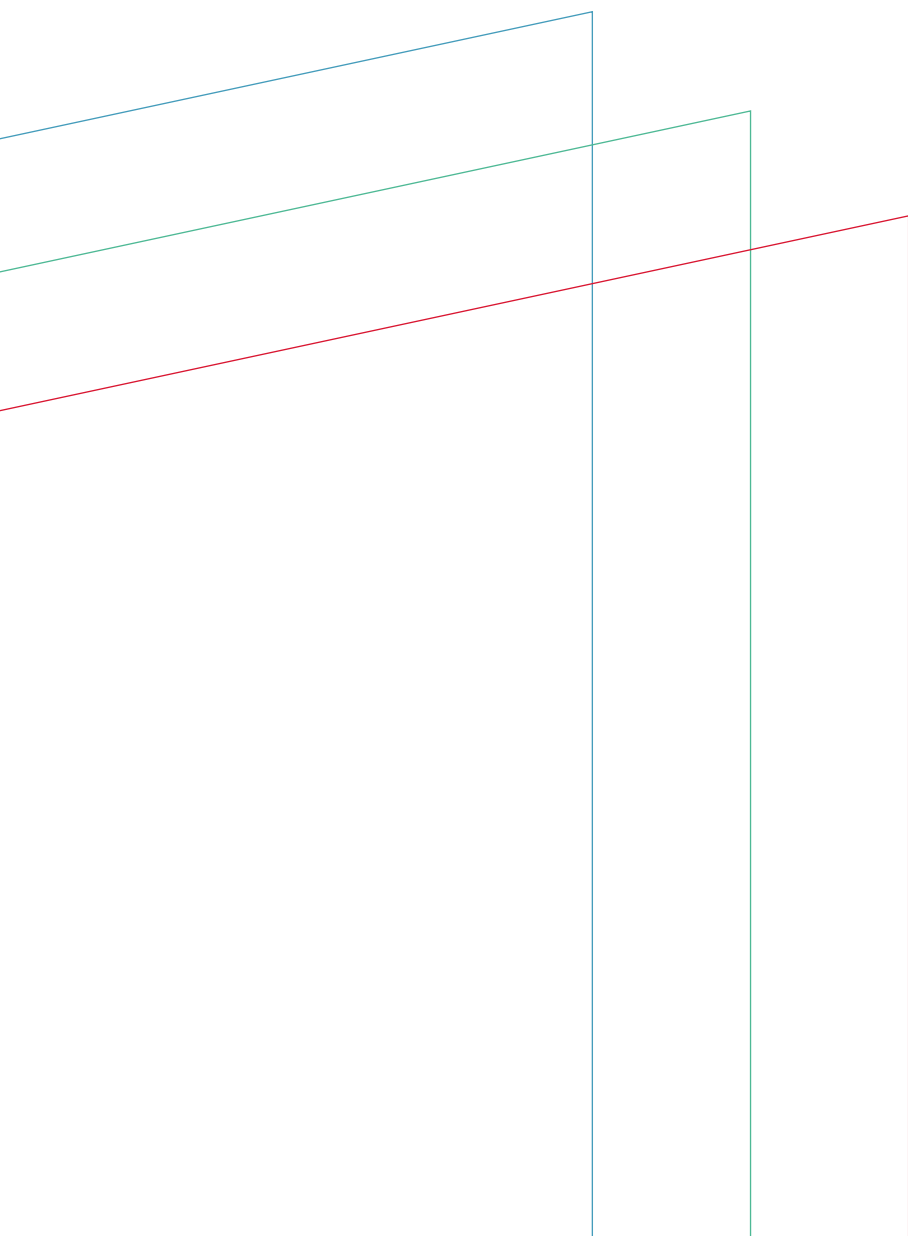


PATIENTS NOT PASSPORTS

LEARNING FROM THE
INTERNATIONAL STRUGGLE
FOR UNIVERSAL HEALTHCARE





CONTENTS

SUMMARY	2
INTRODUCTION	5
WHAT IS IN THIS REPORT?	5
THE HOSTILE ENVIRONMENT IN THE NHS	6
Key policies	6
The government's justification	6
Evidence of impact	7
Opposition	10
Historical roots	11
INTERNATIONAL ACCESS TO HEALTHCARE	12
Access to healthcare in Spain	13
Access to healthcare in Italy	17
Access to healthcare in Germany	19
Access to healthcare in Sweden	20
LEARNING FROM INTERNATIONAL POLICY AND PRACTICE	23
LEARNING FROM INTERNATIONAL OPPOSITION AND RESISTANCE	26
CONCLUSION	31

SUMMARY

This report focuses on the set of policies introduced as part of the government's Hostile Environment immigration policies – which restrict access to public services and criminalise everyday activities – to expand border enforcement into the National Health Service (NHS) and restrict access to healthcare.

To understand what might happen if the government continues to restrict access to healthcare in this way, we explore what can be learned from international practice, describing levels of migrant access to healthcare across Europe and the impact of different policies and practices.

Throughout the report, we highlight campaigns and movements that have successfully challenged barriers to accessing healthcare. We hope that these experiences of broad-based opposition to charging migrants for healthcare, and their achievements in improving the accessibility of health systems, will be instructive to healthcare professionals, healthcare bodies, unions, and campaigners here in the UK, and help inform collective organising against the policy in the months and years ahead.

