



Migrant Healthcare Access in Northern Ireland: Current and proposed arrangements and the potential impact of Immigration Reform

Northern Ireland Strategic Migration Partnership
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About NISMP

Northern Ireland Strategic Migration Partnership (NISMP) aims to work across the spheres of government in Northern Ireland and with other key stakeholders to ensure that Northern Ireland is a welcoming place for new migrants. It seeks to support the retention and integration of people in a way that helps meet skills and labour needs to support future economic growth. It provides a regional advisory, developmental and consultative function, enabling our partners and stakeholders to develop an appropriate Northern Ireland migration policy structure. This will ensure that Northern Ireland's needs and concerns in respect of immigration are recognised within the constraints of UK wide strategy. This paper will speak to issues directly impacting Northern Ireland in the wider context of UK immigration policy. It has been approved by representatives on the Partnership. However this does not necessarily reflect the views of Partner Organisations, some of whom have not been canvassed.

Introduction

The aim of this paper is to make clear the specific circumstances of Northern Ireland in relation to the proposed changes relative to those in the rest of the UK. It will seek to do so by:

- Providing a brief overview of migrants and healthcare in Northern Ireland
- Outlining the current arrangements in Northern Ireland as they differ from the rest of the UK;
- Highlighting the impact of the land border of the Republic of Ireland on the provision of primary healthcare to non UK citizens;
- Describing current pressures and difficulties resulting from migrant access or restrictions on migrant access; and
- Outlining the areas where the proposed changes in the Immigration Bill will have the most significant impact on Northern Ireland.

Background – Migrants and Health in Northern Ireland

Northern Ireland has historically been a country of emigration rather than one of immigration. However with the stability of the region resulting from the Good Friday/Belfast Agreement, and the expansion of the European Union, Northern Ireland experienced a period of significant demographic change. Between 2001 and 2009, the rate and nature of immigration to Northern Ireland saw substantial changes occur. During this time period it is estimated that upwards of 110,000 migrants came to Northern Ireland (OFMdfM, 2011: p4). Where previous immigrants to Northern Ireland tended to be from former commonwealth countries- China and India respectively – Eastern European migrants became the largest numbers, with Poland currently the country with the largest number of nationals living in Northern Ireland. During the tenure of the Worker Registration Scheme, figures showed relatively high numbers of migrants from A8 countries, compared with the UK as a whole (OFMdfM, 2011: p5). More than half of those were from Poland, which continues to be the largest national minority group in Northern Ireland. While many migrants have remained, others have returned to their home countries.

Since 2009, migration figures in Northern Ireland have begun to stabilise, and most recent figures indicate a slight decrease in international in-migration (NISRA 2013b: p4). Most recent

figures from the Northern Ireland Statistics and Research Agency (NISRA) show that a total of 12,900 people came to live in Northern Ireland from outside the UK in the period from mid-2011 to mid-2012 (2013b: p1), with migrants from outside of the UK and Republic of Ireland making up roughly 4.5% of the overall population (NISRA, 2013b: p9) as identified in the 2011 census. Only 2% of the overall population – roughly 36,000 people - is composed of migrants from outside of the European Union (NISRA, 2013b: p9), and it is unclear in the census data what the immigration status of these individuals is, and as such not possible to determine their entitlement to healthcare in the UK under new immigration proposals.

In spite of stabilising numbers, Northern Ireland continues to deal with the fall-out from years of uncharacteristic demographic change in the delivery of public services. This is true of the healthcare sector, where it is evident through rising demand for interpreting services, variance in requirements for specialised dietary needs and an increase in births to foreign mothers – the rate of which has risen from 3% in 2001 to almost 10% in 2010 (OFMdfM, 2011: p6). However due to the nature of the migrant population in Northern Ireland, these consequences are not altered by immigration control. In fact there are some circumstances in which there is the potential for immigration restrictions to pose further problems in the delivery of healthcare to migrants in this region. These circumstances will be examined throughout this paper.

