



Patients Not Passports



Challenging healthcare charging in the NHS

Updated October 2020

Medact

Patients Not Passports: Challenging healthcare charging in the NHS

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About Medact

Medact's mission is to support health professionals from all disciplines to work together towards a world in which everyone can truly achieve and exercise their human right to health.

We do this through research and evidence-based campaigning for solutions to the social, political and economic conditions which damage health, deepen health inequalities and threaten peace and security.



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This briefing is designed to be used as a tool and reference guide for anyone working to improve access to healthcare. It has been written with this in mind and expects readers to take the information they need to use without having to read the entire briefing.

1 - Introduction



The NHS was conceived as a universal service, a project designed to guarantee the right to health available to all who need it, regardless of ability to pay. However it has long been under threat from the forces of privatisation and the market logic of neo-liberalism. This has manifested in political decisions to restrain the budget, open procurement to the free market, and increasingly treat care delivery as a service to be earned, not a right guaranteed to all. Hostile Environment immigration policies facilitate this process, increasingly restricting care by embedding the mechanisms of immigration enforcement into the framework of the NHS. The Hostile Environment is enacted through a series of changes to the NHS charging regulations that expanded the range of services that were chargeable, increased the cost of NHS services, and introduced upfront charging for care accompanied by ID checks on patients in order to determine their eligibility for care. Behind this very visible restriction of access to healthcare, NHS Trusts engage in the sharing of patient data and reporting of patient debt to the Home Office, information which is then used by Immigration Enforcement teams to track, detain, and deport people. These policy changes are the culmination of years of successive Governments eroding migrants' right to access the NHS and represent a drastic step backwards from the vision of the NHS as a truly universal service.

Migrant communities and healthcare workers themselves have been leading the push back against these harmful policies. Since 2014 Docs Not Cops has worked to challenge the expansion of border controls and charging in the NHS, initially focusing on the Immigration Health Surcharge and increased fees for migrants brought in under the Immigration Act 2014. In 2017 they launched the Patients Not Passports campaign in response to the introduction of ID checks and upfront charging. Medact, Migrants Organise, and the New Economics Foundation joined the campaign and together the three groups support opposition to the policy from frontline healthcare workers and communities impacted by charging. At the same time the Medact Migrant Solidarity group, a volunteer group of healthcare workers supported by Medact, started delivering trainings in NHS Trusts to raise awareness of the policy, and worked to get a number of Royal Colleges to speak out against charging.

This briefing is designed to be a tool to support people in campaigning against the Hostile Environment in the NHS. It sets out the policy and ideological background to NHS charging; reframes and challenges some of the arguments used to justify the policies; and presents evidence and analysis of the impact of restricting access to the NHS. It also includes new data on NHS Trust's response to these policies and reveals how little has been done to mitigate or monitor the harm they are causing.

This document sits alongside the Patients Not Passports Toolkit and two other Patients Not Passports reports: *Migrants' Access to Healthcare During the Coronavirus Crisis* and *The International Struggle for Universal Healthcare*. Together they offer resources and information to support healthcare workers, migrant communities and concerned citizens to launch campaigns in their Trusts and in their communities against the Hostile Environment in the NHS. You can find the toolkit at www.PatientsNotPassports.co.uk.

2 - Why Does the NHS Charge for Care?



Immigration Enforcement Logo - Licenced under CC BY-SA 4.0

2.1 - History of Charging in the NHS

The NHS is built on the principle that healthcare should be free at the point of use to all who need it. It is a mantra that is deeply embedded in our understanding of healthcare delivery in the UK. To fully grasp the significance of the changes brought about by the Immigration Act 2014¹ and the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2015² and 2017³ we need to understand how and when the NHS started charging people for healthcare.

Since its inception the NHS has been able to charge for some services. In 1946 Aneurin Bevan introduced the National Health Services Act⁴ which placed on the Secretary of State for Health the responsibility to provide a comprehensive health service for the people of England and Wales and led to the creation of the NHS. Although the Act enshrined in law that the vast majority of services would be provided free of charge, it did allow charging in a few areas, including dental and optician services, aftercare and domestic help, and for some of the more expensive medical devices. It did not make any provision about particular categories of people that would be required to pay or would be excluded from services.

Unfortunately it was only a year later, in 1949, that the Act was amended to include a provision that allowed for the Secretary of State to levy charges for NHS services on people who were not 'ordinarily resident' in Great Britain⁵, a provision that remained unchanged in both the 1977⁶ and 2006⁷ National Health Services Acts that followed. 'Ordinary residence' is a loosely defined category derived from case law that we will discuss in detail in [Section 3.1 \[p15\]](#).

Despite having the power to do so, no Secretary of State brought forward regulations to actually implement charging for over 30 years, until the introduction of The National Health Service (Charges to Overseas Visitors) Regulations 1982⁸ marked a new era in attempts to charge people to use the NHS. This change was not without opposition as we shall discuss in [Section 5.3 \[p31\]](#). It was the Immigration Act 2014 that made the next significant change in who was able to access NHS care, modifying the definition of 'ordinary residence' to make it reliant on the person having indefinite leave to remain in the UK⁹ (we explain 'ordinary residence' and different types of immigration statuses in [Section 3 \[p14\]](#)). This change excluded vast numbers of people from NHS care and allowed for the application of the Immigration Health Surcharge to those people applying for temporary visas (discussed in detail in [Section 2.4 \[p10\]](#)).

The provisions in the National Health Services Act 2006 and the Immigration Act 2014 that allow for charging for NHS care are enacted through regulations made by the Secretary of State for Health and Social Care. These regulations are not subject to parliamentary scrutiny in the way acts of parliament are, instead they are made and modified unilaterally by the Department of Health and Social Care (DHSC).

2.2 - Current Charging Policy

The current regulations that govern charging for NHS care, the National Health Service (Charges to Overseas Visitors) Regulations 2015¹⁰ and 2017 amendment¹¹, introduced a number of significant changes to the ways in which people are charged for using the NHS. Together they have fundamentally altered the principles that underpin the delivery of healthcare in England, going further than any of the charging regulations that preceded them.

The information in this briefing applies only to England. Scotland, Wales, and Northern Ireland all have devolved power over their healthcare systems. All countries do charge people for using the NHS, however the policies and practices vary greatly and are outside the scope of this document.

The 2015 regulations placed a requirement on NHS Trusts to identify and charge people not eligible for free

NHS care¹²; increased the cost that people could be charged to 150% of the national tariff¹³; and introduced the Immigration Health Surcharge¹⁴. The 2017 regulations placed a statutory duty on NHS Trusts to charge people upfront for treatment if they were thought to be ineligible for free NHS care¹⁵; increased the range of services that were chargeable to include some community and mental health services¹⁶; and mandated that NHS Trusts record people's chargeable status on their patient record¹⁷.

Never before have Trusts been required to charge people upfront for routine NHS care. Prior to 2017, Trusts had been required to charge people retrospectively, a policy that still led to people facing large bills as a result of accessing the NHS, but the 2017 regulations represent a particularly drastic shift in charging practices. It is clear that the principle policy objective of the NHS, to improve people's health and wellbeing¹⁸, is now secondary to determining a person's immigration status and therefore eligibility for care.

The 2017 regulations extended charging beyond secondary care and into areas of community care that had never previously been chargeable. Initially this had included a requirement for school nurses to check and charge school children however, following widespread criticism, the DHSC modified the guidance to exempt this service¹⁹. Many other services are now chargeable including: termination of pregnancy, community mental health services, and some district nursing services²⁰. The DHSC had originally planned to extend charges to A&E and some GP services by 2016²¹ but have delayed this process following outcry from the healthcare community and civil society²². The intention to extend charging still remains and the 2017 regulations should be understood in the context of Government plans to extend charging to all NHS services.

It is important to note that throughout this section we have only covered the history of the statutory changes that served to solidify exclusion from the NHS on the grounds of race and immigration status. While these changes play an important role in driving both discriminatory practice and culture in the NHS, they are just one part of the structures of racism and imperialism that lead to people being excluded from care. Since the inception of the NHS migrant and black and minority ethnic communities in the UK have faced exclusion, substandard care, worse clinical outcomes, and direct discrimination; regardless of the existence of laws that seek to legitimise this racism. The fight against NHS charging is not only a fight against these policies and regulations, however new, it is a fight against the deep roots of racism, colonialism and all of the structures that allow it to continue today.

2.3 - The Government's Attempt to Justify A Charging Regime

The Government claims these new charging measures are necessary to meet their target to recover £500 million a year from use of the NHS by overseas visitors²³. This section will explore the myths that underpin these figures and detail why the policy is not designed to, and will never achieve the Government's targets.

A 2012 review of the likelihood that charging so-called overseas visitors would bring in meaningful income for the NHS stated that it would be very difficult to achieve the Government's target, even if they were able to identify everyone excluded from free care by the regulations. This was partly a result of the fact that many of the people charged would never be able to afford to pay the bill, and partly a result of the NHS not being set up "*structurally, operationally, or culturally*" to identify and charge such a small group of people²⁴. In order to justify pursuing a policy that was unlikely to achieve its aims and that would require a cultural restructuring of the NHS, the Government would have to rely on something other than the facts. So called 'health-tourism' is often used to frame discussions about NHS charging policy, using a baseless myth to support the supposed need to exclude people from accessing the NHS.

The Myth of 'Health Tourism'

So-called 'health tourism' is a political concept that is almost ubiquitous in the media^{25,26} and is often pointed to as a major drain on NHS resources²⁷. However, in reality there is very little evidence to substantiate the existence of the phenomenon, with some studies even suggesting that migrants are more likely to return to their home country to access treatment when they need it²⁸. On the other hand, there is robust evidence to show that on the whole migrant populations are healthier and use health resources less than host populations²⁹.

