

Sustaining services, ensuring fairness

A consultation on migrant access and their financial contribution to NHS provision in England

Please send your completed response to migrantaccess@dh.gsi.gov.uk or by post to:

International Healthcare Team
Department of Health
Fifth Floor, Wellington House,
133-155 Waterloo Road
London SE1 8UG

Response template

Overarching principles

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

Response:

Yes.

Rights of Women endorse the response of the Immigration Law Practitioners' Association regarding the principles to consider when assessing charging migrants for access to healthcare. We consider that their response more than adequately sets out the founding and continuing principles of NHS care and the role that migrants play within the NHS and accessing services through it.

Question 2: Do you have any evidence of how our proposals may impact disproportionately on any of the protected characteristic groups¹?

Response:

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¹ As defined in the Equality Act 2010: age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity

Women

Women as a group in general may face particular discrimination when attempting to access healthcare services in a number of circumstances, both around maternity (a protected characteristic as defined in the Equality Act 2010), and as the majority of applicants for spousal visas, the largest number of sole parents and due to the specialised medical services they may require.

Article 12 of the Convention to Eliminate all forms of Discrimination Against Women requires signatory states to allow women access to healthcare, including family planning, on an equal basis to men. According to the Special Rapporteur on Migrants, this is particularly pertinent for migrant women as:

In host States, many female migrants are employed in relatively low-skilled jobs within the manufacturing, domestic service or entertainment sectors, often without legal status and little access to health services. They are often subject to exploitation and/or physical and sexual violence by their employers or clients. They may be particularly vulnerable to HIV and have few alternative employment opportunities²

There are therefore, a number of concerns about the imposition of charging for healthcare whilst in country. Women require additional specialist services, and certain categories of women, particularly migrant women, have particular vulnerabilities. Women who are trafficked into the UK for the purposes of exploitation may have healthcare needs as a direct result of their treatment.

Similarly, women who have been forced into marriage overseas may have healthcare requirements as a result of the violence she has suffered. Both trafficking and forced marriage are forms of violence which disproportionately impact on women and therefore, are regarded as discrimination. The 6th Report of the House of Commons Home Affairs Committee (2008) found that many victims of domestic abuse suffer long term physical and mental ill-health [§§244-246].

244. Abused women are five times more likely to attempt suicide than the general population, and a third of all female suicide attempts can be attributed to experience of domestic violence.[249] Asian women are two to three times more likely to commit suicide. Jasvinder Sanghera, Director of Derby-based organisation Karma Nirvana, told us that "the majority of young people we see in the age group between 16 to 24 who have issues pertaining to honour-based crimes or forced marriage, have tendencies towards self-harming, very high rates of depression".[250] Nazir Afzal, Director of the Crown Prosecution Service London West, told us "just in the line between Slough and Southall 80 women killed themselves in the last year, and you can work out for yourselves, perhaps, the ethnicity of those individuals".[251]

245. The Government told us that "between 2002 and 2008, the Department of Health has provided 20 streams of funding totalling over £1.95m to 12 mental health voluntary and community sector organisations providing therapeutic services for victims of abuse".[252] Over six years, this amounts to £27,083 per organisation per year.

246. Many victims of domestic violence suffer long-term physical and mental ill health

² A/HRC/14/30 Report of the Special Rapporteur, on the Human Rights of Migrants, Jorge Bustamante, 16 April 2010 §29

following abuse, including substance misuse, self harm and suicide. Whilst the Department of Health is funding some therapeutic services for victims of abuse, it is hard to believe that what amounts to £27,083 a year per organisation is anywhere near enough. We urge the Department of Health to increase its funding of mental health and other therapeutic services for victims.

In the CEDAW Committee's Concluding Observations on the seventh periodic report of the United Kingdom of Great Britain and Northern Ireland (advance, unedited version, 26 July 2013), the Committee urged the government to:

Strengthen the implementation of programmes and policies aimed at providing effective access for women to health-care, particularly to women with disabilities, older women, asylum-seeking and Traveller women; [§53(a)]

It is clear that by limiting the access to healthcare for migrant women, the UK Government would in fact be working against the recommendations of the Committee.

It is also worth noting that women frequently have sole responsibility for children; and even within families, will frequently be responsible for the wellbeing of children of the family. Therefore, there is a disproportionate burden on women to provide children with healthcare, or with access to medical services. The UN Convention on the Rights of the Child (UNCRC) requires that children may have access to the highest standard of healthcare

Discrimination – women as sponsors

Where women are sponsors of family visa applications under Appendix FM of the Immigration Rules, they face an additional burden in providing proof of income and maintenance as compared to men, given that women earn less. Although the health levy may be payable by either partner, the increased costs in paying an upfront health levy may disproportionately affect women as sponsors.

