



Royal College of
General Practitioners

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Submitted by email to: migrantaccess@dh.gsi.gov.uk

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'Sustaining services, ensuring fairness': consultation on migrant access to the NHS

- I. The RCGP welcomes the opportunity to respond to the Department of Health's consultation on migrant access to the NHS.
- II. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.
- III. We gratefully acknowledge the contributions of our members, the RCGP Health Inequalities Standing Group and our clinical champion for social inclusion in formulating this response.

Our response

Summary

1. **The RCGP opposes any change to the eligibility rules for migrants accessing GP services.** We believe that this would be a regressive step for the NHS and would undermine the ability of GPs to protect and promote the health of their patients and the public.
2. We are concerned that limiting access to GP services would impact adversely on the health not only of vulnerable migrants, but also of homeless people, travellers and gypsies, and individuals with chaotic lives – all of whom may struggle to prove eligibility or be deterred by the checks involved. **This runs counter to the government’s duty under the Health and Social Care Act to have regard to the need to reduce health inequalities.** Moreover, there is a real risk that **the proposals will create structures that encourage a discriminatory approach towards certain groups** by frontline practice staff.
3. It is likely that a change in the eligibility rules for general practice would deter early presentation in general practice by a significant number of patients, which may lead to a **costly increase in emergency admissions** (additional pressure that the urgent and emergency care system can ill afford).
4. We are concerned that limiting free access to primary care will have **adverse consequences for the control of infectious diseases – and therefore for the health of the population as a whole.** The UK is currently witnessing a dangerous surge in TB. There is a real risk that these proposals would exacerbate this problem and increase the risk of multi-resistant TB, resulting in both more deaths and increased transmission of the disease. While we note that the consultation proposes to exempt the treatment of infectious diseases from charges, this **fails to recognise that diagnosis is a core activity of general practice.** Often people suffering from infectious diseases do not know what is making them ill - and it is likely that a significant number of individuals would be deterred from presenting at their GP practice for fear of charges and/or eligibility checks. Similarly, we are concerned that limiting access to primary care would **impact detrimentally on immunisation rates** as it would be more difficult to engage with and encourage presentation by parents from non-eligible migrant groups.
5. **The RCGP would strongly oppose the imposition of any new administrative burden on general practice as a result of the proposals under consultation.** We

struggle to see how a new system for checking eligibility - and potentially charging patients - could be introduced without increasing the administrative pressure on individual GP practices. General practice in the UK is already facing a workforce and workload crisis¹ - GP surgeries simply do not have the capacity to take on an additional administrative burden, nor are they set up to undertake eligibility checks or charge patients.

6. We note the conclusion of the Department of Health's 2012 review of overseas visitor charging policy: "the NHS is not currently set up structurally, operationally or culturally to identifying [sic] a small subset of patients and charging them for their NHS treatment. Only a fundamentally different system and supporting processes would enable significant new revenue to be realised."² **We suggest that robust evidence is needed to show that the cost of realising such a fundamental structural change would be outweighed by the additional revenue it might yield.**

7. **We are extremely concerned that these policy proposals are neither accompanied by an impact assessment nor underpinned by robust evidence.** Indeed, the Department of Health recognises in its comment on the 2012 review of overseas visitor charging policy that "there is no comprehensive evidence covering this subject (be it in academic literature, official statistics or easily accessible data from sources such as Hospital Trusts)"³. We understand that an independent 'audit' has been commissioned to provide a better understanding of the situation. However, given the acknowledged lack of available evidence in this area, we are concerned that this 'audit' will struggle to provide a true picture.

8. Moreover, we feel that the audit should have taken place well before this consultation was launched. **We are concerned that, due to the timing of the forthcoming Immigration Bill, the policy proposals under consultation have been developed in advance of the supporting evidence.** The lack of an impact assessment or evidence

¹ "The existing GP workforce has insufficient capacity to meet current and expected patient needs" - Centre for Workforce Intelligence (2013), GP in-depth review: Preliminary findings, <http://www.cfwi.org.uk/publications/gp-in-depth-review-preliminary-findings>. See also: "Longer waiting times for GP appointments predicted as concerned GPs raise fears about the impact of cuts for patient care", RCGP press release, 17 August 2013, <http://www.rcgp.org.uk/news/2013/august/longer-waiting-times-for-gp-appointments-predicted.aspx>

² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210439/Overseas_Visitors_Charging_Review_2012_-_Summary_document.pdf

³ Ibid.

base makes it very difficult to respond fully to this consultation, particularly given that **fundamental questions about the feasibility and/or cost effectiveness of the plans proposed have not yet been addressed by the government.**

Detailed response

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

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

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

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

10. We know that travellers and gypsies are generally reluctant to register and access primary care, and are more likely to use accident and emergency services⁴. It is likely that, by introducing additional checks to determine eligibility and immigration status, the proposals will further deter these protected characteristic groups from accessing general practice, thereby exacerbating health inequalities and increasing unplanned emergency admissions.

Question 4: Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK? (Yes / No / Don't know)

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

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

⁴ Parry, et al. (2007), *The Health Status of Gypsies & Travellers in England*, Journal of Epidemiology and Community Health 2007;61:198-204, http://www.sheffield.ac.uk/polopoly_fs/1.43714!/file/GT-final-report-for-web.pdf

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

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

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

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

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

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

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

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

14. We agree that non-EEA visitors should continue to be liable for the full costs of their NHS healthcare, as per current access arrangements for non-EEA nationals. Visitors should be charged for the full cost of their treatment (in secondary care services only), plus an additional administration charge to cover the provider's costs.