Generally, 'health tourism' refers to the idea that people deliberately travel to the UK to seek free treatment for a pre-existing condition. It is a term usually reserved for people that are not citizens of the UK but in practice, under the rules that base access to the NHS on 'ordinary residence', it would also extend to British migrants who live abroad but return to the UK to access healthcare³⁰. Research commissioned by the Department of Health into the categories of overseas visitors that use the NHS noted that while overseas visitor managers in hospitals often recognised the category of 'health tourist', they were unable to prove that people they grouped into this category were actually travelling to the UK for the express purpose of accessing care³¹. In other words, Overseas Visitor Managers — those tasked with identifying and billing chargeable patients — were making unfounded assumptions about some patients that may well have led to them being challenged about their eligibility for care, or under the current charging regulations would have led to them being charged upfront for care unless they could prove their entitlement.

The Economic Justification

The Government's own estimate puts the cost of deliberate misuse of the NHS by overseas visitors at £300 million at most, equating to roughly 0.3% of the NHS budget³². This figure does not represent what could be considered recoverable through charging people for care; it includes the use of primary care and A&E services and does not take into account an assessment of the likelihood of the people charged being able to pay the bill. The Government itself admits that these figures are a very rough estimate, and even if it did extend charging to all services it would still be unlikely to recoup the total costs of this supposed 0.3%.

This estimate also obscures the concomitant cost of deterring people from care that arises from the policy, and the cost of implementing and administering ID checks and invoicing patients. In reality the people most likely to be charged for care are those who are least able to pay, many of whom will be long-term residents who have been unable to regularise their immigration status. A concerning indication of the numbers of people that have been unable to pay the bills they owe to the NHS is the number of Trusts that have resorted to using bailiffs to chase down unpaid debt³³. Three quarters of Trusts are now using private firms to pursue patients suggesting that not only are Trusts failing to use their discretion to write off debts owed by people that have no means to pay; but also that private companies are now profiting from exclusionary Hostile Environment policies. It thus comes as no surprise that in 2019 Health Secretary Matt Hancock provided an additional £1 million funding to NHS Trusts to increase the number of 'cost-recovery experts' in an attempt to address the administrative burden on NHS Trusts.³⁴

The financial impact of restricting care has been investigated by three recent studies across Europe that found providing universal access to preventative healthcare, including access for undocumented migrants, is more cost effective than restricting access to people with certain migration statuses thus forcing them to rely on emergency care^{35,36,37}.

The European Agency for Fundamental Rights (FRA) performed a cost analysis study on hypertension and prenatal care, and applied their findings to models representing three European countries' healthcare systems³⁸. The FRA only calculated the cost incurred by the health service and did not account for the cost to the individual or to society as a whole, and so it is likely to have underestimated the impact. Nevertheless, they found significant savings in providing preventative care (both primary and secondary care) as opposed to

emergency care alone. Additionally, a German study evaluated health system expenditure on asylum seekers and refugees with full access to healthcare compared to those without over a 20 year period. They found that as a result of restricting access to asylum seekers and refugees the health system expenditure increased by an estimated one billion euros³⁹. Lastly, a study from the Centre for Health and Migration analysed four EU countries for the direct (to the individual) and indirect (to wider societies due to disability and disease burden) costs of restriction to healthcare access. The results show that primary health care provision was always cost saving when compared to hospital treatment; and that, between 49%, and 99% of medical and non-medical costs of hospitalisation could be saved if timely primary care is provided⁴⁰. While these studies do not perfectly mirror the situation in England, they do make clear that restricting access to care is often more costly in the long run, both to individuals and to society as a whole. As we discuss in [Section 4.1 \[p22\]](#), the deterrent effect of the Hostile Environment extends far beyond the groups of people the charging regulations aim to exclude and has a significant impact on all parts of the NHS.

The Government's often used refrain "the NHS is a national, not an international, health service"^{41,42} mobilises the myth of 'health tourism' to justify a policy that is based on unreliable evidence and, as we will detail in [Section 4 \[p21\]](#), causes harm and leads to discrimination.

2.4 - Creating a Hostile Environment

The expansion of charging and subsequent immigration checks in the NHS is not an isolated policy development. These measures form part of what is known as the Hostile Environment; the name Theresa May, as Home Secretary, gave to a range of policies designed to make life in the UK unliveable for migrants⁴³. Other policies introduced under the banner of the Hostile Environment include immigration checks on bank account holders, the sharing of school children's nationality data with the Home Office, and the Right to Rent scheme which demands landlords conduct passport checks on renters⁴⁴. There has been a concerted effort among campaigners, civil society groups, and professional associations to challenge the inherent discrimination and exclusion that comes with the implementation of these policies. In early 2019, the Joint Council for the Welfare of Immigrants forced a major High Court victory that concluded the Right to Rent scheme was certain to give rise to unlawful discrimination⁴⁵. The Government has given very little justification for the measures brought or expanded under the Hostile Environment and has been challenged by the National Audit Office for having no evidence base for its policies⁴⁶. Similarly a report from the Institute for Public Policy Research found that the Hostile Environment has not lead to an increase in so-called 'voluntary returns' – migrants leaving the UK on their own or via indirect pressure and persuasion from the Home Office – and that the policy is failing on its own terms⁴⁷.

Alongside immigration checks and upfront charges for care the Hostile Environment is enacted in the NHS through a number of different but overlapping policies.

The Immigration Health Surcharge

The 2014 Immigration Act introduced the Immigration Health Surcharge (IHS)⁴⁸, a mandatory additional fee people pay as part of their visa application in order to access NHS services. The IHS is designed in a way that prices people out of being able to regularise their immigration status and prevents them from moving to or staying in the UK. The fee is levied per person per year and is not adjusted by income, and must be paid in full with the visa application. In December 2018 the fee was increased from £200 to £400⁴⁹ and in 2020 the cost increased further to £624⁵⁰. A family of four would thus need to pay an extra £4,992 on the cost of an application for two years leave to remain. This has led to families being forced to separate, including the case of an NHS nurse forced to send her children back to Kenya because she could not afford to pay for her whole family⁵¹. This fee is imposed despite what individuals pay in through their tax contributions and essentially amounts to discriminatory double taxation for migrants.

The coronavirus pandemic gave rise to significant outcry about the injustice of migrant NHS and social care workers being required to pay the IHS. This culminated in May 2020 with major health institutions^{52,53}, the leader of the opposition⁵⁴, campaign groups, and even commentators normally hostile towards migrants' rights, like Piers Morgan⁵⁵, speaking out against the charge. The fact that migrant healthcare workers providing essential care work had to pay the IHS became a national scandal. Despite initial hostility toward removing the charge, the Government eventually conceded and committed to exempting NHS and social care workers⁵⁶, however by October 2020 the policy remained unchanged. This remains a significant moment in the campaign to scrap NHS charging, with widespread recognition of the unjust nature of these policies resulting in a major policy shift from the Government. Unfortunately, the predominant argument levelled against the policy – that health workers should be exempt because they already 'pay in' to the health service by working in it, and during the crisis have risked their lives to do so – only serves to undermine the foundations of the argument against NHS charging. Access to the NHS does not and should not rely on the scale of individual contribution, through tax, national insurance, or any other means. By associating entitlement to free NHS care with migrants having to work or risk their lives for the health service this campaign reinforced the idea that people must earn their right to care and in doing so set an impossibly high expectation for what people must do to earn this right. Nonetheless, the national debate surrounding the IHS shed light on the reality of discriminatory policies for migrants to access NHS care on an unprecedented scale.

Sharing Patient Data

The Home Office has been encouraging other Government departments to share with them the personal data of people that use public services, which is then used by Home Office Immigration Enforcement teams. These practices are widespread and can be seen in the Department for Education⁵⁷ and more recently in the Department for Work and Pensions⁵⁸. NHS data is shared with the Home Office in three main ways.

NHS Trusts Making Enquiries to the Home Office

As part of the process of determining a person's eligibility for free NHS care, Trusts can utilise the Home Office's checking service to access information about their immigration status⁵⁹. This service includes a hotline to the Home Office at a cost of 80 pence per minute to the NHS⁶⁰. Trusts send non-clinical information about the person to the Home Office, which they can then use to update their records and potentially take enforcement action. The Trust does not need to gain the consent of the person in order to share their information in this way. Recently it was revealed that the Home Office offered to embed immigration officials in NHS Trusts and Local Authorities to help them identify people eligible for charging, with officers available at a cost to the Trust of £60 an hour⁶¹.

NHS Trusts Reporting Patient Debt to the Home Office

When a person has unpaid debt to the NHS of more than £500 for longer than two months, the Trust is encouraged to share this information with the Home Office. The Home Office is then able to use the presence of the debt to refuse that person's application for leave to remain⁶². A recent report from the Independent Chief Inspector of Borders and Immigration revealed that the Home Office runs a programme called Operation DINTEL that uses the information supplied by NHS Trusts to aid the work of their Immigration Enforcement Teams⁶³. These brutal policies place individuals at risk of arrest, deportation, and destitution when they seek care. Burdened by unmanageable healthcare debts, individuals become trapped; unable to regularise their immigration status because of the costs this involves and any immigration application or appeal threatened by their outstanding debt with the NHS⁶⁴. Sharing of debt information is not mandatory and at present most Trusts do not share this information however, the Home Office is working to make the practice more widespread⁶⁵.

Automated Checking Systems

Increasingly NHS Trusts are uploading patient data into automated systems used to identify potentially chargeable patients. In 2019 it was discovered that NHS England had set up a pilot scheme in which

Lewisham and Greenwich NHS Trust would share patient data with credit checking agency Experian. Experian would then use a person's credit footprint to produce a 'residency score' which the Trust would consider when assessing the likelihood that a person was 'ordinarily resident' and therefore entitled to use the NHS⁶⁶. NHS England had been encouraging other NHS Trusts to join the pilot scheme, which had been running since 2016. However, with little uptake and mounting concerns about the sharing of confidential patient data it was discontinued in 2019.