In *R (ota MM) v SSHD* [2013] EWHC, the High Court found that a lack of flexibility in the interpretation of income requirements under Appendix FM may amount to discrimination when taken in combination with a variety of other factors. The financial threshold, set above the level for the minimum wage, was found to be excessive when looked at with the aggravating factors of requiring high levels of savings, discounting family support, or the earning potential of a spouse who would enter the UK. This, the court found, may unjustifiably interfere with a British citizen's right to remain in their country of nationality.

Were an additional health levy included on the cost of a visa, it may also be said that this would become an impossible financial burden on certain groups of British citizens, particularly those on a low income; and taken with other measures designed to restrict any reliance on the state, may prevent some British citizens from establishing a family life with spouses or other dependants in the UK. This is likely to be particularly profound for women, who still make up the majority of low-paid professions and remain less well remunerated than men.

Discrimination – specialist healthcare

We further endorse the response of Maternity Action on the discrimination faced by women who require maternity care.

Who should be charged?

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

Response:

Rights of Women endorse the response of ILPA regarding the ordinary residence test.

We suggest that any improvements in understanding how to apply the ordinary residence test, or to ensure it is applied with greater rigour can be tackled cost effectively through adequate training of hospital overseas managers.

Question 4: 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)

Response:

The consultation document defines permanent residence as Indefinite Leave to Remain (ILR). We consider that an individual or family may be permanently resident prior to an application for ILR, where they have social, cultural and economic links with the UK. We also consider that the proposition that migrants who wish to settle will receive settlement in 5 years as ill-conceived, given that there are many circumstances in which migrants will be placed on a 10 year route to settlement, or circumstances where someone never applies for or receives ILR, for example where:

- someone fails the Life in the UK test
- Someone fails the English language test
- Someone has a criminal record, for any offence and is required to wait for 7 years before making an application for ILR.
- An individual chooses not to make an application.

In an answer to a written question in the House of Lords on 5 August 2013, Lord Taylor of Holbeach informed the house that women make up 68% of spouse dependants, and only 48% of female migrants were employed. This therefore points to a serious deficit in income for female migrants who may be required to meet additional healthcare costs. They may also be part of family units who are unable to meet the requirements to renew their spouse visas after 30 months in country and are therefore required to wait for 10 years until they may apply for Indefinite Leave to Remain. The Home Office describes the 10 year family life route in their Immigration Directorate Instructions as:

Where an applicant in the UK does not meet certain of the eligibility requirements for the 5-year partner route (relating to immigration status, finance or English language), they can still make an application under the rules, on the correct application form and paying the relevant application fee, and be considered under the requirements for the 10-year route, including the requirement to meet the provisions of EX.1. If granted, they will have a longer route to settlement: 10 years (granted in four periods of 30 months, with a fifth application for indefinite leave to remain).³

There are a number of women who may face particular difficulties in regularising their status, for example where they are not in the UK as a spouse of a British national or settled person. For many of these women, their route to settlement in the UK does not take 5 years, but 120 months. This requires the applicant to hold valid leave to remain for the full period, with up to 4 applications to renew leave. The 10 year route application made on the basis of family or private life under paragraphs 275ADE- DH or where a parent must rely on the exception to the Immigration Rules, EX.1 which states:

(a) (i) the applicant has a genuine and subsisting parental relationship with a child who-

(aa) is under the age of 18 years, or was under the age of 18 years when the applicant was first granted leave on the basis that this paragraph applied;

(bb) is in the UK;

(cc) is a British Citizen or has lived in the UK continuously for at least the 7 years immediately preceding the date of application ;and

(ii) it would not be reasonable to expect the child to leave the UK; or

(b) the applicant has a genuine and subsisting relationship with a partner who is in the UK and is a British Citizen, settled in the UK or in the UK with refugee leave or humanitarian protection, and there are insurmountable obstacles to family life with that partner continuing outside the UK.

