
# Controlling Immigration – Regulating Migrant Access to Health Services in the UK

## Results of the public consultation

22 October 2013
Home Office

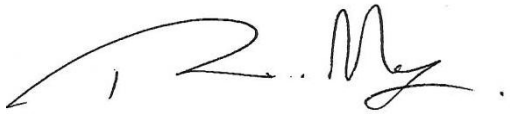
# Foreword

The government has already made changes to our immigration policies with the aim of reducing net migration, which is now down by a third since its peak in 2010. However, we plan to go further in the Immigration Bill. The Bill will make it more difficult for illegal immigrants to live and work in the UK and it will also ensure that legal immigrants make a proper contribution to our key public services. It is vital that our immigration policy is built into our benefits system, our health system, our housing system, the provision of services across government and access to employment.

Effective border controls form an essential component of our work to prevent illegal immigration. These are reinforced with further checks within the UK to trace and remove immigration offenders and are crucial in providing a deterrent to those who might break our immigration laws. Our approach is also to ensure that services and benefits are closed off to those with no right to be here. We have achieved this in part by sharing the responsibility for preventing illegal migration across Government and other public bodies. We have also given responsibility to private sector providers; for example, there are established procedures that penalise those who transport people into the country without proper documents and for employers who employ people with no right to work.

These proposals respond to longstanding public concern that the current rules regulating migrant access to the NHS are too generous, particularly when compared with wider international practice, poorly applied and act as a draw to health tourists. This Home Office consultation was run in parallel with a separate Department of Health consultation which analysed the vulnerabilities of the current charging regime for overseas visitors in England. The Department of Health consultation set out options for reforming the charging regime and covered a number of detailed implementation issues.

There has been a significant response to the consultation and I am grateful to all those individuals and organisations who have taken the time to respond and to those who have contributed their experience and insight to what is a complex issue. This document reports what you have told us during the consultation, what we have learned from this process, how the comments received have helped to refine our thinking, and what will happen now.



**Rt Hon Theresa May MP**
Home Secretary

# Table of contents

# 1. About the consultation

Currently, all temporary, non-EEA migrants who come to the UK for more than six months are likely to qualify for free NHS care either upon their arrival or very shortly after by reason of being ordinarily resident or exempt from treatment charges by Regulation. Compared to other countries, many of which have health insurance requirements, this approach is overly generous. This level of generosity has been the subject of ongoing public concern. It is also inconsistent with the general position on access to benefits and social housing where access is confined to those non-EEA migrants who have permanent residence status (indefinite leave to enter or remain), refugee or humanitarian protection status or discretionary leave granted to exceptional cases.

On 3 July 2013, the Home Office published its consultation document '*Controlling Immigration – Regulating Migrant Access to Health Services in the UK'* which sought public views on proposals for action in immigration legislation to better regulate migrant access to free NHS services. The consultation, which ran for eight weeks, closed on 28 August.

Reflecting the Government's policy that a migrant's entitlement to UK benefits and public services should reflect their immigration status the consultation document sought views on the following three proposals:

- Making permanent residence in the UK the new qualifying test for free NHS treatment, thereby aligning healthcare more closely with existing rules on migrant access to state benefits and social housing;
- Whether the most effective means of regulating temporary migrants'[1] access to the NHS would be via either the introduction of a levy/surcharge to be paid at the same time as an application for leave to enter or remain in the UK, or a requirement that they hold medical insurance; and
- Proposals to make the UK less attractive to health tourism by extending charging to primary medical care services.

The consultation document was available online to the general public on the Home Office website: http://www.ukba.homeoffice.gov.uk/policyandlaw/consultations/. Notification of the consultation was also emailed to more than 1,100 stakeholders registered with the Home Office as having a particular interest in immigration, including businesses and organisations.

In tandem with the Home Office consultation which focused on the case for UK-wide action under immigration powers, and to the same timescale, the Department of Health published a consultation setting out its proposals for reforming the way in

[1] Non-EEA nationals granted leave to enter permitted to enter or remain as workers, students and family members.

which overseas visitors are charged for NHS services in England[2]. Given the overlap in focus between the two consultations, the Department of Health's document necessarily contained some of the questions from the Home Office consultation and responses to these were shared with and taken into account by the Home Office. A detailed analysis of all responses to the Department of Health consultation will be set out in the consultation report issued by that Department. The Department of Health will also publish the results of an independent 'audit' on the take up of NHS services by migrants in England.

This report summarises the responses to the consultation and the Government's proposals in light of them. It should be noted that, in general, those responding to consultations are self-selecting and may not therefore be representative of the population as a whole.

[2] *Sustaining services, ensuring fairness. A consultation on migrant access and their financial contribution to NHS provision in England*. Published by the Department of Health on 3 July 2013.

# 2. About the respondents

Responses were received via an online survey, by post and by email. The online survey received 2,376 responses. A further 81 responses were submitted via email or post of which 27 were sufficiently quantifiable to include in the overall statistical analysis of responses. The remainder of these, which were in the form of unquantifiable narrative responses, were considered alongside the quantitative data.

A list of the organisations that provided responses by email or post are set out at annex B, excluding any that asked not to be identified. Given the anonymous nature of the online survey, it is not possible to provide a list of organisations that responded in this manner.

**Quantifiable responses**

The majority of respondents were members of the public (75%)[3]. Of those respondents from the public that provided nationality information[4], fifty-five per cent were UK citizens, with forty per cent from outside the European Economic Area (referred to in this document as non-EEA citizens) and five per cent from European Union countries (excluding the UK), Iceland, Liechtenstein, Norway and Switzerland[5]. Of the forty per cent of individual responses from non-EEA citizens, three-quarters were temporary migrants with a time-limited immigration status.

Of the remaining respondents, twelve per cent were from the health sector, eight per cent were from organisations representing individuals or groups[6], three percent were from local authorities, legal advisors and health insurance companies and the remaining two per cent were other respondents who did not fall into any of these groups (Table 1).

Of the 160 organisations representing individuals or groups, thirty-seven per cent reported representing migrants and twenty-nine per cent represented students. These were by far the most represented groups within this category.

[3] Seventy five per cent of 1,955 respondents provided this information.
[4] 1,458 respondents provided nationality information.
[5] Referred to as EU respondents hereinafter.
[6] Including community groups and institutional investors.

**Table 1: Respondent type**

| | Respondents | % |
|---|---|---|
| Members of the public | 1,471 | 75% |
| Organisations representing individuals or groups | 160 | 8% |
| Health sector (consisting of) | 235 | 12% |
| *NHS employees* | *146* | *7%* |
| *GPs* | *69* | *4%* |
| *NHS Trusts* | *20* | *2%* |
| Professionals (consisting of) | 49 | 3% |
| *Legal advisors* | *38* | *2%* |
| *Local authorities* | *10* | *1%* |
| *Health insurance companies* | *1* | *<1%* |
| Other | 40 | 2% |
| **TOTAL** | 1,955 | 100% |

448 responses were received where no information was provided for this question.

## Presentation of data

Due to the small number of responses received from (non-UK) European nationals, comparisons by citizenship will only be reported for responding members of the public who were UK and non-EEA citizens.

Responses from those representing GPs, NHS trusts and employees[7] are reported. Where numbers permit, comparisons are made with other respondent groups. Differences have only been reported if they are statistically significant (at the five percent level).

Some respondents may not have answered every question. The percentages given for each of the consultation question responses relate only to the number of people who answered that particular question.

Responses received by the Department of Health to questions also asked in the Home Office consultation, have been taken into account by the Home Office, but will be reported on separately in the Department of Health's consultation report. These responses have not been included in the quantifiable results contained in this document to avoid the risk of double counting respondents who answered the same questions in both consultations. It should however be noted that the replies to both consultations showed similar patterns and often similar replies.

[7] Referred to as health sector respondents in the rest of this report

# 3. Detailed analysis of responses

### i) Responses to the consultation questions

**Question 1** asked '*should all temporary migrants, and any dependants who accompany them, make a direct contribution to the costs of their healthcare?'*

Of the quantifiable responses to this question, thirty-four percent felt that temporary migrants should make a direct contribution to the costs of their healthcare. Sixty-two percent disagreed.

When these figures were broken down by type of respondent, a marked difference appeared between the views of the health sector and other respondents.
Sixty-six per cent of health sector respondents felt that temporary migrants and their dependants should contribute to the cost of their healthcare. Most respondents from the public and organisations did not agree (65% and 77% respectively).

Of the responding members of the public, however, a higher proportion of UK citizens (43%) felt that temporary migrants and their dependants should contribute directly to the cost of their healthcare, compared with non-EEA citizens (18%). Just over half (54%) of UK citizens were against temporary migrants or their dependants making a contribution to their health care costs.

The views of those who provided narrative responses were wide ranging. Some noted that British citizens abroad are expected to pay for their healthcare, perhaps through health insurance, and that it is fair that migrants in the UK should do the same. Others however, felt that everyone should receive NHS care free of charge and regardless of their immigration status. Some also noted that temporary migrants may already be contributing to public services and the wider economy including through payment of tax and National Insurance if working in the UK, and consequently any additional charges for NHS services may result in them being double-charged.

There was also some concern that these proposals could lead to breaches of human rights or a discriminatory approach to healthcare and there were also questions about the impact of charging on vulnerable groups, destitute migrants and migrant families. Some respondents felt that these proposals may have a negative impact on the economy by reducing the UK's attractiveness as a place to work or study. Concerns around the privacy implications of these proposals, including any data sharing arrangements between Government departments, were also mentioned.