NHS England has also been working to develop an automated checking system called the 'message exchange for social care and health' or 'MESH' system. This system allows NHS Trusts to share patient records with the Home Office who then use an algorithm to assess whether a person is likely to be chargeable. The system then produces a report assigning patients a red, yellow, or green flag indicating whether or not they need to pay or need further investigation by the Overseas Visitor Manager⁶⁷. The tool allows for thousands of patient records to be shared in minutes and boasts that it will aid in upfront charging, reduce waiting lists (by denying appointments), and lead to increased early cancellations (for patients that cannot pay). A number of case studies suggest that NHS Trusts are using the MESH system to send automated letters to patients asking them to demonstrate their entitlement to care, however we do not know what criteria are used to identify these people, leaving potentially life changing decisions to a computer algorithm. This is particularly concerning in light of a recent successful legal challenge by Foxglove and JCWI which found that the Home Office was using a racist algorithm as part of its decision-making process for visa applications⁶⁸.

Prior Bulk Data-sharing Arrangements with the Home Office

In 2017 it was revealed that NHS Digital had signed a Memorandum of Understanding (MoU) with the Home Office that allowed for bulk sharing of non-clinical patient data for the purposes of Immigration Enforcement⁶⁹. The MoU was the formalisation of data-sharing practices that had seen NHS Digital share over 5000 patient records with the Home Office in 2016 alone⁷⁰. Following campaigning from Doctors of the World, the National Aids Trust, and migrant-led organisations such as the Voice of Domestic Workers, alongside calls to halt data-sharing from the Health and Social Care Select Committee⁷¹, the MoU was eventually scrapped⁷². However, NHS Digital have already entered negotiations with the Home Office for a revised MoU⁷³ that is likely to try and replicate the arrangement that was previously in place.

To ensure the NHS remains a safe space for all who need it we echo calls from the European Agency for Fundamental Rights⁷⁴, the European Commission Against Racism and Intolerance⁷⁵, Liberty⁷⁶, and Platform for International Cooperation on Undocumented Migrants (PICUM)⁷⁷ for a 'firewall' between the data held by vital public services and Immigration Enforcement.

2.5 - Commitments to Universal Healthcare

Medact works to promote the function of the health system as a foundation for societal well-being and a platform for the expression of ethical behaviour. In spite of some improvements in healthcare coverage across the world, hundreds of millions of people still lack adequate access to healthcare and protection from the costs of illness, disease and injury⁷⁸. Health systems have long been commercialised and marketised through structural adjustment programmes, resulting in greater inefficiency and inequity⁷⁹. Though there is a global movement, buoyed by the World Health Organisation's commitment to Universal Healthcare, this principle is being reinterpreted so that certain groups continue to feel alienated, demonised and neglected.

In the UK, we are rightly proud that our NHS was founded on a principle of treating everyone in the country regardless of status, wealth or origin. It has consistently demonstrated the effectiveness and efficiency of Universal Health Coverage since its inception in 1948, and is one of the most equitable and cost-effective health systems in the world.⁸⁰ However, the removal of the Secretary of State's duty to secure or provide comprehensive health services in the Health and Social Care Act 2012 set in motion changes to the health

system that have jeopardised this standing⁸¹. The idea that people can be either eligible or ineligible to access care contradicts the central reasoning behind collective provision, in which pooling finances through general taxation shares risks and ensures equity in healthcare for all. In addition, the way a society supports and cares for refugees, asylum seekers and migrants is often a demonstration of its commitment to equality and fairness in society more broadly. The 2015 and 2017 charging regulations represent a significant step backwards in the UK's attempt to provide truly universal healthcare and moves us away from a fair and equitable healthcare system.

The charging system also contradicts a global commitment to Universal Healthcare Coverage (UHC)⁸². UHC is defined by the World Health Organisation (WHO) as 'ensuring that all people have access to needed health services (prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship'⁸³. The UK is obliged to work towards this ambitious target by adhering to the EU's commitments to the Sustainable Development Goals (which include UHC in SDG 3⁸⁴), as well as through commitments to reduce health inequalities and protect public health enshrined in UK law by the Health and Social Care Act 2012^{85,86}. Furthermore, the UK is a signatory of several human right treaties, including the International Convention on Economic, Social and Cultural Rights in which Article 12 explicitly lays out a human right to the highest attainable standard of physical and mental health⁸⁷. This right is not dependent on migration status, but rather applies equally to all people⁸⁸.

3 - Who is Entitled to NHS Care?



NHS healthcare is not free for everyone

If you are visiting England or not living here on a lawful and settled basis, you may have to pay for your hospital treatment.

For more information go to www.nhs.uk/visitingengland

3.1 - Ordinary Residence

Entitlement to free NHS care in England is currently reliant on a person being 'ordinarily resident' in the country. DHSC guidance states that a "person will be 'ordinarily resident' in the UK when that residence is lawful, adopted voluntary [sic], and for settled purposes as part of the regular order of their life for the time being, whether of short or long duration"⁸⁹, a definition which is derived from case law, principally the case of *Shah vs London Borough of Barnet*⁹⁰. The 2014 Immigration Act, the piece of legislation that brought in much of the Hostile Environment, changed the law so that a person is now required to have indefinite leave to remain in the country in order to be considered ordinarily resident, directly linking entitlement to health services with a person's immigration status⁹¹. The concept of 'ordinary residence' is problematic for a number of reasons: it is difficult to demonstrate or document; the indefinite leave to remain requirement ignores the reality of many people's difficult journey through the immigration system; and it is a complicated legal term that NHS practitioners and administration staff are poorly placed to judge. It is important to note that access to the NHS is not reliant on an individual's tax contribution, a common misconception that underpins many people's understanding of entitlement to NHS services.

Proving Ordinary Residence

One of the major problems faced by people whose entitlement to care is challenged is that there is no single document that can demonstrate that they are 'ordinarily resident'. It is often based on the person's ability to provide a series of documents, a photo ID (often a passport) and proof of address, along with a decision letter from the overseas visitor manager in the Trust that the person is settled in the UK for the time being. This means the policy is likely to have a disproportionate impact on people who do not have documentation or who are unable to provide proof of address. When considering the scale of the impact this policy will have it is worth remembering that 16.5% of people living in the UK hold no passport at all⁹². This is further complicated by the standard question recommended by the DHSC, which requires Trusts to ask if a person has lived in the UK for the last six months⁹³. This gives the false impression that someone has to have been living in the UK for a specified period of time to be ordinarily resident.

ID Checking Pilots

To support Trusts in meeting their requirement to identify and charge patients upfront, the Department of Health and Social Care (DHSC) launched a pilot scheme in 2016 that trialled a requirement for patients to bring two forms of identification document (ID) with them to their appointments⁹⁴. The pilot ran in 18 Trusts for a year prior to the commencement of upfront charging in October 2017. Previous studies show being asked to provide identification to access healthcare deters people from seeking help when they are unwell⁹⁵. The DHSC is yet to publish any evaluation of the result⁹⁶ despite pressure from the Health and Social Care Select Committee⁹⁷. With data obtained via freedom of information (FoI) requests, we do know that the pilot scheme had been largely ineffective at identifying people for charging, finding only 50 people that were ineligible for free care out of 8,900 ID checks⁹⁸. There has been no formal conclusion of the pilot and it remains unclear how many of the Trusts are still running the ID checking scheme.

The Windrush Scandal

The problems people face when they can no longer access vital public services are exemplified by what happened to people from the Windrush Generation as a result of changes in the Immigration Act 2014⁹⁹ and the ensuing Hostile Environment policies. Many people that had migrated to the UK before 1973 had no official documentation to prove they had indefinite leave to remain and as a result of the changes could no longer demonstrate their entitlement to free NHS care. This led to people being denied access to care¹⁰⁰, communities deterred from seeking care¹⁰¹, and left many people homeless and destitute¹⁰².

There was widespread outrage about the situation, including from the High Commissioners of Caribbean Commonwealth Nations¹⁰³, eventually leading to the resignation of then Home Secretary, Amber Rudd¹⁰⁴.

In the wake of the scandal, the Government commissioned an independent review in order to assess what happened and what lessons could be learnt. The review was wide ranging and concluded with 30 recommendations for changes in Home Office practice, from improving knowledge of racism, discrimination, and Britain's colonial history; to the need to better understand the impact and intention of its own policies. The review also identified that the harmful impact on the Windrush generation was predictable, and that the Home Office had not heeded warnings about this or reacted to the early indication that there was a problem¹⁰⁵. The Home Office responded to the review by committing to implement a number of training schemes, and to continue the support currently in place for members of the Windrush generation. It did not commit to ending the Hostile Environment, instead suggesting the policy would continue into 2022 while an ongoing review was finalised¹⁰⁶. Although these interventions recognised that structural racism was a factor in the targeting and harm suffered by Caribbean communities; they failed to address the wider impact of the Hostile Environment on other communities and actively promoted the idea that the problem was that British people were targeted, not the policies themselves.

3.2 - The Transient Nature of Immigration Status

The immigration system in the UK is incredibly complex. In this section we try to breakdown some of the basic concepts that underpin the system. If you want to get a more detailed understanding, we highly recommend Corporate Watch's 'The UK Border Regime: A Critical Guide'¹⁰⁷ which we draw from heavily for this section.

How Does the UK Immigration System Categorise People?