On each occasion that a woman makes an application in reliance on her family life, a fee is due; the current fee for a family life application is £578⁴. It is a huge financial burden for some, particularly women. For example, on a call to our immigration and asylum legal advice line, we received a call from a single mother who had received limited leave to remain on the basis of her family life in the UK but who was unable to work because her childcare responsibilities placed limits on her hours but was ineligible for any benefits, including out of work benefits. To further require her to pay for any medical care either she or her child received would risk a breach under the UNCRC, and may also amount to a breach of Article 8, by creating a right which cannot be enjoyed by some migrants based on their financial status.

Further, women face particularly barriers to regularising their status where they have been in violent relationships, where they are dependant either on their partner but do not come within the Home Office

³ Home Office Immigration Directorate Instructions, Family Members under the Immigration Rules, section FM 1.0, p8 available at

<http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/IDs/chp8-annex/partners.pdf?view=Binary> accessed 28.8.13

⁴ Home Office current fees, <http://www.ukba.homeoffice.gov.uk/aboutus/fees/>, accessed 28.8.2013

domestic violence rule. In the period from April 2012 to March 2013, the Rights of Women Immigration and Asylum Law advice line advised 39 women who reported domestic abuse and were eligible for the domestic violence rule, as against 45 women who reported domestic abuse but were ineligible. For these women, an application under Article 8, the '10 year-route' is frequently their only option to remaining in the UK, even where they have British national children.

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 the unfair exclusion of any groups?

Response:

We are concerned that any attempt to make access to the NHS easier for a distinct group of individuals risks creating a discriminatory barrier on accessing free healthcare. In particular, by increasing access to the NHS for expatriates, it appears that the consultation accepts that it is very difficult to establish and charge expatriate users of the NHS who are not ordinarily resident in the UK. At §3.15 the Consultation document sets out that *“effective screening and subsequent application of the charging rules for expatriates is extremely challenging for hospital staff, in terms both of validating entitlement and of confronting the patient”*.

The purpose of the change to the regulations appears to accept the difficulties in charging and therefore releases certain groups of people of an obligation to make a further contribution.

There is a clear ground for legal challenge on the basis of differential treatment if only expatriates were able to access the NHS after 7 years of National Insurance contributions. There are a substantial minority of migrants who are not eligible, or chose not to acquire permanent settlement after 5 years. Once those migrants had established 7 years of National Insurance contributions, they would either be able to qualify for NHS treatment on the same basis as British national expatriates and former legal residents, or would be able to establish a discrimination claim on the basis of nationality/race.

The Equality Act 2010 defines discrimination as section 13(1)

A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others.

The Equality Act also includes indirect discrimination - where there is a condition, a rule or policy that applies to everyone but particularly disadvantages people who have a particular protected characteristic. The condition requiring national insurance contributions disproportionately impacts on people of different racial and ethnic backgrounds compared to people of British backgrounds.

A protected characteristic is set out in section 9 as:

(1) Race includes—

(a) colour;

(b) nationality;

(c) ethnic or national origins.

(2) In relation to the protected characteristic of race—

(a) a reference to a person who has a particular protected characteristic is a reference to a person of a particular racial group;

(b) a reference to persons who share a protected characteristic is a reference to persons of the same racial group.

A refusal to allow someone without settled status or British nationality with the same NI contribution record as a British expatriate NHS treatment free at the point of service on the basis of membership of a group with protected characteristics as defined within the Act amounts to direct discrimination for which there can be no justification in law. Where both a British expatriate and a migrant with 7 years NI contributions sought medical treatment, according to the consultation proposal, the migrant would be denied medical treatment free at the point of service unless they had achieved settled status.

In *R (European Roma Rights Centre) v Immigration Officer at Prague Airport*, [2004] UKHL 55, Baroness Hale described the law underlying discrimination “*is that individuals of each sex and all races are entitled to be treated equally... The Ingredients of unlawful discrimination are: (i) a difference in treatment between one person and another person (real or hypothetical) from a different sex or racial group; (ii) that the treatment is less favourable to one; (iii) that their relevant circumstances are the same or not materially different; and (iv) that the difference in treatment is on sex or racial grounds*”⁵ She then goes on to describe that where less favourable treatment can be shown, there must be a satisfactory explanation.

This is further highlighted by §3.16 of the Consultation document which is a proposal to allow British citizens without any connection to the UK aside from nationality, to return to the UK and qualify for free NHS treatment under the “*ordinary residence*” test. If the purpose of the consultation is to enforce the principle of “*fair contribution*” to the NHS through residence and direct taxation, it is unclear why a British citizen without any link to the UK would be entitled to free healthcare where a contributing migrant on a route to settlement and making contributions in the form of indirect and direct contributions would not be so entitled. This highlights the underlying flaw in assessing access to the NHS through National Insurance contributions; as our current healthcare system is not based on direct contributions, but funded through a variety of direct and indirect taxation sources.

