Healthwatch Report - Access to healthcare for vulnerable migrants

Healthwatch commissioned Refugee and Migrant Forum Essex & London (RAMFEL) to look into issues around access to healthcare for vulnerable migrants. In particular we were asked to look at - Ensuring people have access to the right health and care services they need to stay well.

RAMFEL works with a range of vulnerable migrants that have different entitlements to healthcare along with varying needs. For example an undocumented migrant would not automatically have entitlement to secondary care, but they may in fact be an undocumented migrant who is an asylum seeker or victim of trafficking after which they would have entitlement to secondary care. The rules are complicated for us to understand at RAMFEL as professionals in this field, so for healthcare professionals, vulnerable migrants themselves and those administering access it can be very confusing.

Methodology

9 individuals gave in depth interviews regarding their experience of accessing healthcare and 11 people (separate to the in-depth interviews) completed questionnaires as part of this small research project. We have added anonymous case studies based on individuals we have worked with. We also spoke to staff of RAMFEL and other organisations in Redbridge regarding their experience of supporting clients who had difficulty accessing healthcare.

What is the law around access to healthcare?

A useful guide can be found via Doctors of the World
https://www.doctorsoftheworld.org.uk/Handlers/Download.ashx?IDMF=2841d219-9ff0-40cf-9cf6-9eefd32d042c

A summary of this information is below;

Primary care is free for everyone!

Everyone in England is entitled to free primary care regardless of nationality or immigration status.
Therefore, asylum seekers, refugees, people on work visas and overseas visitors, whether lawfully in the UK or not, can all register with a GP practice and see a GP without charge.

Secondary care is where it gets complicated…

Secondary care should only be refused if it is not deemed immediately necessary otherwise the treatment should go ahead and payment should be sought later on. However as has been prevalent in the news recently at the start of the windrush scandal, treatment for cancer can be denied even though the patient’s condition is likely to deteriorate without treatment. If a migrant has to pay for their treatment then NHS guidelines on chasing that debt are;

Pursuing overseas debt - Relevant bodies are recommended to consider employing the services of a 13.71.debt recovery agency that specialises in the recovery of overseas debt, except in relation to persons whom it is clear to the relevant body will be unable to pay (e.g. destitute illegal migrants for whom such action may not be appropriate or cost-effective).
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/697626/guidance_on_implementing_the_overseas_visitor_charging_regulations_april_2018.pdf

The following categories of people are exempt from all NHS charges;

- *Non-EEA nationals who have paid the health surcharge as part of their visa application to enter or remain in the UK (this includes people who have No Recourse to Public Funds added to their leave to remain conditions as they have paid or received a fee waiver for the health surcharge).*
- *Refugees (those granted asylum, humanitarian protection or temporary protection under the immigration rules) and their dependents;*
- *Asylum seekers (those applying for asylum, humanitarian protection or temporary protection whose claims, including appeals, have not yet been determined), and their dependents;*
- *Individuals receiving section 95 support and refused asylum seekers, and their dependents, receiving section 4 support or local authority support under Part 1 of the Care Act 2014;*
- *Children who are looked after by a local authority;*
- *Victims, and suspected victims, of modern slavery;*
- *Those receiving treatment under the Mental Health Act;*
- *Prisoners and those held in immigration detention and;*
- *Refused asylum seekers in Scotland and Wales.*