Some respondents expressed a view that temporary migrants are unlikely to make large demands on UK health services, and should therefore not be charged. A few

however raised concerns regarding abuse of the existing system. One respondent noted that it may be easier and cheaper for migrants with pre-existing medical conditions to travel to the UK on a work/student visa in order to receive ongoing care. Another noted that the system may be open to abuse from 'family members' who join their relatives in the UK and 'quickly begin to use the health service'. Some respondents however noted that the Government had provided no credible evidence that health tourism existed and the various proposals were not evidence based.

**Question 2** asked *'should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK?'*

Sixty-nine per cent of all respondents to the consultation did not feel that access should be based on permanent residence.

When the responses were broken down by group, it was found that the majority of health sector respondents (55%) reported that access should be based on permanent residence. This was a far higher figure than for responding members of the public (25%) and organisations (15%).

Of responses from members of the public, a higher proportion of UK citizens (34%) held the view that access should be based on permanent residence, compared with non-EEA citizens who responded (15%). Just under two thirds (64%) of UK citizens disagreed, holding the view that access to free NHS services should not be based on permanent residence in the UK.

The narrative responses to question two largely covered the same themes as for question one (see above). Additional comments specific to this question revealed some opposing views. Some respondents for example, felt that permanent residence was the correct criteria for determining access to free NHS care, with some suggesting that migrants should have free NHS care only where they were both permanently resident and contributing to UK health services through taxes. Others however, disagreed; they considered that the existing test for determining entitlement to free healthcare (an 'ordinary residence' test) should be retained. Some respondents also noted that the path to permanent residence is longer for some migrants than others, and that some temporary migrants may never be eligible for permanent residence, and consequently free healthcare, at all.

<u>The Government's response (questions 1 and 2)</u>

Questions 1 and 2 are considered together in this report as they both address the basic question of to whom charging for NHS services might apply.

We have considered all responses to these questions carefully but remain convinced that only permanent migrants should be automatically eligible for free NHS care. This is consistent with Government policy that those subject to immigration control should have access to public benefits commensurate with their immigration status. Migrants who are permanent UK residents have committed to a long-term relationship with the UK, and may consequently make significant contributions to the UK economy and society. It is right that this commitment and connection to the UK, afforded by their permanent residence status, enables them to enjoy the benefits of living in the UK to the same extent as a British citizen, including equal access to public services.

Whilst we recognise that temporary migrants may also contribute to the economy, the tax paid by a temporary migrant who will be living in the UK only for a limited time, even a high net worth individual, will generally be less than that of a permanent resident worker over his/her lifetime. In addition, their depth of connection to the UK is weaker than that of permanent migrants. This is already reflected in the rules on migrant access to benefits and social housing; as access to these benefits is largely limited to permanent residents and those granted refugee status or humanitarian protection[8]. Our proposal that temporary non-EEA nationals become chargeable for their healthcare will align the rules governing access to the NHS care with these wider, existing rules.

As proposed in our consultation, we will continue to honour our international commitments in relation to vulnerable groups such as asylum seekers, refugees, humanitarian protection cases and victims of human trafficking, all of whom will continue to have free access to the NHS and will not be subject to the proposed immigration health surcharge when the new provisions are implemented.

In taking forward our proposals, we will ensure that our data protection and privacy obligations are met. A Policy Equality Statement has been produced to ensure that our proposals are not discriminatory and is set out at Annex C. An Impact Assessment has also been produced through which we have taken account of the potential economic impact of our proposals and we are confident that the UK's attractiveness to high value migrants will be maintained. The impact assessment will be published alongside this consultation response

**Question 3** asked *'What would be the most effective means of ensuring temporary migrants make a financial contribution to public health services?'*

The following three options were proposed:

a) A health levy paid as part of the entry clearance process
b) Health insurance

[8] See paragraph 6 of the Immigration Rules and section 115 of the Immigration and Asylum Act 1999.

c) Other option (please detail your proposals)

Forty-five per cent of all respondents and a similar proportion of UK citizens (44%) reported that an 'other' option should be used instead. This was the most popular response. After categorising all of the 'other' responses alongside those responding with health insurance and a health levy as proposed in the consultation:

- Thirty three per cent opted for health insurance;
- Twenty four per cent suggested that contributions should be through tax and National Insurance, and
- Twenty two per cent opted for a health levy.

The remaining twenty one per cent of respondents provided a wide range of suggestions. Of these, three per cent felt that services should be charged for as they are used and five per cent felt that access to the NHS should remain free to all.

The health levy option was the most popular response from health sector respondents (40%); this was significantly higher than responding members of the public (19%) and organisations (17%).

Of those that provided narrative responses, some again felt that the most effective means of contribution is through existing payments of tax and National Insurance, with concern that migrants in employment would otherwise be making a disproportionate contribution to the health system. Some respondents noted that the levy would be simpler to administer than health insurance and there was concern that the administrative costs of introducing and managing a health levy may not justify the funds recouped. Overall, and whilst generally not supportive of the proposals, most of those that provided qualitative responses felt a health levy to be preferable to health insurance.

## The Government's response

We want to ensure that all chargeable, temporary migrants will in the future be able to make a contribution towards UK health services in a simple and effective manner, commensurate with their immigration status, in a way which imposes minimal burden on the NHS.

In light of the consultation, we have considered a range of options including the feasibility of introducing either a 'pay as you go' system of charging (through which all temporary migrants would be liable to NHS hospital treatment charges) or a requirement that migrants hold health insurance. Both of these options would however place significant administrative burdens on the NHS, which would face an increased challenge in recovering unpaid and disputed treatment charges. The pay

as you go option is likely to prove expensive for those migrants who require extensive treatment and consequently impact disproportionately on protected groups (e.g. older people or the disabled) as well as increasing the risk of bad debt to the NHS. The NHS would risk spending significant sums on debt recovery in proportion to the sums collected in treatment charges from a wider range of patients.

The health insurance option would also prove significantly more expensive for temporary migrants when compared to a form of health levy. Most existing private insurance policies do not provide a satisfactory level of coverage for our purposes as they are supplemental to NHS care, relying on the NHS to provide cover for certain conditions as well as emergency care. To meet our requirements, insurance companies would need to develop new insurance packages capable of providing comprehensive private insurance that covered all eventualities, including maternity and emergency care. Anecdotal evidence from discussions with the insurance industry suggests this could cost the migrant around £3,000 per year in insurance premiums. Where migrants have existing health problems, comprehensive private health insurance could prove prohibitively expensive, giving rise to concerns about the compatibility of a mandatory health insurance policy with UK equality legislation[9]. There is also a risk that some migrants could either cancel or fail to renew their insurance once in the UK; thereby raising the risk of bad debt to the NHS should they later require treatment that they are unable or unwilling to pay for.

Mindful of the need to avoid placing significant additional financial burdens on the NHS, the potential cost to the migrant of health insurance and the need to ensure that the UK maintains its attractiveness to skilled workers and fee-paying international students that contribute positively to economic growth, we intend to introduce a requirement that temporary, non-EEA migrants pay an upfront fee to the Home Office when applying for a visa or permission to extend their stay for a further temporary period. This fee, in the form of an immigration health surcharge, will effectively enrol the migrant for free subsequent access to NHS services that they may require during their stay in the UK; although there may possibly be further charges for certain, discretionary treatments. Payment of an upfront surcharge reduces the risk of bad debt to the NHS and will prove considerably cheaper for the individual than private health insurance whilst providing comprehensive healthcare coverage. The power to apply the surcharge will be created in the Immigration Bill, and the level of charge for each class of case together exemptions for particular groups will be specified in regulations.

**Question 4** asked *'if a health levy were established, at what level should it be set?' The options suggested were £200, £500, and an 'other' option (to be specified by respondents).*

[9] Further financial detail is contained in the Impact Assessment.

When considering the 'other' responses alongside the specific cost options proposed in the consultation, fifty-one per cent of all respondents felt that any levy should be set at or less than £200, twenty-one per cent were in favour of a levy being set at £500 or more and twenty-eight per cent felt that there should not be a levy.

**Table 2: Suggested amount for migrant health levy**

| Levy amount | Respondents | % |
|---|---|---|
| £0 | 524 | 28% |
| Less than £200 | 435 | 23% |
| £200 | 539 | 28% |
| £201-£499 | 12 | 1% |
| £500 | 288 | 15% |
| More than £500 | 107 | 6% |
| Total | 1,905 | 100% |

237 other comments were received for this question which did not provide an alternative amount for the levy and are not included in the table.

Some respondents to this question did not suggest an amount for the levy, but instead commented that if one were to be introduced, it should be set at a low rate.

Those who provided narrative responses did not generally support a levy but felt that if one were to be introduced, should be set at a low rate; and of the options provided, a general preference was expressed for a rate set at £200.

## The Government's response

The Immigration Health Surcharge (formerly referred to as a levy) will operate on the principle of pooling the risk of migrants requiring NHS treatment. In selecting the proposed level of the surcharge, we have considered a number of factors, including the comparable cost of health insurance requirements in other countries competing to attract highly skilled workers and fee paying students, the range of health services that would be available free of subsequent charge, and the average costs of providing health services to migrants, most of whom will fall in the 20-44 age bracket. The Department of Health estimates that the full annual cost of healthcare is on average around £1,600 per person in England, and ranges from around £700 for adults under 44 to over £6,000 for the very elderly[10].