It is difficult to see how increasing access for some people and not others based on nationality conforms to a vision of “*fair contribution*”; and raises questions over the attempts to set out a fair contribution system. We do not believe that a system which attempts to incorporate elements of direct contribution, and which links National Insurance contributions to entitlement can be fair or workable. It also raises the possibility of excluding other groups of currently eligible individuals at a later stage – for example the disabled, those who have not accumulated 7 years contributions, or women who have not made contributions because they have had caring responsibilities.

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 their healthcare?

Response:

Rights of Women endorse the response of ILPA to question 6.

⁵ Baroness Hale, *R (European Roma Rights Centre) v Immigration Officer at Prague Airport* [2004] UKHL 55, §§73-75

We also question whether if a direct contribution is proposed, then if there would be a refund policy in place for those who had paid a levy for a particular period of time, but who left the UK before the expiry of their visa (for example, spouses whose relationship breaks down within the probationary period). In the event that the money was payable in a one-off levy akin to the visa application fee, it is difficult to see how it could be classified as a “contribution” for an individual’s use of the NHS if it could not also be refunded in the event that a migrant did not remain in the UK for the full-term of their visa.

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?**

Response:

(C) Rights of Women considers that the costs of healthcare do not need to be covered as set out in the consultation document. We endorse the consultation response of Maternity Action regarding particular difficulties faced by pregnant women.

Domestic abuse

Rights of Women have concerns about how the levy will operate for spouses on dependant visas where there is marital breakdown. This becomes a more acute problem in the instances of marriages that breakdown as a result of domestic abuse.

We would seek confirmation that once the levy had been paid, healthcare would continue for the full period, independently of the visa. We are concerned that in the minority of cases where relationships breakdown due to domestic abuse, the abusive partner has been able to curtail the visa of the other spouse and that this may extend to curtailing the access to healthcare for the spouse. In *(R (ota) Balakoohi v SSHD [2012] EWHC 1439* , at paragraph 70:

EM was not an independent witness in relation to either the SSHD's consideration of HB's LR status or HB's paragraph 389A application. He was the other party to the marriage and HB's LR or ILR status was dependant to a significant extent on his conduct. Moreover, the manner in which he reported its suggested breakdown to the SSHD and in which he reported HB's suggested abusive conduct to the police were sufficiently unusual that further details about the contents of his statement to the UKBA and his statements to the police should have been obtained by further enquiries and interview before the UKBA relied on them in relation to any of the four decisions I am concerned with. The UKBA should have been as aware as the police were of the potentially self-serving nature of EM's statements.

The judgment made a clear link between the control of immigration status and domestic abuse and that where one spouse is wholly dependant on the other, they are placed at risk. Rights of Women has considerable experience in advising migrant women who are victims of domestic abuse. In the period from April 2012 to March 2013, Rights of Women advised on 205 separate calls from women to the immigration and asylum legal advice line, with 93.6% of these first time calls. Of the total, 41% of callers

identified themselves as victims of domestic abuse within the government definition. In our experience, those women who we advise on the immigration and asylum law advice line report additional forms of abuse including:

- threats to have the applicant removed if she attempts to seek help or fails to comply with the perpetrators demands;
- the theft of her passport and other relevant documentation;
- the provision of false information about the applicant's immigration status to ensure that she becomes an overstayer (by stating that an application for ILR has been made when it has not);
- Threats to report a partner to the police if she seeks assistance or to leave the relationship.

If in addition to immigration status, access to health care was also tied to a potentially abusive spouse, there would be significant difficulties faced by a victim of violence; and they would face both a real and imagined barrier to healthcare.

The effect of this may be to remove any access to medical care for that person, even where they had been a victim of domestic abuse. It is also not clear from the consultation document what the status of women on limited leave to remain under the Destitute Domestic Violence Concession (DDVC) would be in respect of healthcare.

Were a system of health insurance implemented, we would be very concerned that a sponsoring spouse would be able to remove another spouse's access to healthcare through cancelling their insurance, which may have further repercussions when that person makes an application for ILR. For those people who are in the UK temporarily as the sponsored dependant of either a British or settled person, or a worker, we would be very concerned that they would not be fully aware of their health cover and as a dependant may find that they have limited health cover that does not meet their needs, or the needs of their children.