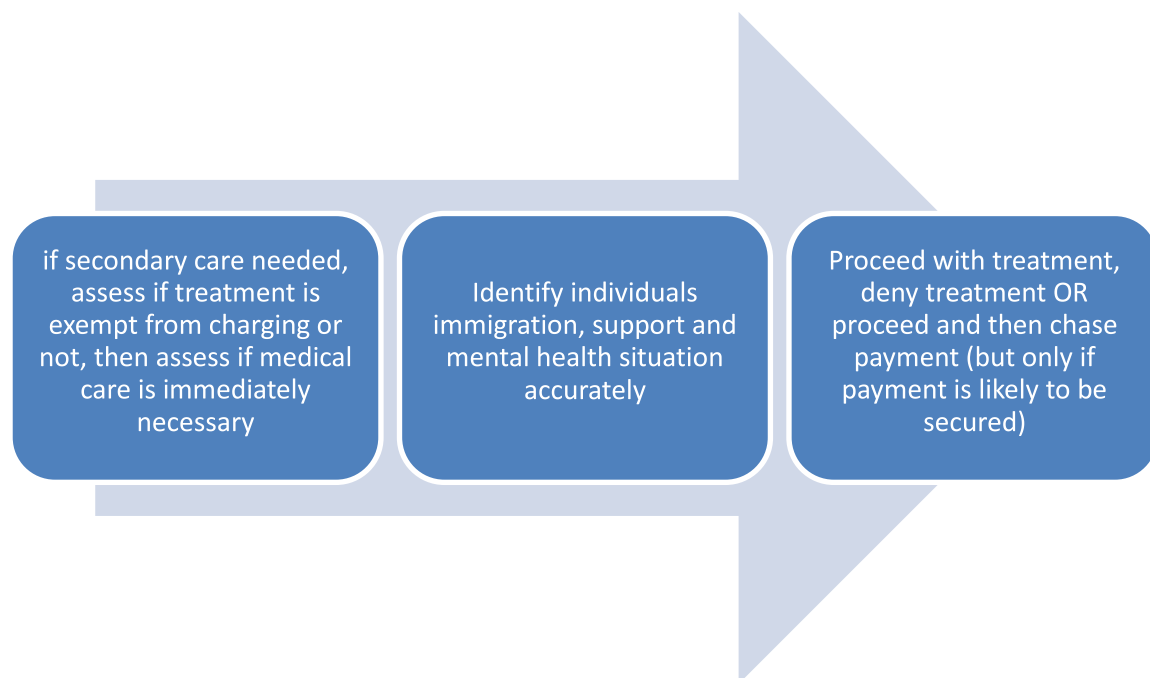
Victims of torture, female genital mutilation, domestic violence, sexual violence will not be charged for treatment needed as a result of their experience of violence (including mental health treatment).

Secondary treatment can be given if it falls into categories of care that are exempt from NHS charges;

- *accident & emergency services, including all A&E services provided at an NHS hospital, e.g. those provided at an A&E department, walk-in centre, minor injuries unit or urgent care centre. This does not include those emergency services provided after being admitted as an inpatient, or at a follow-up outpatient appointment, for which charges must be levied unless the overseas visitor is exempt from charge in their own right;*

- *services provided for the diagnosis and treatment of a number of communicable diseases, including HIV, TB and [Middle East Respiratory Syndrome (MERS)] (see [regulations] for exact list)*
- *services provided for the diagnosis and treatment of sexually transmitted infections*
- *family planning services (does not include the termination of pregnancy or infertility treatment)*
- *services for the treatment of a physical or mental condition caused by: torture, female genital mutilation, domestic violence, or sexual violence*
- *palliative care services provided by a registered palliative care charity or a community interest company*
- *services that are provided as part of the NHS111 telephone advice line*

Therefore in order to not be entitled to secondary care treatment you have to be without status and not fit into any of the categories above. Migrants who fall into the categories above are advised to let the NHS know that they fit into those categories, but it would be very difficult for a vulnerable migrant to acquire that knowledge and to accurately interpret the various laws required to fully understand their position. It will also be equally complex for NHS staff. As highlighted above in many cases it will then be inappropriate or not cost effective for the NHS to chase the debt based on their own guidance. A summary of the overall process is below and outlines the complex assessment that the NHS must complete for ***everyone*** who accesses its service, this is clearly not practical and has led to accusations of racial profiling.



Findings

1. **Vulnerable migrants deterred from accessing medical services**

   Vulnerable migrants especially those with insecure immigration status are being put off accessing medical services even when they need them as they worried about the consequences. Clients tend to hear information from friends or the media, leading to information often being inaccurate;

   “I have recently heard that if you are an “overstayer” or with “no recourse to public funds” and need medical operation you have to pay the medical bill from the hospital, even for childbirth…previously I accessed healthcare, hospital and GP’s easily but now I am very worried”.