We believe that the surcharge must be set at a competitive and proportionate rate. We therefore intend for the surcharge to be set at a rate of around £150 per annum for students and around £200 per annum for other migrants for each year of leave granted – which although cheaper than the average annual cost of NHS care per capita would deliver over £1.9 billion to Government over a ten year period. Further financial detail is contained in the Impact Assessment.

[10] Source: Nuffield G&A and Mental Health age cost indices. Healthcare expenditure taken from the Department of Health Annual Report and Accounts, 2011-12.

The Immigration Health Surcharge will be set by the Home Secretary through secondary legislation. The surcharge amount will be kept under review and the Home Secretary will have the power to vary the surcharge should the need arise, again through secondary legislation. Prior to implementation of the surcharge, we expect to engage in further policy development as to the level to be paid by migrants granted leave to enter or remain under the family provisions.
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**Question 5** asked *'should some or all categories of temporary migrant be granted the flexibility to opt out of paying a migrant health levy, for example where they hold medical insurance for privately provided healthcare?'*

Forty-five per cent of all respondents and just under half of UK citizens (48%) felt that there should be flexibility for all categories of temporary migrant to opt out of paying a migrant health levy, for example where they held private medical insurance.

Of those reporting that flexibility should be granted for 'some categories' to opt out of paying the levy (501 respondents), the most frequently reported categories were:

- working migrants – those who contribute through tax and National Insurance (122 respondents);
- migrants who hold private health insurance (111 respondents), and
- international students (35 respondents).

The greatest proportion of health sector respondents however reported that there should be no flexibility to opt out (37%). This was significantly higher than for responding members of the public (18%).

Of those that provided narrative responses, some suggested that those who have health insurance should be able to opt out of paying a levy, although one respondent noted that this could create a new market for false insurance documents and a few others questioned whether insurance policies would be maintained once the migrant was in the UK. Some felt that there should be no opt out and a few expressed concern about the administrative impact on the NHS of operating dual systems of charging.

<u>The Government's response</u>

We have considered the case for allowing migrants to opt out of paying the immigration health surcharge, either on an individual basis or as a class of case where an undertaking is given to make their own private provision for healthcare during their stay in the UK. Our view is that this would create unhelpful administrative complexity both for the Home Office and the NHS; it may also add to confusion at

the visa application stage for migrants. As already noted, migrants would also only be permitted to opt-out where they held fully comprehensive insurance that was not supplemental to NHS care - such insurance products are not commonly available at this time.

The surcharge will therefore be a mandatory requirement for temporary migrants, unless they are otherwise exempt (see the Government's response to question 8, below).

**Question 6** asked *'should a migrant health levy be set at a fixed level for all temporary migrants, or varied (for example according to the age of the migrant)?'*

Forty per cent of all respondents felt that it should be set at a variable level according to migrant characteristics, whilst thirty-six per cent felt that it should be at a fixed rate.

The greatest proportion of health sector respondents reported that any levy should be fixed (47%). This was significantly greater than respondents from the public (34%). For respondents from the public, the variable level attracted most support (forty per cent were in favour).

Of responses from members of the public, a higher proportion of UK citizens held the view that any levy should be fixed (40%), compared with non-EEA citizens (26%).

Of those that provided narrative responses, most felt that the levy should be at a fixed rate in order to avoid discriminating against individuals on the basis of age or other characteristics. Others disagreed, suggesting the levy should be varied according to factors such as health or age, reflecting the potential costs to the NHS of their treatment. Some also noted that a fixed levy may not cover the full cost of treatment received.

<u>The Government's response</u>

Having taken into account the responses received, we consider that a surcharge set at a variable rate would prove administratively complex and may be intrusive for the visa applicant. We therefore intend to set the surcharge at a fixed rate regardless of age or health profile.

**Question 7** asked *'should temporary migrants already in the UK be required to pay a health levy as part of any application to extend their leave?'*

Sixty-nine per cent of all respondents and sixty-two per cent of UK citizens, did not think that migrants should have to pay a levy as part of any application to extend their leave. Consistent with previous responses however, the greatest proportion of health sector respondents felt that migrants should be required to pay the levy as part of their application to extend (65%). This was significantly more than respondents from the public (24%) and organisations (12%).

Of those providing narrative responses, some felt it would be unfair for this requirement to apply retrospectively to migrants already in the UK. Some respondents also noted that migrants in the UK should be exempt from a levy as they will have contributed to the UK economy in some way.

The Government's response

To ensure that migrants receive a level of access to public services commensurate with their immigrations status, permanent residents will be exempt from paying a surcharge. This means that all temporary, non-EEA migrants will be required to pay a surcharge as part of any visa application, including applications to extend their leave, unless otherwise exempt.

Migrants granted leave before this policy is implemented will however have made a decision to come to UK (and planned their finances accordingly) based on a number of factors including an assumption that they would be eligible for free healthcare. Transitional arrangements will therefore be put in place so that temporary migrants already in the UK at the time this policy is implemented will not be liable to pay a surcharge and will not be otherwise charged for healthcare for the remainder of their original grant of leave. Temporary migrants will however be required to pay the surcharge as part of any further immigration application.

**Question 8** asked *'are there any categories of migrant that you believe should be exempt from paying the health levy or other methods of charging (over and above those already exempt on humanitarian grounds or as a result of international obligations)?'*

Sixty-one per cent of all respondents and over half of UK citizens (56%) felt that some categories should be exempt.

The greatest proportion of health sector respondents did not think that there are any categories that should be exempt (56%). This was significantly greater than responses from members of the public (25%) and organisations (15%). Most respondents from the public and most organisations, in contrast, held the view that some categories should be exempt (64% and 79% respectively).

Respondents were asked to detail the categories they felt should be exempt from paying a surcharge (1,278 respondents). They included:

- those who paid tax and National Insurance and were contributing to the UK economy (417 respondents),
- students (223 respondents),
- dependants, including spouses and children (147 respondents), and
- vulnerable people, including asylum seekers, the elderly and those with disabilities (145 respondents).

Some respondents highlighted that all children should be exempt, not just those in local authority care. Some respondents also felt that young people leaving local authority care should also be exempt from charging up to a specific age.

Some respondents also highlighted pregnant women as a vulnerable group who should be exempt from charging and considered that access to maternity services should be free of charge.

A further 213 respondents used the open text to express the view that no migrant should have to pay the levy.

Pregnant women, children, international students, destitute migrants, failed asylum seekers, victims of human trafficking and those illegally present in the UK were highlighted in the narrative responses as those who should be exempt.

The Government's response

We are mindful of our international and humanitarian obligations as well as the need to ensure the UK maintains its status as an attractive destination for highly skilled migrants who contribute to economic growth. We are also conscious of the need to ensure that a migrant's access to free NHS services should be commensurate with their immigration status and that current arrangements are overgenerous.

Asylum seekers, refugees and those receiving humanitarian protection or temporary protection currently receive free healthcare, as do recognised victims of human trafficking and our proposals will not alter these arrangements. The terms of existing reciprocal healthcare agreements with other countries will also be honoured; no health surcharge will be imposed where the terms of these agreements require that patients receive free treatment for the duration of their stay as a temporary migrant.

Temporary migrants who make an application via the Tier 2 intra company transfer route (ICT) will not be required to pay a surcharge and will continue to enjoy free NHS care. This is because the ICT route aims to bring the most highly-skilled, international workers to the UK and encourages substantial investment. This in turn

boosts our economy and benefits UK workers who work with and learn from these skilled migrants and who may also utilise reciprocal ICT arrangements in other countries. Lead ICT migrants are required to be in employment (unlike students) and are able to support themselves through that employment.

Exemptions from the surcharge will be kept under review by the Home Office. The Home Secretary will have the power to amend the list of exempt categories via secondary legislation where deemed appropriate to do so..

We have noted the views of some respondents that international students should not pay a surcharge. International students in many other countries are generally expected to pay for their healthcare, often through a health insurance requirement, and there are no compelling reasons as to why the UK should continue to operate a comparably more generous system. Whilst we recognise that international students make a valuable, indirect contribution to the UK economy, they are nevertheless temporary migrants, who should have access to public services commensurate with their temporary status. Even so, and mindful of the need to maintain the UK's attractiveness as a place of study, we intend to set the surcharge for international students at a lower rate than that set for other migrants.

Table 1 of the Impact Assessment provides an international comparison of basic medical health insurance in some of our key competitor countries in specific circumstances where the migrant had no pre-existing condition or adverse clinical history. Despite such insurance not covering many medical conditions, the cost for migrants of obtaining necessary healthcare in most of these countries is generally between £300 and £500 per year – a significantly higher rate than our proposed health surcharge..

**Question 9** asked *'should any requirement to hold health insurance be a mandatory condition of entry to the UK (as determined by the Home Office).'*

Fifty-nine per cent of all respondents felt that possession of health insurance should not be made a mandatory condition of entry to the UK, with thirty-six per cent holding the view that it should.

Consistent with previous questions, the greatest proportion of health sector respondents reported that it should be a condition of entry (61%). This was significantly more than respondents the public (33%) and organisations (22%) who responded to the consultation.

Whilst most UK and non-EEA citizens felt that it should not be a mandatory requirement (56% and 70% respectively), more UK citizens held the view that it

should be a mandatory condition of entry (41%), compared with non-EEA citizens (23%) who responded.

Of those that provided narrative responses, most did not address this question specifically, but many noted that whilst they were not in favour of these proposals, they considered a health levy preferable to health insurance.

