"Ensuring fair use of the NHS efficiently and effectively..."

DO NO HARM

Max Wind-Cowie
Claudia Wood

DEMOS

Demos is Britain's leading cross-party think tank. We produce original research, publish innovative thinkers and host thought-provoking events. We have spent 20 years at the centre of the policy debate, with an overarching mission to bring politics closer to people.

Demos is now exploring some of the most persistent frictions within modern politics, especially in those areas where there is a significant gap between the intuitions of the ordinary voter and political leaders. Can a liberal politics also be a popular politics? How can policy address widespread anxieties over social issues such as welfare, diversity and family life? How can a dynamic and open economy also produce good jobs, empower consumers and connect companies to the communities in which they operate?

Our worldview is reflected in the methods we employ: we recognise that the public often have insights that the experts do not. We pride ourselves in working together with the people who are the focus of our research. Alongside quantitative research, Demos pioneers new forms of deliberative work, from citizens' juries and ethnography to social media analysis.

Demos is an independent, educational charity. In keeping with our mission, all our work is available to download for free under an open access licence and all our funders are listed in our yearly accounts.

Find out more at **www.demos.co.uk**.

DO NO HARM

Max Wind-Cowie
Claudia Wood

First published in 2014

Magdalen House, 136 Tooley Street
London, SE1 2TU, UK

ISBN 978 1 909037 70 0
Series design by Modern Activity
Typeset by Modern Activity

Set in Gotham Rounded
and Baskerville 10

DEMOS

Contents

Introduction

There is nothing 'inhumane' about wanting to ensure that public services in the UK are protected from misuse and abuse. It is not just the right of the British state to defend the integrity of the welfare state; it is their duty. In order to maintain public confidence and consent for nationalised healthcare, it is imperative that voters feel that access is available only to those who qualify for free treatment and that the system is robust enough to detect and prevent fraud.

But we also have a duty to treat people with humanity, decency and concern. Doctors of the World, which commissioned this research, work day in and day out with vulnerable people who are in need. That is very much in the British tradition. We need to ensure that steps taken to defend the NHS against malicious misuse do not deprive the vulnerable of the help that they need – arguably, to do so would be to kill the spirit of the NHS while striving to defend it.

Indeed, any policy designed to save money, without generating public health risks, must be scrutinised on its ability to do just that. It would be a tragic mistake to pass legislation with the express intention of reducing the costs to the NHS of health tourism, which ended up costing more than it saved because of the subsequent guidance and regulations drafted to enforce it. This area of policy is dominated, in public and political discourse, by a discussion of 'health tourism' – referring to individuals who travel to the UK specifically to access healthcare. But the consequences of the policy responses would have an impact on far more people than this specific and vanishingly small category. They reach far beyond that – touching the lives of vulnerable people resident in the UK but prevented or put off from accessing healthcare.

It would be short-sighted to allow the important task of protecting the NHS from fraud to expose the British public

to increased risks stemming from communicable disease. This risk is all the more significant and obvious as the world is struggling to combat the Ebola outbreak – an epidemic with the potential to become truly global. The disease requires early diagnosis if there is to be any hope of treatment and containment. And it would be morally indefensible to leave vulnerable people – from children and young people to unwell but undocumented migrants – at risk and untreated. Furthermore, it runs the very real risk of putting doctors and other medical staff in danger of feeling obliged to ignore their Hippocratic oath – we cannot allow doctors to feel morally and legally compromised when faced with vulnerable people in need of treatment.

A focus on preventing health tourism demands certain policy responses – but these do not necessarily reflect what is best on a more holistic scale. In particular, there is a danger of allowing already vulnerable groups such as undocumented migrants to be excluded from vital healthcare (even when they are entitled to it and there is a public good in provision). It is not the Government's intention – stated or otherwise – to fall into any of those traps. And it is the intention of Demos and Doctors of the World – in this report – to propose measured, supportive means by which the NHS might be protected without adding to the costs of bureaucracy, creating a threat to British public health or leaving innocent and vulnerable people without care.

The Government has two clear aims that we can support: to protect the NHS from misuse and abuse and to give vulnerable people the care they need – all the while in ensuring that public money and our public health infrastructure do not suffer on a fool's errand to demonstrate action. It is possible to achieve both.

This research has been divided methodologically into two important stages. First, we have examined and analysed the Government's legislation and the regulatory guidance. We hope that this report will be considered a constructive response to that process. Second, Demos and Doctors of the World ran a series of expert consultations involving leading figures from the charitable sector, frontline healthcare and legal experts in order to examine potential solutions to the three ambitions of protecting the NHS, preventing disease and protecting access for vulnerable groups. Working with these expert groups and frontline organisations such as Doctors of the World, we have developed a series of challenges that we believe have the potential to undermine the Government's attempts to resolve these difficult questions. These are some of them:

- The cost of developing new IT infrastructure in order to deliver these proposals – let alone the capacity of government to do so successfully, given its track record – presents a clear challenge to the efficiency of delivery.

- The capacity of the NHS to plan and allocate resources effectively and efficiently is likely to be dramatically undermined by new gaps in data created by individuals and families failing to access healthcare because of an inability to afford treatments and concerns about eligibility.

- At the individual level, there is concern that early diagnosis – and the associated reduced costs of treatment for a wide range of illnesses – will be undermined. This will increase costs for individuals and also, in circumstances where payment is not possible, for the state.

- At the wider level, missed opportunities to diagnose communicable diseases such as TB and HIV will increase the cost of treatment and create new public health challenges, which pose a threat to wellness and will increase costs for the NHS.

- The threat from antibiotic-resistant diseases and associated public health risks and higher costs of treatment will be exacerbated by missed opportunities to diagnose and insulate.

- Charging for non-crisis mental health treatment presents a clear challenge to efficiency, security and ethics – posing a potential threat to the community, leaving very vulnerable people unable to access healthcare and resulting in much higher costs from higher levels of emergency and crisis care interventions.

- Pregnant women and their newborn children are likely to be exposed to unnecessary risk under higher charging tariffs and as a result of the charging of families for health visiting services.

- The proximity between NHS data and Home Office enforcement agencies – perceived or real – poses an enormous ethical challenge for healthcare professionals and the NHS as a whole. It will lead to fear on the part of patients and moral dilemmas for doctors, and potentially to the use of private and confidential medical information for inappropriate enforcement purposes.

But we have also identified ways forward for the Government, which would enhance the efficiency, security and morality of the Department of Health's proposals. Overwhelmingly, our proposals are focused on the question of how to ensure that individuals access the healthcare that they need – so that questions around charging do not prevent the tackling of disease or result in accusations that the NHS is in breech of obligations under pre-existing law. As this aim is shared with the Government, we hope that the Department of Health will look closely at the recommendations that have emerged.

Our recommendations

This report recommends that the government should:

- consider setting up triage clinics
- impose blanket exemptions for children who need NHS care
- establish a principle of one-way information sharing
- educate the administrators
- impose a rolling impact assessment

Set up triage clinics

Government should look at the possibility of setting up a new network of co-located, triage-focused walk-in clinics bringing together frontline NHS staff with expert advisers from Citizens Advice Bureau and other support agencies. We would suggest they be funded via co-operation from the bodies and public services that would most benefit from the long-term savings they would bring, and be located alongside either existing services or in existing premises managed by partner organisations.

The purpose of these clinics would be clear – to act as a first port of call for unregistered patients with a healthcare concern, to signpost those with further healthcare needs and to provide specialist support for those entering into the mainstream healthcare system where necessary. These clinics would be exempted from charging requirements and would function on a 'triage' basis. A patient would be able to see a nurse-practitioner for assessment. Then, if there were concerns about the need for additional healthcare provision and/or further diagnostics, the nurse-practitioner would refer the patient to a support agency adviser who would explain to them what they are eligible for, where they could access care and what charges they might incur.

These clinics should be managed in partnership with NGOs in order to reinforce their independence from the NHS' wider charging framework when it comes to advice and to management. Organisations like Doctors of the World have an important potential role to play in ensuring that as the NHS seeks to defend itself against misuse it does not incur the human and financial costs of accidentally limiting access to treatment.

Impose blanket exemptions for migrant children

There are significant ethical concerns about migrant children and young people incurring costs for healthcare. They are not morally responsible for their presence in the UK and it is unethical to punish them for their migrant status. Furthermore, it is a false saving. Many of the public health risks that are outlined in this report could be partially answered by being

clear about all children always being eligible for free treatment. Doing so would ensure that NHS planning and resource allocation for the health of children is captured by avoiding 'data blind spots' created by patients dropping out of the healthcare system.

Establish a principle of one-way information sharing

We urge the Government to establish a principle of 'one-way osmosis' at the heart of its new infrastructure. The principle is that any and all information the Home Office holds on the status of migrants may be shared with the relevant NHS entity but no information held by the NHS (up to and including the request for information itself) can be seen by the Home Office. This may seem unfair to the hard-working civil servants tasked with ensuring that border enforcement improves, but the wider impact on public health that is a potential consequence of allowing further information sharing is potentially devastating. Furthermore, it is easy to see how allowing the Home Office access to migrant health records could establish a precedent for such information sharing that could reach well beyond non-British nationals. Enshrining the principle of one-way osmosis here and now – and in law – would go a long way to assuaging such fears.

Educate the administrators

Government has a duty to ensure that frontline NHS staff do not inadvertently hinder the treatment of migrants by virtue of a lack of understanding. But the rules are by necessity complex and NHS staff are already overstretched and required to develop detailed understanding of myriad rules, regulations and requirements. We call on the Government to implement a campaign to educate administrative staff in particular based on the principle 'let's see what you *are* entitled to'. Even as NHS staff are expected to take more of a role in preventing misuse and abuse, their primary objective should remain – meeting healthcare needs. Engraining an approach based on a positive engagement with what migrant patients are entitled to – particularly given the under-use of the NHS by many eligible migrants – is important to promoting a culture of trust and mitigating public health risks. NHS staff should be asked to work from the premise that they are there to help any patient access the healthcare they need – and that while a migrant patient may complicate that overriding mission, it never negates it.