Despite differences in policy and context across the countries reviewed in this report, there is a remarkable uniformity in terms of how restrictive policies are introduced and the arguments used to support them. However, these arguments often lack evidence or directly contradict existing evidence bases. When restrictions have been implemented, it is clear that they harm migrant health and increase costs for health systems. Invariably, restrictive policies are met with multifaceted resistance from local and regional governments, healthcare professionals, non-governmental organisations (NGOs), migrant communities, and wider populations demanding change.

THE HOSTILE ENVIRONMENT IN THE NHS

The Immigration Act of 2014, and further regulations in 2015 and 2017, expanded the range of NHS services that are subject to charges. Those without leave to remain in the UK now must

pay an additional visa fee to access the NHS (the “Immigration Health Surcharge”), and NHS Trusts are required to check the eligibility of patients for care. Those unable to prove their eligibility are charged up to 150% of the cost price for secondary and community care services. Behind this, NHS Trusts share patient data and report patient debt to the Home Office, information which is then used by immigration teams to track, detain, and deport people.

The government has attempted to justify these policies by referring to the alleged strain placed on the NHS by migrants and the need to recuperate the cost of providing care to ‘overseas visitors’. They have frequently invoked the narrative of ‘health tourism’ that is widespread in the media. However, these arguments are misaligned with the principles of the NHS and the economic realities of migration and healthcare.

Evidence collected about the impact of implementing the charging regulations so far shows that migrants – including those entitled to care under current policy – are deterred from seeking care, face great delays in accessing treatment, or have care denied outright. This is compounded by data-sharing agreements between NHS bodies and the Home Office. By presenting barriers to upstream, preventative care, charging regulations and data sharing risks worsening health and displacing healthcare demand towards more costly acute, emergency care.

Resistance to the Hostile Environment in the NHS is gaining ground through networks of locally organised groups of healthcare workers joining forces with migrant community groups and NHS campaigning organisations. Grassroots opposition has been accompanied by opposition from civil society and healthcare organisations, from the British Medical Association (BMA) to the Academy of Medical Royal Colleges and the Royal College of Midwives.

It is important to acknowledge that charging is not a recent development. A similar charging policy, with a similar rationale, was introduced in the 1980s and was met with widespread resistance from trade unions, migrant organisations, law centres, and health professionals. The No Pass Laws to Health campaign formed as a key umbrella organisation for this resistance. This resistance is

the antecedent to today's organising initiatives under the banner of the Patients not Passports campaign.

LEARNING FROM INTERNATIONAL POLICY AND PRACTICE

Based on a review of existing international comparisons and deep dives into four case study countries – Italy, Sweden, Germany, and Spain – we can see that migrants are frequently excluded from healthcare systems.ⁱ This is despite international commitments from host countries to the goal of Universal Healthcare Coverage and, in many cases, claims from those countries to have reached this goal in practice.

Across each case study country, migrants face a range of barriers to accessing care. Broadly, these are the result of (1) restrictive national policy; (2) the integration of healthcare and immigration enforcement; and (3) the administration of healthcare in practice, such as requirements to show identification or proof of address, which can be hard for some to produce.

Across all the countries studied, there is evidence that restrictive national policy harms migrants. In Spain, where this impact was quantified, researchers found a 15% increase in mortality amongst the migrant population – corresponding to 70 additional deaths per year – as a direct result of restrictive reforms over a three-year period. This is despite many regional government attempts to soften negative impacts by bypassing national law to varying degrees.

Across Europe, governments have attempted to justify restrictive healthcare policies on similar terms to Westminster. The principle of so-called health tourism is invoked, as is the need to keep costs down. There is strong evidence from across case study countries, however, that restricting healthcare for migrants' costs, rather than saves, money. Researchers in Germany, for instance, found that restricting the healthcare entitlements of asylum seekers cost the health system over a billion euro compared with offering unrestricted access.

While policy and practice in the countries studied have waxed and waned significantly in recent years,

and while there is still some way to go, the general trend across countries is towards more inclusive health coverage, with migrants better able to access healthcare and enjoy their rights. This change has not occurred as a result of national governments voluntarily responding to the evidence but is rather the result of multifaceted opposition and pressure from city and regional governments, healthcare workers, civil society, NGOs, international organisations, and wider publics.

Given the domestic evidence about the negative impact of NHS charging, and the international evidence about healthcare restrictions highlighted in this report, it is damning that the UK government continues to pursue these policies. Unless the government repeals the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2015 and 2017, alongside the Immigration Act (2014), these healthcare restrictions are likely to continue to cause further damage to both health and the healthcare system.

LEARNING FROM INTERNATIONAL RESISTANCE

Across the countries studied, successful opposition to charging policies have used several strategies and tactics simultaneously. These frequently include the following:

- **Mitigation and alternative healthcare provision.** In the shorter term, strategies to oppose restrictive national policies and practices have focused on limiting their negative effects on migrant populations. Mitigation seeks to limit harm by setting up alternative healthcare systems to treat migrants. However, without national policy change, the provision of alternative care outside of the mainstream in this way runs the risk of creating substandard structures of care for migrants and may create a perverse incentive for further healthcare restrictions.
- **Resistance in healthcare settings.** This approach attempts to continue to treat migrants within mainstream health systems, despite exclusionary national policy. It has been achieved by either mass non-compliance by healthcare workers or resistance at a city or regional government level with alternative legislation. Resisting national policy change in this way has

ⁱ The international case studies chosen here are all from Europe because the scope of the review meant that we were constrained by the focus of the existing literature, and because we wanted to focus on countries with both comparable health systems and similar racialisation and demonisation of migrants.

the advantage of limiting the impact of restrictive policy while contributing to efforts to overturn national policies by making them difficult to implement in practice.