The Government's response

This question sought views as to whether, as an alternative to a surcharge, temporary non-EEA migrants should be required to hold health insurance as a condition of leave to enter or remain in the UK. The requirement to hold health insurance is common practice in other countries.

We are not persuaded that a mandatory health insurance requirement is feasible or enforceable at this time. As discussed earlier in this document, a health insurance requirement would place a significant administrative burden on both the Home Office and the NHS and require insurance companies to create new, fully comprehensive insurance policies that could prove prohibitively expensive for many temporary migrants[11].

**Question 10** asked *'should chargeable migrants pay for all healthcare services, including primary medical care provided by GPs?'*

Sixty-four per cent of respondents thought chargeable migrants should not pay for all healthcare services including primary medical care provided by GPs.

Following the same pattern as for other responses, the greatest proportion of health sector respondents reported that chargeable migrants should pay for all services (67%). This was significantly more than respondents from the public (27%) and organisations (16%). Most respondents from the public and organisations felt that chargeable migrants should not have to pay for primary care (69% and 76% respectively).

As before, whilst most UK and non-EEA citizens felt that chargeable migrants should not have to pay for all healthcare services (58% and 82% respectively), more UK citizens held the view that chargeable migrants should pay (39%), compared with non-EEA citizens (12%) who responded.

Of those that provided narrative responses, most respondents again expressed a view that charges should not be extended to primary care services as migrants already pay for their healthcare through taxes and other economic contributions.

[11] The Impact Assessment provides further detail.

There were also concerns that the introduction of charging for primary healthcare services would place an administrative burden of GPs and their staff – with some suggesting that GPs would be required to carry out the functions of immigration officers. Some felt that unregistered migrants would seek treatment at Accident and Emergency departments, placing these under increased pressure.

Some respondents highlighted that migrants might be discouraged from seeking early treatment for communicable diseases such as tuberculosis or HIV/AIDS, with a consequential negative impact on public health. Some also felt that other vulnerable groups might be discouraged from seeking healthcare at an early stage, leading subsequently to the provision of more expensive treatment.

The Government's response

All primary medical care services, including GP services, community-based care and continuing care (where individuals are assessed as sufficiently in need of it) are currently provided free to everyone in England and Wales regardless of their status in the UK. This means that illegal migrants and tourists can access primary care services free of charge - something they may not be able to do in their country of origin. The lack of immigration controls at the primary care stage may also be exploited by illegal migrants and tourists with a view to receiving free secondary (hospital) care to which they are not entitled, since hospital administrators struggle to identify which GP-referred patients and chargeable and which are not. This position has encouraged health tourists to come to the UK with the specific intention of obtaining expensive NHS treatments at UK taxpayers' expense.

We do not believe that illegal migrants and tourists should be able to access the NHS for free as this is not commensurate with their limited immigration status and the NHS should not act as an incentive to break the UK's immigration laws.

We note that the Department of Health in England and each of the Devolved Administrations in Scotland, Wales and Northern Ireland already has the power via their own domestic legislation, to introduce charging for primary care services. In Scotland and Northern Ireland, tougher controls are already in place to protect primary care services from misuse by illegal migrants and tourists. In England, the Department of Health has signalled a clear commitment to take the necessary action to reform the NHS primary care registration process and the administration of NHS overseas visitor charges in its recent public consultation.

We have reached the view that the UK health ministries are best placed to determine the most appropriate means of delivering an effective gate-keeping function which controls migrant access to primary care and other services using existing legal powers. We have decided not to take action in the Immigration Bill on this particular issue, but will continue to work with and support the UK health ministries in

establishing, improving and operating effective immigration status checks in this area and to promote best practice and consistency across the UK.

### ii) Impact on protected characteristics

Respondents were asked whether the proposals set out in the document would have any positive or negative impacts on individuals based on the following protected characteristics: age; disability; marriage or civil partnership status; pregnancy; race (including nationality, ethnic or national origins or colour); religion or belief; gender; gender assignment; or sexual orientation.

Fewer than eighteen per cent of those responding to the question felt that the proposals would have positive impacts on any of the protected characteristics, with a larger proportion of the opinion that they would have negative impacts, ranging from forty per cent (for sexual orientation and gender reassignment) to fifty-seven per cent (for pregnancy) (Table 3).

Between a fifth and a third of respondents (19%-30%) indicated that they did not know if the proposals would have impacts on protected characteristics.

A more detailed summary of responses is set out in the Policy Equality Statement (annex C).

**Table 3: Proportion reporting the proposals would have a negative impact on people with protected characteristics**

| | Health Sector | | Respondents from the public | | | | Overall | |
|---|---|---|---|---|---|---|---|---|
| | | | UK citizens | | Non-EEA citizens | | | |
| | Respondents | % | Respondents | % | Respondents | % | Respondents | % |
| **Age** | 75 | 36% | 368 | 50% | 329 | 62% | 948 | 53% |
| **Disability** | 74 | 36% | 381 | 52% | 338 | 63% | 984 | 55% |
| **Marriage/Civil partnership** | 55 | 27% | 333 | 46% | 288 | 55% | 822 | 47% |
| **Pregnancy** | 77 | 37% | 391 | 54% | 355 | 66% | 1023 | 57% |
| **Race (incl. nationality, ethnic or national origins or colour)** | 65 | 31% | 365 | 50% | 320 | 60% | 926 | 52% |
| **Religion or belief** | 55 | 27% | 306 | 43% | 251 | 47% | 754 | 43% |
| **Gender** | 53 | 26% | 305 | 43% | 261 | 50% | 761 | 43% |
| **Gender Reassignment** | 46 | 23% | 298 | 42% | 238 | 45% | 710 | 40% |
| **Sexual orientation** | 46 | 23% | 282 | 40% | 235 | 45% | 693 | 40% |
| **Total range** | **200-208** | | **711-732** | | **524-540** | | **1,748-1,808** | |

The Government's response

Temporary, non-EEA migrants will be required to pay a surcharge unless otherwise exempt. The surcharge will be set at a fixed rate and will be payable by all chargeable migrants regardless of their country of origin, medical condition, sexual orientation or other protected characteristic.

For that reason, we do not agree that these proposals will have a negative impact on protected characteristics. Payment of an upfront surcharge as part of a visa application will entitle migrants to free NHS care for the duration of their grant of leave[12]. Consequently there will generally be no disincentive to seek medical attention given that it will already have been paid for. The alternative approach of

[12] Possibly subject to some limited exceptions for expensive, discretionary treatments

requiring migrant to hold private medical insurance policies would however have had a major negative impact on persons with protected characteristics.

There were some concerns that individuals will be questioned about their immigration status based on their name or appearance. Overseas Visitor Managers (OVMs) in hospitals should already check to see if a person is chargeable for their healthcare. These proposals will not affect the way in which OVMs operate as residence status will remain the basis for determining if a person is chargeable for their healthcare[13]. Chargeable migrants that have paid a health surcharge will have their entitlement to free NHS care evidenced on their Biometric Residence Permit. This will allow them to easily and proactively demonstrate that they are entitled to free NHS care, regardless of language abilities. Eligibility checks for those paying the surcharge will accordingly be on a non-discriminatory basis.

Some public health conditions (e.g. HIV) are classified as disabilities and the proposals will not affect the free availability of treatment for these conditions.

[13] The Department of Health has consulted on proposals to improve the administration of the charging regime for overseas visitors including the possible introduction of temporary NHS numbers for chargeable patients.

# 4. Summary of conclusions and next steps

The Government believes that those subject to immigration control should have a form of access to public benefits and services that is commensurate with their immigration status. The current law regarding migrant access to free, publicly funded health services does not achieve this. The Government therefore intends to take action to align the rules regulating migrant access to the NHS with wider government policy on migrant access to benefits and social housing.

To that end, the Immigration Bill provides for the following UK-wide outcomes in respect of non-EEA nationals:

- Permanent residence will be set as the new qualifying criteria for free NHS care
- Temporary, non-EEA migrants will be required to pay an immigration health surcharge as part of any visa application made on or after the date on which these proposals are implemented (subject to certain exemptions – see below).

The table below summarises the impact that this will have on particular migrant groups. It should be noted however that treatments provided on public health grounds will remain free of charge.

Table 4: Impact of these proposed changes on migrant groups

| | **Chargeability for NHS treatment** | |
|---|---|---|
| **Migrant group** | **Current** | **Future** |
| Non-EEA permanent migrants (those with indefinite leave to enter or remain in the UK) | Free NHS care | Free NHS care |
| Temporary non-EEA migrants (non-visitor categories) | Free NHS care | Required to pay a surcharge (subject to exemptions) |
| Non-EEA migrants (visitor categories)[14] | Subject to overseas visitor charges – but with limited entitlement checks undertaken in practice | Subject to overseas visitor charges. The Department of Health will introduce stronger eligibility checks in England. |
| EEA nationals | Generally free if properly settled in the UK | Generally free if properly settled in the UK |
| Illegal migrants | Subject to overseas | Subject to overseas visitor |

[14] We expect that wider related action by the Department of Health to strengthen the administration of the overseas visitor charging arrangements in England will ensure that NHS treatment charges are applied more accurately and consistently to those liable to pay them, including short term visitors and illegal migrants.

| | | |
|---|---|---|
| | visitor charges– but with limited entitlement checks undertaken in practice | charges. The Department of Health will introduce stronger eligibility checks in England. |
| Beneficiaries of reciprocal healthcare agreements | Free NHS care to the extent of our obligations under the agreement and usually limited to immediately necessary treatment during a temporary stay | Free NHS care to the extent of our obligations under the agreement and usually limited to immediately necessary treatment during a temporary stay |
| Asylum seekers, those with refugee or humanitarian protection status, and victims of human trafficking | Free NHS care | Free NHS care |

**How will it work?**

Temporary, non-EEA migrants, including those on a route to settlement in the UK, will be considered chargeable for healthcare. Migrants who are not otherwise exempt from charging will be required to pay an immigration health surcharge alongside an application for leave to enter or remain in the UK. The surcharge will work on the principle of pooling the risks of temporary migrants requiring NHS treatment, allowing us to set the surcharge at a proportionate and competitive rate.