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)?

Response:

(c) We are opposed to the introduction of a health levy for reasons given elsewhere. Rights of Women endorse the response of ILPA to question 8, and raises the following additional points:

Given that the average time before permanent settlement is 5 years according to the consultation, a 5 year health levy payable upfront would amount to £1000 additional to the visa application over a 5 year period' or £500 were an applicant to pay for the first period of the grant of the visa (30 months). The current cost of visas is high when compared to average incomes for immigrants from particular countries

and for others, it still represents a substantial financial investment. The Home Office sets fees based on factors including⁶:

- *the cost of processing applications;*
- *the importance of attracting certain groups of migrants to the UK; and*
- *The value of a successful application to the migrant.*

Therefore we believe that any increase above £200 would be excessive and would adversely discriminate against some migrants and their family members.

Through Freedom of Information Act requests, the Home Office have clarified that there is a substantial difference between the unit cost price of making a visa application and the fee charged to an applicant. In February 2013, the percentage figures for spouse applications above cost price for visas varied from 82% (Leave to Remain, postal application using form FLR (M)) to 440% above cost price for a PEO Indefinite Leave to Remain application using application form SET(M).

Given that there is therefore a large profit margin already being accrued by the Home Office on top of the cost of processing a visa application, it would appear excessive to further increase visa fees to provide for healthcare, where there is already an excess in respect of the application, a surplus reported in the NHS budget and as per the ILPA response, no certain information regarding the costs of migrants to the NHS.

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

Response:

(a) A fixed level is fairer and easier to administer. A variable rate is likely to discriminate against characteristics such as age, disability, gender, and maternity.

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 provided healthcare?

(Yes/ No / Don't know)

Response:

Rights of Women endorse the response of Maternity Action with regard to pregnant women requiring

⁶ UK Home Office, Fees for our Services <http://www.ukba.homeoffice.gov.uk/aboutus/fees/> accessed 28.8.13

health insurance.

We are also concerned that where a migrant is in receipt of a dependant's visa, then a system where healthcare is accessed by health insurance may lead to the unwanted consequence that in abusive relationships, or in the event of relationship breakdown, one spouse or civil partner would have the ability to terminate the healthcare access of the other.

As set out above, in the circumstances of a violent relationship, this could have serious consequences on the dependant spouses ability to achieve permanent settlement, it may risk contravening the duties on the UK to have in place effective measures to protect women from violence as highlighted in *Opuz v Turkey* (2009) (33401/02).

For spouses who are not in an abusive relationship, where one person is able to cancel the health-care of the other, it may still lead to situations where applicants would be in the country legally (if applying to remain under any other provision, including Article 8) but without health insurance which would have an impact on the health and wellbeing of those individuals as well as any children.

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)

Response:

Rights of women oppose any requirement to pay a further health levy in order to extend leave. We endorse the response of ILPA.

Rights of Women consider that the requirement to pay an additional levy may breach Article 8 in certain circumstances. This would arise particularly on renewal where an applicant or sponsor for a family visa under Appendix FM were unable to pay the fee, health levy, or where circumstances differed from the initial application; if the migrant had established a family life in the UK with the intention to remain permanently within the first visa cycle, we consider that a refusal to renew a visa on the basis of lack of available funds to pay the health levy would be a disproportionate interference in the family rights of the migrant and sponsor. This would be particularly acute where the parties were married, or had children.

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?

Response:

Rights of Women endorse the response of Maternity Action.

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?

Response:

No.

Rights of Women endorse the response of Maternity Action and raises the following additional points:

We are bound by the European and International human rights framework to not charge all migrants without status as part of a blanket policy. There are a number of exceptions under the UN Convention on the Rights of the Child which require states to offer healthcare to children who are present within the member state by virtue of Article 24:

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Where access to healthcare for children is restricted on the eligibility of a parent to afford treatment, it may be a breach of the UNC RC which is directly applicable in England and Wales. It is also of concern that no regard has been given to the welfare duties in respect of children whilst considering the impact of charging for access to healthcare. The access to healthcare is dependant on the resources, knowledge and health of the parents, therefore a failure to provide ante-natal or post-natal treatment to the mother of a child, may result in a breach of those rights under the UNCRC.

In addition, there are other categories of migrants without regular status who are further protected by the operation of national and international law. By virtue of the Council of Europe Convention on Action Against Human Trafficking, Article 12(1)(b) specifically requires the provision of emergency treatment to all victims within the member territory and by virtue of Article 12(3):

In addition, each Party shall provide necessary medical or other assistance to victims lawfully resident within its territory who do not have adequate resources and need such help.