Introduce a rolling impact assessment

We urge the Government to commit to undertake a follow-up, rolling impact assessment of this policy. This would have the advantage of allowing the Department of Health and other key stakeholders to react to the ongoing effects of the reforms and – through measurement of real-world responses to the changes – to adjust policy and behaviour accordingly. Government should ensure that central to these evaluations is a commitment to understanding the impact on frontline medical staff's workload and to understand if the fundamentals of the Hippocratic oath remain intact as these policies become embedded.

This would equip the Government with the data from which to make the case for further changes should they be necessary. The lack of data behind the existing reforms has led to severe criticism and concern. Government can mitigate the likelihood of such concern in the future by engaging in the systematic recording and publishing of relevant data now.

We can have it all

Britain can be a healthy, safe and welcoming country while also ensuring that our NHS is not vulnerable to fraud or misuse. The Government is not 'wrong' to seek to reassure taxpayers that we will not be taken for a ride. But great care is required to ensure that we do not inadvertently put the efficiency of the NHS at risk, reduce the robustness of this country's public health or outrage common decency. The proposals set out above are a modest response to the wealth of evidence that – if handled badly – the Government's reforms may unintentionally threaten perverse and tragic consequences. This report outlines what some of those consequences may be and it explains

how we might mitigate these risks – it does so in full support of the principle that the NHS be safeguarded for its eligible users. We can have it all when it comes to migration and the NHS, provided we act with care, on the basis of evidence and in support of the principles that underpin the relationship between a doctor and a patient.

1 What is the problem?

The debate on migrant access to the NHS is often focused on a discussion of 'health tourism'. As outlined above, this frame is unhelpful because it unfairly and inaccurately draws migrants – documented and undocumented – into a category with those who are in the UK primarily to access healthcare. An individual who is here to work and becomes ill – therefore requiring treatment – is not comparable legally or morally to an individual who travels to the UK with the intention of defrauding the NHS. And yet, because of that political frame, all too often migrants are subsumed into policies designed to tackle the supposed menace of health tourism. It is important to understand the current framework and the estimated extent of misuse before considering what remedies may be necessary – and what some of the objections to existing recommendations are.

Broadly speaking, health tourists are defined as people travelling to the UK with the intention of obtaining free healthcare to which they are not entitled.[1] However, as a 2012 government review states:

Any definition [is] predicated on the actual rules of entitlement at the time but often distorted by personal perceptions of who should be entitled to free care. The common view is that any unpaid debts for chargeable NHS treatment constitute health tourism, although this excludes those who have evaded identification and charging in the first place.

The summary report of the review notes that the latter is impossible to quantify.[2]

Policy context

Historically, the National Health Service Act 1946 set out the duty of the minister of health to provide services free of charge for 'the people of England and Wales'.[3] Charging for those not 'ordinarily resident' in the UK was introduced in the National Health Service (Amendment) Act 1949, although these powers were not formally enacted through regulations until 1982. These charges have to date only ever applied to hospital treatment rather than primary care.[4]

The mechanisms in place for identifying and charging relevant migrants constitute the basis for preventing health tourism – the focus of much of the current debate. NHS hospitals have a statutory obligation to identify all chargeable overseas visitors and either charge them for treatment or recover the costs of their treatment from them. The role of identification, assessment and charging is undertaken by overseas visitor managers and their teams.[5]

Chargeable overseas visitors are temporary non-European Economic Area (EEA) migrants not eligible for an exemption. Exemptions include those living lawfully in the UK for at least 12 months, those in work, those arriving for permanent residence, students, refugees and asylum seekers.[6] Determining that a non-EEA migrant is chargeable depends on an NHS body proving that they are not 'ordinarily resident' in the UK (a common law concept not defined by statute). When making an assessment, a relevant NHS body needs to consider whether they are:

living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, whether they have an identifiable purpose for their residence here and whether that purpose has a sufficient degree of continuity to be properly described as 'settled'.[7]

In contrast, EEA nationals and their dependants residing in the UK are entitled to free NHS treatment immediately, as is their right under the European Free Movement Directive.[8] In addition, the EU Social Security Regulations enable the UK to claim back payment for NHS primary and secondary treatment provided to any insured EEA person on a short-term visit to the UK (and registered EEA pensioners residing in the UK) from the patient's home state.

While there are restrictions in place for non-EEA migrants accessing secondary care in the UK, all overseas visitors currently have a right to free primary care from the NHS. GPs have discretion over registering patients, and are entitled to refuse registration on 'reasonable, non-discriminatory' grounds. But if a GP refuses to register a migrant, the migrant is entitled to apply for assignment to an alternative primary medical care supplier. Despite this, a government review reports that there is

evidence of a prevailing incorrect belief that a person must be ordinarily resident in the UK in order to qualify for free primary medical services. Some practices have deregistered or failed to register people they believe to be 'ineligible' in some way due to their immigration status.[9]

Migrants who are not entitled to receive free NHS hospital treatment following referral from a GP are given the option of delaying the treatment until they have saved the necessary funds to pay, returning to their home state for treatment or, if the treatment is not essential, refusing it.

All overseas visitors to the UK who are registered with a GP are entitled to claim NHS prescriptions under the same rules as UK citizens (they pay the NHS prescription charge per item unless they hold a valid exemption under the prescription charging rules).[10] The same applies to dental care and eye tests.

In addition to free primary care, current regulations do not permit charging any overseas visitors for accessing:

- other NHS providers that are not hospitals, for example care homes providing NHS continuing care

- other providers that are not NHS bodies but are providing NHS funded and commissioned services, including social enterprises, independent sector treatment centres and other independent providers

- local authorities, which may begin to provide or commission secondary care in the provision of public health services as a result of the Health and Social Care Act 2012[11]

Under the existing frameworks for providing care while avoiding misuse and abuse, then, how much of an issue is health tourism for the NHS?

The scale of the 'health tourism' problem

As stated above, health tourism is difficult to define and quantify. There is no robust evidence and few reliable estimates of the actual numbers of health tourists coming to the UK. Much of what is publicly reported is based on estimated debt owed to the NHS by chargeable migrants (discussed below), or anecdotes from health professionals regarding abuse of the system.[12]

The government report *Quantitative Assessment of Visitor and Migrant Use of the NHS in England* has suggested that 'the plausible bounds for the number of health tourists who deliberately travel to England to use the NHS is 5,000 to 20,000 cases',[13] though the report states that 'this is a structured judgement rather than an empirically based estimate'.[14]

Estimating the costs

A variety of different costs have been attributed to deliberate abuse of the NHS by those ineligible for treatment in the UK who have come specifically for that purpose. There is large discrepancy between the figures, largely due to the way costs have been calculated. For example, some have used written-off debt only (money from chargeable patients that is now impossible to retrieve), while others use total outstanding debt.

The provenance of cost estimates is not always immediately clear. On 5 July 2011, Richard Littlejohn wrote an article in the *Daily Mail* claiming that health tourism was costing the UK £200 million.[15] However, Full Fact found that this is actually the upper bound of an original estimate, which calculated that health tourism could cost the NHS anywhere in the region of £50 million and £200 million.[16]

Even the lower estimate here is several times higher than Health Minister Anne Milton's departmental estimate on irrecoverable bad debt owed to the NHS of £12 million.[17]

A number of newspapers, including the *Daily Mail*, *Daily Express* and *Telegraph*, subsequently reported, on 3 May 2012, that health tourism was costing the NHS over £40 million.[18] This figure was based on data acquired by *Pulse* magazine, which sent freedom of information requests to all 168 trusts in England asking for information on 'outstanding debts they are owed as a result of treating foreign nationals since April 2009'.[19] Of the 35 hospitals which responded, 24 provided comparable data, giving a rough overall average estimate.[20] Full Fact further noted that these figures on outstanding debt do not refer to the debt which has been 'written off' – the rough estimate of £40 million 'is not necessarily the same value as the amount the Government no longer anticipates being able to recover… whether this is "free" treatment, as some of the papers claimed, is therefore a moot point'.[21]

The highest annual cost attributed to health tourism is in the region of £2 billion, reported in the *Daily Mail* on 22 October 2013.[22] Full Fact disputed this, citing that this figure instead represents the total cost of all use of NHS services by all migrant groups and overseas visitors.[23]

Government estimates

The report *Quantitative Assessment of Visitor and Migrant Use of the NHS in England* found that health tourists cost the NHS 'around £100 million to £300 million' each year.[24] This is an increase on figures previously released by the Department of Health, which put the figure at £12 million annually (see above). However, the report commented that 'studies assessing migrant

healthcare use are limited by poor reporting systems and difficulties in identifying individuals who are born outside of the host country within healthcare databases'.[25]

The report used two separate definitions of health tourism:

- deliberate intent: people who have travelled with a deliberate intention to obtain free healthcare to which they are not entitled, and therefore use the NHS to a greater extent than they would routinely need during their limited stay. This is typically for urgent or emergency hospital treatment sought on arrival, usually but not always as a one-off, and may include maternity care[26]

- taking advantage: frequent visitors registered with GPs and able to obtain routine treatment including prescriptions and some elective (non-emergency) hospital referral[27]

The estimates of costs attributable to these definitions are given in table 1.

Table 1 **Estimated costs of health tourism in the UK per year**

Health Tourism	Plausible additional cost (£m)	
	Central Estimate	Range
Incremental cost of deliberate health tourism for urgent treatment	60–80	20–100
Incremental cost of regular visitors taking advantage	?	50–200

?: unable to estimate
Source: Prederi[28]

Table 2 gives the summary of gross costs.

Table 2 **Summary of costs of visitor and migrant use of the NHS in the UK per year**

Visitor/ Migrant Group	In-scope Population (Daily Equivalent, 000s)	Gross Cost (£m)	Weighted average Cost Per Head (£)
Total EEA	443	261	588
Total Non-EEA	1,461	1,075	736
Total Expats	65	94	1,449
Total Regular Visitors and Migrants	1,969	1,430	726
Total Irregular Migrants	580	330	570
Total 'normal' use of NHS	2,549	1,760	690
Deliberate health tourism for urgent treatment	?	60–80	?
Incremental cost of regular visitors taking advantage	?	50–200	?
Total – 'normal' use plus abuse and misuse	?	1,870–2,040	?