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

15. We agree that illegal migrants should continue to be charged for non emergency secondary care services, although it is important to be realistic about the ability of many

illegal migrants to pay these costs. We believe that primary medical care and treatment in A&E should remain exempt from charges. As outlined below (question 16), limiting access to GP services is likely to impact adversely on the health of vulnerable migrants, who would be deterred from presenting with symptoms early, and carries significant risks for the management of infectious diseases, and therefore for public health. We feel that managing this group of patients in primary care is likely to be more cost effective in the long term, not least as avoidable emergency admissions will be reduced. Again, it would be helpful to see a cost/benefit analysis to address these issues.

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

16. We agree that all people, including temporary migrants and visitors to the UK, should have the right to register at and be treated by a GP practice. As outlined below (question 16), we oppose any change to the eligibility rules for migrants accessing GP services. Moreover, we would strongly oppose the imposition of any new administrative burden on general practice as a result of the proposals under consultation. General practice is already operating under considerable strain and does not have the resources to undertake additional checks on patients in order to determine their immigration status. We discuss in more detail the risks and challenges of implementing an eligibility and charging regime in GP surgeries below (question 25).

17. We note that the consultation asserts that GP referrals to secondary care allow some patients to evade charges for hospital treatment. We are not aware of evidence underpinning this assertion and would welcome further details.

18. **Question 16:** Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs? (Yes / No / Don't know)

19. While we recognise the need to ensure that those accessing NHS services make a fair contribution (*if* a cost effective, fair system could be found to make this happen), we believe that access to GP services should continue to be free of charge for temporary migrants, for reasons of social inclusion, cost-effectiveness, public health and feasibility of implementation.

20. Limiting access to GP services is likely to impact adversely on the health of vulnerable migrants from both eligible and non-eligible groups. Not only will charging for primary medical care act as a deterrent to presentation by non-eligible groups, but both eligible

and non-eligible groups may be deterred from seeking care if GP services are perceived to be tantamount to immigration services, or if patients fear questioning and/or discrimination when approaching a GP surgery. We are also concerned that some eligible migrant groups – including refugees and asylum seekers – would find it more difficult to access GP services, due to a low level of English language skills, lack of appropriate documentation or because they are unaware of their rights.

21. An extension of charging to primary care is likely to have a detrimental impact on the health of other eligible groups, including homeless people, travellers and gypsies and individuals with chaotic lives – all of whom may struggle to prove eligibility or be deterred by the checks involved. This runs counter to the government's duty under the Health and Social Care Act to have regard to the need to reduce health inequalities.
22. It is likely that a change in the eligibility rules for general practice would deter early presentation by a significant number of patients, including those suffering from chronic conditions such as diabetes or hypertension, leading to a higher rate of emergency admissions and increased costs overall for the health service.
23. Similarly, we are concerned that limiting free access to primary care will have adverse consequences for the control of infectious diseases – and therefore for the health of the population as a whole. The UK is currently witnessing a dangerous surge in TB. There is a real risk that these proposals would exacerbate this problem and increase the risk of multi-resistant TB, resulting in both more deaths and increased transmission of the disease.
24. While we note that the consultation proposes to make the treatment of infectious diseases exempt from charges, this it fails to recognise that diagnosis is a core activity of general practice. Often people suffering from infectious diseases do not know what is making them ill - and it is likely that a significant number would be deterred from presenting at their GP practice for fear of charges and/or eligibility checks. In addition, we are concerned that limiting access to primary care would impact detrimentally on immunisation rates as it would be more difficult to engage with and encourage presentation by parents from non-eligible migrant groups.
25. It is also important to understand that general practice is not set up to identify and charge patients. We struggle to see how a new system for checking eligibility - and potentially charging patients - could be introduced without increasing the administrative pressure on individual GP practices. As outlined above, general practice simply cannot afford this additional administrative burden.

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

26. We believe that everyone should have access to the emergency care they need, regardless of their ability to pay. We would therefore strongly oppose any changes to the eligibility rules for access to emergency treatment in A&E or emergency GP settings.

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

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

27. We would strongly oppose locating initial NHS registration within GP practices. As the consultation notes, individual GP practices do not have the capacity or systems to undertake immigration or eligibility checks. Without reference to an impact assessment, it is difficult to advise which body should handle registration. We reiterate that robust evidence is needed to show that the cost of developing a new NHS wide system would be outweighed by the additional revenue it might yield.

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

28. General practice is not set up to undertake eligibility checks or to charge patients, nor does it have the capacity to take on any additional administrative burden.

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

30. As regards challenges for implementing a charging system within GP practices, it is important to consider who would screen patients for eligibility and take payment, and how and where they would do so. In most practices it is likely that receptionists would be asked to take on this role – in which case they would require comprehensive training in the potentially sensitive and complicated process of screening and charging patients. We are concerned that busy reception desks would simply not have time to deal with complex cases, nor to process charging for services on a significant scale.
31. There is a real risk that the proposals would encourage discriminatory screening practices and decision making by practice staff, who often face significant time pressures when registering patients. Great care would need to be taken to avoid discriminatory screening of individuals based on characteristics such as race, physical appearance, accent or language skills.
32. Moreover, we are concerned that restricting access to GP services – and the resulting perception that practices are undertaking immigration checks and/or discriminating against particular patient groups – could lead to ‘them versus us’ stand offs in reception areas, potentially resulting in an increase in violence and disruption in practices, eroding trust in the doctor-patient relationship and deterring patients from approaching GP services. In order to help to avoid the stigmatisation of individuals, practices would need to offer dedicated confidential areas - space that many surgeries would struggle to provide.

The RCGP welcomes the opportunity to respond to this consultation and looks forward to further dialogue with the Department of Health on this subject.

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

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council