   Trying to understand entitlement to healthcare is becoming increasingly complex and is creating anxiety and mis-information with vulnerable migrants in Redbridge. No one in our research was able to accurately define their entitlement to NHS services. For example in the quote above, someone who has leave to remain in the UK with a No Recourse to Public Fund (NRPF) restriction, will have paid or received a fee waiver for an Immigration Health Surcharge which entitles them to access healthcare during their period of leave the same as a UK citizen. However as you can see from the quote above it may put people off accessing healthcare.

   Florence told us that she,

   “avoids using healthcare services which may incur a cost. Its hard to go to get treatment when you have no status because you have no money. It’s too scary to imagine what would happen if I needed to access healthcare for a serious condition, but not be able to afford to pay for it. The hospital was really really good and the mid-wives were excellent”.

   None of the people we interviewed understood the difference between primary and secondary health care, no one was able to explain exactly their entitlement to healthcare and at least 3 clients felt they weren’t entitled to support that they in fact were, a common theme though was one of fear of being denied care, of being unable to pay for care or of receiving treatment leading to future immigration applications being denied.

2. **Poverty, destitution and low income**

   Those interviewed were a mix of asylum seekers, refugees and other vulnerable migrants with and without status, therefore the financial means of the clients varied. However in different ways financial issues did affect their ability to access healthcare.

   Transport

   "I have a budget of £5 for day to live on. It's difficult for me to pay for travel to and from hospital appointments"

   “If I don’t have money I walk to the GP even though its far away”.

38% of those interviewed mentioned issues with transport affected their ability to access healthcare however 43% of clients said they experienced financial difficulties.

3. **Lack of access to correct and understandable information**

Many of the clients we interviewed spoke enough English to complete the interview or questionnaire, out of the 4 clients who needed an interpreter to complete the interview however 3 of them said that lack of interpreting and translation was an issue, the one client who did not find it an issue was because the medical staff spoke his language;

“Language is a major barrier for non-English speakers. I find it difficult to know where to go or find the location of the GP. Unable to access online services as I can't read English”.

"Accessing healthcare in Ilford is not good, a lot of problems, no interpreters"

“Everything was good [but], they don’t provide interpreters”

4. **Psychological effect of the “hostile environment”**

One mother who had recently given birth by caesarean felt hounded by the home office in the days after giving birth, the home office used discharge information to find her current address and performed an immigration raid which left her “physically shaking” afterwards. Struggling at the time with homelessness and her new born baby as a first time mum, the immediate intervention of the Home Office and the collusion with medical services certainly engendered a feeling of hostility at an already difficult time. The child in question is a British citizen, and the mum now has leave to remain.

Another mother we interviewed was diagnosed with cancer, shortly after which she was presented with a bill for treatment of the cancer and of the cost of giving birth 6 years ago, that she had up until that point been unaware she needed to pay for.

5. **Lack of advice and support**

Mohammed was unable to apply to renew his HC2 certificate through the asylum support related services who he informed us should process this for him and was unable to pay for medicine at that time. Other interviewees had similar experiences and there was no clear point at which the NHS would provide them with the necessary information, to ensure they understood their rights and entitlements. RAMFEL is also concerned that whilst asylum seekers have a right to access medical care as well as clients with leave to remain with NRPF attached, they may fall foul of unsophisticated attempts to screen people who may have to pay for medical treatment.

“Belinda is concerned about what will happen once the maternity card runs out this April because she has no status. She's concerned as she is destitute”.

All clients interviewed had been able to register with a GP, although this result may be slightly misleading in that all individuals interviewed were clients of RAMFEL.

Case Study #1

Mrs. A from Tanzania has been suffering from mental health issues for several years, at various points she has been sectioned under the mental health act, attempted suicide and has a long history of self-harm and addiction. Mrs. A has no status in the UK, this places limits on the services she can access unless she passes thresholds for care within the care act. Mrs. A is street homeless and is not taking her medicine as it makes her drowsy and she is worried about being attacked on the streets, or freezing on the streets whilst asleep in winter. Mrs. A is regularly attended to by emergency services, for self-harm and mental health issues. As she is unable to care for herself properly she is referred to the Redbridge Home Treatment Team. She is refused access to care because she has “no recourse to public funds” and is only self-harming in an attempt to access housing. After a lengthy legal battle Mrs. A wins temporary support, whilst in support Mrs. A again attempts suicide, disengages with support services and her support by the home treatment team is stopped again.