Current Health Access Arrangements in Northern Ireland

In Northern Ireland, healthcare is devolved to the Northern Ireland Executive under the auspices of the Department of Health and Social Services and Public Safety (DHSSPS). Health reforms in 2009 established several health authorities with various responsibilities under the DHSSPS. Northern Ireland is different to the rest of the UK in that it provides for an integrated system of health and social care. In addition, Northern Ireland shares a land border with another EU Member State, the Republic of Ireland

Direct responsibility for health and social services provision is in the hands of the health and social care trusts, and patient registration is managed by the Business Services Organisation (BSO). While a GP, in theory has the discretion to register patients, in practice this does not happen as payments for treatment of patients is normally based on the patient having been registered through BSO. The Public Health Agency is responsible for overall population health and social well being improvement, health protection, and public health support to policy-makers and as such has a direct interest health and well being of migrants and their relationship to the overall population's health.

At present, access to healthcare in Northern Ireland is based upon the ordinarily resident test. Migrants who are deemed ordinarily resident are entitled to free healthcare in the region. The guidance on foreign nationals states that restrictions exist only around lawful residence, so those who have legally entered the country and maintain legal status under immigration law for more than six months have full access to the following services:

- GP registration
- Utilisation of all medical and social services
- Secondary care provision where there are not charges – with the exceptions of dentists and opticians as is the case for the wider population .

Anyone in Northern Ireland, regardless of residence, is entitled to the following services free of charge:

- Emergency treatment at A&E;
- Treatment of diseases on the Notifiable Disease List (NOID);
- Family planning;
- Treatment of sexually transmitted diseases and testing for HIV (treatment for HIV not covered);
- Mental health treatment where the treatment has been deemed compulsory (Belfast Health Development Unit, 2011: p27).

What Present Proposals Mean for Northern Ireland

In a meeting hosted by the Home Office in Northern Ireland, one participant from a health and social care trust described the measures outlined in the immigration bill as a 'sledgehammer to crack a walnut.' There is a sense that in Northern Ireland, the overall cost of the implementation of these proposals would be more than the costs recovered by charging temporary migrants for health services. There are two key reasons why this could be the case: the nature of the migrant population in Northern Ireland and the cost of administering emergency care versus the cost of delivering primary care. Additionally, there are potential implications on a public health level, the potential denial of health services to individuals with complex immigration status but with legal entitlement to care, as well as increasing the likelihood of racial profiling and inequalities in the health service.

Hosting only 1% of the overall population of non-EU migrants in the UK (Home Office, 2013b p8), Northern Ireland is unlikely to see a relatively high impact on health services as a result of non-European migration. While there are not specific figures on usage of the NHS by temporary, non-EU migrants in Northern Ireland, statistics on interpreting services across health trusts in Northern Ireland for June-September 2013 give some insight into the nationalities of those accessing health professionals. Most recent figures indicate that the highest usage for interpreters in the health services is for European languages. This is consistent across all six health and social care trusts and the prominence of European languages is substantial (Regional Interpreting Service, 2013). Based on the migrant profile in Northern Ireland and the assessment of relative impact on local health services outlined in the report, it could be concluded that the most substantial impact on health services by a migrant group is outside of the control of immigration legislation, and limiting the access of non-EEA migrants will have little to no impact on overall provisions of health services in this region. The 'healthy migrant effect', the notion that non-EU, highly skilled migrants tend to be relatively young and healthy migrants (Home Office, 2013b) would suggest that this group has little to no negative impact on healthcare services. The 'healthy migrant' conclusion is supported by 2011 census data in Northern Ireland, which indicates on the whole those individuals from outside the EU have a lower average age and higher proportion of employment in high skilled jobs, and individuals from BME groups reported lower rates of long term poor health and disability – particularly those from an Asian ethnic background, which had the lowest rates of poor health and disability of any ethnic group (NISRA, 2013a). There are some conditions and illnesses which have a higher prevalence amongst migrant communities, which will be discussed in the following section, however, overall evidence would suggest that there is a chance that the costs of

administering changes to accessing the NHS may outweigh overall present costs – which appear to be minimal. A pilot programme was recently carried out in the region, in conjunction with the Home Office, on collecting fees from chargeable hospital patients. While at this point the evidence from this pilot has not been published, anecdotal evidence from those involved indicates difficulty in the administration of the scheme. It would be useful once this data becomes available to learn from the difficulties arising from the pilot.