?: unable to estimate
Source: Prederi[29]

As table 2 indicates, it is impossible to know the actual numbers of either deliberate health tourists seeking urgent treatment, or the numbers of regular overseas visitors taking advantage. Regardless, the report gives the figure that health tourism costs the NHS as between £100 million and £300 million, although it is unclear from the report whether this is considered irrecoverable.

The Government's focus on tackling the undeniably unethical – if also unsatisfactorily quantified – issue of health tourism warps our understanding of the broader cost of access

to healthcare by migrants. All of the existing evidence available highlights that migrant communities are less likely to access health services for which they are eligible – so it is likely the UK is spending less on treating migrants than we might be expected to were take-up at proper levels. Research by Doctors of the World found that – in London – a large number of people eligible for healthcare and NHS registration were not accessing health services. Doctors of the World found that 90 per cent of the 1,449 people surveyed were 'not registered with a General Practitioner even though they were eligible for registration', while 20 per cent of these 'were deterred from seeking care for fear of the immigration control consequences'.[30] The reasons for this low take-up are complex and outlined in more detail below, but any attempt to estimate the overall costs of migrant healthcare needs to take into account current under-spend. There are also significant concerns that the Government's proposals will serve to exacerbate this issue.

Overall, it is clear that while there is an ethical and political case for tackling health tourism in the UK, the potential savings of moves to remedy the present situation are speculative at best. Furthermore, there is little understanding of the cost of untreated illness in migrant communities – more on which later – and of the current underspend due to low take-up in those communities. All of these questions and issues require proper thought and consideration before any meaningful solution can be developed; one which avoids counter-product impact.

International comparisons

Comparisons with the health services of other countries are often made in UK discourses on health tourism. In particular, groups keen to see a reduction in immigration often emphasise the idea that the UK exists as a 'soft touch' or as 'too generous' when it comes to granting healthcare access to immigrants.[31] This is paralleled by a government discourse, which similarly stresses how other countries often require temporary migrants to obtain either comprehensive health insurance or to undertake extensive health check-ups prior to emigrating.[32]

Other groups have collected data which they say disproves the notions that the UK is either too generous or a soft touch. In an article entitled 'The truth about "health tourism"' Doctors of the World noted:

In France and Belgium, for example, migrants have free access to essential primary and secondary healthcare with medical providers getting reimbursed for treatment. In Portugal, undocumented migrants have full access to healthcare once they have stayed over 90 days.[33]

However, other evidence suggests that in reality migrant healthcare in other countries is rarely as simple and affordable as it might seem, with multiple barriers in place including knowledge, language, financial and long-term bureaucratic obstacles to both primary and secondary services. There is also a tendency to homogenise migrant experience in discussions of how healthcare is provided abroad, with little emphasis placed on differentiating between vulnerable migrant groups and others.

One key lesson, though, is that it is possible to provide categorical exceptions for pregnant women and children – enshrining these clearly and transparently in law. In Spain, for example, all pregnant women and children under 18 are entitled to access to the national healthcare system – irrespective of their administrative status. And in Sweden, where until recently undocumented migrant children would be retrospectively charged, the law was changed in 2013 to provide minors with free healthcare. Such blanket exemptions appear to be workable and even desirable in developed economies – and they provide an answer to some of the dilemmas and issues explored below.[34]

2 Government consultation and current proposals

In May 2011 the Coalition Government announced a review of the regulation and practice of charging overseas visitors for NHS treatment. The subsequent 2012 report, conducted by the Department's International Policy Team found 'significant weaknesses' in the system of charging patients and the recovery of costs for treatment, of which health tourism is a part. These findings were published in July 2013 in conjunction alongside consultation documents reviewing migrant access to the NHS.[35]

The 2013 consultation proposals included: increasing the financial contribution of temporary non-EEA migrants; the adoption of a revised definition of qualifying residence (with non-EEA migrants required to have indefinite leave to remain rather than just meet the more generous ordinarily resident test); measures to improve the system for identifying chargeable patients; and the extension of charging to primary and community healthcare.[36]

Example consultation questions

The government consultation document received 2,376 responses from an online survey, as well as a further 81 responses submitted via email or post.

Should all temporary migrants, and any dependants who accompany them, make a direct contribution to the costs of their healthcare?

Just over one-third (34 per cent) of respondents answering this question felt that migrants should 'make a direct contribution to the costs of their healthcare'. Just under two-thirds (62 per cent) felt that migrants should not contribute in this manner.

Broken down, two-thirds of respondents from the health sectors agreed that temporary migrants should contribute towards the costs of their healthcare whereas 65 per cent of the public and 77 per cent of respondents from organisations disagreed with the statement.

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

Over two-thirds (69 per cent) of the respondents did not agree that access to health services should be based on permanent residence. Over half (55 per cent) of health sector respondents were in favour of linking permanent residence to free access to NHS services. This is in stark contrast with the responses in favour from the public (25 per cent) and organisation representatives (15 per cent).

In response to the consultation the Government has put forward a four-phase approach to improving the system of charging for NHS treatment:

- *Phase 1: Improve the current system of identification of, and cost recovery from, chargeable patients within secondary care.* An appointed cost recovery director will establish a cost recovery unit from the beginning of 2014.

- *Phase 2: Test and introduce a better NHS registration system, identifying chargeable patients 'upstream' of secondary care.*

- *Phase 3: Home Office to implement health surcharge through the Immigration Bill.* The expectation is that the surcharge will be paid to the Home Office at the same time as a visa application fee.

- *Phase 4: Extend charging policy to some primary care and A & E services.* This is likely to include pharmacy, dentistry, maternity, optical and community care and A&E services but exclude charging for GP consultations.[37]

The health surcharge will have to be paid by all non-EEA migrants and dependants who are not short-term visitors and do not have indefinite leave to remain. This will include students under tier 4 of the points based system; migrant workers under tier 1 or tier 2 of the points based system; and family migrants such as non-EEA partners and dependants of British citizens, settled migrants and temporary migrants.[38]

The Government calculates that, overall, in 2012 at any given point there were around 950,000 people in the UK who would be liable to pay the health levy. Two-thirds (650,000) of this population were non-EEA students. Some groups would continue to be exempted from paying for NHS care, including refugees, asylum seekers, refused asylum seekers receiving section 4 or section 95 support, children in local authority care, and victims of trafficking.[39]

Alongside seeking to introduce the new health surcharge, the Immigration Act 2013 is also carrying through the proposal to redefine the residency test for non-EEA migrants, who will need to have indefinite leave to remain rather than simply meet the ordinary residence criteria.

3 Pitfalls and problems

Through our work with leading experts in frontline healthcare, public health, ethics and migrant support, we have identified three key areas of concern over the current proposals. We believe that the proposals pose risks to efficiency, security and ethics. All of these are potentially solvable should the Government commit to further work on implementation. Below we set out some of the risks that are inherent in seeking to impose the new charging structure. Many of these were flagged up during the initial consultation period by the numerous organisations and individuals who submitted responses.

Of particular concern – and highlighted in all of our engagement with expert contributors – has been the question of access even when persons seeking it were eligible to receive it. Over and over again in our consultation sessions, we heard stories of individuals not gaining access to necessary healthcare even when they were entitled to it. This appears to us to be the biggest single problem with the complexity that charging frameworks build into the system. A combination of patient and practitioner ignorance means that even the best-intentioned reforms lead to perverse, unintended and tragic consequences. To quote just one of the experts who raised this issue with us:

Even now we have migrants who think they are ineligible when they could get treatment, NHS administrative staff who make assumptions about eligibility that are just plain wrong, doctors who are unsure and uncertain and a mess that no-one really understands. This will make it worse.

The evidence for NHS staff ignorance about what the rules really are, and what they are intended for, is not merely

anecdotal. We can see the effect of misunderstood and wrongly enforced regulations in vulnerable communities. In its response to this consultation Homeless Link noted that homeless people currently face a number of barriers to primary care health services. In particular they are already frequently 'refused registration at GP practices'. Homeless Link pointed to a 'series of local audits across eleven local authority areas', which found that '7% of homeless people have been refused registration to a GP or dentist in the last year'. Looking at migrants in particular, Doctors of the World's evidence demonstrates there is a huge problem. DOTW found that 90 per cent of the 1,449 people surveyed were 'not registered with a General Practitioner even though they were eligible for registration', while 20 per cent of these 'were deterred from seeking care for fear of the immigration control consequences'.[40] Whatever else the Government seeks to do as it implements these reforms, one thing is clear – a process of education must be undertaken (of NHS staff as well as of patients) to explain what people *are* eligible for, not just what they must pay for. Otherwise lives will be put unnecessarily at risk in the pursuit of political point-scoring.

Through our expert engagement work, Demos and Doctors of the World have identified key potential interventions that – if enacted – would help to mitigate risks and prevent accidental and perverse outcomes from implementation. We summarise the main problems and pitfalls that have been identified to us below.

Efficiency

The primary aim of the Government's proposals is not revenue focused, it is – rightly – about protecting the NHS from misuse and abuse. However, it would seem obvious that any attempt to prevent NHS resources from being misused should take seriously the need to safeguard those resources.

Infrastructure

There are serious concerns about the cost of implementing an effective system for monitoring access to healthcare in such a way as to improve the recovery of debts for treating non-eligible patients. The British Medical Association, for example, warns that the proposed reforms will 'involve a significant and complicated change to the way in which healthcare is accessed'. It also criticises a lack of detailed accompanying equalities and impact assessments detailing the exact costs and benefits.[41]

Furthermore, the Immigration Law Practitioners' Association (ILPA) has cited figures taken from a Department of Health impact assessment which demonstrates that the administrative cost of imposing a health levy or surcharge, and of increasing the number of chargeable primary care services to migrants, would outweigh any potential benefits in potential debt which could be recouped by the NHS. In a response to the Department of Health consultation it stated: 'the effect of the charges deterring persons from coming to the UK is unlikely to exceed 0.5% of Gross Domestic Product in a given year' – this being £8 billion in 2012 – concluding, 'if, as per the consultation document, charges levied will total about one billion and will not all be collected, then it would appear that the costs look set starkly to outweigh the financial benefits'.[42] This implies that, by the Government's own quantification of the likely economic impact, the taxpayer will be left out of pocket.

