely to be living in the UK as dependants of a male migrant. It is unclear from the consultation document how their entitlement to free healthcare will be protected in the case of domestic abuse and/or relationship or family breakdown.

The proposals could impact on different groups of women in a number of ways:

Black and minority ethnic (BME) women and women from specific nationalities – As these proposals target non-EEA nationals, BME women and some nationality groups are much more likely to be expected to pay for their healthcare access. Women with 'no recourse to public funds' are doubly disadvantaged and are at particular risk of poor maternal and infant health. BME women are also more likely to suffer from particular medical conditions that

[1] http://www.un.org/womenwatch/daw/cedaw/cedaw.htm

require ongoing medical treatment, including cervical cancer[2] and cardiovascular disease.[3]

Disabled women - As the proposals will require a new group of migrants to directly contribute to the costs of their healthcare, those who are living with a pre-existing disability or health condition are likely to be more affected. Disabled women also face a high risk of violence and spend longer periods of time in healthcare institutions than disabled men as they are less likely to be cared for by a partner.[4] The proposals to require non-EEA migrants who have paid the levy to make an additional contribution for specific services could easily lead to discrimination against people with disabilities requiring specialist and expensive treatment. This could include women living with HIV and women with mental health problems.

Maternity – The consultation specifically targets maternity services for additional charges, even when non-EEA migrants have paid the levy. The proposal to charge for maternity services for 'pre-existing' pregnancies is unworkable and discriminatory.

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.[5] Furthermore, Black African women face a rate of maternal deaths six times that of white women[6] and asylum seeker and refugee women make up 12 percent of all maternal deaths, but only 0.03 percent of the population.[7]

Many frontline administrators and public service providers presume that asylum seeking or undocumented women are giving birth in the UK to improve their chances of receiving leave to remain in the country. This discrimination results in unfavourable and sometimes hostile treatment of migrant women who are pregnant and poorer outcomes.

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

The current understanding of 'ordinary residence' should not be replaced. We do not believe that this definition is 'vague', as claimed in the consultation document, but is actually a useful concept. The ordinary residence qualification captures the key point which should be considered when establishing eligibility for NHS

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[2] Cancer Research UK (2009) Cancer incidence and survival by major ethnic group, England, 2002 2006. Cancer Research UK and NCIN http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@sta/documents/generalcontent/crukmig_1000ast-2749.pdf

[3] British Heart Foundation (2010) Factfile for GPs about Women and Heart Disease http://www.bhf.org.uk/publications/view-publication.aspx?ps=100136

[4] Iglesias, M., Gil, G., Joneken, A., Mickler, B. and Knudsen, J.S. (1998) Violence and disabled women. Independent Living Institute http://www.independentliving.org/docs1/iglesiasetal1998.html

[5] 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

[6] Knight, M (2009) 'Inequalities in maternal health: national cohort study of ethnic variation in severe maternal morbidities' British Medical Journal

[7] 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

services: the 'settled' nature of someone's life in the UK. As a broad definition which does not attempt to link eligibility to specific immigration or residency status (categories which are subject to regular change by the Home Office), it avoids the risk of unintentionally excluding certain groups which by any reasonable measure should expect healthcare entitlement (for example, people granted humanitarian protection).

Question 4: Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK?

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 NHS access. Women who have experienced violence including domestic and sexual violence, forced marriage, 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[8], 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.

Question 5:
Do you agree with the principle of exempting those with a long term relationship with the UK (evidenced by National Insurance contributions)? How long should this have been for? Are there any relevant circumstances under which this simple rule will lead to an unfair exclusion of any groups?

The principle of exempting those with a long-term relationship from the UK from charges is a sound one, but the proposals for evidencing this relationship are highly flawed.

Some people will have been long-term residents of the UK without having paid the required 7 years NI contributions, for reasons including disability and caring

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

responsibilities. Women are less likely than men to have accumulated seven years of NI contributions during the same period of residence in the UK, as women are more likely than men to take breaks from work to care for children and others. This proposal would exclude many migrant women from this exemption, who may have a long-term relationship with the UK but have often spent long periods of time without employment, due to caring for children or older relatives. Furthermore, BAME women have significantly higher rates of unemployment in the UK.

Question 6: Do you support the principle that all temporary non-EEA migrants, and any dependants who accompany them, should make a direct contribution to the costs of the healthcare?

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.

Question 7: Which would make the most effective means of ensuring temporary migrants make a financial contribution to the health service?

a) A health levy paid as part of the entry clearance process
b) Health insurance (for NHS treatment)
c) Other – do you have any other proposals on how the costs of their healthcare could be covered?

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 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.

Question 8: If we were to establish a health levy at what level should this be set?

a) £200 per year
b) £500 per year
c) Other amount (please specify)?

We do not think a levy should apply.

Question 9: Should a migrant health levy be set at a fixed level for all temporary migrants? Or vary according to the age of the individual migrant?

a) **Fixed**
b) **Varied**

We do not think a levy should apply.

Question 10: Should some or all categories of temporary migrant (Visa Tiers) be granted the flexibility to opt out of paying the migrant levy, for example where they hold medical insurance for privately owned healthcare?

(Yes/No/Don't know)

No.

Question 11: Should temporary migrants already in the UK be required to pay any health levy as part of any application to extend their leave?

(Yes/No/Don't know)

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.