Payment of this surcharge will allow chargeable migrants access to NHS services without further charge in much the same way as a permanent resident, possibly subject to paying for certain treatments. They will still be charged in the same way as British Citizens or permanent residents for those services that attract a charge.

Payment of the surcharge will be a precondition of entry and stay. The surcharge will be set at a certain rate per annum and must be paid upfront for each year of leave granted. This means a student coming to the UK for three years would pay three times the annual surcharge rate at the same time as their application for entry clearance. Those granted leave to enter or remain for less than a year will pay the surcharge on a pro-rata basis, calculated on the basis of how many months of stay they are granted. The surcharge will be refunded where an application for leave to enter or remain is refused. The surcharge will not be refunded where the migrant returns home earlier than planned, does not use their visa to come to the UK, or does not use the NHS whilst in the UK. Certain categories of temporary migrant will be exempt from paying the surcharge (see below).

Short term visitors and illegal migrants will, as now, be liable for NHS full treatment charges, subject to existing exceptions, and will not have the option of paying a

surcharge in order to access the NHS without further charge. Vulnerable groups such as asylum seekers, refugees, humanitarian protection cases, children in local authority care and recognised victims of human trafficking will also continue to have free access to the NHS in line with our international commitments, and will not be subject to the immigration health surcharge.

Suitably transitional arrangements will be put in place. Temporary, non-EEA migrants already in the UK at the time this policy is implemented, will not be liable to pay a surcharge and will not be charged for healthcare for the remainder of their leave. Once their leave expires however, the migrant will be required to pay the surcharge as part of any further immigration application.

The surcharge amount will be set by Home Secretary through secondary legislation, but is expected to be set at a rate of around £150 per annum for students and around £200 per annum for other temporary migrants. The Home Secretary will also have the power to vary the amount of the surcharge, again through secondary legislation.

**Who will be exempt?**
Certain vulnerable groups, including asylum seekers, refugees, humanitarian protection cases, children in local authority care and victims of human trafficking, currently receive free healthcare and our proposals do not affect these arrangements.

Temporary migrants who make an application via the Tier 2 intra company transfer route (ICT) will not be required to pay a surcharge, for reasons already discussed in this document.

We are exploring in detail whether any further specific migrant categories should be exempt from the surcharge. These exemptions will be set out in secondary legislation and more detail on this will be provided at a later date.

A migrants' entitlement to free healthcare will be recorded on their biometric residence permit. This will allow them to demonstrate their entitlement easily and will also facilitate wider entitlement checks on a non-discriminatory basis.

*Any questions about this policy can be sent to the following email address: homeofficeNHSconsultation@homeoffice.gsi.gov.uk*

# Annex A: Data tables setting out the quantitative responses to the consultation questions

Table 5. All responses

| Summarised questions | All respondents Total number = 2,403 | | |
|---|---|---|---|
| | | Count | Percentage |
| Should all temporary migrants and any dependants make a direct contribution to the costs of their healthcare | **Yes** | 801 | **34%** |
| | **No** | 1,467 | **62%** |
| | **Don't know** | 106 | **5%** |
| | **Total** | 2,374 | **101%** |
| Should access to free NHS services be based on permanent residence in the UK? | **Yes** | 674 | **29%** |
| | **No** | 1,625 | **69%** |
| | **Don't know** | 50 | **2%** |
| | **Total** | 2,349 | **100%** |
| What would be the most effective means of contributing to public health services? | **Health levy** | 477 | **22%** |
| | **Health insurance** | 724 | **33%** |
| | **Other option** | 990 | **45%** |
| | **Total** | 2,191 | **100%** |
| If a health levy were established at what level should it be set? | **£200 per year** | 524 | **25%** |
| | **£500 per year** | 284 | **13%** |
| | **Other amount** | 1,334 | **62%** |
| | **Total** | 2,142 | **100%** |
| Should categories of temporary migrant be granted the flexibility to opt out? | **Yes, some categories** | 501 | **24%** |
| | **Yes, all categories** | 958 | **45%** |
| | **No** | 453 | **21%** |
| | **Don't know** | 222 | **10%** |
| | **Total** | 2,134 | **100%** |
| Should a levy be set at a fixed or varied level? | **Fixed level** | 736 | **36%** |
| | **Varied level** | 820 | **40%** |
| | **Don't know** | 516 | **25%** |
| | **Total** | 2,072 | **101%** |
| Should all temporary migrants already in the UK pay a health levy as part of any application to extend their leave? | **Yes** | 592 | **28%** |
| | **No** | 1,468 | **69%** |
| | **Don't know** | 68 | **3%** |
| | **Total** | 2,128 | **100%** |
| Are there any other categories that should be exempt? | **Yes** | 1,278 | **61%** |
| | **No** | 592 | **28%** |
| | **Don't know** | 228 | **11%** |
| | **Total** | 2,098 | **100%** |
| Should health insurance be a mandatory condition of entry into the UK? | **Yes** | 759 | **36%** |
| | **No** | 1,244 | **59%** |
| | **Don't know** | 117 | **6%** |
| | **Total** | 2,120 | **101%** |
| Should chargeable migrants pay for all healthcare services? | **Yes** | 660 | **31%** |
| | **No** | 1,356 | **64%** |
| | **Don't know** | 92 | **4%** |
| | **Total** | 2,108 | **99%** |

Table 6. Responses to the consultation by respondent group

| Summarised questions | | **Organisations which represent individuals and groups** **Total number = 160** | | Professionals (legal advisors, health insurance companies, local authorities) **Total number = 49** | | **Health sector** (GP, NHS trusts and employees etc) **Total number = 235** | | **Respondents from the public** **Total number = 1,471** | | Those responding in **another capacity** **Total number = 40** | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Count | Percentage | Count | Percentage | Count | Percentage | Count | Percentage | Count | Percentage |
| Should all temporary migrants and any dependants make a direct contribution to the costs of their healthcare | **Yes** | 29 | **18%** | 19 | **40%** | 153 | **66%** | 461 | **32%** | 20 | **50%** |
| | **No** | 122 | **77%** | 29 | **60%** | 74 | **32%** | 954 | **65%** | 18 | **45%** |
| | **Don't know** | 7 | **4%** | 0 | **0%** | 5 | **2%** | 46 | **3%** | 2 | **5%** |
| | **Total** | **158** | **99%** | **48** | **100%** | **232** | **100%** | **1,461** | **100%** | **40** | **100%** |
| Should access to free NHS services be based on permanent residence in the UK? | **Yes** | 23 | **15%** | 21 | **44%** | 128 | **55%** | 366 | **25%** | 18 | **45%** |
| | **No** | 134 | **85%** | 27 | **56%** | 102 | **44%** | 1,069 | **73%** | 21 | **53%** |
| | **Don't know** | 1 | **1%** | 0 | **0%** | 3 | **1%** | 24 | **2%** | 1 | **3%** |
| | **Total** | **158** | **101%** | **48** | **100%** | **233** | **100%** | **1,459** | **100%** | **40** | **101%** |
| What would be the most effective means of contributing to public health services? | **Health levy** | 26 | **17%** | 11 | **22%** | 94 | **40%** | 273 | **19%** | 13 | **33%** |
| | **Health insurance** | 38 | **25%** | 18 | **37%** | 65 | **28%** | 452 | **32%** | 8 | **21%** |
| | **Other option** | 90 | **58%** | 20 | **41%** | 74 | **32%** | 707 | **49%** | 18 | **46%** |
| | **Total** | **154** | **100%** | **49** | **100%** | **233** | **100%** | **1,432** | **100%** | **39** | **100%** |
| If a health levy were established at what level should it be set? | **£200 per year** | 30 | **20%** | 12 | **25%** | 53 | **24%** | 322 | **23%** | 8 | **21%** |
| | **£500 per year** | 10 | **7%** | 6 | **12%** | 73 | **32%** | 156 | **11%** | 7 | **18%** |
| | **Other amount** | 108 | **73%** | 31 | **63%** | 100 | **44%** | 938 | **66%** | 24 | **62%** |
| | **Total** | **148** | **100%** | **49** | **100%** | **226** | **100%** | **1,416** | **100%** | **39** | **101%** |
| Should categories of temporary migrant be | **Yes, some categories** | 37 | **24%** | 13 | **28%** | 58 | **26%** | 325 | **23%** | 13 | **33%** |
| | **Yes, all categories** | 51 | **34%** | 23 | **49%** | 64 | **28%** | 712 | **50%** | 12 | **31%** |
| | **No** | 50 | **33%** | 10 | **21%** | 84 | **37%** | 252 | **18%** | 11 | **28%** |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| granted the flexibility to opt out? | **Don't know** | 14 | **9%** | 1 | **2%** | 20 | **9%** | 150 | **10%** | 3 | **8%** |
| | **Total** | **152** | **100%** | **47** | **100%** | **226** | **100%** | **1,439** | **101%** | **39** | **100%** |
| Should a levy be set at a fixed or varied level? | **Fixed level** | 62 | **42%** | 14 | **29%** | 105 | **47%** | 479 | **34%** | 9 | **24%** |
| | **Varied level** | 44 | **30%** | 21 | **44%** | 85 | **38%** | 558 | **40%** | 20 | **53%** |
| | **Don't know** | 41 | **28%** | 13 | **27%** | 36 | **16%** | 366 | **26%** | 9 | **24%** |
| | **Total** | **147** | **100%** | **48** | **100%** | **226** | **101%** | **1,403** | **100%** | **38** | **101%** |
| Should all temporary migrants already in the UK pay a health levy when extending their leave? | **Yes** | 18 | **12%** | 14 | **29%** | 149 | **65%** | 340 | **24%** | 17 | **43%** |
| | **No** | 123 | **80%** | 32 | **65%** | 76 | **33%** | 1,069 | **74%** | 19 | **48%** |
| | **Don't know** | 12 | **8%** | 3 | **6%** | 6 | **3%** | 34 | **2%** | 4 | **10%** |
| | **Total** | **153** | **100%** | **49** | **100%** | **231** | **101%** | **1,443** | **100%** | **40** | **101%** |
| Are there any other categories that should be exempt? | **Yes** | 124 | **79%** | 27 | **57%** | 76 | **34%** | 920 | **64%** | 24 | **60%** |
| | **No** | 24 | **15%** | 16 | **34%** | 126 | **56%** | 362 | **25%** | 15 | **38%** |
| | **Don't know** | 9 | **6%** | 4 | **9%** | 25 | **11%** | 153 | **11%** | 1 | **3%** |
| | **Total** | **157** | **100%** | **47** | **100%** | **227** | **101%** | **1,435** | **100%** | **40** | **101%** |
| Should health insurance be a mandatory condition of entry into the UK? | **Yes** | 33 | **22%** | 24 | **49%** | 143 | **61%** | 474 | **33%** | 16 | **40%** |
| | **No** | 106 | **70%** | 25 | **51%** | 77 | **33%** | 910 | **62%** | 19 | **48%** |
| | **Don't know** | 12 | **8%** | 0 | **0%** | 13 | **6%** | 76 | **5%** | 5 | **13%** |
| | **Total** | **151** | **100%** | **49** | **100%** | **233** | **100%** | **1,460** | **100%** | **40** | **101%** |
| Should chargeable migrants pay for all healthcare services? | **Yes** | 24 | **16%** | 23 | **47%** | 157 | **67%** | 392 | **27%** | 19 | **49%** |
| | **No** | 118 | **76%** | 26 | **53%** | 72 | **31%** | 1,005 | **69%** | 20 | **51%** |
| | **Don't know** | 13 | **8%** | 0 | **0%** | 5 | **2%** | 64 | **4%** | 0 | **0%** |
| | **Total** | **155** | **100%** | **49** | **100%** | **234** | **100%** | **1,461** | **100%** | **39** | **100%** |

