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

I. The RCGP welcomes the opportunity to respond to the Home Office’s consultation on migrant access to health services in the UK.

II. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

III. We gratefully acknowledge the contributions of our members, Devolved Councils, the RCGP Health Inequalities Standing Group and our clinical champion for social inclusion in formulating this response.
Our response

Summary

1. The RCGP opposes any change to the eligibility rules for migrants accessing GP services. We believe that this would be a regressive step for the NHS and would undermine the ability of GPs to protect and promote the health of their patients and the public.

2. We are concerned that limiting access to GP services would impact adversely on the health not only of vulnerable migrants, but also of homeless people, travellers and gypsies, and individuals with chaotic lives – all of whom may struggle to prove eligibility or be deterred by the checks involved. This runs counter to the government’s duty under the Health and Social Care Act to have regard to the need to reduce health inequalities. Moreover, there is a real risk that the proposals will create structures that encourage a discriminatory approach towards certain groups by frontline practice staff.

3. It is likely that a change in the eligibility rules for general practice would deter early presentation in general practice by a significant number of patients, which may lead to a costly increase in emergency admissions (additional pressure that the urgent and emergency care system can ill afford).

4. We are concerned that limiting free access to primary care will have adverse consequences for the control of infectious diseases – and therefore for the health of the population as a whole. The UK is currently witnessing a dangerous surge in TB. There is a real risk that these proposals would exacerbate this problem and increase the risk of multi-resistant TB, resulting in both more deaths and increased transmission of the disease. While we note that the consultation proposes to exempt the treatment of infectious diseases from charges, this fails to recognise that diagnosis is a core activity of general practice. Often people suffering from infectious diseases do not know what is making them ill - and it is likely that a significant number of individuals would be deterred from presenting at their GP practice for fear of charges and/or eligibility checks. Similarly, we are concerned that limiting access to primary care would impact detrimentally on immunisation rates as it would be more difficult to engage with and encourage presentation by parents from non-eligible migrant groups.
5. **The RCGP would strongly oppose the imposition of any new administrative burden on general practice as a result of the proposals under consultation.** We struggle to see how a new system for checking eligibility - and potentially charging patients - could be introduced without increasing the administrative pressure on individual GP practices. General practice in the UK is already facing a workforce and workload crisis\(^1\) - GP surgeries simply do not have the capacity to take on an additional administrative burden, nor are they set up to undertake eligibility checks or charge patients.

6. We note the conclusion of the Department of Health’s 2012 review of overseas visitor charging policy: “the NHS is not currently set up structurally, operationally or culturally to identifying [sic] a small subset of patients and charging them for their NHS treatment. Only a fundamentally different system and supporting processes would enable significant new revenue to be realised.”\(^2\) **We suggest that robust evidence is needed to show that the cost of realising such a fundamental structural change would be outweighed by the additional revenue it might yield.** As part of this, we would like to see a rigorous assessment of the scale of health tourism and abuse of health services in the UK, in order to substantiate the consultation’s assertion that “the UK has a significant problem with health tourism”.

7. **We are extremely concerned that these policy proposals are neither accompanied by a comprehensive impact assessment nor underpinned by robust evidence.** Indeed, the Department of Health recognises in its comment on the 2012 review of overseas visitor charging policy that “there is no comprehensive evidence covering this subject (be it in academic literature, official statistics or easily accessible data from sources such as Hospital Trusts)”\(^3\). We understand that an independent ‘audit’ has been commissioned by the Department of Health to provide a better understanding of the

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\(^3\) Ibid.
situation. However, given the acknowledged lack of available evidence in this area, we are concerned that this ‘audit’ will struggle to provide a true picture.

8. Moreover, we feel that the audit should have taken place well before this consultation was launched. **We are concerned that, due to the timing of the forthcoming Immigration Bill, the policy proposals under consultation have been developed in advance of the supporting evidence.** The lack of a comprehensive impact assessment or evidence base makes it very difficult to respond fully to this consultation, particularly given that fundamental questions about the feasibility and/or cost effectiveness of the plans proposed have not yet been addressed by the government.

**Detailed response**

*Please note that we have responded only to the questions that are relevant to the work of the RCGP.*

**Question 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)

**Question 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)

9. While we support the principle that all temporary non-EEA migrants should make a fair contribution to the costs of their healthcare (if a cost effective, fair system could be found to make this happen), we oppose any change to the eligibility rules for migrants accessing GP services.

**Question 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)

10. The lack of a robust cost/benefit analysis and impact assessment makes it difficult to answer this question. We feel that, should a levy or insurance scheme be imposed, it is vital that this system does not require individual GP practices to carry out any additional checks on patients.
Question 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)

Question 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)

Question 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

11. Again, it is difficult to answer these questions without reference to a robust cost/benefit analysis and impact assessment.