At present, determining eligibility for healthcare provision is a sensitive and complicated process, which requires significant staff time, training and background knowledge. There are already concerns raised by the voluntary and community sector of individuals who have entitlements to health care not being able to access those services due to confusion over eligibility on the part of those administering care (Health Development Unit, 2011). This problem is likely to be heightened when more restrictions are introduced, with further differentiation between migrant groups being added to an already murky understanding of which migrant groups have rights to access free healthcare. This could lead to human rights violations as those with entitlement to care are denied that care, as well as cost implications at two levels – increased administrative costs and health concerns being dealt with in a more expensive manner, through secondary care.

The notion of health tourism and associated abuses supported by anecdotal evidence (as referred to in the consultation paper for the Immigration Bill) of the NHS by migrants is inconsistent with statistical evidence on migrants and use of the social security and welfare system which indicates that migrants are less likely than the overall UK population to be benefit abusers (though there is no Northern Ireland specific data on this). It is also refuted in the data referred to above describing the relative health of BME and migrant populations in Northern Ireland.

Cost of Administering Secondary versus Primary Care

The second set of concerns over the is in the high cost of secondary care. A report by the Health Foundation (2010) using the quality outcomes frameworks established in 2004 utilised a database of 50 million patients to evaluate the impact of improved primary care using indicators of mortality and care costs. The research states that while there is not significant evidence of healthcare cost reduction in the case of general preventative measures, there is value in targeting specific at risk groups for intervention. Northern Ireland has a persistent problem with strain on hospitals. The region has more people admitted to hospital than the rest of the UK and overall patients in Northern Ireland have longer hospital stays (DHSPSSNI, 2013). This poses a significant cost to the NHS, as secondary care costs are significantly more expensive. Appointments with GPs average £25/visit, as opposed to a visit to A&E, which starts at £83/visit (Law Centre NI, 2013). In addition to the same risks associated with a lack of emphasis on primary care treatment resulting in increased hospital usage, there is a slight but notable prevalence of certain illnesses in migrant population which are most appropriately treated through primary care. These include diabetes, cardiovascular disease, helicobacter pylori infection, vitamin D deficiency and related illness, iron deficiency and anaemia (Belfast Health Development Unit, 2011). Without access to free primary care, there is a risk that otherwise manageable conditions could deteriorate, requiring more serious hospital care at a

much higher cost to the NHS than regular primary care treatment. There are also specific issues around lower uptake of maternity services, higher prevalence of post-natal depression, and a higher occurrence of domestic violence among BME groups (Belfast Health and Development Unit, 2011). –these issues all have the potential to suffer without access to primary health and social care services or where there is additional confusion over access to those services.

Conflict with Key Principles of DHSSPSNI Transforming Your Care Strategy

The consultation document *Transforming Your Care* was produced by the Department of Health, Social Services and Public Safety in Northern Ireland in December 2011. It is a review of health and social service delivery in Northern Ireland, and outlines a set of clear principles which will underpin a reform of healthcare policy and provision in the region. The review identified twelve ‘principles for change’, several of which are important to the current proposals in that implementation of these proposals could result in service provision which contradicts the following:

1. *Using outcomes and quality evidence to shape services* – As mentioned, there is little evidence of health tourism in Northern Ireland, and the anecdotal evidence falls outside of the categories of temporary migrants referred to in the changes. The problems identified describe individuals coming to Northern Ireland specifically for medical treatment without a legal right to reside in the region. Evidence does exist pointing to institutional barriers to healthcare access for those who have legal entitlement and will continue to have legal entitlement if proposals are adopted. Implementation of new restrictions would be addressing an issue which is not supported by clear evidence in the region, and potentially exacerbating a complication for which there is an evidence base.
2. *Providing the right care in the right place and at the right time* – This document outlines several areas where denying access to primary care services could place additional strains on emergency services. This increases the likelihood of preventable illness developing into serious maladies, which has economic, public health, and human rights implications.
3. *A focus on prevention and tackling inequalities* – This document has referred to the issue of denying primary care access and its long term consequences. It also outlines several areas where these proposals have the potential to not only fail to tackle existing health inequalities, but to exacerbate them amongst certain communities.
4. *Safeguarding the most vulnerable* – It is well documented that BME and migrant communities are amongst the most socially excluded groups in society. They are at greater risk for multiple deprivation, to be victims of crime and to live in inadequate accommodation. While many of the migrants in the group most affected by the proposals could fall outside some of these categories of deprivation, the knock-on effects of increasing barriers to healthcare and making eligibility for services more complex run the risk of impacting upon other BME and migrant groups regardless of eligibility;
5. *Realising value for money* – More evidence is needed to determine what the administrative costs involved in implementing these proposals, however early stages of anecdotal evidence from pilots around private patients indicate that additional layers of bureaucracy in administering healthcare access creates problems which have implications for time and resources. Given the limited estimated cost to the health

service incurred by temporary migrants, it is unlikely that these proposals would realise value for money.