There is scope for opposition in the UK to apply some of the strategies and tactics used internationally to resist the Hostile Environment in the NHS in various ways, including both local-level resistance by NHS Trusts and conscientious objection by healthcare workers. This is the arena in which engagement and intervention by unions holds considerable promise. Healthcare workers' opposition to the policy could be strengthened by advice from their unions and representative bodies as to their rights and obligations considering the charging duties.

Public perception and policy change

Opposition in most of the countries examined have set their long-term strategic sights on national policy change and have done so across the countries reviewed using several common tactics, often simultaneously. Most commonly, tactics have included (1) holding large public demonstrations against restrictions and the mobilisation of a broad base of actors to exert pressure; (2) demanding universal access, rather than exemptions; and (3) broadening the argument beyond economics. Across the cases studied, policy change has been the result of this pressure placed on government, rather than a result of voluntary government action due to the evidence that restrictive policies are do not work, endanger lives, and cost money.

The examples in Europe, and previous movements in British history, suggest the following key principles and ideas for taking the movement forward in the UK:

- Continue to employ language that highlights both the moral and economic failings of the policy, as well as its roots in an austerity agenda that further undermines the universalism of the NHS. This can help lay the groundwork for an accurate understanding of the policy, its dangers, and the need for collective resistance to overcome it.
- Ensure that local and individual advocacy is channelled into a campaign for wholesale reversal of the policy, rather than simply focusing on exemptions that set groups against each other and lead to further fragmentation.
- Undertake work that can remind NHS Trusts of their legal obligations – under the Human Rights Act, the Equalities Act, and their duty of care to patients – and that can facilitate them acting in defence of their communities.
- Engage healthcare worker unions and royal colleges in developing guidance for their members that protects their rights and the rights of their patients, supporting them in opposing the policy on these grounds and developing campaigns of mass non-compliance.
- Create opportunities and structures for frontline organisations, often overwhelmed with casework, to develop campaigns around individual injustices that can highlight the egregious and widespread nature of the policy.

INTRODUCTION

When the NHS came into being in 1948, chief among its founding principles was universalism. Paid for by general taxation and free at the point of use, the NHS was set up to be accessible to all based on need rather than ability to pay.

Over 70 years from its inception, the NHS still consistently scores highly in terms of the quality of its services and equality of access to them. In 2014, the Commonwealth Fund ranked the UK's health system first among 11 countries because of its ability to equitably deliver high health outcomes with comparatively low levels of healthcare expenditure.¹ Seven in ten people back the principles behind the NHS, and other options get less public support.²

However, a number of policies designed to limit access to the NHS based on migration status, that have ebbed and flowed throughout the duration of the NHS's history, threaten to prevent it from realising its goal of achieving full universalism in practice. Most recently, as part of their Hostile Environment immigration policies - which restrict access to public services and criminalises everyday activities - the government expanded border enforcement into the NHS and restricted access to care. In 2015 and 2017, new regulations expanded charging for NHS services, accompanied by identification (ID) checks, and required NHS Trusts to check patients' immigration status and eligibility for care. Behind this, NHS Trusts share patient data and report patient debt to the Home Office, information that is then used by immigration teams to track, detain, and deport people.

The COVID-19 pandemic is exposing the dangers of restricting access to healthcare. Public health systems only function when everyone can access services without fear or judgement, yet many feel unable to seek care. Research conducted for the Patients Not Passports campaign by Medact, Migrants Organise, and the New Economics Foundation shows that making COVID-19 exempt from charging has not been enough: migrants are not coming forward for healthcare because of the fear created by the Hostile Environment.³

WHAT IS IN THIS REPORT?

This report explores what can be learned from international practice, to understand what might happen in England if we continue to restrict access to healthcare. It describes levels of migrant access to healthcare across Europe and the impact of different access policies and practices on health and healthcare systems. Throughout, we highlight campaigns and movements that have been effective at promoting universalism and challenging barriers to accessing healthcare. We hope that these experiences of broad-based opposition to migrant charging, and their achievements in improving the accessibility of health systems, will be instructive to healthcare professionals, healthcare bodies, unions, and campaigners here in the UK, and help inform collective organising against the policy in the months and years ahead.

The first section sets out the background - including the details of key policies limiting migrants' access to healthcare, the arguments used to justify them, and the existing evidence base. The second section outlines the findings from a review of policy and evidence from four case study countries. The final two sections discuss the learning we can draw from international examples as well as the strategies and tactics of resistance.

THE HOSTILE ENVIRONMENT IN THE NHS

This section summarises the key policies underpinning the expansion of the Hostile Environment into the NHS, focusing on charging for NHS services, ID checks in NHS institutions, and data sharing with the Home Office. It describes the arguments made by the government to justify the policies, the evidence behind these claims, and the existing evidence of impact so far, alongside the opposition to the hostile environment in the NHS and the history of charging.

For a more in-depth look at the introduction of the Hostile Environment into the NHS, the ideological background, and an overview of likely outcomes of restricting access to healthcare, see Medact's briefing paper: *Patients Not Passports: Challenging healthcare charging in the NHS*.⁴

KEY POLICIES

The Coalition government's Immigration Act, passed in 2014, ushered in a series of changes to who is eligible to access free NHS services. The Act itself tied entitlement to care to immigration status by restricting free services to those who have indefinite leave to remain in the UK.