Table 7. Reponses to the consultation by citizenship

| | | British citizens Total number = 800 | | EU citizens Total number = 75 | | Other citizens Total number = 583 | |
|---|---|---|---|---|---|---|---|
| | | Count | Percentage | Count | Percentage | Count | Percentage |
| Should all temporary migrants and any dependants make a direct contribution to the costs of their healthcare | **Yes** | 338 | **43%** | 14 | **19%** | 106 | **18%** |
| | **No** | 432 | **54%** | 59 | **79%** | 455 | **78%** |
| | **Don't know** | 24 | **3%** | 2 | **3%** | 20 | **3%** |
| | **Total** | 794 | **100%** | 75 | **101%** | 581 | **99%** |
| Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK? | **Yes** | 268 | **34%** | 13 | **17%** | 84 | **15%** |
| | **No** | 511 | **64%** | 61 | **81%** | 486 | **84%** |
| | **Don't know** | 14 | **2%** | 1 | **1%** | 9 | **2%** |
| | **Total** | 793 | **100%** | 75 | **99%** | 579 | **101%** |
| What would be the most effective means of ensuring temporary migrants make a financial contribution to public health services? | **Health levy** | 182 | **23%** | 10 | **14%** | 80 | **14%** |
| | **Health insurance** | 255 | **33%** | 32 | **44%** | 159 | **28%** |
| | **Other option** | 345 | **44%** | 30 | **42%** | 327 | **58%** |
| | **Total** | 782 | **100%** | 72 | **100%** | 566 | **100%** |
| If a health levy were established at what level should it be set? | **£200 per year** | 163 | **21%** | 19 | **26%** | 135 | **24%** |
| | **£500 per year** | 136 | **18%** | 4 | **6%** | 16 | **3%** |
| | **Other amount** | 477 | **62%** | 50 | **69%** | 403 | **73%** |
| | **Total** | 776 | **101%** | 73 | **101%** | 554 | **100%** |
| Should some or all categories of temporary migrant be granted the flexibility to opt out of paying a migrant health levy, for example where they hold medical insurance for privately provided healthcare? | **Yes, some categories** | 171 | **22%** | 15 | **21%** | 137 | **24%** |
| | **Yes, all categories** | 371 | **48%** | 35 | **48%** | 300 | **52%** |
| | **No** | 172 | **22%** | 13 | **18%** | 65 | **11%** |
| | **Don't know** | 67 | **9%** | 10 | **14%** | 71 | **12%** |
| | **Total** | 781 | **101%** | 73 | **101%** | 573 | **99%** |
| Should a migrant health levy be set at a fixed level for all temporary migrants, or varied (for example according to the age of the migrant)? | **Fixed level** | 303 | **40%** | 24 | **33%** | 145 | **26%** |
| | **Varied level** | 284 | **38%** | 39 | **54%** | 233 | **41%** |
| | **Don't know** | 171 | **23%** | 9 | **13%** | 185 | **33%** |
| | **Total** | 758 | **101%** | 72 | **100%** | 563 | **100%** |
| Should all temporary migrants already in the UK be required to pay a health levy as part of any application | **Yes** | 282 | **36%** | 11 | **15%** | 46 | **8%** |
| | **No** | 482 | **62%** | 61 | **82%** | 517 | **90%** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| to extend their leave? | **Don't know** | 18 | **2%** | 2 | **3%** | 12 | **2%** |
| | **Total** | 782 | **100%** | 74 | **100%** | 575 | **100%** |
| Are there any other categories of migrant that you believe should be exempt from paying the health levy or other methods of charging (over and above those already exempt)? | **Yes** | 435 | **56%** | 51 | **70%** | 426 | **75%** |
| | **No** | 279 | **36%** | 12 | **16%** | 68 | **12%** |
| | **Don't know** | 68 | **9%** | 10 | **14%** | 74 | **13%** |
| | **Total** | 782 | **101%** | 73 | **100%** | 568 | **100%** |
| Should any requirement to hold health insurance be a mandatory condition of entry into the UK? | **Yes** | 322 | **41%** | 17 | **23%** | 132 | **23%** |
| | **No** | 445 | **56%** | 54 | **73%** | 403 | **70%** |
| | **Don't know** | 28 | **4%** | 3 | **4%** | 44 | **8%** |
| | **Total** | 795 | **101%** | 74 | **100%** | 579 | **101%** |
| Should chargeable migrants pay for all healthcare services, including primary medical care provided by GPs? | **Yes** | 311 | **39%** | 11 | **15%** | 69 | **12%** |
| | **No** | 460 | **58%** | 60 | **81%** | 475 | **82%** |
| | **Don't know** | 25 | **3%** | 3 | **4%** | 35 | **6%** |
| | **Total** | 796 | **100%** | 74 | **100%** | 579 | **100%** |

Table 8. Respondent information

| | | Count | Percentage |
|---|---|---|---|
| Are you responding on or behalf of: | **An organisation which represents individuals and groups** | 160 | **8%** |
| | **Professionals (legal advisors, educators, local authorities)** | 49 | **3%** |
| | **GPs/NHS Trust/Medical and NHS employees** | 235 | **12%** |
| | **Respondents from the public** | 1,471 | **75%** |
| | **Other** | 40 | **2%** |
| | **Total** | **1,955** | **100%** |
| How did you hear about this consultation? | **UK press (national newspaper)** | 436 | **18%** |
| | **International press** | 76 | **3%** |
| | **Government website** | 642 | **27%** |
| | **Overseas websites** | 52 | **2%** |
| | **Word of mouth** | 338 | **14%** |
| | **Social networking sites** | 455 | **19%** |
| | **Other** | 415 | **17%** |
| | **Total** | **2,414** | **100%** |

| | | | |
|---|---|---|---|
| Who does your organisation represent? | **GPs** | 4 | **3%** |
| | **Health insurers** | 1 | **1%** |
| | **Students** | 41 | **29%** |
| | **Migrants** | 51 | **37%** |
| | **NHS workers** | 5 | **4%** |
| | **Other** | 37 | **27%** |
| | **Total** | **139** | **101%** |