It is implicit in the wording of the Article, that any identified trafficking victims who enter and remain in the UK lawfully, for example as migrant domestic workers, are entitled to medical assistance regardless of their ability to pay. Further, any identified victim of trafficking who subsequently gained leave to remain on a basis other than asylum, would remain not chargeable for care, including psychiatric assistance and counselling, arising from their position as trafficking victims.

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

Response:

Rights of Women endorse the response of Maternity Action regarding a particular exemption for maternity. We also endorse the response of ILPA; and have particular regard to their proposed exemption

for children and women who are domestic workers in private households and diplomatic households.

Should the consultation responses result in a charge being levied to visitors for emergency care, we are strongly of the view that victims of crime should be exempt from paying charges for care that arises from their ordeal. To charge victims of crime would risk a decrease in reporting, and where crimes rely on forensic evidence, such as in rape or sexual assault, then there would be a concomitant reduction in the capacity of the police to correctly identify perpetrators of violence, crimes under the Sexual Offences Act, or other violent crime.

There must also be a continuing exemption for foreign nationals who are convicted of crimes which result in a custodial sentence⁷. A significant minority of the female prison population are foreign nationals, many of whom have health needs while they are in the prison estate, including pregnancy. A disproportionate number of foreign national women give birth while in custody.⁸ Under the Standard Minimum Rules for the Treatment of Prisoners, those prisoners who have been sentenced are entitled to medical services which treat and detect any physical or mental defects that may hamper rehabilitation.⁹ Given the particular vulnerability of the prison population and the possible removal of civil legal aid for anyone seeking to bring a claim against prison authorities, we believe that it would be a contravention of the UN minimum standards to not include an exemption for healthcare needs of foreign national prisoners.

What services should we charge for?

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?

Response:

Yes. We support the right of every person to register with a GP and do not agree that their registration records their chargeable status as we consider that everyone should be entitled to free GP care.

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?

(Yes / No / Don't know)

Response:

7 12% of the regular prison population are foreign nationals as at 31st March 2013, Office of National Statistics, Offender management statistics, quarterly bulletin, October-December 2012 England and Wales, 25 April 2013

8 No Way Out: A briefing paper on foreign national women in prison in England and Wales, January 2012.

9 Standard Minimum Rules for the Treatment of Prisoners, 1955, Article 62

Rights of Women endorses the response of (?) and sets out the following additional points:

1. Charging for access to primary care will undermine other government initiatives that rely heavily on the services provided by a GP and would be unclear how victims of physical, psychological or sexual violence would be able to access services. In the 2013 Call to Action to End Violence Against Women and Girls, commitment 103 is for GPs to engage with perpetrators of violence; it is difficult to see how this commitment can be maintained when a number of perpetrators would never be in contact with the GP.
2. The Home Office *Call* set out as its main aim, the prevention of domestic abuse, for which early identification is required. For migrant women, this may be particularly important; this is true for others in vulnerable positions, including drug addicts, homeless people, or those from the traveller community. In the Consultation document, the Department acknowledges that by limiting access to primary healthcare for migrants, there is a risk that those in particularly vulnerable categories may be unable to prove their entitlement to healthcare, even where they are British citizens
3. On 18 April 2013, the Department of Health published further guidance to assist NHS frontline staff in the identification and assistance of victims of human trafficking. At the time, the public health minister, Anna Soubry said:

Human trafficking is abhorrent, and a form of slavery which causes misery and suffering to the thousands of victims and their families. Surgeries and hospitals are sometimes the only place where victims come into contact with people who care and are concerned for their welfare so it is vital that we make the most of these opportunities.¹⁰

4. Furthermore, for victims of domestic abuse, or children subject to abuse at home, the GP provides a vital service and can act as the first identifier. This is also similar for health visitors, who make visits to the family home and therefore frequently act as a referral point for families in crisis. Refuge estimates that for 1/3 of women¹¹, domestic abuse either commences or worsens during a pregnancy. Therefore this is a time of real vulnerability for women, and early access to primary care can lead to disclosures of abuse.
5. In respect of women as a vulnerable group, the CEDAW Committee has already highlighted concerns with accessing healthcare:

The Committee is concerned at reports that women with disabilities, older women, asylum seeking women and Traveller women face obstacles in accessing medical healthcare. The Committee is particularly concerned that women with disabilities face limited accessibility to pre-natal care and reproductive health services. The Committee is also concerned at legal impediments in accessing reproductive treatments by some groups of women in Northern Ireland.