In 2015, new regulations placed a legal duty on NHS Trusts to identify those not able to prove their eligibility for free care, and to charge those migrants up to 150% of the cost of treatment for all secondary care (with some exemptions).⁵ It also introduced the Immigration Health Surcharge: an additional fee that those applying for visas for longer than six months have to pay to access the NHS, as part of the application process.⁶ The surcharge has been subject to several rate increases since 2014, rising from £200 to a planned £624 per person per year in 2020. In May 2020, the government gave in to mounting pressure and exempted health and social care workers from the surcharge, but it remains in place for other migrants.

In 2017, further regulations required NHS Trusts to collect fees upfront before care is provided, and extended the charging requirements to include some community services, such as community care and mental health services.⁷ NHS Trusts were also mandated to record people's chargeable status on their patient records.⁸

There are some exceptions to these arrangements. If treatment is determined to be 'urgent' or 'immediately necessary', then care cannot be withheld regardless of the patient's ability to pay upfront. However, they are not exempt from charges, which are then collected after treatment. In theory, those seeking asylum are exempt while awaiting the outcome of their asylum claim, as are certain at-risk groups, such as survivors of domestic abuse, torture, or trafficking. As we show in the evidence section, however, the complex nature of the charging regulations means that many health professionals and patients are unsure about who is and is not subject to them, or which parts of their treatment are chargeable or not. Consequently, even those entitled to free care face barriers to access in practice.

The expansion of charging is not an isolated policy development: it is part of the government's self-described 'hostile environment' agenda. Alongside ID checks and upfront charging, the Hostile Environment impacts people's ability to access the NHS through a number of intersecting policies, including measures to encourage NHS England to share patient data with the Home Office. Regulations in 2015 guided NHS Trusts to report patients with NHS debt to the Home Office, information which can then be used by the Home Office as a reason to refuse visa applications or deny entry to the country at the border. The patient's personal details, such as their address, are also shared with the Home Office and used by immigration enforcement teams.

THE GOVERNMENT'S JUSTIFICATION

The government has attempted to justify these policies by attributing the financial strain on the NHS to migrants, by claiming a need to recuperate the cost of providing care to 'overseas visitors', and by appealing to the notion that it is fair to make migrants contribute towards the healthcare they receive.^{9,10,11} They have repeatedly used the refrain that 'the NHS is a national, not an international

health service', invoking the narrative of 'health tourism' that is widespread in the media.¹² Echoing previous statements, the government used the refrain 'what people get out, they also put in' to justify charges.¹³

These claims are spurious, for two main reasons. First, they demonstrate a misunderstanding – or perhaps the wilful mischaracterisation – of the principles underpinning the NHS. Contributions have never been a factor in a person's entitlement to care. It is not a system that requires someone to 'put in' before they can use services. Rather, it is about pooling risk and guaranteeing access to care, universally. Charging takes us further away from this ideal by introducing the notion that it is acceptable that some people should have to pay for their treatment or go without. Normalising the practice of charging patients for care, and introducing the bureaucracy to do so, opens the possibility of charging for other groups of people. Indeed, government departments and research bodies have explicitly highlighted the need for a 'change of culture' in the NHS, away from entitlement, if the charging policy is to succeed. The Department of Health, for instance, commissioned Ipsos MORI to evaluate the charging policy, which included an assessment of 'how far the cost recovery programme has led to changes in culture and behaviour among frontline clinical and administrative staff'.¹⁴

Second, these claims misrepresent the economics and history of migration and the NHS. The reality is that migrants are far from a drain on resources. Migrant populations are healthier and use fewer resources than host populations.¹⁵ They also contribute to the cost of public services through taxes and form a large section of the workforce. The NHS itself has depended on migrant workers since its inception. Today almost a quarter of all hospital staff, and a fifth of all health and social care staff, are born outside the UK.^{16,17} Moreover, medical professionals coming to the UK have often received expensive medical training in their country of origin, frequently countries previously occupied as part of the British Empire, for which the UK makes no financial contribution. The NHS, therefore, is in reality a beneficiary of time and resources from elsewhere in the world, and – far from being the result of 'national effort' – is intimately linked to British colonialism.

Evidence of so-called health tourism – where people travel to the UK to seek free treatment – is also weak. The government's own estimates put the cost of deliberate misuse of the NHS at just 0.3% of the NHS budget.¹⁸ This figure includes 'misuse' by British expatriates. As we explain in the evidence section, the cost of implementing charging policies is likely to far exceed this, both due to the cost of the infrastructure required to recuperate costs, and the cost implications of deterring access to preventative care.

The NHS has been under strain in recent years, but neither migrants living in the UK nor so-called health tourists are the problem. Migrants have been scapegoated for real issues facing the health system arising from underfunding at a time of growing demand for care.¹⁹ While the government pledged extra funding for the NHS in its 2019 manifesto, commitments are less than the 3.4% needed to maintain current care standards in the face of rising health needs.²⁰ A study published in the *British Medical Journal* in 2019 compared the NHS to 11 other high-income countries with high-performing health systems on a wide range of metrics.²¹ It found that NHS coverage is still good, and there are few unmet needs due to costs, but austerity is threatening to damage the NHS's standing as a beacon of equity and efficiency.²² They noted that migration is unlikely to be the cause of difficulty, finding that 'both in absolute magnitude and as a proportion of the population, migrants in the UK make up less of the population than the average of comparator countries. Unless migrants coming to the UK are somehow dramatically sicker than those going to other similar countries, they are unlikely to be putting disproportionately greater pressure on healthcare demand in the UK than elsewhere.'²³