Immigration systems are designed to sort people into categories based on their entitlement to live, work, or visit a particular geographic space. In the UK migrants are sorted into these four main categories:

EEA Citizens

People who are citizens of EU countries and other countries within the European Economic Area (EEA). Generally, they have a right to live and work in the UK, however this is reliant on them exercising their 'treaty rights' which generally means they are self-sufficient¹⁰⁸. When the UK formally exits the European Union it is likely that EEA citizens will be fall into the same category of non-EEA citizens for the purposes of immigration control, unless they have successfully acquired 'settled status' prior to the UK's exit.

Non-EEA Citizens

People from countries outside the EEA who usually need to apply for a visa to enter the UK, for many this will include payment of the Immigration Health Surcharge mentioned earlier.

Refugees and Asylum Seekers

People granted or seeking protection from the state as a result of fleeing persecution in their own country. Asylum seekers are people who are in the process of making a claim for asylum and have not yet had their claim approved or refused. As we will discuss later, this category does not indicate whether a person is in fact a refugee, but

whether or not the Home Office recognises them as such.

'Undocumented migrants'

This is a very broad category that essentially includes any person that is in breach of immigration rules. It can include: refused asylum seekers; EEA citizens who are not exercising their 'treaty rights'; people that previously had leave to remain which has now run out (often known as 'overstayers'); people working outside the terms of their visa - a student working too many hours per week for example; the children of people without leave to remain that are born in the UK; and people that are entitled to citizenship but have no papers - many of the Windrush generation for example¹⁰⁹. This category of migrants are also sometimes referred to as 'irregular' or 'illegal' migrants. We do not use this term in solidarity with migrants and campaigns for migrants' rights. We believe that no person is illegal – illegality is not a characteristic of an individual but a status produced by policies and legislation¹¹⁰.

A person's immigration status can change easily and quickly, with them one day being entitled to NHS care and the next being chargeable. The rules change frequently and have doubled in length since 2010¹¹¹, this complexity coupled with cuts to legal aid support¹¹² mean people are increasingly unable to navigate the immigration system. When the Home Office makes a decision to refuse a person's application for asylum, that person is able to appeal the Home Office's decision. Just under half of these decisions are overturned at appeal stage¹¹³ suggesting serious flaws in the way the Home Office handles these applications. The average waiting time for an appeal – prior to the coronavirus crisis – was around 52 weeks¹¹⁴. It has greatly increased as a result of the pandemic. During this time appellants are unable to lawfully work, offered minimal financial support, and moved around the country to live in cramped and low-quality asylum accommodation.

The spectre of the 'illegal migrant' is mentioned repeatedly in the British media, migrants are referred to as 'illegal' more frequently than any other qualifier, and 'illegal migrants' are vastly more likely to be talked about in relation to rule breaking and crime¹¹⁵. The charging regulations rely on this depiction of 'illegal migrants' to justify the harm the policy causes. It is clear however that in reality people end up breaching immigration rules in a multitude of ways, often as a result of laborious appeals procedures, lack of access to legal representation, or the extortionate costs of regularising one's immigration status.

3.3 - Who and What is Exempt from Charging?

Exemptions from the charging system include certain services and treatment, as well as certain groups of people. Broadly the exempted services cover all A&E and primary care; communicable and sexually transmitted disease services; and other community services like school nursing (depending whether they are funded by NHS Trusts or by Clinical Commissioning Groups). Certain groups of people excluded from charging include vulnerable people (survivors of torture, trafficking or domestic abuse), people with certain communicable diseases, or people in the care of the State¹¹⁶. The complex nature of the policy and poorly communicated information about people's entitlement to care deters people from seeking treatment as a result of fear and confusion about facing potential charges¹¹⁷. We discuss the deterrent effect of the policy in detail in [Section 4 \[p21\]](#).

Why Don't the Exemptions Work?

While the guidance aims to exclude from the charging system groups that have increased vulnerability to health inequalities, in reality it is difficult for many people to demonstrate that they qualify for the exemptions. Health problems arising from domestic abuse, sexual violence and torture are exempt from charging, but it is well known that people find it difficult to disclose historic or current abuse^{118,119}; and that in general healthcare practitioners are not well trained in handling disclosures^{120,121}. To qualify for many of the exemptions people are required to present written confirmation from their GP or a charity to substantiate their experiences¹²², a process that in itself can be traumatising and difficult for people to do. Similarly, to meet the exemption covering survivors of trafficking and modern slavery the person has to have been referred to the National Referral Mechanism (NRM)¹²³. This is something that many survivors are unwilling or unprepared to do, not least because around half of claims submitted to the NRM are refused¹²⁴ leaving that person vulnerable to detention or deportation. Through their advice line offering advice and support to pregnant women and new families Maternity Action have identified that, far from exempting survivors of domestic abuse from having to pay, the NHS charging regime often serves to trap women in situations where they face violence¹²⁵. These exemptions from charging only apply to treatment directly related to the exempt condition, this is often a subjective decision taken by healthcare workers leaving many people uncertain what charges they may face, especially in the context of survivors of trauma that may have long standing mental and physical health needs¹²⁶.

Services provided for the treatment of many communicable diseases, including the diagnostic tests required to identify them, are also exempt from the charges. The problem is that people do not present with a diagnosis, they present with symptoms and for many the fear of incurring charges will still prevent them from seeking care¹²⁷. The exemption only applies to the diagnostic tests and treatment for the specific condition, so people will still risk charges for other tests and any other comorbidities even if one of their healthcare problems is exempt. The policy is still too recent for there to be much data about the impact of charging on people with exempt conditions. However, concerns have been raised by the Faculty of Public Health about underdiagnosis and undertreatment of communicable diseases arising from NHS charging policy¹²⁸ and by a coalition of HIV charities about the prevention of HIV positive migrants from accessing the care they need¹²⁹. A recent study revealed an increase in delayed diagnosis of TB in non-UK born populations in East London following the commencement of the Migrant Visitor Cost Recovery Program in 2014¹³⁰. Whilst this study does not show the impact of the introduction of upfront charging in 2017, it does give an indication of the deterrent impact of the Hostile Environment in the NHS. In addition, there is evidence the broader Hostile Environment deters individuals with tuberculosis from accessing care¹³¹. Research carried out by the New Economics Foundation, Migrants Organise, and Medact during the coronavirus crisis, found that even where people were too afraid to seek care despite being aware of the exemptions of infectious diseases. Survey responses from over 50 migrant support organisations confirmed that the exemptions alone, even when explained by support workers, were not enough to reassure people that accessing the NHS would not incur large debts or risk having their data shared with the Home Office¹³².

Although A&E and GP services are exempt from charging, we know that they are sites at which people face questions about their entitlement to care and are identified for charging later. It is increasingly common practice for people to be issued with pre-attendance forms in A&E asking people to demonstrate their eligibility for free care, a process that can lead to delays in care or deter people from seeking treatment altogether¹³³. Similarly, people are often inappropriately required to present a passport and proof of address to register with their GP¹³⁴ despite Government guidance clearly stating this is not required¹³⁵. These practices undermine the exemptions that are supposed to ensure vital services remain open and accessible to all and are another example of prioritising immigration control over the provision of healthcare.

Refugees and people seeking asylum are also exempt from NHS charges, an exemption designed to stop this very marginalised group being made destitute or excluded from care altogether. This is particularly important as refugees and asylum seekers are known to have a higher prevalence of mental and physical health problems when compared to the general population¹³⁶. Many refugees and asylum seekers have limited

knowledge of the health systems in their host country and experience fear and mistrust of services¹³⁷, as such it often falls to healthcare workers to identify and support people to access care¹³⁸. Refused asylum seekers, on the other hand, are not exempt from charging under the 2017 regulations. Research conducted by Medact Manchester revealed that healthcare workers had a limited understanding of different immigration statuses and the impact these statuses had on a person's entitlement to care. Only 1 in 5 felt comfortable defining the terms 'asylum seeker', 'refugee' and 'economic migrant', while 1 in 3 failed to identify refused asylum seekers as being eligible for free emergency care¹³⁹. Some of the researchers conducted a similar study, this time surveying over 500 healthcare workers, finding that 80% of respondents were not comfortable defining the immigration categories on which entitlement to care rest¹⁴⁰. Not only is it inappropriate for healthcare workers to interrogate people's immigration status prior to or during treatment, but it is also clear that healthcare workers are poorly placed to apply the exemptions designed to ensure vulnerable people are not denied care. Moreover, this exemption fails to recognise the transient nature of immigration statuses and that a person's status can often shift from asylum seeker to refused asylum seeker and back again depending on the progress of their application or appeal to the Home Office.

3.4 - Urgent & Immediately Necessary Treatment

The 2017 Guidance groups NHS treatment into three categories of urgency, in order of severity they are: immediately necessary, urgent, and non-urgent treatment¹⁴¹. The assessment of the person's condition and a determination as to which category applies to them is conducted by a clinician and is supposed to be recorded on a specific form¹⁴². The Guidance explains each category in detail, but in brief they are:

<u>Immediately Necessary</u>	Treatment that needs to be delivered promptly in order to save a person's life, prevent their condition from becoming life threatening, or prevent permanent and serious damage occurring.
<u>Urgent</u>	Not immediately necessary but cannot wait for the person to be reasonably expected to leave the UK.
<u>Non-Urgent</u>	Routine treatment that can wait until the person has left the UK. If a person's condition is determined to be urgent or immediately necessary then care cannot be withheld regardless of that person's ability to pay. This does not exempt them from charging altogether, but instead means that charges will be collected retrospectively, after the treatment is delivered. People are also liable for the cost of the clinician's assessment of urgency.