Question 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)

12. We have no comments to make on this question.

Question 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.

13. We have no comments to make on this question.

Question 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)

14. We have no comments to make on this question.
Question 10. Should chargeable migrants pay for all healthcare services, including primary medical care provided by GPs? (Yes / No / Don’t know)

15. While we recognise the need to ensure that those accessing NHS services make a fair contribution (if a cost effective, fair system could be found to make this happen), we oppose any change to the eligibility rules for migrants accessing GP services, for reasons of social inclusion, cost-effectiveness, public health and feasibility of implementation.

16. Limiting access to GP services is likely to impact adversely on the health of vulnerable migrants from both eligible and non-eligible groups. Not only will charging for primary medical care act as a deterrent to presentation by non-eligible groups, but both eligible and non-eligible groups may be deterred from seeking care if GP services are perceived to be tantamount to immigration services, or if patients fear questioning and/or discrimination when approaching a GP surgery. We are also concerned that some eligible migrant groups – including refugees and asylum seekers – would find it more difficult to access GP services, due to a low level of English language skills, lack of appropriate documentation or because they are unaware of their rights.

17. An extension of charging to primary care is likely to have a detrimental impact on the health of other eligible groups, including homeless people, travellers and gypsies (who are protected characteristic groups under the Equality Act 2010) and individuals with chaotic lives – all of whom may struggle to prove eligibility or be deterred by the checks involved. This runs counter to the government’s duty under the Health and Social Care Act to have regard to the need to reduce health inequalities.

18. It is likely that a change in the eligibility rules for general practice would deter early presentation by a significant number of patients, including those suffering from chronic conditions such as diabetes or hypertension, leading to a higher rate of emergency admissions and increased costs overall for the health service.

19. Similarly, we are concerned that limiting free access to primary care will have adverse consequences for the control of infectious diseases – and therefore for the health of the population as a whole. The UK is currently witnessing a dangerous surge in TB. There is a real risk that these proposals would exacerbate this problem and increase the risk of multi-resistant TB, resulting in both more deaths and increased transmission of the disease.
20. While we note that the consultation proposes to make the treatment of infectious diseases exempt from charges, this fails to recognise that diagnosis is a core activity of general practice. Often people suffering from infectious diseases do not know what is making them ill - and it is likely that a significant number of individuals would be deterred from presenting at their GP practice for fear of charges and/or eligibility checks. In addition, we are concerned that limiting access to primary care would impact detrimentally on immunisation rates as it would be more difficult to engage with and encourage presentation by parents from non-eligible migrant groups.

21. It is also important to understand that general practice is not set up to undertake eligibility checks or to charge patients, nor does it have the capacity to take on any additional administrative burden.

22. Even if initial registration were not located within GP practices, we struggle to see how a new system for checking eligibility - and potentially charging patients - could be introduced without increasing the administrative pressure on individual GP practices. Firstly, checking each patient’s chargeable status is likely to take significant additional time and may involve a phone call by the receptionist (or person in charge of registration) to the body handling initial registration or a related helpline. GP practices would then also need to monitor the changing eligibility status of registered patients on the practice list. For some patients this process would be likely lead to an increased need for interpreters/health advocates in order to explain and undertake the necessary eligibility checks. Secondly, charging patients on a significant scale would result in an additional administrative burden for practices – both in terms of frontline time spent on transactions and back office accounting and bureaucracy.

23. It is vital to consider who would screen patients for eligibility and take payment, and how and where they would do so. In most practices it is likely that receptionists would be asked to take on this role – in which case they would require comprehensive training in the potentially sensitive and complicated process of screening and charging patients. We are concerned that busy reception desks would simply not have time to deal with complex cases, nor to process charging for services on a significant scale.

24. There is also a real risk that the proposals would encourage discriminatory screening practices and decision making by practice staff, who often face significant time pressures when registering patients. Great care would need to be taken to avoid discriminatory screening of individuals based on characteristics such as race, physical appearance, accent or language skills.
25. Moreover, we are concerned that restricting access to GP services – and the resulting perception that practices are undertaking immigration checks and/or discriminating against particular patient groups – could lead to ‘them versus us’ stand offs in reception areas, potentially resulting in an increase in violence and disruption in practices, eroding trust in the doctor-patient relationship and deterring patients from approaching GP services. In order to help to avoid the stigmatisation of individuals, practices would need to offer dedicated confidential areas - space that many surgeries would struggle to provide.

26. Finally, we note that the consultation implies that GP referrals to secondary care allow some ‘heath tourists’ to evade charges for hospital treatment (paragraph 5.4). We are not aware of evidence underpinning this assertion and would welcome further details.

The RCGP welcomes the opportunity to respond to this consultation and looks forward to further dialogue with the Home Office on this subject.

Please do not hesitate to contact me if you have any questions about our response.

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council