The Government's review of Families in Trouble have demonstrated the role that primary healthcare may have in identifying families' in trouble. The review of research also identified that there were frequently increased and complex health needs for families in trouble and that by early interventions with the

¹⁰ Anna Soubry from <https://www.gov.uk/government/news/help-for-nhs-staff-to-spot-and-support-trafficking-victims> accessed 28.8.13

¹¹ <http://refuge.org.uk/get-help-now/what-is-domestic-violence/domestic-violence-the-facts/> accessed 27 August 2013, as quoted from Department of Health, 2004

family, the cost to society as a whole could be reduced.

Further, we consider that the requirement to pay for visits to primary health services would prevent many migrants from accessing these services for any care considered non-essential. There is a particular concern around childhood vaccinations which are currently routinely offered in infancy. Vaccination programmes require the majority of children to be vaccinated in order to maintain herd immunity.

We would also be very concerned about the introduction of charging for medical access for those in Immigration Removal Centres (IRCs). These services are provided in conjunction with the NHS, and any emergency treatment required is received in an NHS hospital. Anyone who is in an IRC by definition is liable for removal from the UK and therefore does not have a valid visa, therefore they do not have access to public funds, an entitlement to work and may not have any income at all. Unlike migrants in the community, they are not at liberty to make choices around paying for health-care, including taking loans, borrowing money from friends or family, etc. Therefore, they are in a position of unique vulnerability while they await removal. Many of those who are held in IRCs cannot be removed. Those who are in IRCs are very unlikely to have any form of health insurance, and many will not have paid any form of health levy. They are also unlikely to be able to afford to pay for any primary care.

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

Response:

No.

Rights of Women endorse the responses of ILPA and Maternity Action.

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

Response:

No.

At times of crisis, women need to be in a position to access emergency care, this may include: giving birth, becoming victims of crime, suffering domestic abuse or victims of trafficking. A barrier that leads to women avoiding emergency care at a time of need risks further harm, and can put others at risk, including children.

Women may present to A&E as the result of sexual or physical violence and the A&E is often the first place that potentially abusive situations are identified. A&E staff are trained to identify possible victims of trafficking and of domestic abuse. The College of Emergency Medicine, Clinical Effectiveness Committee, produces guidance recommending that staff undergo training so that they are prepared to

deal with disclosures and to ask questions around domestic violence. The College of Emergency Medicine also estimates that 12% of all attendances at A&E are due to domestic abuse¹². NICE also produce guidelines on the treatment of abuse.

Rights of Women have advised a woman on her immigration status after she arrived in the UK for a family visit together with her husband and children. She was the victim of a serious assault from her husband and as a result, was taken to hospital with severe injuries. He husband was charged and prosecuted in the UK and she was seeking advice on her next steps with her children.

This highlights that there are a number of people who will visit the UK, either with or to see family members, who may experience domestic abuse during that period. We have advised a number of women who have been brought to the UK for the purpose of marriage, as well as victims of trafficking who have been brought by family members as visitors but who are then forced to participate in economic or sexual slavery.

For those migrants who are spouses of British nationals or those settled in the UK and then become victims of domestic abuse, emergency hospital treatment may prove a lifeline. Further, in order to make an application under Immigration Rule 289, or DV-ILR, a woman needs proof of the domestic abuse that she has suffered. The Guidance provided by the UKBA (29 July 2013) provides for either one piece of evidence from an initial list, or two pieces from a non-exhaustive list of evidence. This includes:

- Medical report from a doctor at a UK hospital confirming the applicant has injuries consistent with being a victim of domestic violence. These may not be physical injuries. For a definition of injuries see related link: Definition of domestic violence.

- A letter from a General Medical Council (GMC) registered general practitioner confirming they examined the applicant and are satisfied the applicant had injuries consistent with being a victim of domestic violence.

Given the nature of the information required, it is likely that this would be noted in an emergency situation. For women this may prove the only contact they have had with authorities. A&E departments are given information on identifying those who are possible victims of domestic violence. They are also able to give those women presenting as potential abuse victims information and assistance, including telephone numbers, make reports to social services and contact refuges.

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

Response:

Rights of Women endorse the response of ILPA

¹² The College of Emergency Medicine, Guideline for the Recognition and Management of Domestic Violence in Emergency Departments, June 2010

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

Response:

No.