Questions about the likely ability of the Government to make changes cost-effective were raised throughout our expert consultation sessions. One experienced contributor, who had direct experience of working with central government on major IT infrastructure projects, told us, 'The track record is appalling and expensive. The idea that for this relatively small – and contested – amount of fraud or misuse we will invest in such a huge IT project, given that track record, is insane.'

It is true that government IT programmes have often run over budget in the past. The NHS in particular has a history of over-spending on abortive IT innovation and infrastructure. For example, last year the Public Accounts Committee estimated the cost of the NHS' new patients' records database at £10 billion and rising. The original budget was just over £6 billion.[43]

Non-treatment

There is an important question about how long-term costs might increase as a result of reluctance to seek treatment on the part of migrants with healthcare needs. The proposals do not seek to prevent individuals from accessing emergency healthcare but they do extend the charging framework to areas of primary and A&E care. This could well have the effect of preventing people from accessing needed care until such a point as they no longer have a choice – failure to treat many conditions when they first arise results in more expensive treatments later. An expert contributor observed:

If you treat diabetes up front, that's one set of costs. But if it is left until someone needs emergency care then you're doubling, quadrupling those costs potentially. If someone couldn't afford the healthcare in the first place, it's a mistake to presume that they're going to be able to retrospectively pay for even higher costs.

The extension of new eligibility and charging mechanisms into primary and A&E care – with the potential for charging also to reach into diagnostics – poses a considerable threat to the long-term efficiency of NHS healthcare provision.

Resource planning

There are concerns about the potential impact on the capacity of the NHS to plan resource allocation over the long term. There is a danger that if migrants are put off from accessing healthcare – because of the charging regime itself or perceptions of it – the NHS will struggle to build up an accurate data profile of emerging trends in healthcare needs. This will be particularly problematic in cases of communicable disease. One of the expert contributors explained:

The problem is that we increasingly need live, accurate big data – so that we can predict both the long term and the short term of different output areas. So we can predict an outbreak of a communicable disease, for example, in the short term. And we know where is going to have more and more diabetes cases in the longer term. That means we can use resources properly, efficiently. So we actually want as many people as possible connecting with primary healthcare – so we build that picture. This risks putting people off engaging and that risks our resource distribution planning.

Many of these efficiency dilemmas spring from an ongoing concern about the confusion – among NHS staff and patients – about eligibility for treatment, exemptions and qualifications. These issues do not merely impede individuals' ability to access healthcare. The lack of clarity in the existing system – let alone under the new and more complicated framework – presents huge efficiency challenges for the NHS. It will limit the ability of planners to allocate resources efficiently. It will lead to missed opportunities for savings as conditions are left untreated and costs escalate. The development and introduction of new IT infrastructure – capable of managing such a complex tracking system – is likely to spiral out of control.

Savings

There remain pressing questions about the true costs of the status quo. As outlined above, there is little reliable evidence for the price-tag attached to either 'health tourism' or migrant use of healthcare more generally. Little work has been carried out to examine the likely economic impact of the proposed changes – and where such work has been undertaken it implies that there will be a net loss to the exchequer.[44] Finally, we do not know the full extent of 'under-use' by migrant communities – the recurring problem of migrants believing themselves to be less eligible than they are and, therefore, not seeking treatment to which they are entitled. Work on under-claiming in the benefits system has shown a propensity to over-estimate one's ineligibility for government support in that area.[45]

Expert evidence in our consultation process demonstrates that this is also a problem regarding healthcare access within migrant communities. Research by Doctors of the World found that in London a large number of people eligible for healthcare

and NHS registration were not accessing health services: 90 per cent of the 1,449 people surveyed were 'not registered with a General Practitioner even though they were eligible for registration', while 20 per cent of these 'were deterred from seeking care for fear of the immigration control consequences'.[46] That being the case, it may well be that Britain is spending less on the provision of health services to non-EU migrants than we technically ought to be – a figure not properly factored in to the Department of Health's figures.

Security

When we use the term 'security' in this context, we are referring to the risks to public health of the Government's proposed reforms. It is important to acknowledge that the Government has been clear in its intention and in its guidance that communicable diseases will not be affected by the new framework. Patients presenting with conditions such as HIV and tuberculosis will be offered treatment at no financial cost. But there is a significant question mark over whether they will present at all. Expert contributors were very concerned about the potential results:

Even under the current system we work with a lot of people who presume they are not eligible. They don't access the healthcare that they are entitled to. I can't imagine how these proposals will affect these communities – it is going to give more and more people the idea that they're not able to go and get tested. Which means they won't be treated and they will pass on disease.

With drugs, HIV becomes a manageable disease and infection risks can be massively reduced… People are already reluctant to be tested. If there's a fear they'll be charged, and if there's the potential to be charged for the test itself – even if not for treatment – we could undo all the good work that has been done.

It only takes one person being turned away. Even if they are being denied registration or treatment incorrectly. And if a community – these are often very close-knit communities, by necessity – gets the idea that they can't use the NHS the impact can be devastating.

These concerns are entirely legitimate. Public health is a complex and fragile area of policy and any changes to healthcare provision that jeopardise the safeguarding of the public from infectious and communicable disease is worrying. Again and again throughout our expert roundtables, the key issue that arose in relation to public health is the fear that even when migrants (in particular vulnerable migrants such as asylum seekers) are entitled to free healthcare they will not take it up.

Diagnosis

The British Medical Association (BMA) has made the point that charging for an increasing number of primary care services, even while ensuring that GP consultations remain free, could still have implications for public health 'by taking away vital opportunities to identify symptoms of communicable disease in routine consultations'. This sentiment was generally echoed across the responses to government consultations. The BMA particularly focused some aspects of its response on the impact that extending the coverage of the charging system would have on diagnosis of and support for people with a learning disability and to treat those with mental health needs. It argued that, were the proposals in the consultation document to go forward, migrants with these disabilities should be given the same charging exemptions as those for 'infectious diseases including STIs [sexually transmitted infections]'.[47]

As outlined above – there are already massive reported discrepancies between the eligibility of many migrants living in Britain and levels of actual access. New rules, which add further complexity, will add to this existing problem. The combination of staff ignorance and patient fears may mean that well-intentioned public health measures contained within these reforms – such as the commitment to providing treatment for communicable diseases such as TB and HIV – do not achieve their desired effect.

Antibiotic resistance

Further to these basic public health concerns there is a particular and growing threat from the rise of antibiotic and antimicrobial-resistant strains of communicable disease. The Government has clearly recognised this as an important threat to the bio-security of the UK. In August 2014, research conducted by the World Health Organization (WHO) warned of a 'doomsday scenario of a world without antibiotics'[48] and in July 2014 David Cameron announced a wide-ranging review to look at the growth in resistance and propose strategies for resisting what he described as 'an almost unthinkable scenario where antibiotics no longer work and we are cast back into the dark ages of medicine where treatable infections and injuries will kill once again'.[49]

A failure to engage with migrant communities, identify symptoms and isolate cases of antibiotic-resistant communicable disease will hasten the spread of such infections in the UK. This has clear public health implications, and could potentially be extremely costly for the NHS. To use just one example, the WHO has examined the healthcare economics of treating TB versus those of treating anti-microbial-resistant TB. Routine treatment for TB costs about $2,000 a patient, but rises to $250,000 for strains of TB that are resistant to traditional treatment – an increase of more than 100 per cent.[50] And what is the biggest single cause of new, resistant strains? Failure to deliver treatment fully and to monitor the patient's use of drugs – a clear danger if, as the BMA warns, the charging mechanisms put individuals off seeking treatment even when they are eligible to receive it.

Mental health

Finally, it is important to address the potential impact of this charging framework on mental health needs within migrant communities. Mental health services are already overstretched and highly patchy. But under these reforms there is a danger that migrants with mental health needs will be left utterly locked out of what services do exist – in particular talking therapies and community support.

The Academy of Royal Medical Colleges singled out mental health services as an area of particular concern in its submission – arguing that the impact of charging for an increased number of primary care services would be disproportionately felt by 'migrants with mental health and related problems' who are unlikely to possess the financial means required to pay for the care they need and may also 'lack the insight required to seek the help they need to avoid crisis situations', which may also result in further risks to their public health.[51] One expert contributor commented:

It is a horrendous situation if the only meaningful access to mental health services available to particular groups comes at a moment of crisis and with statutory intervention. That's the worst outcome for the individual but also for the service. And it looks as though we are going to be faced with either sectioning patients or nothing – meaning, as well, that when it comes to release I am not clear what services we will be able to put in place to support very vulnerable people.

Britain's public health security faces threats old and new – as well as an increasingly tight funding environment. Nothing should be done to add to the danger of outbreaks of communicable disease (in particular diseases which are adapting to resist treatment). And yet, under these reforms there is deep concern that – despite the intentions of government – our capacity to identify, monitor and tackle public health risks in the UK will be dangerously diminished.

Ethics

We have already noted the justifiable and important moral responsibility to protect the NHS from misuse and abuse – and from perceptions that the service is not robust in defending resources. But there are clear ethical dilemmas unresolved in the current proposals.

Children and young people

One area of particular concern is the impact on children of the proposed reforms. For example, the ILPA has highlighted

the potential negative impact of increasing the number of chargeable primary care services.

There is a particular ethical dilemma when it comes to the treatment of pregnant women and newborn children. Antenatal care is already chargeable, but these proposals run the risk of creating new barriers to access for vulnerable pregnant women. Under government plans, the tariff for antenatal services will be charged at 150 per cent – so women will be faced not just with meeting the medical costs of their treatment but also those of services as an additional levy. The proposals also cover charging for health visiting – putting children at risk by making a service designed, in part, to establish the wellbeing of newborn children in the home – dependent on parental willingness and ability to pay.

The ILPA cautioned against such an approach, noting that evidence given in the report *The Treatment of Asylum Seekers* by the Joint Committee on Human Rights suggests that charges 'deter pregnant women from getting medical help or lead to their being denied help'.[52] This has been corroborated by the research carried out by Doctors of the World, which reported in its 2012 pan-European study that 'on average 79 per cent of respondents were not accessing antenatal care'.[53] As evidence suggests that beginning antenatal care after 20 weeks is related to increasing the risk of infant mortality and maternal death, a case can be made that charging for primary care maternity and antenatal services increases these risks among would-be mothers from vulnerable backgrounds. This is clearly not the Government's intention but could be a perverse and deeply unjust consequence of these reforms.