EVIDENCE OF IMPACT

Migrant health

There is strong evidence from qualitative and survey research that the Hostile Environment within the NHS is harming migrants. Assessing the full impact of the policies is difficult: as members of the Doctors of the World Expert Consortium on Refugee and Migrant Health note, it 'requires good quality data, and transparent evidence-based policy making. Currently, this is sadly lacking in England.'²⁴ The government did commission an impact review of the charging regulations, but did

not publish the findings – refusing even to share it with MPs on the Health Select Committee.²⁵

Evidence collected thus far shows that charging policies are deterring migrants from seeking care. This is compounded by data-sharing agreements and the threat of the NHS passing information to the Home Office. Research conducted in a Doctors of the World healthcare clinic found that one in three patients were deterred from seeking health care due to charging, including heavily pregnant women and people with cancer, diabetes, cataracts, kidney failure, fibroids, and post-stroke complications.²⁶ Reasons cited included fears of incurring debt or fear of the Home Office being informed about their presence in the country. Researchers found that the deterrent effects of antenatal care charges were particularly stark, with two in three pregnant women in the sample not accessing care at 10 weeks of pregnancy.

‘One volunteer noted that many service users were “terrified of being deported or detained because they cannot pay for the maternity or antenatal care”.’²⁷

Because of the complexity of charging regulations, it is often unclear to healthcare professionals and people in need of care who is and is not eligible for free services, and which services are chargeable. Policies have not been uniformly applied or interpreted. The result is that people who are entitled to care under the current policy are also disengaging from, or being denied, care. There is evidence, for instance, that undocumented people have had lifesaving care withheld or delayed because health professionals have not applied the policy correctly, and asylum seekers with an active claim have been denied chemotherapy and palliative care.²⁸ Research by Maternity Action found several cases where hospitals and GP practices incorrectly refused treatment because of immigration status, in spite of guidelines that maternity care must be provided as immediately necessary.²⁹ A recent study from Medact and the Royal College of Paediatrics and Child Health found that children were also having treatment delayed or denied due to the requirement to prove entitlement to care.³⁰ This included children with cancer and congenital conditions, as well as pregnant women facing complications, resulting in several intrauterine deaths.

The Faculty of Public Health argues that such disengagement from services and denial of treatment can lead to missed opportunities for prevention, which can result in significant harm to those affected. By presenting financial barriers to preventative services, the regulations are likely to deter people from seeking upstream care, resulting in a worsening of health.³¹

Research with patients at a Doctors of the World clinic found ‘significant negative effects on migrants’ physical, psychological and social well-being’. The research also found that charging has placed large debt on migrants, which is in itself a key determinant of ill health.³² Charges levied against patients ranged from £40 to £80,000, with many unable to pay them back. The study found evidence that stress related to debt can compound the symptoms of physical ill health that patients sought care for in the first place.³³

Research by Maternity Action found that invoices, letters, and phone calls from Overseas Visitor Managers (OVMs) ‘induced very high levels of anxiety and fear, affecting their physical as well as mental health’.³⁴ Investigations by *The Guardian* revealed that three-quarters of NHS Trusts were using bailiffs to chase unpaid patient debt, often with little success, indicating that many of the people billed for care simply have no means to pay.³⁵

Finally, the Equality and Human Rights Commission found that delaying treatment is having a displacement effect, with patients attending emergency services rather than routine appointments to manage or prevent disease.³⁶ As well as the implications for health, this is likely to contribute to health system costs – timely treatment is often more cost effective than downstream treatment via acute, emergency care.

‘I think people often don’t access healthcare until it’s a crisis, and then they end up having to go into A&E for conditions that aren’t identified early: lack of screening, long term conditions going untreated, deteriorating, not managed, physical and mental health issues ...’³⁷

Public health

Charging and data sharing deter migrants from seeking treatment for infectious diseases, which presents a risk to both migrants and the health of the wider population, despite such diseases being exempt from charging. One study looked at the impact of the introduction of the Migrant and Visitor Cost Recovery Programme in 2014 on the health-seeking behaviour of people living with tuberculosis in East London. It found a significant increase in time to diagnosis and time to treatment for non-UK-born citizens after 2014, compared with their UK-born counterparts.³⁸

The current pandemic is a case in point. Recent research by Migrants Organise, Medact, and the New Economics Foundation found that migrants were not coming forward for healthcare because of Hostile Environment policies.³⁹ While treatment for COVID-19 is exempt from charging, the exemption is not working. Few migrants know about it. Those who do are fearful of patient data sharing and immigration enforcement: The Department for Health and Social Care has made no assurances that patient data will not be shared with the Home Office. In one publicised case, an undocumented man known as Elvis died in his home from suspected COVID-19, having displayed symptoms for two weeks, but not having sought care, for fear of being charged for treatment and that he or his wife would be reported to immigration authorities.

