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 THE CHURCH  
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ARCHBISHOPS'  
COUNCIL

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Chairman  
Mission and Public Affairs

**Controlling Immigration – Regulating Migrant Access to Health Services in the  
UK (Home Office Consultation Document)**

**Response by the Mission and Public Affairs Division of the  
Archbishops' Council of the Church of England**

The Mission and Public Affairs Division welcomes the opportunity to respond to this consultation paper, in the pages that follow.

**Philip Fletcher  
Chairman  
Mission and Public Affairs Council**

*The Mission & Public Affairs Council of the Church of England is the body responsible for overseeing research and comment on social and political issues on behalf of the Church. The Council comprises a representative group of bishops, clergy and lay people with interest and expertise in the relevant areas, and reports to the General Synod through the Archbishops' Council.*

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**1. Principles underlying our approach to the government proposals**

There are two broad principles governing the Council’s response to both of the current consultations.

**Firstly, we recognise that it is in the interest of the UK as a nation, and it is its right, to control movement across its borders.** For the great majority of nations, the changes involved in globalisation have included freer movement of people; as a relatively affluent island nation, the UK has better opportunities than many to police its borders. This is not a self-evident truth: it flows from the acceptance of the rights to sovereignty of nation-states, which in turn are sufficiently embedded in the biblical record and the Judaeo-Christian tradition to merit respect from Christians.

**Secondly, the UK as a nation has a degree of obligation to all those who are within its borders.** For example, if someone is a victim of crime, it is not conceivable that we should erect barriers to police involvement on the ground that this person is not a national or is subject to immigration control. Indeed even those here unlawfully are entitled to be protected from crime while they remain. Once again, this view is not self-evident and is not universally

accepted, but it arises from a view of society which evolved with striking clarity in the formation of the nation of Israel in the Hebrew scriptures – where some specific duties of equal treatment for ‘aliens’ are spelt out.

The importance of these two principles, which do not in themselves point to any specific policy conclusions, is that they make it important for the nation to resist two dystopian nightmares: on the one hand the fear of being ‘overrun’, ‘swamped’ by others, and on the other hand the nightmare of a society that is divided into an in-class and an out-class, a country within a country, where those within the scope of civic entitlement are divided from those who are excluded from it. That this latter constitutes a nightmare may be less self-evident than the ‘swamping’; but social exclusion institutionalised in law would in fact be a very different phenomenon from the aspects of de facto social exclusion already suffered by many in Britain. One concern reflected in this submission is that in moving away from the ‘swamping’ nightmare we may be in danger of moving too far towards the inherently dangerous and unstable ‘outclass’ scenario, where as well as a border round our nation we erect too many boundaries between the in and the out within our society. This is not to imply that those here for short periods of time or indeed unlawfully can expect the full range of rights and entitlements enjoyed by citizens and others with right to remain. But it does mean that the case for and impact of each new proposed boundary between the in and the out requires serious scrutiny..

## **2. ‘Health tourism’ and abuse of the NHS by non-contributors**

### ***Health tourism and the NHS ‘pull factor’***

The proposals in the consultation paper are premised on the view that health tourism, and abuse of the NHS by temporary as well as short-term migrants, are on a scale that poses a major problem. There are no official figures to support this view. It may be true, or it may be that some anecdotal evidence is being accorded much more significance than is merited. The government has commissioned an independent professional audit, ‘to provide a more comprehensive assessment of the extent of NHS use and abuse by non-residents’. This report will be published at the same time as the government’s response to the current consultation. It is unfortunate that it has not been possible for the fullest possible analysis of the facts to be available to those seeking to make informed responses to the consultation itself.

Accordingly, the emphasis on free healthcare as a significant ‘pull factor’ drawing significant numbers of people to the UK is not yet supported by objective evidence. However, we fully

accept that there have to be limits to free access to NHS services for those visiting the UK, and we are not opposed to a £200 healthcare levy on entry for short-term and temporary migrants – as long as there is a mechanism for exempting people under certain circumstances, for example where there is hardship and where clear and relevant family ties are involved.

### ***Charging for secondary health care***

Charges have been in place for many years for many forms of secondary healthcare. It is acknowledged, in the consultation paper and more widely in the NHS, that both the requesting and the making of payments under these charging arrangements have been patchy at best. Since these rules for charging for secondary interventions are well established, and do not affect the primary interface between all those living in the UK and the NHS, we are not opposed to the proposals to place these charges on a more systematic basis.

### ***The contributory principle***

One premise of the government's proposals is that, in general, access to health provision should be on a contributory basis: 'ensuring that entitlement to key public services is linked to contribution' is a stated priority in the consultation paper. The Home Secretary's foreword says 'The Government believes migrants should come to the UK for the right reason - to contribute to our society rather than simply taking from it.' It is reasonable for our country to welcome newcomers who are prepared for a fair balance of give and take. That is what is implied by the traditional criteria of 'settledness'. It is well known that many migrants are net contributors to the British economy. While the argument for public services as a *quid pro quo* can be sustained for some state provision, it is not obvious that primary healthcare comes under this heading.

## **3. Who is my neighbour?**

Since the beginning of the NHS, there has never been a system of gatekeeping for primary care on the basis of contributions made – to introduce this for migrants could be the thin end of an unfortunate wedge, affecting in due course others who are perceived as a net drain on the national NHS funding pot. It is a fundamental principle of the Christian ethic that we owe a duty of care to our neighbour, defined in the famous parable as just anyone whom we run across who has a clear and crying need. This parable of the good Samaritan is not, of course, directly analogous to the current dilemma, because in Jesus' story the person in need is an indigenous citizen, while the one who attends to his medical and other care needs is a foreigner.