Public Health Concerns

While the majority of migrants to Northern Ireland are largely healthy and do not pose significant health risk to the population as a whole (Health Development Unit, 2011), there are some public health issues associated with denial of free primary care for migrants. Some infectious diseases, such as TB and HIV have higher rates amongst non-UK nationals, and in winter of 2012/2013 there was an outbreak of measles amongst one migrant community in Belfast – resulting in several hospitalisations and an emergency vaccination take up initiative (Law Centre NI, 2013).

Increasing Inequalities and Racial Profiling in the Health Service

A recent study into the health and well-being of migrants in Belfast identified a series of institutional problems in healthcare access amongst migrants. Common barriers were identified including confusion and fears about access to healthcare amongst several groups, lack of confidence and trust in professionals through difficulties in accessing the system, institutional racism and negative attitudes of some staff, lack of prioritisation of staff training and cultural awareness, and confusion about immigration restrictions (Belfast Health Development Unit, 2011). The study identified priorities for action, two of which were improving access in healthcare for migrants and improving training and guidance to healthcare professionals. By increasing restrictions to healthcare for certain migrant groups and further complicating eligibility, there is a risk that already overstretched services with unmet training needs will inadvertently add to a sense of institutional racism and racial profiling through implementation of these proposals.

Reducing health inequalities has been identified as an area of focus for the Department in its recent policy review (DHSSPS, 2013), and inequality in healthcare access has already been identified as a problem in BME and migrant communities in Northern Ireland (Belfast Health and Development Unit, 2011). The introduction of the restrictions proposed in the immigration bill have the potential to worsen inequalities, adding layers of exclusion based on multiple indicators of deprivation. For example, restrictions of access to treatments such as IVF are very complex in nature as they impact even more directly on citizens of the UK who are entitled to such treatments. For example a couple with one British Citizen and one ‘temporary migrant’ could be subject to restricted access to IVF treatments based on one of the couple’s immigration status. How would this be applied in practice? Would a couple where the UK Citizen is a female be able to access IVF treatment but not where the UK Citizen is a male (because the nature of the treatment is such that the female is the direct recipient of the treatment)? If so, there is a strong case for gender discrimination as well as potential for discrimination against same sex couples of whom one partner is not a UK citizen. This would be an issue if the health levy was conditional on age and status of health, as it would be a public agency directly discriminating on the grounds of categories like age and disability.

Additional Concerns

There are several additional concerns with the implementation of the healthcare aspects of the immigration bill. First, there are gaps in important details in several areas which depending on

how the bill is implemented could create complexities and administratively expensive outcomes. It fails to identify the status of those migrants already on temporary visas, and how differentiation is made at the point of administration for those individuals (ie: if a levy is to be applied at the point of visa, how will those individuals be charged and therefore show evidence of eligibility for treatment)? If the money collected from the health levy is administered in a manner similar to the now defunct Migrant Levy, there is a risk that the money will not be directly allocated to the health and social care trusts, and as such there would not be any mitigating impact on healthcare costs to service providers. Finally, these proposals do not acknowledge the pathway to naturalisation and citizenship which is the case for many temporary migrants in Northern Ireland. This is important in NI, which has a larger proportion of migrants who are part of a family unit than many other regions (according to verbal evidence in several forums) which makes them more likely to be future candidates for indefinite leave to remain. Preserving and encouraging the health and well-being of individuals who are at an early stage of the naturalisation process will have long-term benefits for the National Health Service, as they will eventually have access to free health provision.

Options to Mitigate Impact on Northern Ireland

There are several considerations relating to the above concerns which could mitigate negative impacts on Northern Ireland without major disruption to the immigration bill. These options are outlined below.