Staff

The Hostile Environment requires NHS Trusts to check the immigration status of patients and make decisions about who can access care, often by asking healthcare workers to include this in their assessments. This undermines the personal and professional ethical standards that underpin their work, including codes of practice set out by regulatory bodies.⁴⁰ A survey of BMA members found that doctors regularly face pressure from OVMs – members of hospital administrative staff tasked with enforcing the regulations – when making clinical judgements about a patient's need for care. The survey also found that the regulations are having a negative impact on workload, by taking time away from patient care.⁴¹ Anecdotal evidence suggests that patients are selectively asked for ID based on their appearance and that it

is common for OVMs to scan patient lists for names that 'look foreign'.⁴² This could erode trust in health services and health professionals, and undermine professional duties of care expected of NHS staff as well as the equality duty of NHS Trusts.⁴³

Costs

While most of the arguments made for restricting healthcare are based on cost savings for the NHS, the evidence does not support these claims. The government's own research notes that NHS Trusts incur costs to implement a charging regime, both from the employment of the OVMs and from the time spent by healthcare staff screening patients to identify those not eligible for care. Their research estimates the total cost of employing OVMs to be up to £17 million and the value of staff time lost in screening patients to be more than £1 million.⁴⁴ They also report that 'cost recovery is compromised by the fact that undocumented migrants make up the largest group of chargeable overseas visitors, many of whom have few resources to pay charges incurred', making it likely that the NHS will never retrieve the money.⁴⁵

To determine the full financial impact of the policy, it would be necessary to consider further evidence of the resources required to implement the policy and to mitigate its most damaging impacts. These resources would include, for instance, the increased costs for migrant charities supporting individuals faced with NHS debt (frequently when they should not have been charged), free health clinics, outpatient teams, hospital training for staff, production of advertisements and outreach materials, management time, and responses to legal actions. It would also be essential to factor in the cost of deterring people from seeking timely and effective preventative care, which, as already mentioned, displaces demand towards more costly acute, emergency forms of healthcare.



Patients Not Passports protest. From Docs Not Cops (used with permission)

OPPOSITION

Docs Not Cops, set up after the Immigration Act was passed in 2014, is a campaign group of healthcare workers and patients opposing the introduction of the Hostile Environment into the NHS, specifically on the charging regime and the government's attempt to turn NHS staff into border guards.

After the 2017 regulations, Docs Not Cops created the Patients Not Passports campaign to support opposition to charging and data sharing with the Home Office from frontline healthcare workers and communities affected by charging. Medact, Migrants Organise, and later NEF, joined the campaign.

Resistance is now led by a network of locally organised groups of healthcare workers who are joining forces with migrant community groups, and NHS campaigning organisations, supported by Docs Not Cops, Medact, and Migrants Organise.⁴⁶ These campaigns work alongside those directly impacted by NHS charging, such as the Justice for Simba Campaign and Windrush Action, uniting broad sections of their communities in opposition.

The Patients Not Passports campaign has been accompanied by opposition from other NGOs – such as Doctors of the World and Maternity Action, among others – civil society and healthcare organisations. The BMA has called for a full and independent review of the regulations, while the Academy of Medical Royal Colleges and the Royal College of Midwives have both also called for their immediate suspension.^{47, 48} In June 2019, BMA members overwhelmingly voted for a motion calling for an end to all NHS charging and denounced the racism inherent in the Hostile Environment.⁴⁹

Since the COVID-19 pandemic hit, there have been repeated calls for the charging regulations to be suspended, for a firm commitment that the NHS will not share patient data with the Home Office, and for the government to launch an information campaign notifying both the public and NHS staff that everyone can access care safely. These calls have been put to the Minister of State for Health and the Home Secretary in letters signed by 60 MPs, the Mayor of London, the BMA, six Royal Colleges, and over 100 civil society organisations.^{50,51,52,53}

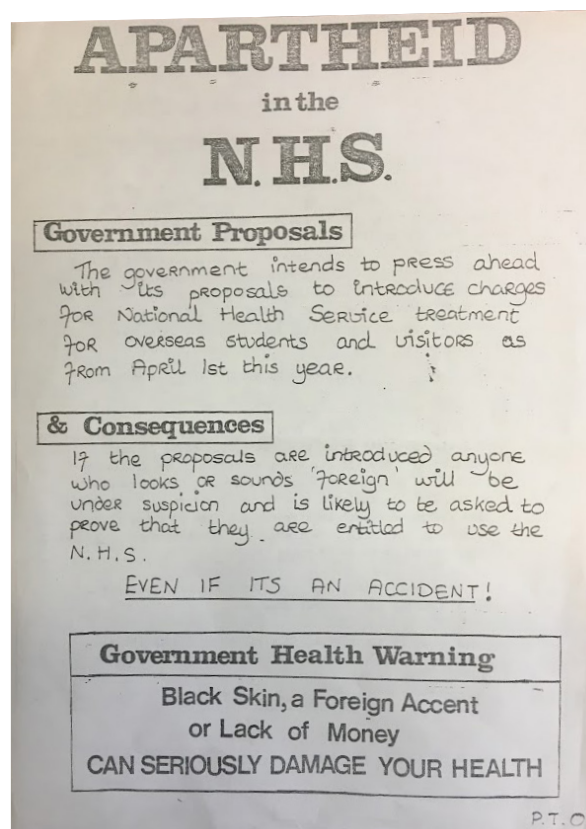
HISTORICAL ROOTS

While the introduction of, and resistance to, NHS charges is often framed as a recent development, it is important to acknowledge the history of NHS charges for migrants. In March 1981, the UK government announced its intention to introduce a policy for the charging of visitors deemed not ordinarily resident for NHS treatment.ⁱ Similar to the 2015 and 2017 regulations, this policy was justified through claims of health tourism and alleged 'widespread abuse' of the health service by foreign nationals. Claiming that the introduction of these charges would save the NHS £5 million, the UK government introduced NHS charges for healthcare on 1 October 1982.