The definition of urgent treatment is both complicated and highly subjective. Clinicians are required to judge both the severity of the condition and the impact it has on a person's life, alongside making a judgment about the timescale within which the person is likely to leave the UK; taking into account their immigration status and their ties to the UK. In immigration hearings, such a decision would be made through the courts by an immigration judge, whereas in healthcare this burden falls on healthcare workers and Overseas Visitor Managers who are ill equipped to make judgments about the nature and impact a person's immigration status has on their entitlement to care¹⁴³. For a healthcare worker to fully understand the likelihood of a person leaving the UK they would need to undertake detailed investigation of the person's circumstances and have a thorough understanding of the processes of the Immigration System, something they cannot and should not be expected to do. Research conducted by the British Medical Association identified that many doctors reported facing pressure from overseas visitor managers when making these already complex decisions about a person's entitlement to care and highlighted some instances where non-clinical staff were making decisions about urgency in contravention of the Guidance¹⁴⁴.

The complexity of making decisions about urgency and the harm caused when these decisions are made poorly can be seen in the experiences of Elfreda Spencer¹⁴⁵ and Nasar Ullah Khan¹⁴⁶. Both were unable to pay upfront for their care, their treatment was deemed to be non-urgent and as such was withheld pending payment. Both had been declared not medically fit to fly, yet, despite clearly being unable to leave the UK due to their health conditions, their treatment was still deemed to be non-urgent. Elfreda Spencer died in January 2018 without receiving treatment. The type of cancer she had was treatable and has a high survival rate when treatment is given.. Nasar Ullah Khan's case was further complicated by recent changes to the way in which people are prioritised for organ donation. In 2018 following a decision in the Court of Appeal the practice of de-prioritising people who were not 'ordinarily resident' in the UK¹⁴⁷ was deemed to be lawful. This means that only people with indefinite leave to remain will make it to the top of the transplant list. Nasar Ullah Khan was unable to get the transplant he needed to live. As a result he was denied all other treatment that may have been able to prolong his life for years. He died in February 2019, aged just 38 years old, from a condition he likely would have recovered from. He had to fight to access palliative care, and had to launch a campaign for his family to be granted a visa to see him before he died. All because of his immigration status.

The Special Case of Maternity Care

All maternity treatment is deemed to be immediately necessary and as such should never be withheld as a result of the person's ability to pay¹⁴⁸. Despite this a number of Trusts involved in the ID checking pilot used their maternity departments to trial the scheme^{149,150}. There is ample evidence to suggest that as a result of the charging policy many women are deterred from seeking care¹⁵¹ and that the confusing way charges are communicated by Trusts often leads women to withdraw from care¹⁵². Maternity Action surveyed women that had been impacted by charging for maternity care and found that none of them had been given any information about support they might access to manage the debt they would incur¹⁵³. In reality it does not matter whether charges are demanded upfront or pursued after care is given, for many women the prospect of being charged at all is enough to stop them accessing maternity services¹⁵⁴.

4 - The Impact of NHS Charging Policy



4.1 - Deterrence and Delay

One of the widest ranging and devastating impacts of NHS charging policy is the role it plays in deterring people from seeking care. The Hostile Environment works in a way that embeds the practices of immigration enforcement in the working of vital public services, using a range of behind the scenes data-sharing systems and reporting mechanisms. This makes these systems difficult to identify, and can leave people uncertain about whether they will come into contact with immigration enforcement when they access health services. This invisible threat is then bolstered by publicity campaigns in NHS Trusts using posters supplied by the DHSC¹⁵⁵ that warn people of the likelihood that they will face charging. Although many of the most hostile posters were removed from the DHSC site in August 2018, Trusts still have them on display, including in A&E waiting rooms. Researchers surveyed service users at Doctors of the World's London clinic and found that around 80% of undocumented migrants reported fear of arrest as a deterrent from seeking care, and around 30% of asylum seekers stated that having been denied healthcare previously was a barrier to accessing further care¹⁵⁶. A later study of people using Doctors of the Worlds clinic found that those who were facing charges for secondary care faced an average delay to treatment of 37 weeks, with this delay remaining essentially the same (36 weeks) for those people who needed 'urgent' or 'immediately necessary' care¹⁵⁷.

Health Seeking Behaviour

An effective healthcare system relies on proper and appropriate use of each service provision, with correct and efficient signposting and a focus on preventative care. The impact of restrictive regulations on deterring people from care has been found to change health seeking behaviour, with people more likely to use emergency care instead of primary care. In the UK, Doctors of the World found undocumented migrants reported using A&E above GP services, and were more likely to use emergency services than planned care¹⁵⁸. Similarly, Maternity Action found that women in the UK were likely to avoid care until a point of crisis¹⁵⁹. Research conducted by the BMA highlighted that in their members frontline experience both people who were eligible for care under the regulations, and those who were not, were being deterred from seeking care¹⁶⁰. The deterrent impact of the policy was wholly predictable and evidenced in a number of studies on the effect of policies on the health seeking behaviour of migrant populations. These studies found that when barriers to care exist people will resort to using A&E instead of primary care; or will pursue unconventional options such as self-treatment, borrowing their friend's ID, or discharging themselves before treatment is complete^{161,162}.

Delaying seeking care until emergency treatment is required is incentivised if it is the only service that is free to access. Not only is this behaviour risky for individual health but it also puts additional pressure on the health system through increasing demand on an already stretched emergency service, shifting utilisation away from cheaper preventative care, to expensive emergency treatment^{163,164}. Although primary care remains free in theory, in reality migrants find it difficult to access¹⁶⁵ and GP registration is known to be lower among people that have recently migrated to the UK¹⁶⁶. The Hostile Environment is likely to increase inappropriate use of NHS emergency services and, by creating a culture of suspicion and refusal of migrants' right to access healthcare, is also likely to further hinder people's ability to register with and access a GP. This will lead to worse health outcomes for migrants and to increased strain on NHS resources that face continuing cuts to funding¹⁶⁷.

How the Policy Generates Fear

ID checking and charging policies are enacted with wide variability both between and within Trusts¹⁶⁸, with patient experience often relying on the knowledge, seniority, and willingness of the healthcare worker advocating on their behalf. An analysis of data obtained by the Joint Commission for the Welfare of Immigrants under the Freedom of Information Act and analysed by Medact supports this fact.

Our Research:

The data revealed that of the 99 Trusts that responded 32% had no policy to cover the implementation of the charging regulations and, of the remaining Trusts, 22% used only the standard DHSC guidance. 28% of Trusts did report having local policies, however of these only 7% had policy specifically relating to the charging regulations, with the rest relying on their general overseas visitors' policy¹⁶⁹.

The combination of a visible threat of being charged with the invisible and unpredictable mechanisms of identifying chargeable individuals makes these policies even more damaging to the patient and healthcare worker relationship. They rely on the fear of accruing insurmountable debt as a means to deter people from using the health services altogether. The barriers migrants, and particularly undocumented migrants, already face in accessing healthcare are well evidenced^{170,171}, and this policy is likely to make the situation worse. There remains relatively limited research into the specific impact of the charging regulations in the UK, however Doctors of the World found that 1 in 5 of the patients of their London clinic did not access mainstream NHS services due to fear of the Home Office or of facing unaffordable bills. They found this deterrence to be the case even for people with urgent health needs such as heavily pregnant women, people with cancer, people with kidney failure and those suffering from post-stroke complications¹⁷². Additionally, a recent study revealed an increase in delayed diagnosis of TB in non-UK born people living in East London following the launch of the Migrant Visitor Cost Recovery Programme in 2014¹⁷³. Supporting these UK based studies, a systematic review into the impact of European immigration policies on the health status of undocumented people found that although the policies of healthcare restriction for undocumented people varied greatly, being deterred from using services due to the fear of deportation, harassment, and not knowing what they were entitled to was common throughout¹⁷⁴.

Comparison with the Spanish Healthcare System

The 2012 Spanish health care reform known as the Royal Decree Law 16 (RDL 16/2012)¹⁷⁵ introduced similar restrictions to healthcare to the 2017 NHS regulations and has been found to reduce access to healthcare for undocumented migrants. The Centre for Research in Health and Economics (Centre de Recerca en Economia I Salut, CRES) analysed data on use of services, satisfaction and self-reported health, before and after the reforms were introduced. The research outcomes demonstrated a sharp decrease in utilisation of primary and secondary care by undocumented people following the reforms¹⁷⁶. REDER, a network of charities and civil society organisations, have collated evidence on those affected by the reforms, documenting 3,340 cases of people being denied access to healthcare. REDER has found that people officially exempt from charging have wrongly been excluded from care, including 146 pregnant women, 243 minors¹⁷⁷, and 26 asylum seekers. Sweden has a healthcare policy that restricts healthcare on the basis of migration status, however primary care remains free for all. Despite this blanket exemption, MSF Sweden has found that primary health care is often denied¹⁷⁸, a finding in keeping with the experience of people without proof of address in the UK¹⁷⁹.

This comparison paints a concerning picture of the likely long-term impact of these policies in England.

4.2 - Maternal Health

The impact of targeted charging on health outcomes can be evaluated in more detail with regards to maternal health due to the availability of several comprehensive reports on the experiences of women facing charges for NHS care. The National Institute for Health and Care Excellence (NICE) make clear recommendations for best practice in antenatal care with evidence showing that having an early booking appointment, regular midwife reviews and prompt referral to a consultant-led team or hospital care, is required for optimum health

outcomes¹⁸⁰. NICE have also recognised that migrant women face additional barriers to care and are at increased risk of poor outcomes in pregnancy and in response they have released specialist guidance aiming to address this disparity¹⁸¹. The recent MBRRACE study into maternal deaths demonstrated the shocking inequalities pregnant women face in the UK. The study showed that black women are five times more likely to die during their pregnancy, mixed race women three times, and Asian women almost twice as likely to die as white women¹⁸². Despite examining deaths occurring in 2015-17, a time when the renewed push to charge migrants was only beginning to gather momentum under the Hostile Environment, the study attributed the NHS charging regulations as a likely cause in the deterrence and subsequent death of three women.