Contribution

This theme was picked up by the BMA in its response to the consultation, and broadened out. Responding to the proposed shift from 'ordinary residence' requirements to the necessity of possessing indefinite leave to remain, the BMA generally stated that the imposition of a health surcharge or levy on migrants, and charging them for particular primary care NHS services, is unfair. The BMA echoed many institutions in asserting: 'many migrants who do not have indefinite leave to remain in the UK are working, paying tax and making National Insurance contributions'.[54] It further noted that as all those 'applying for LR [leave to remain] following a Tier 2 Visa will have to meet a salary threshold of at least £35,000'[55] from 2016, it is likely that a large number of people reaching this threshold will be contributing through tax to the upkeep of the NHS. Demanding that all migrants pay for a number of primary care services alongside a levy with every renewal of their visa against this background could lead to some paying twice over for access to healthcare.[56]

In its response to the proposals Liberty argued that the Government appears to accept that migrants are likely to be left facing bills for healthcare that they will not be able to afford to meet – damaging the 'efficiency' case for these reforms and possibly impairing access to healthcare, and therefore leaving vulnerable families at risk.[57] Liberty quotes the Government's own consultation document: 'undocumented migrants make up the largest group of chargeable visitors, approx. 500,000, many of whom have few resources to pay charges incurred'[58] and argued that 'government is unlikely to extract much money from this group, who will either not seek the care they need (at least not until they are critically ill), or simply be unable to pay for any treatment provided'.[59]

Bureaucratic over-reach

There are considerable fears about how the new charging regime – and the machinery required to make it work – will interact with the immigration bureaucracy as a whole. While it is important to protect the integrity of the NHS, the necessity of providing people in need with care and of protecting the population from public health threats should not be overlooked. One expert contributor explained:

The problem is that you will end up in a situation where doctor–patient confidentiality breaks down completely. Why would someone go to see a GP about what may feel like a minor problem if

they know that doing so entails a risk of exposure to the Home Office bureaucracy they're avoiding? You might say 'well, they should be deported anyway' – but that should not be a factor in the consulting room. Once it is, there's very little hope of getting people (even people who have a right to be here but because of past experiences are very wary of the state and state power) to seek the treatment they need.

There is a danger that a new perceived proximity between enforcement – in the form of the Home Office – and care – in the shape of the NHS – will deter individuals from accessing healthcare. The impact on already vulnerable families of creating new fears about accessing vital healthcare could be devastating. Children will be left unable to get the care they need and are entitled to because of a perceived risk of retributive state action. That presents significant ethical problems for these policies. These may not be entirely unfounded fears – the Home Office already uses NHS data for enforcement purposes – and it is hugely important that vulnerable migrants feel insulated from such risks.[60]

The African Health Policy Network (AHPN) provide a chilling example of how these reforms may work the other way round too – in affecting the capacity of asylum seekers to build their case adequately. Access to primary care services is vital not only in regards to public health, but also for 'certain migrants trying to qualify for key categories of the immigration and asylum system'.[61] AHPN identified two pertinent instances. First, victims of domestic abuse must provide 'proof of domestic violence in order to qualify for an extended stay in the UK after the breakdown of a relationship in which their partner was the sponsor. In these situations, a GP's testimony is vital. Second, 'refused asylum seekers' are required to 'be assessed by a doctor (typically a GP) when applying for section 4 support on health grounds'. Limiting access to some primary care services runs the risk of unfairly treating migrants who fall into these categories.[62]

Summary of key findings

It is clear that there remain difficult challenges – on grounds of efficiency, security and ethics – for the Government in achieving its stated ambition of protecting the NHS while ensuring that access to healthcare is not further limited. These are some of the key problems:

- The cost of developing new IT infrastructure in order to deliver these proposals – let alone the capacity of government to do so successfully, given its track record – presents a clear challenge to the efficiency of delivery.

- The capacity of the NHS to plan and allocate resources effectively and efficiently stands to be dramatically undermined by new gaps in data created by individuals and families failing to access healthcare because of an inability to afford treatments and concerns about eligibility.

- At the individual level, there is concern that early diagnosis – and the associated reduced costs of treatment across a wide range of illnesses – will be undermined. This will increase costs for individuals and, in circumstances where payment is not possible, for the state.

- At the wider level, missed opportunities to diagnose communicable diseases such as TB and HIV will increase the cost of treatment and create new public health challenges, which pose a threat to wellness and will increase costs for the NHS.

- The threat from antibiotic-resistant diseases – and associated public health risks and higher costs of treatment – will be exacerbated by missed opportunities to diagnose and insulate.

- Charging for non-crisis mental health treatment presents a clear challenge to efficiency, security and ethics – posing a potential threat to the community, leaving very vulnerable

people unable to access healthcare and resulting in much higher costs from higher levels of emergency and crisis care interventions.

- Pregnant women and their newborn children are likely to be exposed to unnecessary risk under higher charging tariffs and if families are charged for health visits.

- The proximity between NHS data and Home Office enforcement agencies – perceived or real – poses an enormous ethical challenge for healthcare professionals and the NHS as a whole. It will lead to fear on the part of patients and moral dilemmas for doctors, and potentially to the use of private and confidential medical information for inappropriate enforcement purposes.

As we can see, there are multiple challenges presented by the implementation of the Government's proposals. But many of these can be overcome – while maintaining the Government's ambition of eliminating health tourism. Below we explore the means to answer these dilemmas.

4 Navigating a way forward

It is clear that there are a great many fears, doubts and worries about these proposed reforms in the minds of those who work at the front line every day. It is not the intention of the Coalition Government to reduce access to healthcare for those who have come to this country and are in need. But there is a danger that, despite their protestations, this will be precisely the unintended and tragic consequence of efforts to demonstrate better safeguarding of NHS resources. This report is not intended as a political exercise in opposition – rather, it is the intention of Demos and Doctors of the World to contribute to the ongoing debate about how best to reconcile two objectives: to protect the NHS from misuse and abuse and be seen to do so by the public, and to give vulnerable people the care they need while in our country without spending public money and damaging our public health infrastructure. That being the case, through our engagement with healthcare professionals, expert advocates and organisations that work with vulnerable people we have developed the following proposals, which we believe, if implemented, stand a chance of ensuring that future changes are efficient, secure and moral.

The approaches we suggest are not focused merely on migrants. Any changes to the way in which the NHS operates have to be undertaken in the wider context of our health service and the challenges it faces. It is a mistake, we believe, to regard the issues faced by migrants as unique. As much of the evidence above demonstrates, their concerns often overlap with those of other vulnerable groups – such as homeless people – when they need to access healthcare. And it is in the interests of the long-term efficiency of services in the system as a whole and in the mitigation of public health risks that no one is encouraged, tacitly or otherwise, to disengage from the

NHS. At a time when resources are tight and emerging threats from communicable disease are high it is all the more imperative that strategic decision making be informed and data-driven. This becomes harder and harder the less our planners know about the population and its healthcare needs.

Many of the experts with whom we engaged were angry generically at the existing system of charging and, indeed, at the Government's proposed changes. But underlying this frustration is a sense that – even while disagreeing at heart with the proposals – improvements can be made in order to mitigate risks. Given that everyone in this debate is agreed on the central importance of not preventing access to healthcare, we would argue that the Government should consider seriously the proposals laid out below as a means to meeting its objectives.

Set up triage clinics

The question of access – even when eligibility exists – was one that pervaded this work. As explained above, a combination of fears within migrant communities about what access they are permitted and ignorance among NHS staff about their responsibilities and the reality of the rules create a toxic climate of mutual mistrust. This has direct consequences, leading to individuals not getting care they need and to which they are entitled. It also has an impact on the efficiency of the NHS, so patients engage with healthcare at times of crisis, which pushes up costs. And it poses a threat to our collective public health.

There is a simple intervention that government – potentially in partnership with local health and wellbeing boards – could undertake to mitigate some of this risk. The Government should look at the possibility of setting up a new network of co-located, triage-focused walk-in clinics bringing together frontline NHS staff with expert advisers from Citizens Advice Bureau (CAB) and/or other support agencies. These could be located either as stand-alone services, in conjunction with existing hospitals and NHS services or elsewhere – such as on the premises of partner charities. They would be focused on areas with high numbers of migrant residents.

The purpose of these clinics would be to act as a first port of call for unregistered patients with a healthcare concern, to filter those with further healthcare needs and to provide specialist support in entering into the mainstream healthcare system where necessary. These clinics would be exempted from charging requirements and would function on a 'triage' basis. A patient would be able to see a nurse-practitioner for assessment. Then, if there were concerns about the need for additional healthcare provision and/or further diagnostics, the nurse-practitioner would refer the patient to a CAB adviser for support in understanding what they are eligible for, where they can access care and what charges they might incur.

Such a system has a number of advantages. It would provide the NHS with a network of clinics that stand outside either overstretched, non-expert GP services or A&E departments, which are struggling with non-emergency demand. Patients would have a place to go in order to seek help, which was not enmeshed in the new charging framework and therefore did not pose an existential risk to those concerned about their immigration status. And NHS administrators would have some of the pressure of developing a detailed understanding of eligibility and their responsibilities mitigated by the provision of expert advice from trained CAB staff.

The public health benefits are also abundantly clear. A major fear among experts is that the new charging framework will make migrants reluctant to access diagnostic services – even where they are eligible for free care – because of fears about cost. It is very human to avoid seeking advice and care for as long as possible because it is easier to do so than either to educate oneself or find resources to pay. But it is also a threat to our collective public health. These clinics would engage concerned and confused migrants without the attached fear of charging – and in doing so would provide a vital service in linking patients with HIV, TB and other communicable diseases into the free services we provide to reduce the overall threat.