**Respondents from the public**

| | | | |
|---|---|---|---|
| Nationality | **A UK citizen** | 800 | **55%** |
| | **A citizen of other European countries or Iceland, Lichtenstein, Norway or Switzerland** | 75 | **5%** |
| | **Other** | 583 | **40%** |
| | **Total** | **1,458** | **100%** |
| Time limit on stay? | **Yes** | 432 | **75%** |
| | **No** | 148 | **26%** |
| | **Total** | **580** | **101%** |
| What is your sex? | **Male** | 811 | **56%** |
| | **Female** | 518 | **36%** |
| | **Prefer not to say** | 126 | **9%** |
| | **Total** | **1,455** | **101%** |
| Age range | **up to 17** | 2 | **<1%** |
| | **18-24** | 134 | **9%** |
| | **25-44** | 974 | **67%** |
| | **45-64** | 205 | **14%** |
| | **65 years and over** | 40 | **3%** |
| | **Prefer not to say** | 92 | **6%** |
| | **Total** | **1,447** | **99%** |

# Annex B: List of organisations that provided responses by email or post

Association of British Insurers
Barnardo's
Bliss – for babies born too soon, too small, too sick
British Medical Association
British Red Cross, Luton office
Buckswood School
Centrepoint
Coram – Children's Legal Centre
Definitive Immigration Services
East of England Local Government Association
Edinburgh University Students' Association
English UK
GuildHE – a formal representative body for Higher Education in the UK
Homeless Link
Immigration Law Practitioners' Association
Japanese Chamber of Commerce and Industry
Joint Council for the Welfare of Immigrants
Laura Devine Solicitors
Lewis Silkin LLP
Liberty
London School of Economics
Maximus UK
Migration Watch UK
Migration Yorkshire
National AIDS Trust (NAT)
New Zealand High Commission
NHS Blood & Transplant
NHS Protect
North West Regional Strategic Migration Partnership
Nottingham & Nottinghamshire Refugee Forum
NUS
Office of the Children's Commissioner
Oxford City Council
Pestalozzi – inspiring young people to make a difference in the world
PICUM – Platform for international cooperation on undocumented migrants
Positive Life
Public Health England
Refugee Children's Consortium
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Russell International Excellence Group
Scottish Refugee Council
Slough Immigration AID Unit
South East Strategic Partnership for Migration

South West Migration Partnership
The Church of England Archbishops' Council
Tower Hamlets New Residents and Refugee Forum
TUC
UCEA –Universities & Colleges Employers Association
UNISON – the public service union
University of Maryland
University of Nottingham
University of Oxford
University of Reading
University of Sheffield
University of Sheffield Students' Union
Universities UK supported by Conservatoires UK
UK Council for International Student Affairs
Waverley Care – HIV Scotland (joint response)
West Midlands Strategic Migration Partnership
Women's Resource Centre
Wouth West Public Health Registrars

# Annex C: Policy Equality Statement

Home Office

**Name of Policy/Guidance/Operational Activity**
**Migrants' Access to Health Services in the UK**

*For "policy" – any new & existing policy, strategy, services, functions, work programme, project, practice and activity. Includes decisions about budgets, procurement, commissioning or de-commissioning services, allocating resources, service design and implementation.*

*Include:*

- *Details of the intended policy aims*
- *Outline of the objectives*
- *What outcomes it will achieve*

Policy Aims

The aim of this policy is to ensure that migrants subject to immigration control have access to free healthcare in a manner commensurate with their type of immigration status. The present rules governing migrant access to the NHS are not consistent with wider government policy on migrant access to benefits and social housing; existing immigration legislation largely restricts access to these benefits to those non-EEA nationals with indefinite leave to remain and those granted refugee status or humanitarian protection in the UK.

Currently, migrants coming to the UK for more than six months to work, study or settle are likely to qualify for free healthcare on their arrival in the UK or very soon after. Compared to the rules in other countries, many of which require migrants to hold health insurance, the UK's position is overly generous.

Objectives and Proposals

The policy will result in a change to the current qualifying test for free NHS care; that will render non-EEA temporary migrants, with the exception of intra company transferees, potentially chargeable for NHS care. Permanent UK residents i.e. those with indefinite leave to enter or indefinite leave to remain, will continue to have free access to NHS services - this reflects their close and continuing long-term relationship with the UK. A number of vulnerable groups will also be exempted from having to pay the surcharge.

Chargeable migrants (who are not otherwise exempt) will be required to pay a health surcharge at the same time as they make an application for leave to enter or remain in the UK.

Payment of this surcharge will allow chargeable migrants access to NHS services in generally the same way as a British citizen or permanent resident, subject to exceptions for certain discretionary treatments as determined by the Department of Health and Devolved Administrations.

Payment of the surcharge will be a precondition of entry and stay and must be paid in full at the time of application. The surcharge will be set at a certain rate per annum and must be paid for each year of leave granted. This would mean a student coming for three years would pay three times the annual surcharge rate at the same time as their application for entry clearance. Those granted leave to remain for less than a year will pay the surcharge on a pro-rata basis, calculated on the basis of how many months of stay they are granted. The surcharge will not be refunded where the migrant returns home earlier than planned or does not use the NHS whilst in the UK.

The surcharge amount will be set by secondary legislation, but is expected to be set at around £150 per annum for students and £200 per annum for other temporary migrants. The Secretary of State will also have the power to vary the amount of the surcharge, again through secondary legislation.

Migrants who are applying for leave to enter or remain under the intra-company transfer category will also be exempted from the requirement to pay the surcharge. The ICT route aims to bring the most highly-skilled international workers to the UK. UK workers benefit by working with these migrants, sharing expertise and by making use of reciprocal ICT arrangements in other countries. The ICT route also brings investment to the UK, boosting our economy and creating jobs for resident workers, not just migrant workers. Lead ICT migrants are required to be in employment (unlike students) and are able to support themselves through that employment. Many (especially in the case of longer-term ICT migrants) will contribute towards the cost of the NHS through tax and NI.

No migrant will be refused health care under this proposal, although they may be charged for it. Treatment on the grounds of public health will also remain free of charge.
Short term visitors and illegal migrants will, as now, be liable for NHS full treatment charges, subject to existing exceptions, and will not have the option of paying a surcharge in order to access the NHS without further charge.

The surcharge will only apply to migrants applying for leave to enter/remain in the UK for a period of over six months. It will apply to both visa-nationals and non-visa nationals.

Transitional arrangements will be put in place for affected migrants who are already in the UK at the time the policy is implemented. The Government recognises that migrants granted leave before this policy is implemented will have made a decision to come to the UK based on a number of factors, including an assumption that they would be eligible for free healthcare. It is anticipated therefore that temporary non-EEA migrants already in the UK at the time this policy is implemented, will not be liable to pay a surcharge and will not be charged for health care for the remainder of their leave. Once their leave expires however, the migrant will be required to pay the surcharge as part of any further immigration application.

The Immigration Bill will not contain any proposals on primary care.

<u>Outcomes</u>

The outcomes of the proposals will be:

- Bringing rules on migrant access to the NHS into line with wider government policy on migrant access to UK benefits and public services.
- Continued provision of a humanitarian healthcare service which meets human rights

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| obligations and protects public health. |
| **Summary of the evidence considered in demonstrating due regard to the Public Sector Equality Duty.** |

This can be (but not limited to):

- *Links to new/existing reports*
- *Extracts from consultation responses and any follow up with respondents*
- *Any data captured/published. Also remember, where relevant:*
  - *Transparency Team – notify to discuss any new data or to inform them of any intent to publish data*
  - *Privacy Impact Assessment – should be conducted for any publication of personal information*
- *Reference to research – new or existing*
- *Minutes of meetings/Notes from stakeholder workshops where equality considerations were addressed/discussed (remember to capture the names of participants – particularly relevant for external organisations/individuals)*
- *Actions taken as a consequence of any identified equality issues.*

Meetings between Home Office and Department of Health officials to scope out the proposals from their own perspectives helped identify equality issues. These equality issues were taken into account in the consultation and informed development of these proposals.

A draft PES was completed on 25 June, which specified the equality issues that had already been identified; it also indicated that further consideration would need to be given to these aspects and that consideration should be given as to whether any mitigations should be put in place.

Subsequently, the proposed measures were subject to public consultation, http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/consultations/34-healthcare/. The consultation document made reference to equality issues, including the potential discriminatory impact of health insurance against migrants of a certain age or sex as well as those with pre-existing medical conditions and some people with disabilities (page 19).

The consultation document asked whether respondents thought the proposals would have any impact, positive or negative, on individuals based on the protected characteristics defined in the Equality Act, and asked for suggestions about how such impacts might be managed, maximised or mitigated.

The potential equality issues identified both by respondents to the consultation and through previous considerations are set out below.

**Race:**

Race includes colour, nationality and national or ethnic origins (s9 of the Equality Act). 52% of respondents to the consultation expressed concern about the impact of these proposals in relation to race particularly that ethnic minorities "***are likely to be discriminated against within a system that is much more suspicious of their entitlement to services. Those who do not speak English as a first language are unlikely to be able to articulate their rights as effectively as others"***

One respondent also noted:

**"*British citizens and those with permanent residency status who have a skin colour other than white would be more likely to have their eligibility to free health care questioned than white British/residents. This would represent discrimination based on race."***

Overseas Visitor Managers (OVMs) in hospitals already check to see if a person is chargeable for their healthcare. Decisions on chargeability are based on the person's residency status in the UK, not race or other characteristics. These proposals will not affect the way in which OVMs operate, as residence will remain the basis for determining if a person is chargeable for their healthcare. Moreover, chargeable migrants that have paid a health surcharge will have their entitlement to free NHS evidenced on their Biometric Residence Permit. This will allow them to easily and proactively demonstrate that they are entitled to free NHS care, regardless of language abilities.