When introduced, the policy elicited widespread resistance from trade unions, migrant organisations, law centres, and medical professionals. The No Pass Laws to Health Campaign formed as a key umbrella organisation for this resistance.

The absence of a statutory duty, coupled with substantial administration costs and the lack of revenue generated, ultimately led to local health authorities deserting the charges. Only seven months into the scheme, Bath District Health Authority abandoned the charging regime having only raised three invoices, while Mid Essex Hospital reported having only raised £4 through charging. By 1984, large numbers of hospitals had abandoned the charging regime altogether.ⁱⁱ

This resistance, although often overlooked, is the antecedent to today's organising initiatives against the Hostile Environment under the banner of the Patients Not Passports campaign, and is further discussed in the learning section at the end of this report.



Flyer used by the No Pass Laws to Health campaign in the 1980s.
From the Institute for Race Relations (used with permission)

ⁱ This was to be done by amending Section 121 of the NHS Act 1977.

ⁱⁱ This historical context is drawn from Dr Kathryn Medien's ongoing research into the history of internal border controls in the UK.

INTERNATIONAL ACCESS TO HEALTHCARE

Most of the world's governments have committed to achieving universal health coverage by 2030, and many countries claim to have healthcare systems that provide universal access to care. The Organisation for Economic Co-operation and Development (OECD), for instance, concluded a report in 2016 by stating that 'most EU countries have achieved universal (or near-universal) coverage of health care for a core set of services'.⁵⁴ In practice, however, this 'universal' access often only applies to those with citizenship or regular residency status. Migrants – particularly undocumented migrants (Box A) – frequently face exclusion.

In 2007, Platform for International Cooperation on Undocumented Migrants (PICUM), the Europe-wide migrant coalition, compared European countries according to undocumented migrants' access to healthcare. They categorised countries according to the following typology:

1. Countries in which all care is provided only on a payment basis.
2. Countries that offer free health care in very limited cases.
3. Countries with wider coverage, but with legislation that is restrictive, ambiguous, and has a high degree of uncertainty.
4. Countries with a parallel administrative or payment system in place for undocumented migrants. However, undocumented migrants are still treated in the mainstream health system.
5. Countries where the spirit of the law is to provide universal access to healthcare. Therefore, free access to healthcare is offered to all, including undocumented migrants.⁵⁵

PICUM found that while EU member states had ratified the right to health via multiple international instruments in human rights law, the practices

of many European states deviate from these obligations.⁵⁶

This section of the report examines access to healthcare in an international and historical context by exploring four case study countries and how access to healthcare has changed since the original PICUM comparison of countries in 2007. The international case studies chosen here are all from Europe. This is both because the scope of the review meant that we were constrained by the focus of much of the existing literature, and because we wanted to focus on countries with both comparable health systems and similar racialisation and demonisation of migrants to ensure that the learning was applicable to the UK context.

BOX A: DEFINITIONS

Often, comparisons are broken into different groups that include refugees, asylum seekers, and undocumented migrants as follows:

- Refugees are people granted or seeking protection from the state as a result of fleeing persecution in their own country.
- Asylum seekers are in the process of making a claim for asylum and have not yet had their claim approved or refused. Once a claim is approved, they gain formal recognition as a refugee.
- Undocumented migrant is a broad category that includes any person who is in breach of immigration rules, including refused asylum seekers, people whose leave to remain has run out, the children of people without leave to remain, and people who do not have the paperwork to claim citizenship entitlement.⁵⁷

These definitions are not comprehensive (many migrants, for example, are on temporary work, student, or marriage visas). In addition, these distinctions are more fluid than this categorisation suggests. A person's immigration status can change quickly and frequently due to changing personal circumstances, rulings, appeals, and the application of the law.

Throughout this report, we use 'migrant' as a catch-all term, encompassing those not born in the country but with different immigration statuses.

The four case study countries – Sweden, Germany, Italy, and Spain – were chosen to represent the two opposing ends of the PICUM typology. Sweden was ranked in the most restrictive category (category 1), with care for undocumented migrants provided on a payment basis at the time. Germany offered free health care in very limited cases (category 2). Italy had a parallel administrative system in place for undocumented migrants, but treated migrants within the mainstream health system (category 4), whilst the spirit of the law in Spain was to provide universal access to healthcare, including to undocumented migrants (category 5).

The case studies draw heavily on pre-existing comparative literature, especially research by PICUM and Doctors of the World, as well as academic and grey literature published in each of the four countries since the original comparison.

Throughout, we attempt to answer four sets of questions:

- Policy barriers: How included are migrants within healthcare systems? How has this changed over time? What mechanisms are used to exclude migrants? How are policies and practices justified?
- Outcomes for health and systems: What is the impact of different policies and practices on health and health systems?
- Drivers of change: What drives changes in policy and practice?
- Successful campaign arguments, strategies and tactics: What campaigns and movements have been effective in challenging barriers to accessing healthcare and promoting universalism? What arguments, tactics, and strategies have they employed?

ACCESS TO HEALTHCARE IN SPAIN

Summary

- Under national policy, migrants are entitled to access healthcare on the same grounds as citizens, but barriers exist in practice, such as fear of being reported to immigration authorities. Proactive actions by some regional governments have helped to overcome access barriers.