These clinics should be managed in partnership with NGOs in order to reinforce their independence from the wider charging framework of the NHS relating to advice and

management. We suggest they should be funded via co-operation from the bodies and public services that would most benefit from the long-term savings they would bring – a combination of Public Health England, local health and wellbeing boards, and the NHS more centrally. Organisations like Doctors of the World have an important potential role to play in ensuring that as the NHS seeks to defend itself against misuse it does not incur the human and financial costs of accidentally limiting access to treatment.

Impose blanket exemptions for children

As outlined above, there are particular ethical concerns about children and young people incurring costs for healthcare. They are not morally responsible for their presence in the UK and it is unethical to punish them for their migrant status. Furthermore, it is a false saving. Many of the public health risks that are outlined above could be partially answered by being clear – and transparent – about children always being eligible for free treatment. This would answer the moral challenge of our obligation to offer children the care they need while also providing us with valuable diagnostic data – making up, in part, for some of the blind spots that are at risk of being created.

Establish a principle of one-way information sharing

The new charging structure relies on linking Home Office and NHS data through new IT infrastructure. As is noted throughout this report, there is a huge amount of scepticism about the Government's capacity to deliver such a system – scepticism grounded in past experience. But there are wider concerns about the Government's intentions than issues of practicability. First are the ethical concerns of creating a system that allows information garnered from consultation with a GP or other medical practitioner to be passed to those tasked with enforcement.

Whatever one believes about immigration and this country's efforts to exert control over our borders, it is important to comprehend the centrality of confidentiality to the doctor–patient relationship. In order to achieve proper diagnosis and treatment, a physician must be able to establish trust with their patient. That is made considerably more difficult if there is an acknowledged chance that information gleaned during consultation might be used to remove an individual from the UK. Doctors are already viewed with mistrust by some migrants – asylum seekers were singled out by our expert consultations as a group prone to particular concerns – and this can interfere with the provision of healthcare even when the patient is eligible.

Having said that, it is of course right and necessary that the Government be able to share Department for Work and Pensions and Home Office information with NHS administrators in order that any workable charging mechanism be established. Without such information, ascertaining where charging is and is not appropriate will be nearly impossible.

With this in mind, we urge the Government to establish a principle of one-way information sharing at the heart of its new infrastructure: that any and all information the Home Office holds on the status of migrants may be shared with the relevant NHS entity but no information held by the NHS (up to and including the request for information itself) can be seen by the Home Office. This may seem unfair to the hard-working civil servants tasked with ensuring that border enforcement improves. But the wider impact on public health that is a potential consequence of allowing further information sharing is potentially devastating. Furthermore, it is easy to see how allowing the Home Office access to migrant health records could establish a precedent for such information sharing that could reach well beyond non-British nationals. Enshrining the principle of one-way information sharing – and in law – would go a long way to assuaging such fears.

Educate the administrators

Time and time again in our expert consultations, the problem of uncertainty and risk-aversion among NHS administrative staff was raised. In the context of a confusing and complex system of eligibility – which incorporates the characteristics of both the individual and their condition – NHS staff often have to make assumptions about government policy in their work. This is unacceptable. It leads to individuals being wrongly refused registration, being turned away and/or threatened with charging unnecessarily. It creates a toxic mistrust.

Government has a duty to ensure that frontline NHS staff do not inadvertently hinder the treatment of migrants through misunderstanding. But the rules are by necessity complex and NHS staff are already overstretched and required to develop detailed understanding of a myriad of rules, regulations and requirements. We call on the Government to implement a campaign to educate administrative staff in particular, based on the principle 'let's see what you *are* entitled to'. It is important to recognise that even as NHS staff are expected to take more of a role in preventing misuse and abuse, their primary objective should remain to meet healthcare needs. Engraining an approach based on a positive engagement with what migrant patients are entitled to – particularly given the under-use of the NHS by many eligible migrants – is important to promote a culture of trust and mitigate public health risks. NHS staff should be asked to work from the premise that they are there to help any patient access the healthcare they need – and that while a migrant patient may complicate that overriding mission, it never negates it.

Introduce rolling impact assessment

The Department for Health has undertaken an impact assessment laying out its understanding of the likely outcomes of implementation, but no commitment has been made to ongoing, continual assessment of the effect of these reforms. In our view that is a mistake.

Government has repeatedly made it clear that it does not intend to restrict access to healthcare – rather, it wishes to ensure that those who are eligible for charging pay for the healthcare they receive. Therefore, it is surely important that the Government maintains up-to-date data on whether or not its objective is being met without the detrimental outcomes that it argues it is keen to avoid? If it were the case, for example, that implementation led to a measurable decline in the diagnosis of communicable diseases it would be vital that the Department for Health be able to respond swiftly to a potentially hugely damaging adverse impact. For this reason, we urge the Government to commit to undertaking follow-up, rolling impact assessment of this policy. In particular, it should commit itself to transparently assessing – and then publishing – the impact of stages 1–3 before implementing phase 4, and further primary and A&E care charging. The Government should ensure that central to these evaluations is a commitment to understanding the impact on frontline medical staff to understand if the fundamentals of the Hippocratic oath remain intact as these policies become embedded.

This would have the advantage of allowing the Department for Health and other key stakeholders to react to the ongoing effects of the reforms and – through measurement of real-world responses to the changes – to adjust policy and behaviour accordingly. Furthermore, it would equip the Government with the data from which to make the case for further changes should they be necessary. The lack of data behind the existing reforms has led to severe criticism and concern. Government can mitigate the likelihood of such concern in the future by engaging in the systematic recording and publishing of relevant data now.

Doing it safely

Britain can be a healthy, safe and welcoming country while also ensuring that our NHS is not vulnerable to fraud or misuse – we can work to ensure fairness without punishing the vulnerable or exposing Britain to public health risks.

It is government's right – indeed, its obligation – to try to identify and prevent misuse and abuse of our public services. In particular, we have a responsibility to make sure that the public have every confidence that the distribution of resources is fair and that no one is 'taking Britain for a ride'. But great care is required to ensure that we do not inadvertently put the efficiency of the NHS at risk, reduce the robustness of this country's public health or outrage common decency. The proposals set out above are a modest response to the wealth of evidence that – if handled badly – the Government's reforms may unintentionally have perverse and tragic consequences. We make them after extensive engagement with the existing evidence and after detailed consultation with experts and practitioners – in order to help the Government to meet its stated objectives safely and fairly. British taxpayers deserve a robust healthcare system that defends them from sickness, which can be achieved in a way that is humane and efficient if the effort is made to take appropriate care as we set out on a journey of reform.

Notes

1 Department of Health, *Sustaining Services, Ensuring Fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England*, 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268630/Sustaining_services___ensuring_fairness_-_Government_response_to_consultation.pdf (accessed 7 Oct 2014).

2 Department of Health, *2012 Review of Overseas Visitors Charging Policy: Summary report*, 2012, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210439/Overseas_Visitors_Charging_Review_2012_-_Summary_document.pdf (accessed 7 Oct 2014).

3 Ibid.

4 Ibid. 'Ordinary residence' is a common law concept, not defined either in NHS acts or regulations.

5 Under additional rules, a person with an outstanding debt of more than £1,000 for NHS treatment is also denied new or extended entry to the UK.

6 For a full list see T Powell, 'NHS charges for overseas visitors', standard note SN/SP/3051, Oct 2013, www.parliament.uk/briefing-papers/SN03051.pdf%E2%80%8E (accessed 7 Oct 2014).

7 Ibid.

8 Department of Health, *2012 Review of Overseas Visitors Charging Policy*.

9 Ibid.

10 Ibid.

11 Ibid.

12 A collation from various reports is cited in Prederi, *Quantitative Assessment of Visitor and Migrant Use of the NHS in England: Exploring the data*, 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251909/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_FULL_REPORT.pdf (accessed 7 Oct 2014).

13 Ibid; for information on how these figures were reached see pp. 61–72.

14 Prederi, *Quantitative Assessment of Visitor and Migrant Use of the NHS in England*.

15 R Littlejohn, 'Happy families? No, another miscarriage of justice', *Daily Mail*, 4 Jul 2011, www.dailymail.co.uk/debate/article-2011231/Bimbo-Ayelabola-Happy-families-No-miscarriage-justice.html (accessed 8 Apr 2014).

16 Full Fact, 'Is "health tourism" costing the taxpayer £200 million?', Jul 2011, https://fullfact.org/factchecks/health_tourism_costs_nhs_reform-2805 (accessed 7 Oct 2014).

17 Hansard, Col 815W, 15 Nov 2011, www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111115/text/111115w0006.htm (accessed 7 Oct 2014).

18 Full Fact, 'Do foreign nationals owe the NHS £40 million?', 3 May 2012, https://fullfact.org/factchecks/nhs_out_of_pocket-27092 (accessed 7 Oct 2014).

19 Ibid.

20 Ibid.

21 Ibid.

22 J Chapman, 'The true cost of health tourism: foreigners using NHS cost Britain up to £2 billion a year, government report reveals… up to 100 times more than thought', *Daily Mail*, 22 Oct 2013, www.dailymail.co.uk/news/article-2470994/TRUE-cost-health-tourism-Foreigners-cost-NHS-2BN-year.html via https://fullfact.org/factchecks/cost_of_health_tourism_nhs-29247 (accessed 7 Oct 2014).

23 Full Fact, 'Unwell and over here: what's the "true" cost of health tourism?', 22 Oct 2013, https://fullfact.org/factchecks/cost_of_health_tourism_nhs-29247 (accessed 7 Oct 2014). Broken down, Full Fact asserted that the report actually showed that £1.43 billion is spent on temporary residents, which includes 'migrants who don't have permanent residency and UK expats', and £330 million is spent on treating irregular migrants, including failed asylum seekers and illegal immigrants. Furthermore, Full Fact stressed that the £2 billion figure again includes monies which the NHS is able to recoup, including £94 million from UK expats, £260 million from citizens of the EEA, and an undisclosed amount from states with reciprocal agreements in place which mean that the NHS provides free treatment for their citizens

24 Full Fact, 'Health tourism – what's the bill?', 28 Oct 2013, https://fullfact.org/health/health_tourism_factsheet_cost-29253 (accessed 7 Oct 2014); Prederi, *Quantitative Assessment of Visitor and Migrant Use of the NHS in England*.