A concern was also raised that as these proposals target non-EEA nationals, black and minority ethnic groups are much more likely to be expected to pay for their healthcare access. As the proposed health surcharge would operate a uniform system of charging for visa applicants however, regardless of their country of origin, there would be no discrimination on the grounds of race.

**Disability:**

55% of respondents to the consultation expressed concern about the impact of these proposals on people with disabilities. Some respondents expressed concern that people with disabilities would be unable to pay for the costs of their health care, and that any surcharge set at a variable rate would have a negative impact on those with disabilities. Some respondents also expressed concern about the proposal for health insurance:

***"Disability (can cover a number of illnesses) including, for example, diabetes. Health Insurance premiums would tend to be higher."***

We have considered the concerns regarding the cost of health insurance and its impact on certain migrant groups, including those with disabilities, the elderly, children and those with pre-existing medical conditions; as such we have determined that a requirement that migrants hold health insurance would place a significantly larger financial burden on some migrant groups than others. The Immigration Bill will set out proposals for an immigration health surcharge rather than mandatory health insurance. The immigration health surcharge will be set at a flat rate for all migrants – as this is a more equitable way of regulating migrant access to the NHS than either a variable rate health surcharge or private medical insurance which might impact disproportionately on disabled persons.

Some public health conditions (e.g. HIV) are classified as disabilities and the proposals will not affect the free availability of treatment for these conditions.

**Sex:**

43% of respondents to the consultation were concerned that the proposals would have a negative impact in relation to sex. A respondent to the consultation raised a concern about women living in the UK as dependants of a male migrant and how they would have their healthcare entitlement protected in the case of domestic abuse and/or family breakdown.

If a relationship with a British citizen or a person settled in the UK has broken down as a result of domestic violence, a person may be able to apply for indefinite leave to remain (otherwise known as permanent residence). The consultation document makes clear that

permanent residents will not be chargeable for their healthcare. In the event of a family breakdown, the migrants, should they chose to remain in the UK, will continue to receive free healthcare for the duration of leave granted (where they have paid the health surcharge as part of their visa application).

**Age:**

53% of respondents to the consultation felt that these proposals would have a negative impact on older people. Some respondents expressed concern that a variable rate health surcharge would lead to older people being charged more than others. There was also concern that older people requiring emergency treatment could be denied access to healthcare while their documents were being checked**.** One respondent noted that:

***"Old age visitors might get neglected by family members assuming it is something small and medicines over the shelf can treat it. This may not allow them to see a doctor to get a thorough check and may risk their life."***

The proposed health surcharge will address all of these concerns. The surcharge will be payable at a flat rate so that older migrants will not be required to make a relatively larger financial contribution. Payment of an upfront surcharge as part of a visa application (for each family member) will entitle migrants to free NHS care - this will mean that there is no disincentive for seeking medical attention. Indeed, migrants may be more inclined to seek medical care given that they have pre-paid a fixed amount that is likely to be substantially cheaper than the full costs of healthcare received.

**Faith and belief:**

43% of respondents thought that there may be a negative impact in relation to religion or beliefs. Some respondents were concerned that as these proposals target non-EEA nationals, Muslims and non-Christian religions were more likely to be expected to pay for their healthcare access.

The proposed health surcharge would operate as a uniform system of charging for visa applicants regardless of their country of origin and with no distinction made on grounds of faith and belief.

**Sexual orientation:**

40% of respondents to the consultation were concerned that the proposals would have a negative impact. Some respondents felt that LGBT migrants may be more reluctant to reveal their personal situations which might exempt them from healthcare charges, and as a result would be denied healthcare. There was also some concern that a variable surcharge would result in different charges:

***"Charging individuals in differing age brackets, disability, marriage, pregnancy, race, religion, gender, gender reassignment and sexual orientation would lead to a breach of human rights and further detrimental effect to families and individuals alike."***

The health surcharge, payable at a flat rate by non-EEA migrants at the time of their visa application, will make no distinctions based on sexual orientation and migrants are not asked about their sexual orientation as part of their visa application.

One respondent raised an issue regarding migrants who may have entered the UK illegally without claiming asylum, as a result of fearing persecution in their own country on the

grounds of their sexual orientation. The concern raised related to this group being denied healthcare even though they should be entitled to the same rights and provisions as an asylum seeker.

Urgent and immediately necessary treatment will never be withheld. In addition, illegal migrants will not be denied healthcare, but may be charged for it. Asylum seekers however will not be required to pay a health surcharge. Those who make asylum claims on the grounds of sexual orientation have their cases handled discretely and sensitively.

**Gender identity:**

40% of respondents to the consultation felt there might be a negative impact in relation to gender identity. There was some concern that migrants who wished to reassign their gender may not be able to afford the treatment costs. Some respondents noted that any requirement to purchase private health insurance would discriminate against a number of groups, including those with a health history linked to gender reassignment. The Department of Health and Devolved Administrations will consider whether specific charges should be retained for certain treatments, including gender reassignment.

**Marriage and civil partnership:**

47% of respondents to the consultation expressed concern about the impact of these proposals in relation to marriage and civil partnerships. One respondent considered that marriage and civil partnerships are affected because of the emotional and financial impact on a person should their spouse be required to pay to use the NHS.

Some respondents raised concerns linked to domestic violence and marriage breakdown – this has been considered under the heading '**Sex**'.

**Pregnancy and maternity:**

57% of respondents to the consultation felt that these proposals might have a negative impact on pregnant women. Some respondents noted that any requirement to hold private medical insurance would result in higher costs for pregnant women. Others considered that treatment for pregnant women should not be delayed for reasons of non-payment. There was some concern that there may be risks to mother and child if migrants are unable to meet the costs of medical care.

Urgent and immediately necessary treatment will never be withheld, but may be charged for. The Department of Health and Devolved Administrations will consider whether specific charges should be retained for certain treatments, including IVF.

**Welfare of children**

Section 55 of the Borders, Citizenship and Immigration Act 2009 requires the Home Secretary to make arrangements to safeguard and promote the welfare of children.

Some respondents raised concerns about the cost of health insurance for children, and noted that children may be denied emergency treatment if their parents do not have the funds to pay for it.

These concerns have been considered and the Immigration Bill will not contain a requirement for mandatory health insurance. Temporary migrants who apply for a visa (in a

non-visitor category) will pay a flat rate health surcharge per family member, which will entitle the family to free NHS healthcare, subject to limited exemptions for certain treatments. Migrants who do not pay the health surcharge will not normally be granted permission to enter or remain in the UK – therefore in most family cases the issue of paying separately for treatment will not arise. Immediately necessary and urgent treatment is never withheld and treatment on the grounds of public health will also remain free of charge.

Under current arrangements, where children are chargeable for NHS treatment as overseas visitors, their parents or guardians are responsible for meeting the costs. This situation will not change.

Children in local authority care are exempt from NHS treatment charges and will not be required to pay a health surcharge in the future.

One respondent stated that children would be negatively affected by these proposals, including – a) the risk of losing their healthcare entitlement following domestic abuse and/or family breakdown; b) that children also have a range of age-specific health needs which are met by primary care and that they are also particularly affected by infectious diseases; and c) children of migrants who are born in the UK will experience follow-on effects from any restriction on maternity services.

These concerns are unfounded. As already noted, if a relationship with a British citizen or a person settled in the UK has broken down as a result of domestic violence, a person may be able to apply for indefinite leave to remain here (otherwise known as permanent residence). The applicant is able to include children in their request for permanent residence. All permanent residents, including children, will as now not be chargeable for their healthcare.

Where a migrant family has paid the health surcharge for the duration of their stay in the UK, they will continue to receive free healthcare for the remainder of their grant of leave even in the event of a family breakdown. The proposals that will be contained in the Immigration Bill will not affect primary care services (including primary care services for children), and the consultation document has made clear that treatment on public health grounds - for infectious diseases – will remain free of charge.

| | | | |
|---|---|---|---|
| **SCS sign off** | *Kristian Armstrong* | **Name/Title** | Head of Asylum, Criminality and Enforcement |
| **I have read the available evidence and I am satisfied that this demonstrates compliance, where relevant, with Section 149 of the Equality Act and that due regard has been made to the need to: eliminate unlawful discrimination; advance equality of opportunity; and foster good relations.** | | | |
| **Directorate/Unit** | Enforcement Partnerships Team | **Lead contact** | Enforcement Partnerships Team |
| **Date** | 23 September 2013 | **Review Date** | 2016 (Two years after implementation) |

**Part 2 - Policy Equality Sign-off**

N.B. The PES can be completed throughout the development of a policy but is only signed at the point the policy is made public i.e. finalised and implemented.

To assist in evaluating whether there is robust evidence that could withstand legal challenge, the following questions must be asked prior to sign-off.

**Q.** Has 'due regard' been made to the three aims of the General Duty (Section 149 of the Equality Act 2010)?

- **Eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
- **Advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
- **Foster good relations** between people who share a protected characteristic.

**Q**. Have all the **protected characteristics** been considered – age; disability; gender reassignment; pregnancy and maternity; race (includes ethnic or national origins, colour or nationality); religion or belief (includes lack of belief); sex; and sexual orientation?

**Q**. Have the relevant stakeholders been involved and/or consulted?

**Q**. Has all the relevant **quantitative and qualitative data** been considered and been subjected to **appropriate analysis**?

**Q**. Have lawyers been consulted on any legal matters arising?

**Q**. Has a date been established for reviewing the policy?

Further resources including: Case Law; Equality Assurance Table; examples of best practice are available on Horizon.

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