Restriction to services she should have received endangered her life and her limited access to certain services means that considerable effort is spent by emergency services whilst other services wait until her health deteriorates to level that they may be compelled to intervene. RAMFEL found it very difficult to provide legal services to Mrs. A because her health and street homelessness were unattended to, even though a viable claim could potentially be made.

Case Study #2

Mrs. B from Ghana lives in Redbridge and was worried about having an operation doctors informed her was necessary as she did not want it to lead to the rejection of her immigration claim due to having more than £500 outstanding debt to the NHS. Only after receiving legal advice from RAMFEL did she decide to go ahead with the operation

Case study #3

Mrs. C has recently received her status to remain in the UK as the sole carer of her son who is a British citizen. When she gave birth to her son a few months ago by caesarean, she gave details of where she was temporarily staying as she was homeless at that time, due to her giving birth by caesarean and other health complications she needed to be visited daily by a health visitor. She believes that the address on her discharge notice was shared with immigration, who visited her at that property to inform her that she should leave the country.

Case study #4

A member of staff at RAMFEL spoke of a client in a previous role they had supported. Mrs D had been in the country for several years, she suffered a stroke whilst out shopping and was rushed to hospital. When she was asked about her passport, she became worried and left the hospital for fear of being detained by immigration services. She was unable to receive treatment that would have lessened the effects of the stroke. Mrs. D was entitled to receive healthcare as she was a victim of trafficking, she didn't know yet what that meant and the hospital were unaware. An assessment of a client's eligibility for healthcare can be an extremely complex issue that requires in depth legal and medical knowledge to assess. The process is one that will leave those entitled without support at certain points and will come at considerable human and administrative cost.

The 'hostile environment' that the government wants to create for vulnerable migrants is one in which they are now increasing intimidated, bullied and scared by those they go to for help. In Redbridge as in case study A & B we can see the devastating and cruel effects this has on people's lives. We find that our clients tend to get most of their information about services through informal networks such as friends, community & religious institutions. Through such networks horrific stories such as those above will spread confusion and fear. There are limited services for vulnerable migrants to get accurate and practical information in the right language or format regarding healthcare, and even with information eligibility to healthcare is incredibly complex and may first require a full review of their legal status in the UK.

Conclusions

Vulnerable migrants are for a range of reasons finding it difficult to access the right health and care services they need to stay well. Most of them are finding their way to services eventually although this sample group are undoubtedly affected by the fact that they are linked in with a service that helps them to access healthcare. From the different difficulties that we have found

Recommendations

1. Redbridge should encourage all services that it manages to recognise vulnerable migrants with health care needs as human beings first and foremost, challenging where possible the governments 'hostile environment' and not take part in the bullying, intimidation or humiliation of certain vulnerable migrants
2. Redbridge should look at where denying treatment is creating additional costs as well as human suffering. For example the case of Mrs. A cost significantly more in emergency services and legal fees than necessary secondary care would have done. In the same way that support to those with TB or other infectious diseases is exempt from restricted access to healthcare, housing etc the council or CCG should undertake research to look at where restricting access costs more overall to the state or the borough.
3. Redbridge needs to provide an advice service through which vulnerable migrants can understand their rights and entitlements to healthcare and be actively supported to access them. For example, clients entitled to free prescriptions should be informed about the HC1 form/HC2 certificate.

   "I had to pay for prescriptions myself and often cutting back on food" quote from an interviewee eligible to apply for free prescriptions.
4. Training needs to be provided to gate keepers in relevant services as to the rights and entitlements to medical or social care of different groups of vulnerable migrants, to ensure there is not a repeat of the case of Mrs. A. Regular updated information regarding changes in law
5. GP surgeries and other NHS services need to be made aware of the obligation to provide interpreting services to clients who need it. More easily accessible interpreted information on-line or in the facilities would be beneficial.