Question 12: Do you agree that non EEA visitors should continue to be liable for the full costs of their NHS healthcare? How should these costs be calculated?

No.

The current system of charging for secondary care is not successful in its aims of recouping the costs of treating Overseas Visitors and in fact leads to greater costs on the NHS by encouraging migrants to avoid seeking healthcare until they are seriously ill. It is not cost-effective and creates significant costs in administration.

This has long-term impacts on their health, increasing the likelihood of need to access more costly treatment in future (which they have a right to access but the charges for which they will not be able to pay).

Question 13: Do you agree we should continue to charge illegal migrants who present for treatment in the same way as we charge non-EEA visitors?

No.

The current approach of charging irregular migrants for care should not be continued. Irregular migrants are on the whole a very vulnerable group who cannot afford to pay for their healthcare. Charging is extremely costly from the perspective of individual health and public health, as chargeable migrants avoid seeking treatment until they are seriously ill and need emergency care. Any treatment they need at this point will be provided but will not be recouped. It would be much more cost-effective to reduce barriers to healthcare access for this group.

The practice of charging vulnerable irregular migrants for their healthcare runs completely contrary to the overarching principles set out at the beginning of the consultation document. It denies healthcare to those in need; it is unfair; it is neither efficient nor workable from a cost perspective; and it actively increases health inequalities in our communities.

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

We welcome the consultation's continued exemptions for services with a public health function. However, 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.[9] 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.[10]

[9] 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

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

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.[11] 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.[12] Refugee and asylum seeking women make up 12 percent all maternal deaths yet less than 0.3 percent of the population.[13]

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.[14] 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.

Question 15: Do you agree with the continued right of any person to register for GP services, as long as their registration records their chargeable status?

We believe that any person should have the right to register with a GP, without recording their chargeable status.

Question 16: Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs?

Maintaining universal access to primary care is vital to both individual and public health.

The consultation question asks about 'temporary migrants', but this is a deceptive term for a broad group of people who are living in the UK for up to 5 years before being considered 'ordinarily resident'. Extending charging to primary care will also

[11] 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
[12] 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
[13] 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
[14] 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

affect the many people living in the UK on a long-term basis who have irregular migration status.

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 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 and reduced 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 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.

Question 17: Do you have any comments or ideas on whether, and if so how, the principle of fair contribution can be best extended to the provision of prescribing, ophthalmic or dental services to visitors and other migrants?

Charging should not be extended to these services.

Question 18: Should non-EEA visitors and other chargeable migrants be charged for access to emergency treatment in A&E or emergency GP settings?

No.

Charging for access to emergency treatment is both unethical and unworkable.

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

There are no systems of processes which could make charging in A&E workable. A&E is already an extremely challenging environment from the perspective of patient flow. If the need to authenticate entitlement to NHS access is added into this mix, processes will be delayed and patients will suffer. It is inevitable that in such a high-pressure environment, staff would resort to 'short cut' methods of

identifying chargeable patients. This will lead to discrimination based on appearance and will unfairly target BME groups.

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

No.

Extending charges to care provided by non-NHS providers, including community providers of services, could undermine services which are there specifically to meet the needs of vulnerable people (e.g. outreach services for homeless people and destitute asylum seekers).

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

It would not be possible to extend charges to non-NHS providers without significantly adding to the administrative burden on those providers and on the NHS as a whole. In addition, this would require sharing of patient information with a much greater range of agencies, which will be extremely difficult to do while respecting data protection principles.

Question 22: How else could current hospital processes be improved in advance of more significant rules changes and structural redesign?

It is important to establish whether the existing rules can be effectively implemented, prior to an expensive overhaul of the current rules including a very costly new system of establishing entitlement

In particular, the Government should first focus on recouping costs through existing EEA rules, before turning attention to non-EEA nationals.

Question 23: How could the outline design proposal be improved? Do you have any alternative ideas? Are there any other challenges and issues that need to be incorporated?

No comment.

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

NHS registration should remain with GP practices, in line with the principle of meeting patients' immediately necessary health needs. If someone is required to register with an external agency completely separate from health services, prior to visiting a GP, there is a risk they will not get to see a doctor and these needs will not be met in a timely way.

Question 25: How can charges for primary care services best be applied to those who need to pay in future? What are the challenges for implementing a system of charging in primary care and how can these be overcome?

There are significant challenges associated with charging for primary care services, which clearly show that such a proposal is unworkable:

- No matter how the system is administered, it will clearly lead to discrimination against people who appear more 'foreign' and are targeted for eligibility checks.
- The system is unethical, as it may lead to patients being stopped at the point of reception, and never getting to see a doctor. Many undocumented migrants already experience this, despite having primary care entitlement.
- Charging is in conflict with the need to provide immediately necessary treatment where needed, as it is not always obvious to patients or administrative staff whether their health needs meet this test. This can only be established after the patient sees the GP – but if they are chargeable they may never get to the consultation.

Question 26: Do you agree with the proposal to establish a legal gateway for information sharing to administer the charging regime? What safeguards would be needed in such a gateway?

No.

We do not agree with such a gateway and strongly question whether any such system of sharing sensitive personal data could be set up with out contravening data protection principles.

Question 27: Do you agree that we should stop issuing S1 forms to early retirees and stop refunding co-payments and if not, why?

No comment.