Maternity Action conducted interviews with health professionals and women affected by charging and found that despite the exemption from upfront payment the prospect of retrospective charging meant that migrant women were more likely to: present later than the NICE recommended time of 10 weeks; miss appointments; discharge early from hospital for the fear of large bills; and feel stressed throughout the pregnancy^{183,184}. In addition to the fear of charging exposing women to unacceptable risks for health outcomes, Maternity Action added to a growing body of evidence that found stress in pregnancy has long-term negative impacts on the child's emotional and cognitive development¹⁸⁵. Similarly, Doctors of the World found that many pregnant women were being denied care due to inability to pay despite their entitlement, as staff did not understand the charging rules¹⁸⁶.

Furthermore, Maternity Action found a concerning impact of targeted healthcare charges on survivors of domestic violence. Their research highlighted a case in which the addition of unaffordable NHS bills to a woman with a newly born baby increased her vulnerability to exploitation and violence from her partner, on whom she was financially dependent¹⁸⁷. This not only highlights the way in which multiple circumstances can combine to magnify the harmful impact of the charging policy, but also shows the limitations of the exemptions from charging. Treatment for conditions that are directly attributable to domestic violence are exempt from the policy¹⁸⁸, however it makes no allowance for circumstances in which vulnerability to violence can be increased as a result of the debt incurred.

4.3 - Mental Health

Refugees, asylum seekers and undocumented migrants are likely to suffer from worse mental health than host populations^{189,190} and are more likely to have been exposed to specific risks that negatively impact mental health, such as detention and conflict¹⁹¹. A study on the health of asylum seekers by Médecins Sans Frontières Sweden found that despite being more likely to be younger and healthier than the host population on arrival; asylum seekers were at higher risk of deteriorating health due to poor living conditions, poor access to healthcare, and social isolation¹⁹². It is well documented that anti-immigration policies restrict access to healthcare and have a negative impact on the mental health of migrant populations causing anxiety and depression¹⁹³. By restricting access to care the recent changes to NHS charging policy under the Hostile Environment will further disadvantage this already marginalised group.

4.4 - Child Health

Under the current charging regulations undocumented children are not eligible for free NHS care, placing England among some of the most restrictive healthcare systems in Europe¹⁹⁴. There are many reasons a child may be undocumented including: children who have an irregular immigration status due to the status of their parents¹⁹⁵; unrecognised survivors of modern slavery and trafficking; and those who are in the process of seeking asylum¹⁹⁶. The charging restrictions are thought to affect an estimate of 120,000 children, 65,000 of whom are thought to be born in the UK¹⁹⁷. There are increasing reports of children being denied or deterred from care¹⁹⁸. Research conducted by the Royal College of Paediatrics and Child Health (RCPCH) and Medact's Migrant Solidarity Group surveyed 200 healthcare workers about their experience of the policy. Over a third of respondents reported that charging policy had impacted patient care, with many reporting delays in

care, deterrence of children and families, denial of care even in some instances where the condition with life threatening, and two reported intrauterine deaths¹⁹⁹.

The available research suggests that undocumented children's engagement with healthcare follows the trend of adults - decreased use and worse outcomes compared to the host populations^{200,201,202}. Charging for secondary services is feared to make it less likely for children to be referred to paediatric services or to visit any health professional²⁰³. Reduced access to health services is also detrimental to a children's safety due to reduced opportunity for health services to come into contact with at-risk children, exacerbating their vulnerability. Meaning children that are current or potential victims of slavery, trafficking, child abuse and sexual exploitation are less visible, undermining the prevention and identification strategies in place to protect these children²⁰⁴.

The NHS charging regulations pose a risk to the health of undocumented children. This is contradictory to the government's stated commitment and obligation to child health as outlined under the United Nations Convention on the Rights of the Child (Article 24), and the UN Global Compact for Migration which was signed by the UK in December 2018²⁰⁵. It is therefore no surprise that the Royal College of Paediatrics and Child Health (RCPCCH) was amongst a number of medical colleges that have called for a suspension of the NHS overseas visitor charges²⁰⁶.

4.5 - Increasing Mortality

Currently there are no quantitative assessments of the impact of NHS charging policy on mortality. This is, at least in part, because the 2017 regulations were introduced too recently to be able to produce a meaningful picture. To get an idea of the possible impact of the regulations we can look to research from Spain following the introduction of Royal Decree Law 16 (RDL 16/2012) a policy similar to the 2017 regulations that restricted access to care for migrants²⁰⁷. The Centre for Research in Health and Economics (Centre de Recerca en Economia I Salut, CRES) produced two studies, one looking at the impact on health accessing behaviours²⁰⁸, and the other at mortality rates²⁰⁹. They found that monthly mortality rates in the undocumented migrant population increased by 15% during the first three years of the policy, equating to about 70 more deaths a year. The study also noted that the mortality rate increased year by year, recording a 22.6% increase from baseline in the third year of the policy. Finally, the research shows that mortality rates are higher still for amenable mortality²¹⁰ - deaths that should not occur in the presence of timely and effective interventions - suggesting that restricted access to care is likely to be the cause of the increase.

This research is novel in its approach to quantifying the impact of charging regulations. Innovation in research methodology is necessary in this field due to the current lack of data and challenges in assessing impact on undocumented people. The data used did not include migration status on the death certificate, instead they used nationality as a proxy measure of migration, utilising an average percentage of undocumented migration to guide their estimates. Despite these limitations, the results show a significant increase in mortality that is consistent across different age ranges, and across migrant groups from Africa, Asia, and Central & South-America after the introduction of the regulations²¹¹.

Our Research:

The assessment of the impact and long-term consequences for the health and wellbeing of those affected by the new charging policies is concerningly low. Of the 99 trusts that responded, only 3% were able to provide evidence of having conducted an equality impact assessment of this change in policy. Furthermore, no Trust had a system in place to monitor the discriminatory impact of this policy or the potentially devastating effect charging could have on the health of the patients they serve²¹².

Inherent Discrimination

Given that no Trust has a system in place to monitor the implementation of the charging policy, it is unsurprising that there is limited evidence available that demonstrates its discriminatory impact. We have heard anecdotal evidence suggesting that patients are selectively asked for ID based on their appearance and that it is common for overseas visitor managers to scan patient lists for names that 'look foreign', a claim that is supported by a number of stories that came to light in the media. Shortly after the policy was introduced there were two separate incidents, one of a woman and another of a baby, both of whom were billed for care seemingly on the basis of their surname alone^{213,214}. In both cases the Trusts sent threatening letters demanding proof of ID or payment for care causing undue distress. In both cases the threat of charging was eventually withdrawn. The presence of structural racism in the NHS is well documented, with members of staff from Black and Minority Ethnic (BAME) backgrounds less likely to be in more senior positions and more likely to report discrimination or face disciplinary proceedings than their white colleagues^{215,216}. There is also evidence that people from BAME backgrounds experience different approaches to care and different treatment outcomes compared to white patients^{217,218}. The systemic biases that disadvantage people from BAME backgrounds are being made worse by the new charging regulations, leading to increasing health inequality and worse outcomes for BAME patients. The causative role played by the Hostile Environment was recognised by Public Health England in its analysis of the factors that lead to disproportionate impact of the coronavirus crisis on BAME communities²¹⁹.

4.6 - Public Health

The stigma and suspicion surrounding migrant populations posing a threat to the public health of the host population has been prevalent for some time²²⁰, however it has been shown that in reality the health problems of migrants and refugees are similar to those of the general population and there is no association between migration and importation of communicable diseases²²¹. Conditions such as HIV and TB pose little threat of transmission to the host population²²², instead it is the restriction of access to healthcare for individuals with an infectious condition that poses a potential for increased risk to public health. This risk will only increase if at-risk populations are marginalised by exclusionary policies²²³.

For this reason, many communicable diseases including HIV and TB are exempt from charging²²⁴. Despite this, concern remains among leading clinicians across Europe that the charging policies will deter patients and hinder early detection and diagnosis. They fear that this dis-engagement could give rise to avoidable disease progression, an increase in mother to child transmission of HIV; and increase the opportunity for the spread of disease^{225,226,227,228}.

In Spain there is already evidence that exemptions for communicable diseases are failing to protect patients. REDER reported the case of a man who presented critically unwell with HIV; confusion about the regulations meant that his treatment was severely delayed and exposed the patient to a high risk of worse outcomes²²⁹. In another case Alpha Pam, an undocumented migrant, was turned away from treatment on several occasions for his undiagnosed TB, despite investigation for TB being exempt²³⁰. He later died as a result of being unable to access the care he needed²³¹. These failings are likely to be replicated in the UK. During the ID checking pilot scheme, a Newcastle NHS Trust asked patients to provide two forms of ID when attending appointments in their communicable diseases department, despite many of the conditions treated there being exempt from charging²³². These barriers prevent marginalised populations from engaging with essential care services and not only lead to disease progression in the individual, but to increased opportunity for disease spread²³³.

With regards to non-communicable diseases (NCDs) prevalent in migrant communities, most are common conditions that can be treated effectively, such as cardiovascular disease, diabetes and hypertensive issues²³⁴. NCDs are best treated early; simple preventative measures can ensure symptoms are controlled, and more severe and costly complications avoided. This is supported by evidence which shows that rather than providing emergency care alone, access to preventative and non-urgent routine care for migrants is in fact

cost-saving for health systems²³⁵. Furthermore, individuals who face barriers to healthcare (such as those associated with charging) suffer further harm in the form of anxiety, an additional mental health burden which contributes to even more cases of preventable ill-health. Below an NHS doctor talks about the impact on one of her patients.