25 Prederi, *Quantitative Assessment of Visitor and Migrant Use of the NHS in England*.

26 Ibid, p 10.

27 Prederi, *Quantitative Assessment of Visitor and Migrant Use of the NHS in England*.

28 Ibid.

29 Ibid.

30 Doctors of the World, 'The truth about "health tourism"', 12 Jul 2013, http://doctorsoftheworld.org.uk/blog/entry/the-truth-about-health-tourism (accessed 7 Oct 2014).

31 Department of Health, *Sustaining Services, Ensuring Fairness*; Department of Health, *2012 Review of Overseas Visitors Charging Policy*.

32 Department of Health, *Sustaining Services, Ensuring Fairness*; Department of Health

33 Doctors of the World, 'The truth about "health tourism"'.

34 Ibid.

35 T Powell, 'NHS charges for overseas visitors'.

36 Ibid.

37 Department of Health, *Sustaining Services, Ensuring Fairness*.

38 MRN, 'Migrant access to health services consultation', Migrants' Rights Network, Jul 2013, www.migrantsrights.org.uk/files/publications/MRN-Healthcare_briefing_July-2013.pdf (accessed 7 Oct 2014).

39 Ibid.

40 Doctors of the World, 'The truth about "health tourism"', 12 Jul 2013.

41 Department of Health, *Sustaining Services, Ensuring Fairness*; BMA, 'BMA response to primary care health tourism consultation', press release, British Medical Association, 14 May 2004, http://web.bma.org.uk/pressrel.nsf/wall/364010FDEBE2B5C880256E9400341125?OpenDocument (accessed 16 Oct 2014).

42 ILPA, *ILPA Response to the Department of Health Consultation: Sustaining Services, Ensuring Fairness: A consultation on migrant access and their financial contribution to NHS provision in England, July 2013*, Immigration Law Practitioners' Association, 2013, http://webcache.googleusercontent.com/search?q=cache:MoGtpSy6-KEJ:www.ilpa.org.uk/data/resources/20831/13.08.28-ILPA-to-DOH-re-charging.pdf+&cd=2&hl=en&ct=clnk&gl=uk (accessed 7 Oct 2014).

43 R Syal, 'Abandoned NHS IT system has cost £10bn so far', *Guardian*, 18 Sep 2013, www.theguardian.com/society/2013/sep/18/nhs-records-system-10bn (accessed 7 Oct 2014).

44 ILPA, *ILPA Response to the Department of Health Consultation*.

45 V Winckler, 'Wales' unclaimed benefit billions', blog, Bevan Foundation, 5 Mar 2012, www.bevanfoundation.org/blog/wales-unclaimed-benefit-billions/ (accessed 16 Oct 2014).

46 Doctors of the World, 'The truth about "health tourism"'.

47 BMA, 'BMA response to primary care health tourism consultation'.

48 J Conly, 'Antimicrobial resistance: revisiting the "tragedy of the commons"', *Bulletin of the World Health Organization* 88, no 11, Nov 2010, pp 797–876, www.who.int/bulletin/volumes/88/11/10-031110/en/ (accessed 16 Oct 2014).

49 F Walsh, 'Antibiotic resistance: Cameron warns of medical "dark ages"', BBC News Health, 2 Jul 2014, www.bbc.co.uk/news/health-28098838 (accessed 7 Oct 2014).

50 WHO, 'Tuberculosis', World Health Organization, nd, www.who.int/trade/glossary/story092/en/ (accessed 7 Oct 2014).

51 Academy of Medical Royal Colleges, '"Sustaining services, ensuring fairness" supplementary comments', nd, www.aomrc.org.uk/doc_view/9721-sustaining-services-ensuring-fairness-supplementary-comments (accessed 7 Oct 2014).

52 Joint Committee on Human Rights, *The Treatment of Asylum Seekers*, Tenth Report of Session 2006–07, HL Paper 81–1, HC 60–1, 2007, www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf (accessed 8 Oct 2014).

53 Taken from All-Party Parliamentary Group on Migration, 'Doctors of the World UK: the importance of equitable access to healthcare for people in England', 9 Jul 2013, www.appgmigration.org.uk/sites/default/files/Doctors%20of%20the%20World%20-%20access%20policy%20briefing%2009072013.pdf (accessed 7 Oct 2014).

54 BMA, 'BMA response to primary care health tourism consultation'.

55 Ibid.

56 BMA, 'BMA response to primary care health tourism consultation'.

57 Liberty, 'Liberty's response to the government's consultations on access to healthcare and data sharing in the NHS', Aug 2013, https://www.liberty-human-rights.org.uk/sites/default/files/Liberty's-response-to-the-Home-Office-and-Department-of-Health-Consultations-on-access-to-NHS-services-August-2013.pdf (accessed 16 Oct 2014).

58 Department of Health, *Sustaining Services, Ensuring Fairness*.

59 Liberty, 'Liberty's response to the government's consultations on access to healthcare and data sharing in the NHS'.

60 J Ball, 'Home Office accessing NHS records to help track down illegal immigrants', *Guardian*, 13 Jul 2014, www.theguardian.com/uk-news/2014/jul/13/home-office-nhs-records-illegal-immigrants (accessed 7 Oct 2014).

61 AHPN, 'Submission to: Sustaining services, ensuring fairness – a consultation on migrant access and their financial contribution to NHS provision in England', African Health Policy Network, nd, www.ahpn.org/Upload/page/145_AHPN_submission_to_consultation____Sustaining_services___ensuring_fairness_46.pdf (accessed 16 Oct 2014).

62 Ibid.

References

Academy of Medical Royal Colleges, '"Sustaining services, ensuring fairness" supplementary comments', nd, www.aomrc.org.uk/doc_view/9721-sustaining-services-ensuring-fairness-supplementary-comments (accessed 7 Oct 2014).

AHPN, 'Submission to: Sustaining services, ensuring fairness – a consultation on migrant access and their financial contribution to NHS provision in England', African Health Policy Network, nd, www.ahpn.org/Upload/page/145_AHPN_submission_to_consultation____Sustaining_services___ensuring_fairness_46.pdf (accessed 16 Oct 2014).

All-Party Parliamentary Group on Migration, 'Doctors of the World UK: the importance of equitable access to healthcare for people in England', 9 Jul 2013, www.appgmigration.org.uk/sites/default/files/Doctors%20of%20the%20World%20-%20access%20policy%20briefing%2009072013.pdf (accessed 7 Oct 2014).

Ball J, 'Home Office accessing NHS records to help track down illegal immigrants', *Guardian*, 13 Jul 2014, www.theguardian.com/uk-news/2014/jul/13/home-office-nhs-records-illegal-immigrants (accessed 7 Oct 2014).

BMA, 'BMA response to primary care health tourism consultation', press release, British Medical Association, 14 May 2004, http://web.bma.org.uk/pressrel.nsf/wall/364010FDEBE2B5C880256E9400341125?OpenDocument (accessed 16 Oct 2014).

Chapman J, 'The true cost of health tourism: foreigners using NHS cost Britain up to £2 billion a year, government report reveals… up to 100 times more than thought', *Daily Mail*, 22 Oct 2013, www.dailymail.co.uk/news/article-2470994/TRUE-cost-health-tourism-Foreigners-cost-NHS-2BN-year.html via https://fullfact.org/factchecks/cost_of_health_tourism_nhs-29247 (accessed 7 Oct 2014).

Conly J, 'Antimicrobial resistance: revisiting the "tragedy of the commons"', *Bulletin of the World Health Organization* 88, no 11, Nov 2010, pp 797–876, www.who.int/bulletin/volumes/88/11/10-031110/en/ (accessed 16 Oct 2014).

Department of Health, *2012 Review of Overseas Visitors Charging Policy: Summary report*, 2012, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210439/Overseas_Visitors_Charging_Review_2012_-_Summary_document.pdf (accessed 7 Oct 2014).

Department of Health, *Sustaining Services, Ensuring Fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England*, 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268630/Sustaining_services___ensuring_fairness_-_Government_response_to_consultation.pdf (accessed 7 Oct 2014).

Doctors of the World, 'The truth about "health tourism"', 12 Jul 2013, http://doctorsoftheworld.org.uk/blog/entry/the-truth-about-health-tourism (accessed 7 Oct 2014).

Full Fact, 'Do foreign nationals owe the NHS £40 million?', 3 May 2012, https://fullfact.org/factchecks/nhs_out_of_pocket-27092 (accessed 7 Oct 2014).

Full Fact, 'Health tourism – what's the bill?', 28 Oct 2013, https://fullfact.org/health/health_tourism_factsheet_cost-29253 (accessed 7 Oct 2014).

Full Fact, 'Is "health tourism" costing the taxpayer £200 million?', Jul 2011, https://fullfact.org/factchecks/health_tourism_costs_nhs_reform-2805 (accessed 7 Oct 2014).

Full Fact, 'Unwell and over here: what's the "true" cost of health tourism?', 22 Oct 2013, https://fullfact.org/factchecks/cost_of_health_tourism_nhs-29247 (accessed 7 Oct 2014).

Hansard, Col 815W, 15 Nov 2011, www.publications.parliament.uk/pa/cm201011/cmhansrd/cm111115/text/111115w0006.htm (accessed 7 Oct 2014).

ILPA, *ILPA Response to the Department of Health Consultation: Sustaining Services, Ensuring Fairness: A consultation on migrant access and their financial contribution to NHS provision in England, July 2013*, Immigration Law Practitioners' Association, 2013, http://webcache.googleusercontent.com/search?q=cache:MoGtpSy6-KEJ:www.ilpa.org.uk/data/resources/20831/13.08.28-ILPA-to-DOH-re-chargingpdf+&cd=2&hl=en&ct=clnk&gl=uk (accessed 7 Oct 2014).

Joint Committee on Human Rights, *The Treatment of Asylum Seekers*, Tenth Report of Session 2006–07, HL Paper 81–1, HC 60–1, 2007, www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf (accessed 8 Oct 2014).

Liberty, 'Liberty's response to the government's consultations on access to healthcare and data sharing in the NHS', Aug 2013, https://www.liberty-human-rights.org.uk/sites/default/files/Liberty's-response-to-the-Home-Office-and-Department-of-Health-Consultations-on-access-to-NHS-services-August-2013.pdf (accessed 16 Oct 2014).