Be this as it may, we believe that as a nation founded on Christian values, we owe some duty of care to everyone within our borders. It is in this sense that we understand Article 25 of the Universal Declaration of Human Rights: ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care ...’ We acknowledge that the obligations of states can legitimately be circumscribed by charging regimes and the setting of eligibility criteria (e.g. to forestall health tourism), but we still attach considerable force to the ‘everyone’ in the Declaration. The original purpose of the NHS, in the relevant Acts, was to be ‘a comprehensive health service designed to secure improvement in the physical and mental health of the people’. It may be argued that the intended meaning of ‘the people’ was ‘the citizenry’ – but Aneurin Bevan, Minister of Health at the time of the introduction of the NHS, robustly defended the view that ‘One of the consequences of the universality of the British Health Service is the free treatment of foreign visitors.’

The consultation paper emphasises that the UK is ‘extremely generous when compared with other countries’. In fact, we are informed that in France and Belgium, for example, migrants have free access to essential primary and secondary healthcare with medical providers getting reimbursed for treatment; while Portugal, undocumented migrants have full access to healthcare once they have stayed over 90 days.

It is true that accident and emergency services are exempted from charging in the proposals, but primary health care in the GP surgery is equally the front line of care for those with immediate medical needs. The proposals do allow for exemptions in the case of some groups of especially needy or vulnerable people<sup>1</sup>, but each of these will raise boundary issues, and universal access in the sense which we have described would be simpler. In practical terms, the average cost of each attendance at accident and emergency is much higher than at GP surgeries and the effect of the proposals may well be to place even more pressure on hard pressed A and E departments. So for reasons both of practicality and principle we question the proposed restriction on access to primary health care.

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<sup>1</sup> ‘3.10: As now, the new test would be subject to exemptions for certain categories of migrant, where they relate to our humanitarian obligations and responsibilities under international agreements, these include those who have been granted refugee status under the Immigration Rules, those seeking asylum, temporary protection or humanitarian protection under those same rules, failed asylum seekers receiving section 4 or section 95 support, children in Local Authority care, victims (and suspected victims) of human trafficking in the UK.’

#### **4. The border in every street?**

‘Permanent residence’ is introduced as a new criterion for access to services, consisting of citizens and those with Indefinite Leave to Remain(ILR). It replaces ‘ordinary residence’, which is based on a definition of ‘settledness’ which has been refined through case law, and which allows a measure of judgment in deciding who is ‘settled’. Whereas at present GPs have in law the discretion, within certain bounds, to decide whom they will accept as patients, this new criterion draws a very clear line, a border beyond which the GP may not let a patient in. There is at the very least a question whether the proposed threshold of ILR is set too high . There are some who can be genuinely regarded as settled, who contribute in every case through direct taxation and in some cases by direct taxation as well, and who would on any criterion of reasonableness merit access to primary healthcare on the same basis as those with permanent residency. The consultation paper describes the current ordinary residence definition as ‘confusing and unwieldy’ in application. The proposed option may have the benefit of tidiness and ease of enforcement, but at the risk of being unduly severe in a number of cases.

#### **5. Conclusions on the proposals and on the direction of policy development**

We are not opposed to the tighter implementation of current charging arrangements, nor to reasonable measures to prevent abuse of our NHS by visitors who cannot claim to live in the UK, including a levy or health insurance requirements, as long as exceptions can be made where need, hardship and settled residence in the UK are combined in the same person or family. However, the proposal to charge for primary health care runs up against not only numerous logistical difficulties, which have been listed in detail by other organisations, but also a series of other types of difficulty which we consider equally problematic for the proposed charging regime. These difficulties relate to NHS staff, to public health, to patients in need, and to our national culture.

##### *Difficulties for NHS staff*

It creates difficulties for NHS staff because those working in GP surgeries would have to identify those who were not entitled to a free service. In practice, they would have either to check the credentials of everyone arriving at the counter, or to decide whom they would challenge for evidence of entitlement. The former option would, as well as creating administrative problems at government level, create an unwelcome extra barrier for everyone wishing to join a GP’s list; while the latter immediately introduces severe risks of unintended

discriminatory behaviour by staff trying to narrow down the range of potentially suspect types of people.

#### *Difficulties for public health*

Difficulties for public health are bound to arise because, despite the statements in the concurrent Department of Health consultation paper that treatment for infectious diseases and sexually transmitted infections will be excluded from charging in England. inoculation programmes are the most obvious instance of public health risks that could be raised by excluding people in line with these proposals.. To exclude a section of the population from primary medical care (both by a legal bar and by the informal disincentives that extra barriers will create) will also mean that early diagnosis and prompt treatment of illnesses and conditions will not happen, with the consequence that more radical and expensive secondary interventions will be required in a proportion of cases.

#### *Difficulties for patients*

Difficulties for patients will clearly result – not only in the suffering of those unable to afford to pay, and of those who fear to expose their (real or imagined) fragility of their position as residents, but in many other ways implied throughout this response. ‘

#### *Difficulties for our national culture*

The difficulties for our national culture are less easy to itemise; but the phenomenon of laying a border down every street is already under way. We do not criticise the duty laid on employers to check the immigration status of those whom they intend to employ, since it addresses the multiple abuses of unscrupulous employers and gangmasters. We can also see the logic in placing a corresponding duty on landlords, since that too will bear down on those profiting from the helplessness of others. We do, however, draw attention to the fact that all such measures add another layer to a growing culture of suspicion and interrogation in our society. This accumulation of thresholds does by small degrees change the openness and mutuality which characterises the British tradition, introducing undertones of wariness and questioning about entitlement. We believe in particular that the proposals for restricting access to primary health care, while containing some elements which we do not oppose, may represent as a whole an unfortunate step towards unhealthy deep divisions between two categories of those who are living in our country.