Rights of women endorse the response of Maternity Action regarding maternity and abortion access. In addition we raise the following concern regarding sexual assault referral centres

Sexual assault referral centres (SARCs) function as both centres of healthcare and evidence gathering. These centres are jointly funded by the Department of Health and local police, together with local partners, including Rape Crisis, Solace Women's Aid, and organisations which work with victims of sexual violence. The SARCs are independent centres offering the full range of sexual health and counselling services together with forensic evidence gathering. The CPS Legal Guidance on forensic evidence states:

One aim of the examination is to recover evidence to support the victim's assertion that a sexual assault has taken place without consent. External and internal areas of the complainant's body can be swabbed for samples that can be submitted for forensic examination with a view to revealing evidence, to identify or eliminate the suspect and the nature of the activity that has taken place.

The centres operate to allow victims to access these services, including evidence gathering, without reporting to the police. A victim who has undergone forensic evidence gathering at a SARC may then choose to make a report to the police at a different time and evidence may be stored for up to one year after examination. In some areas, the centres replaced police rape suites and reports of sexual violence made to the police are referred to SARCs.

An alternative that required a sexual assault victim pay a fee before receiving these services would place the UK at odds with the Istanbul Convention, Article 50(2); although the UK has not ratified the Convention, as a signatory, the UK must not take steps that are in direct opposition to the aims and Articles of the Convention. Article 50(2) requires that in respect of evidence gathering:

2 Parties shall take the necessary legislative or other measures to ensure that the responsible law enforcement agencies engage promptly and appropriately in the prevention and protection against all forms of violence covered by the scope of this Convention, including the employment of preventive operational measures and the collection of evidence.

This commitment is also stated under the General Recommendation 12 (1989) of the CEDAW Committee, which sets out the positive obligations on States to eliminate gender-based violence while General Recommendation 198 goes further in describing the positive obligations on States to eliminate gender-based violence and makes clear that States may be responsible for private acts if they fail to act with due diligence to prevent the violation of rights or to **investigate and punish acts of violence**

It would be anomalous and contrary to the stated aims of the CPS, the refreshed Action Plan to End Violence Against Women and Girls if women and sexual assault victims were charged for evidence gathering, and it is unclear how services provided could be separated between evidence gathering and healthcare, and whether it would be desirable to charge for any services which may lead to the arrest, charge and conviction of a person guilty of offences under the Sexual Offences Act 2003.

If a victim of sexual assault faces a charge for the use of these services, it will diminish the quality of

evidence that is available to the police and CPS to proceed to charge. In the Stern Review, forensic evidence was described as:

The medical examination is a vitally important part of the evidence gathering process: it can in some cases assist in putting together a case that can go through the system and in ensuring good care for victims. [p64]

While recommending that these services become part of the umbrella of NHS services due to poor clinical standards in some areas of the UK. In the 3rd Annual CPS Lecture in October 2010, Baroness Stern reiterated points from her review and described the SARC's as:

SARC's are a very necessary part of a criminal investigation but they are also symbols - symbols of respect for human dignity, symbols of a community that minds when people are assaulted and violated and organises resources and money to help heal that violation.

The signal that would be sent if these services were chargeable for migrants, even irregular migrants would be that justice is limited based on immigration status and the safety of all women, or victims of sexual violence would be compromised by the failure to gather all available evidence. A SARC also provides information to assist in the prosecution of those responsible for human trafficking for the purpose of sexual exploitation and may therefore be attended by trafficking victims who have no immigration status.

Under the Council of Europe Convention on Action Against Trafficking in Human Beings "the Trafficking Convention"; victims of human trafficking are entitled to protection and the aim of the convention is to provide protection and assistance to all victims of human trafficking; as well as ensuring effective investigation and prosecution.¹³

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

Response:

Rights of Women endorse the response of ILPA.

Making the system work in the NHS

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

Response:

Rights of Women endorse the response of ILPA.

¹³ Council of Europe Convention on Action Against Trafficking in Human Beings, Article 1

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?

Response:

Rights of Women endorse the response of ILPA.

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

Response:

Rights of Women endorse the response of ILPA.

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

Response:

Rights of Women endorse the responses of ILPA and Maternity Action.

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?

Response:

No.

Rights of Women endorse the response of ILPA.

Recovering Healthcare Costs from the European Economic Area (EEA)

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

Response:

No.

Rights of Women endorse the response of ILPA.