Littlejohn R, 'Happy families? No, another miscarriage of justice', *Daily Mail*, 4 Jul 2011, www.dailymail.co.uk/debate/article-2011231/Bimbo-Ayelabola-Happy-families-No-miscarriage-justice.html (accessed 8 Apr 2014).

MRN, 'Migrant access to health services consultation', Migrants' Rights Network, Jul 2013, www.migrantsrights.org.uk/files/publications/MRN-Healthcare_briefing_July-2013.pdf (accessed 7 Oct 2014)

Powell T, 'NHS charges for overseas visitors', standard note SN/SP/3051, Oct 2013, www.parliament.uk/briefing-papers/SN03051.pdf%E2%80%8E (accessed 7 Oct 2014).

Prederi, *Quantitative Assessment of Visitor and Migrant Use of the NHS in England: Exploring the data*, 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251909/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_FULL_REPORT.pdf (accessed 7 Oct 2014).

Syal R, 'Abandoned NHS IT system has cost £10bn so far', *Guardian*, 18 Sep 2013, www.theguardian.com/society/2013/sep/18/nhs-records-system-10bn (accessed 7 Oct 2014).

Walsh F, 'Antibiotic resistance: Cameron warns of medical "dark ages"', BBC News Health, 2 Jul 2014, www.bbc.co.uk/news/health-28098838 (accessed 7 Oct 2014).

WHO, 'Tuberculosis', World Health Organization, nd, www.who.int/trade/glossary/story092/en/ (accessed 7 Oct 2014).

Winckler V, 'Wales' unclaimed benefit billions', blog, Bevan Foundation, 5 Mar 2012, www.bevanfoundation.org/blog/wales-unclaimed-benefit-billions/ (accessed 16 Oct 2014).

Demos — Licence to Publish

The work (as defined below) is provided under the terms of this licence ('licence'). The work is protected by copyright and/or other applicable law. Any use of the work other than as authorized under this licence is prohibited. By exercising any rights to the work provided here, you accept and agree to be bound by the terms of this licence. Demos grants you the rights contained here in consideration of your acceptance of such terms and conditions.

1 Definitions

A **'Collective Work'** means a work, such as a periodical issue, anthology or encyclopedia, in which the Work in its entirety in unmodified form, along with a number of other contributions, constituting separate and independent works in themselves, are assembled into a collective whole. A work that constitutes a Collective Work will not be considered a Derivative Work (as defined below) for the purposes of this Licence.

B **'Derivative Work'** means a work based upon the Work or upon the Work and other pre-existing works, such as a musical arrangement, dramatization, fictionalization, motion picture version, sound recording, art reproduction, abridgment, condensation, or any other form in which the Work may be recast, transformed, or adapted, except that a work that constitutes a Collective Work or a translation from English into another language will not be considered a Derivative Work for the purpose of this Licence.

C **'Licensor'** means the individual or entity that offers the Work under the terms of this Licence.

D **'Original Author'** means the individual or entity who created the Work.

E **'Work'** means the copyrightable work of authorship offered under the terms of this Licence.

F **'You'** means an individual or entity exercising rights under this Licence who has not previously violated the terms of this Licence with respect to the Work,or who has received express permission from Demos to exercise rights under this Licence despite a previous violation.

2 Fair Use Rights

Nothing in this licence is intended to reduce, limit, or restrict any rights arising from fair use, first sale or other limitations on the exclusive rights of the copyright owner under copyright law or other applicable laws.

3 Licence Grant

Subject to the terms and conditions of this Licence, Licensor hereby grants You a worldwide, royalty-free, non-exclusive,perpetual (for the duration of the applicable copyright) licence to exercise the rights in the Work as stated below:

A to reproduce the Work, to incorporate the Work into one or more Collective Works, and to reproduce the Work as incorporated in the Collective Works;

B to distribute copies or phonorecords of, display publicly,perform publicly, and perform publicly by means of a digital audio transmission the Work including as incorporated in Collective Works; The above rights may be exercised in all media and formats whether now known or hereafter devised.The above rights include the right to make such modifications as are technically necessary to exercise the rights in other media and formats. All rights not expressly granted by Licensor are hereby reserved.

4 Restrictions

The licence granted in Section 3 above is expressly made subject to and limited by the following restrictions:

A You may distribute,publicly display, publicly perform, or publicly digitally perform the Work only under the terms of this Licence, and You must include a copy of, or the Uniform Resource Identifier for, this Licence with every copy or phonorecord of the Work You distribute, publicly display,publicly perform, or publicly digitally perform.You may not offer or impose any terms on the Work that alter or restrict the terms of this Licence or the recipients' exercise of the rights granted hereunder.You may not sublicence the Work.You must keep intact all notices that refer to this Licence and to the disclaimer of warranties. You may not distribute, publicly display, publicly perform, or publicly digitally perform the Work with any technological measures that control access or use of the Work in a manner inconsistent with the terms of this Licence Agreement.The above applies to the Work as incorporated in a Collective Work, but this does not require the Collective Work apart from the Work itself to be made subject to the terms of this Licence. If You create a Collective Work, upon notice from any Licencor You must, to the extent practicable, remove from the Collective Work any reference to such Licensor or the Original Author, as requested.

B You may not exercise any of the rights granted to You in Section 3 above in any manner that is primarily intended for or directed toward commercial advantage or private monetary compensation.The exchange of the Work for other copyrighted works by means of digital filesharing or otherwise shall not be considered to be intended for or directed toward commercial advantage or private monetary compensation, provided there is no payment of any monetary compensation in connection with the exchange of copyrighted works.

C If you distribute, publicly display, publicly perform, or publicly digitally perform the Work or any Collective Works,You must keep intact all copyright notices for the Work and give the Original Author credit reasonable to the medium or means You are utilizing by conveying the name (or pseudonym if applicable) of the Original Author if supplied; the title of the Work if supplied. Such credit may be implemented in any reasonable manner; provided, however, that in the case of a Collective Work, at a minimum such credit will appear where any other comparable authorship credit appears and in a manner at least as prominent as such other comparable authorship credit.

5 Representations, Warranties and Disclaimer

A By offering the Work for public release under this Licence, Licensor represents and warrants that, to the best of Licensor's knowledge after reasonable inquiry:

i Licensor has secured all rights in the Work necessary to grant the licence rights hereunder and to permit the lawful exercise of the rights granted hereunder without You having any obligation to pay any royalties, compulsory licence fees, residuals or any other payments;

ii The Work does not infringe the copyright, trademark, publicity rights, common law rights or any other right of any third party or constitute defamation, invasion of privacy or other tortious injury to any third party.

B except as expressly stated in this licence or otherwise agreed in writing or required by applicable law,the work is licenced on an 'as is'basis,without warranties of any kind, either express or implied including,without limitation,any warranties regarding the contents or accuracy of the work.

6 Limitation on Liability

Except to the extent required by applicable law, and except for damages arising from liability to a third party resulting from breach of the warranties in section 5, in no event will licensor be liable to you on any legal theory for any special, incidental,consequential, punitive or exemplary damages arising out of this licence or the use of the work, even if licensor has been advised of the possibility of such damages.

7 Termination

A This Licence and the rights granted hereunder will terminate automatically upon any breach by You of the terms of this Licence. Individuals or entities who have received Collective Works from You under this Licence,however, will not have their licences terminated provided such individuals or entities remain in full compliance with those licences. Sections 1, 2, 5, 6, 7, and 8 will survive any termination of this Licence.

B Subject to the above terms and conditions, the licence granted here is perpetual (for the duration of the applicable copyright in the Work). Notwithstanding the above, Licensor reserves the right to release the Work under different licence terms or to stop distributing the Work at any time; provided, however that any such election will not serve to withdraw this Licence (or any other licence that has been, or is required to be, granted under the terms of this Licence), and this Licence will continue in full force and effect unless terminated as stated above.

8 Miscellaneous

A Each time You distribute or publicly digitally perform the Work or a Collective Work, Demos offers to the recipient a licence to the Work on the same terms and conditions as the licence granted to You under this Licence.

B If any provision of this Licence is invalid or unenforceable under applicable law, it shall not affect the validity or enforceability of the remainder of the terms of this Licence, and without further action by the parties to this agreement, such provision shall be reformed to the minimum extent necessary to make such provision valid and enforceable.

C No term or provision of this Licence shall be deemed waived and no breach consented to unless such waiver or consent shall be in writing and signed by the party to be charged with such waiver or consent.

D This Licence constitutes the entire agreement between the parties with respect to the Work licensed here.There are no understandings, agreements or representations with respect to the Work not specified here. Licensor shall not be bound by any additional provisions that may appear in any communication from You.This Licence may not be modified without the mutual written agreement of Demos and You.

This project was supported by:

DOCTORS OF THE WORLD

BARROW CADBURY TRUST

Protecting the NHS from fraud, abuse and misuse is rightly a priority for any government. Only by demonstrating that shared resources are guarded jealously and allocated fairly can we promote public trust and confidence. But as well as being mindful of public sentiment, public policy must be driven by evidence and we should never be afraid to make the case for what is right and what is realistic. This report highlights in particular the dangers to public health of creating new barriers which put migrants off accessing frontline healthcare in a globalised, interconnected world. As the Ebola crisis and the ongoing growth in TB and antibiotic disease have shown, ensuring early diagnosis can be key.

Do No Harm makes the case for changes to the implementation of the government's policies to restrict 'healthcare tourism'. This is built on extensive engagement with experts and practitioners in the worlds of healthcare, migrant support and human rights law. While it is right that government protects the NHS from fraud, it would be wrong to do so at the expense of our moral obligations, public safety and indeed the efficiency of the NHS in these cash-strapped times.

This report argues for new triage clinics to offer diagnostics to those worried about their immigration status; for a rolling impact assessment to test the impact on doctors and patients alike; for exemptions to charging for all children and pregnant women and for more safeguards about the way in which information will be shared between government departments. All of these measures are designed to help the government achieve their objectives while ensuring that new policies do no harm.

Max Wind-Cowie is a Demos Associate.
Claudia Wood is Chief Executive of Demos.

ISBN 978-1-909037-70-0 £10