"I know another who was pursued relentlessly by a debt collection agency for an erroneous bill for something he was entitled to for free. He had two extra consultations with me in primary care to manage the anxiety it created – this would have cost the NHS more than the £60 for which they were hounding him."²³⁶

The Coronavirus Crisis and Access to Healthcare

The coronavirus crisis erupted in early 2020 and had wide ranging implications for migrant communities' ability to access services. Medact, Liberty, JCWI and over 50 charities raised early concerns about the way in which Hostile Environment policies would make it impossible for people to stay safe during the crisis and would trap entire communities out of receiving any support at all²³⁷. Shortly after, news emerged of a man known as Elvis who had died at home after suffering coronavirus symptoms because his status, as an undocumented migrant, made him too afraid to seek help from the NHS²³⁸.

In response, Medact, Migrants Organise, and the New Economic Foundation carried out a rapid research project in order to evidence the way in which NHS charging policy was increasing barriers to care for migrants during the crisis. We interviewed over 50 migrant support organisations and found that years of Hostile Environment policies had eroded trust in the NHS to such an extent that migrants reported being too afraid to access services even where they had been told coronavirus was exempt from charging. Many people reported facing direct and indirect discrimination while accessing services; had been inappropriately challenged about their entitlement to care; and/or faced difficulty navigating the technical and bureaucratic aspects of the NHS²³⁹. These findings were mirrored in reports from Doctors of the World²⁴⁰ and Kanlungan Filipino Consortium²⁴¹, adding to the growing body of evidence of the deterrent impact of the Hostile Environment.

Despite interventions from the BMA²⁴² and 60 cross-party MPs²⁴³ the Government has refused to suspend the charging regulations for the duration of the crisis. The amplified impact of the crisis on migrant communities has prompted action in other countries, with the Irish Government committing to a firewall between health service data and immigration enforcement²⁴⁴, the overnight regularisation of some migrants in the immigration system in Portugal²⁴⁵ and the Korean Government removing the duty on health services to report undocumented migrants²⁴⁶.

4.7 - Impact on NHS Staff?

The Hostile Environment presents a significant challenge to the ethical frameworks that underpin the work of healthcare practitioners. The policies that require staff to check a person's immigration status; the data-sharing systems that send patient information to the Home Office; the decisions made about what care a person can afford, or how much pain they can bear before being expected to leave the UK; these policies make healthcare workers complicit in a system that causes harm to patients by default. Alongside our own personal moral frameworks, all healthcare workers are also governed by standards and codes of practice set out by our regulatory bodies^{247,248}; however, neither the General Medical Council nor the Nursing and Midwifery Council have provided further guidance for practitioners about how to manage the ethical contradictions inherent in the administration of charging. This is despite concerns being repeatedly raised by healthcare workers about the implications of the policy, both on their own practice and on the NHS more broadly^{249,250,251,252}, and repeated motions passed at the British Medical Association Conference calling for the policy to be scrapped^{253,254}.

Our Research:

Our analysis of Fol data from NHS Trusts revealed that a concerning 67% of Trusts provided no specific training for staff. 40% of Trusts either gave no training or did not specify which training they gave, while 27% gave only standard Equality and Diversity training. Of the 99 Trusts that responded to the Fol requests only 1 in 5 offered staff specific training on the charging regulations²⁵⁵.

The long-term impact of the Hostile Environment on people's trust in healthcare workers is yet to be properly evaluated, however we know that across Europe anti-migrant policies have a direct and negative impact on people's trust in the healthcare providers²⁵⁶. Maternity Action conducted research into the impact of the charging regulations on the working practices of midwives, interviewing 15 midwives from across England. These midwives reported persistent tension between their professional duties and the charging regulations; instances where questions about entitlement had undermined trusting relationships with patients; and that they were increasingly required to advocate for patients in ways that went above and beyond their training²⁵⁷.

Following the introduction of similar restrictions to care in Spain in 2012 healthcare workers across the country with Yo Sí Sanidad and the REDER Network began conscientiously objecting to the policy by refusing to charge patients for care²⁵⁸. The required response is necessarily more complicated in the UK context as a result of the interconnected way in which patient data is monitored by overseas visitor managers in Trusts and shared with the Home Office. These mechanisms mean people risk being identified for charging at many different points in the system, not just in their interaction with a healthcare worker. Although advocacy remains a vitally important role for healthcare workers when supporting people who face charges for NHS care, trying to 'hide' patients from the system is, for the time being, likely to be a less effective tactic than it was in Spain. For conscientious objection to work in the NHS we must first build a mass movement in opposition to the policy, led by migrants, healthcare workers, and healthcare institutions working together. In the next section we'll look at responses from the healthcare community, both in the UK and across Europe.

5 - Responses from the Healthcare Community



5.1 - Opposition from Healthcare Institutions

The expansion of NHS charges and introduction of ID checks have drawn widespread criticism from the healthcare community, civil society, and politicians. In December 2018 the Royal College of Physicians, the Royal College of Paediatrics and Child Health, the Royal College of Obstetricians and Gynaecologists, and the Faculty of Public Health released a statement calling on the DHSC to scrap both the 2015 and 2017 regulations and conduct an independent review into NHS charging policy^{259,260}. This was followed shortly after by a statement from the Academy of Medical Royal Colleges, the umbrella body representing all medical royal colleges in the UK, also calling for the regulations to be scrapped and calling for clear separation between the NHS and Immigration Enforcement²⁶¹. Shadow Health Secretary Jon Ashworth has called for a scrapping of the policy²⁶² and a motion of regret was tabled in the House of Lords²⁶³, but was withdrawn before being put to vote. There have been statements warning about the harmful impact of the policy from both the British Medical Association²⁶⁴ and from ex-NHS Chief Executive David Nicholson²⁶⁵ but these did not go as far as calling for an end to the policy, despite a motion passed with an overwhelming majority at the BMA national conference in 2019 calling for all charging policy to be scrapped²⁶⁶.

A number of healthcare and migrants' rights-focused civil society organisations have also called for the policy to be scrapped or launched campaigns against the charges, they include: Medact, Migrants Organise, the New Economic Foundation, the Joint Council for the Welfare of Immigrants²⁶⁷, Doctors of the World²⁶⁸, Maternity Action²⁶⁹, Asylum Matters²⁷⁰, and the National Aids Trust²⁷¹. This work is supported by reports that detail the harmful impact of the policy from the Equality and Human Rights Commission²⁷² and The Lancet Commission on Migration²⁷³.

5.2 - Patients Not Passports – Resistance from the Grassroots

Docs Not Cops, a grassroots campaigning group, emerged in response to the introduction of the Immigration Act 2014. They held protests and took direct action focusing on the expansion of charging and borders in the NHS, erecting fake border checkpoints outside hospitals in London to raise awareness of the harms of the policy amongst staff and the local community. They also mobilised junior doctors to bring a motion to the BMA in 2016 that called on the union to denounce the 2014 Immigration Act²⁷⁴. With the introduction of upfront charging and ID checks in 2017, Docs Not Cops created the Patients Not Passports campaign and throughout 2017 led a series of direct actions aiming to raise awareness about the policy and force the DHSC to abandon their plans to introduce the policy. This saw Docs Not Cops erect fake border checkpoints outside the DHSC^{275,276,277} and hold a mass demonstration outside a central London hospital²⁷⁸. This was then followed by a number of protests by other groups throughout 2018 and into 2019 in which doctors returned medals earned during the Ebola crisis²⁷⁹, actions were targeted at specific NHS Trusts^{280,281}, and attention was focused on particular patient groups²⁸².

The Patients Not Passports campaign has developed into a nationwide movement, with groups established in towns and cities across the country, led by frontline healthcare workers, communities and individuals targeted by the Hostile Environment, and local NHS campaigners, including long-standing NHS campaign organisations like Keep Our NHS Public^{283,284,285}. These groups build coalitions, organise in their local areas, support people to access the care they need and call on NHS Trusts to join them in opposing the policy. Medact, Migrants Organise, the New Economics Foundation, and Docs Not Cops provide support to the work being done locally and coordinate advocacy, research and direct action at a national level

A Toolkit for Action

The Patients Not Passports coalition has produced a toolkit designed to: support health care and community workers to advocate for people facing or impacted by charging; provide a framework to help people start localised campaigns; and give some context to the Hostile Environment in the NHS. The toolkit works alongside our other resources for healthcare workers organising in NHS Trusts - Patients Not Passports Lanyards, Patients Not Passports Advocacy Cards, and this briefing. The lanyards are designed to bring together healthcare workers who oppose the policy in an NHS Trust and provide a talking point for people who do not yet know about the charging regime. The lanyards' advocacy cards provide a condensed version of the advocacy advice in the toolkit, alongside some of the key arguments against the charging policy and a link to the main toolkit, designed to be a quick access resource for healthcare workers. The toolkit itself contains advice, information and resources and can be accessed at www.PatientsNotPassports.co.uk.

The Justice for Simba Campaign

A few days before his 30th birthday, Simba suffered a life-changing stroke that led to him spending two weeks in a coma in intensive care²⁸⁶. When he woke up, he was presented with a bill for £93,000²⁸⁷. Simba has a blood clotting condition and could not afford the cost of specialist treatment, so had stopped attending appointments a few months before his stroke. He has lived in the UK since he was 14, and despite repeated applications to the Home Office, his claim for asylum had been refused and as such he is not entitled to free NHS treatment. Following the stroke, and in coalition with other campaign groups in Sheffield where he lives, Simba launched the Justice for Simba campaign; aiming to overturn the charges for his treatment and to challenge the Hostile Environment in the NHS. The Justice for Simba campaign works closely with the Patients Not Passports campaign, and involves groups of healthcare workers, including Medact Sheffield, and community migrant-led groups and organisations, including These Walls Must Fall and South Yorkshire Migration And Asylum Action Group (SYMAAG). Campaigns like Simba's indicate the anger at the injustice of Hostile Environment policies from migrant communities and their allies, are a powerful demonstration of solidarity and show that communities can work together to fight back against the Hostile Environment.