1. Adoption of a Health Levy rather than Health Insurance for Chargeable Patients

NISMP welcomes the adoption of a health levy rather than an insurance scheme. Many of the concerns around administration and equality which arose during discussions of this bill surrounded the issues of a private health insurance schemes. Questions over how administrators deal with private health insurance within a health service not based upon an insurance system, who is responsible for validating the authenticity of the insurance, and what minimal thresholds for coverage would be required could add layers of administration with cost exceeding overall savings to the health service in Northern Ireland. The difference in cost of coverage and eligibility for insurance varies significantly across age, state of health, disability and gender. This raises concerns about equality, and risks contradicting Section 75 of the Northern Ireland Act which states that public authorities should have due regard to equality issues. For reasons of equality the health levy should not be dependent on factors such as age, gender, health status, etc. and should instead be a flat rate for all affected migrants.

2. Recognition of the Right for Devolved Administrations to conduct Equality Assessments in accordance with its own legislation

There are several potential areas of concern for equality in the implementation of this bill. Some have been flagged up in this paper. Section 75 of the Northern Ireland Act makes clear the duty on public authorities to pro-actively have regard to equality issues among certain groups in Northern Ireland. As such, flexibility within the immigration bill for a devolved administration like in Northern Ireland to apply equality impact assessments based on its own legislation is important. .

3. Ringfencing of any Associated Funds for Direct use by Local Health organisations

Given that the proposals outlined have the stated aim of reducing costs to the health service, it is important that the health service is the direct recipient of the funds collected. Previous similar schemes, notably the Migrant Levy, did not ringfence funds, and there has not been transparency in how they were utilised. In times of significantly restricted resources for public services and the potential increase in administrative costs in implementing the bill, it is vital that monies collected for the benefit of the health service are reallocated specifically for that purpose.

4. Provision of Training/Resources for Training of Front Line Staff

This paper has outlined the potential risks in administrative costs, increased confusion over eligibility, and the potential for racial profiling. To pre-empt these concerns, it would be useful to ensure sufficient increase training is given to staff directly involved in registering patients and collecting associated evidence and payments. At the very least, this money should be taken from the funds raised by the levy.

5. Working with Devolved Regions to Address Current Complications Around Entitlement for Asylum Seekers, Refugees and Migrant Children

There is also the need to work directly with health and social care agencies locally to improve systems which at present complicate access to healthcare for individuals who are entitled to free health services and will remain entitled under the current proposals. One example is the delays associated with renewal of the medical cards for asylum seekers. At present, individuals waiting for asylum decisions are having trouble accessing primary care services due to delays in paperwork coming from social security in the UK. Working directly to address these concerns could help minimise any negative impact increased restrictions of migrants accessing healthcare, and ensure individuals who are entitled to health care receive it when it is needed- increasing the incidence of those who are entitled being blocked or delayed in accessing those services.

6. The Development of a Pilot Scheme for Alternative Primary Care Treatment for those with no Recourse to Public Funds

The DHSSPSNI *Transforming Your Care* document points to the importance of primary care in the efficient treatment of patients, the need to focus on prevention, and a desire to provide care to the most vulnerable in society. There is evidence that lack of access to primary care services has led to inappropriate use of A&E services, as well as threatening public health. Northern Ireland has strict rules surrounding access to GP services as a result of its land border with the Republic of Ireland, but given the concerns raised in this paper there would be value examining other options for delivering primary care to vulnerable groups who have issues with entitlement to NHS primary care. NISMP would welcome the development of a pilot scheme with an innovative approach to delivering services to those with no recourse to public funds with the objectives of reducing risks to public health, reducing strain on A&E services, and reducing health inequalities for vulnerable groups. This proposal would be consistent with arguments made in the responses to the Immigration Bill consultation from the Royal College of GPs (2013) and the British Medical Association (2013).

Conclusions

The nature of the migrant population in Northern Ireland, the relatively low numbers of third-party nationals, and the 'healthy migrant effect' associated with the demographic most impacted by the proposed changes to healthcare access outlined in the immigration bill mean the proposals are unlikely to create notable savings to the health service in Northern Ireland. This paper has outlined the potential for the implementation of these proposals to have the reverse effect, potentially creating further administrative complexity and increased cost in the long term. The proposals contradict many of the principles of the DHSSPSNI's new Transforming Your Care strategy, as well as potentially running counter to local equality legislation. While the Partnership respects the reserved nature of immigration issues, it would be of considerable benefit to both the Northern Ireland Executive and Westminster if there was some local control exercised over the implementation of what is effectively a devolved matter. This paper provides some options to exercise that control without significant disruption to the immigration bill.

Resources

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