5.3 - Current and Historic Struggles for Universal Healthcare

The UK is not alone in restricting access to care for those with precarious or no immigration status²⁸⁸. Wherever policies that restrict care emerge they are met with strategies of resistance whether from healthcare workers, healthcare providers, or municipal governments²⁸⁹. The New Economics Foundation investigated the situation in four European countries, looking at the arguments used to justify restrictions to health services, how campaigns formed to resist them, and what successful tactics these movements used. The findings are presented in *The International Struggle for Universal Healthcare*²⁹⁰, and provide vital insights and learnings for the Patients Not Passports campaign in the UK. PICUM have also detailed a range of innovative city level responses to restrictive healthcare policies, demonstrating that with political will these policies can be challenged²⁹¹. We briefly cover Spain and two non-European movements below, but for more detail you should read the New Economics Foundation report mentioned above.

In Spain, following the introduction of Royal Decree Law 16 (RDL 16/2012)²⁹², a policy similar to the 2017 NHS charging regulations, a mass movement of healthcare workers formed a campaign entitled Yo Sí Sanidad Universal²⁹³. They organised conscientious objection from healthcare workers, accompanying schemes to support people to access care, and a national case study reporting mechanism to track the impacts of the policy²⁹⁴. Alongside the grassroots mobilisation from Yo Sí Sanidad Universal, a network of civil society organisations collectively known as REDER worked to challenge the policy by monitoring the harm caused²⁹⁵ and by challenging the human rights impact of the policy through the Committee on Economic

and Social Rights (CESR)²⁹⁶. The CESR found that the policy contravened Spain's obligations to Article 12, citing that denying healthcare on the basis of migration status represented unacceptable discrimination²⁹⁷. These campaigns eventually led to the Spanish Government repealing RDL 16/2012 and restoring undocumented migrants' right to access healthcare²⁹⁸.

Campaign groups across the world continue to fight for access to healthcare for migrants. In the coronavirus section above we mention some recent successes in preventing data-sharing between health services and immigration enforcement in Ireland and Korea. In Canada, following investigation of the case of Nell Toussaint, a woman living undocumented who brought a legal challenge after being denied life saving care, the United Nations Human Rights Committee made the landmark decision to condemn the Canadian Government for denying healthcare to people based on their immigration status^{299,300}. This led to a national day of action³⁰¹ and an open letter signed by over 1,500 healthcare workers and organisations calling on the Government to provide universal and equitable access to healthcare³⁰². In the USA campaigners in Illinois passed local legislation to ensure Medicaid-like coverage to undocumented people over 65, becoming the first state in the country to do so³⁰³.



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No Pass Laws Here — Histories of Resistance to NHS Charging

The Patients Not Passports campaign and current movement to ensure universal access to healthcare in the UK is not without precedent, and indeed draws on a rich history of resistance to the introduction of charging migrants for NHS care. In 1981, the Government announced their intention to introduce a new policy to charge migrants for using the NHS, using much of the same racist rhetoric we see today. These policies were met with widespread resistance from migrant organisations, unions, health workers, and regional health authorities; brought together under the umbrella of the 'No Pass Laws Here' campaign. The name was drawn from anti-apartheid movements in South Africa, and fought against the new charges with arguments that are familiar today. They emphasised the racist intention behind the policy, linking it to the Government's attempts at the time to restrict citizenship for migrants, and as a way in which Britain was excluding migrants from the spoils of empire. They also pointed out that the policy would in fact lose money for the NHS, and therefore failed on its own terms and could not be excused as an economic necessity. By mobilising a broad section of the health community, along with unions and migrants' rights organisations, the No Pass Laws campaign played a vital role in enabling many hospitals in the NHS to stop implementing the policy, which by 1984 was all but abandoned. You can read more about this campaign in *The International Struggle for Universal Healthcare*³⁰⁴.

5.4 - What Are We Working Towards

The fight against NHS charging is a fight for the future of our health service. It is a fight against institutionalised discrimination; against the weaponisation of public services to attack migrant and BAME communities; against the creeping privatisation of the NHS; and against a deliberate assault on the idea of socialised responsibility for our collective wellbeing. In our fight against the Hostile Environment, we are making the case for the kind of public services we require: for a just and truly universal NHS that meets the needs of everyone regardless of ability to pay or immigration status.

This is why we call for NHS charging to be scrapped in its entirety, and why this briefing does not make recommendations for reform or revision of the policy. There is no version of the Hostile Environment that is compatible with a truly universal NHS, nor compatible with a society that treats its members with dignity and respect. As such we do not make the case for more exemptions to the charging policy, or for the lifting of charges for certain marginalised groups. To do so would concede that there are some people who do not have the right to health and who should be excluded from healthcare, either because they are not unwell enough, do not elicit enough public sympathy, have not jumped through the right bureaucratic hoops, or were simply born in the wrong place.

When we look at the movements against NHS charging that came before us, or campaigns in other countries that we stand shoulder to shoulder with now, it is clear that to overturn these policies we need a broad and united movement. This movement must combine frontline advocacy and support for the people directly impacted, with powerful local campaigns led by people facing charges and the communities around them. It must include health institutions, unions, and local politicians declaring their opposition to Government policy and taking tangible steps to undermine it. It must be building toward safe and effective mass non-compliance of health workers across the country. To win, we will require a mobilisation across every sector of society, united in our opposition to any attempts to undermine the universality of the NHS and to scapegoat migrants. This is what the Patients Not Passports campaign is working towards, this is what we are calling on you to be a part of.

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7 - Resources

Patients Not Passports Toolkit

Produced by Docs Not Cops, Medact, and Migrants Organise.

www.PatientsNotPassports.co.uk

A toolkit designed to support you in advocating for people facing charges for NHS care, and in taking action to end immigration checks and upfront charging in the NHS.

Safe Surgeries Toolkit

Produced by Doctors of the World UK.

www.doctorsoftheworld.org.uk/what-we-stand-for/supporting-medics/safe-surgeries-initiative

This is a toolkit for healthcare professionals and GP practices who want to provide confidential and welcoming services for all their patients including refugees, asylum seekers and undocumented migrants

NHS Charging Toolkit

Produced by the Joint Council for the Welfare of Immigrants.

www.jcwi.org.uk/nhs-charging-toolkits

This short guide is for anyone in England who has been refused NHS healthcare, or told that they will have to pay for it. It is also for people working in frontline charities and advice services, MPs' caseworkers, volunteers, mental health advocates, or anyone else trying to help a person who's been put in that situation.

8 - Endnotes

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9 - Change Log

This briefing was originally published in March 2019. It was updated in October 2020 to include new evidence and research into the impact of the NHS charging regime, growth in the Patients Not Passports campaign, and to correct a small number of errors in the original.

Substantive changes are as follows:

Section 2.1

- Made changes to better reflect the history and development of NHS charging policy.
- Corrected the date at which the 'ordinary residence' requirement was introduced.

Section 2.2

- Added paragraph about the history of racialised exclusion from the NHS

Section 2.3

- Added paragraph about the findings of a 2012 DoH review into overseas visitor charging.
- Clarified the description of research into OVM practices.
- Removed a line attributing 'deliberate misuse' of the NHS to British ex-pats as the research referenced is not clear about the distinction.
- Added additional funding for OVMs announced in 2019
- Added clarification of the findings and explain the relevance of the studies discussing the economic impact of restricting access to care.

Section 2.4

- Added the National Audit Office report into immigration enforcement
- Added about the proposed increase of the IHS to £625
- Added a paragraph about the exemption of health workers from the IHS
- Corrected the cost of Home Office checking service hotline to 80 pence per minute.
- Added new section on automated checking systems

Section 3.1

- Updated to clarify changes brought in by the 2014 Immigration Act
- Added section on the response to the Windrush scandal, including the Lessons Learned review
- Added reference to the health and social care select committee hearing on NHS charging

Section 3.2

- Added consideration of the immigration status of EEA citizens after the UK has exited the European Union.

Section 3.3

- Added findings in Maternity Action's report 'A Vicious Cycle'

Section 3.4

- Added findings from BMA research on the involvement of OVMs in decisions about urgency

Section 4.1

- Added findings from research surveying service users at DOTWs London clinic
- Added findings from BMA research on the deterrent effect of the charging regulations

Section 4.2

- Added the findings of the 2019 MBRRACE study into maternal deaths

Section 4.4

- Added new research from the RCPCH and Medact's Migrant Solidarity Group

Section 4.6

- Added new section on the coronavirus crisis

Section 4.7

- Added a reference for the 2019 BMA annual conference motion calling for charging to be scrapped.
- Added findings of Maternity Action's report 'Duty of Care?'
- Added the need for a mass movement to support conscientious objection

Section 5.2

- Clarified the paragraph about the structure and actions of the Patients Not Passports campaign
- Added section on the Justice for Simba Campaign

Section 5.3

- Added the NEF briefing- The International Struggle for Universal Healthcare
- Added additional detail about successes in other countries
- Added section on No Pass Laws Here campaign in the UK

Section 5.4

- Added new section to outline the goals and aims of the Patients Not Passports Campaign

Recommendations

- Removed and replaced with Section 5.4 as above. The original briefing recommendations were not in keeping with the overall position of the Patients Not Passports campaign – that NHS charging should be scrapped in its entirety.

Additional Reading

- Added the two new Patients Not Passports reports





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