- National entitlement has waxed and waned over the last decade, with the government passing a Royal Decree in 2012 restricting access for undocumented migrants to emergencies only. The policy resulted in a 15% increase in mortality amongst undocumented migrant populations over a three-year period and is likely to have increased costs for the health system.
- Regressive policy change led to widespread protest and resistance, eventually eliciting a reversal of the policy. Most autonomous regions refused to implement the policy and passed alternative legislation guaranteeing higher levels of access. Health professionals signed a pledge of conscientious objection. Civil society organisations coordinated the campaign, documented abuses of rights, and countered false narratives pursued by the government.
- The success of the movement is attributable to multiple avenues of resistance and pressure – from healthcare professionals, regional government, civil society and international organisations.

Access to healthcare

BOX B: THE HEALTHCARE SYSTEM IN SPAIN

The Sistema Nacional de Salud (SNS) is, like the NHS, a Beveridge model healthcare system, where healthcare is delivered publicly and financed primarily through taxation. A universal right to healthcare is enshrined within the Spanish constitution.

A difference is that, while use of private health insurance is low, there are higher levels of private expenditure on healthcare. Charges and co-payments for care are more common. The health system is also decentralised, with the national Ministry for Health setting standards and each of Spain's 17 autonomous regions organising health services accordingly.

Under national policy, asylum seekers, refugees, and undocumented migrants are entitled to access healthcare on equal grounds to Spanish nationals.

Over the last decade, however, national entitlement policy has waxed and waned dramatically. During PICUM's 2007 comparison of European countries, migrants were able to access SNS care, free of charge, although there were administrative barriers related to the need to show identification to register for care with municipal authorities. Reforms over the next four years culminated in the 2011 public health law, which set out a right to healthcare for all people living in Spain regardless of their legal status. At the time, the Spanish health system was lauded as the most inclusive and migrant-friendly in Europe.⁵⁸

PICUM notes that including migrants within the mainstream system 'meant the administrative burden on the system was minimal, data on most of the population and their health were available and research found that migrants contributed more to social protection systems, including the health system, than they cost'.⁵⁹

Despite progressive national policy, however, migrants still faced barriers to accessing the health system in practice, including the conditions for registration at municipalities, which proved difficult either due to a lack of relevant documentation or a fear of 'denouncement', i.e., being reported by health workers to immigration authorities.⁶⁰ A number of autonomous regions in Spain took steps to improve access to care by overcoming barriers at a local level. Andalusia, for instance, developed a system whereby undocumented migrants could access the SNS directly, without signing up with a municipal authority.⁶¹

From 2012 onwards, a series of changes brought in by the newly elected Popular Party transformed the nature of the health system in Spain and the healthcare entitlements of migrants under national policy.

In May, the government passed what it called 'urgent measures to guarantee the sustainability of the National Health System' via Royal Decree, thereby bypassing parliament. The decree redefined who was and was not entitled to publicly financed health care in Spain at the time. Prior to the decree, entitlement was guaranteed by residency. The decree restricted access to those categorised as 'insured', which was defined by whether someone was contributing to the society security system. All other citizens – except for dependents of the insured – were categorised as 'uninsured' and were

required to access care on a fee-for-service basis or by paying for additional insurance. This change fundamentally shifted the nature of the health system, undermining the universalism on which it was based, instead linking healthcare rights to an individual's contribution. This is even though healthcare continued to be funded out of taxation, to which many excluded under the new rules would continue to contribute. The Royal Decree redefined migrant rights to access care, excluding undocumented migrants from all but basic emergency, prenatal, and paediatric care.⁶²

The Royal Decree was presented to the public as an inevitable reform to save the health system and a necessary response to the global economic crisis, by which Spain was particularly hard hit. The Royal Decree measures were introduced alongside large budget cuts and the introduction of, and increases to, co-payments for medication and for some health services. In the year the Royal Decree was implemented, the health care budget was reduced by 14%.⁶³

However, the government did not present any evidence or estimates to show how restricting migrant access to care would save money. Several healthcare experts argued that the policy was likely to cost more, rather than less, due to escalating downstream costs and increased public health risks.⁶⁴ Further, public expenditure on healthcare at the time was low by international standards. Spain spent 7% of GDP on healthcare, compared to an average of 7.5% in the European Union.

Evidence suggests that the Royal Decree in Spain excluded approximately 870,000 people from accessing the health care system, the majority of whom were undocumented migrants, and severely harmed the health of the migrant population.⁶⁵ This harm was caused in spite of regional resistance and conscientious objection from health professionals, which is likely to have softened the impact of the policy. One study reports an estimated 15% increase in mortality in the undocumented migrant population over three years after its implementation, corresponding to 70 additional deaths per year because of the reform.⁶⁶

This 15% figure is an average over those years, with mortality rising to 22.6% in the third year. The study also found an increase in the mortality rate from avoidable deaths, or, in other words, deaths from conditions that respond well to treatment



Yo Si Sanidad protest. From Yo Si Sanidad (used with permission)

and should not occur in the presence of timely and effective healthcare intervention. The increase in these avoidable deaths was higher than in deaths from causes that were not easily treatable, though both rose following the Royal Decree. Finally, the study refers to a decline in primary care usage rates and an increase in the rate of emergency service use, suggesting that the economic arguments used to justify the policy were based on very shaky ground. The government, however, did not commission an evaluation of the proposed cost savings of the policy.⁶⁷

The Royal Decree policy proved to be hugely unpopular. Opposition quickly formed (see *Movements for Change*). After the resignation of the Prime Minister in 2018, the government signed a new Royal Decree granting undocumented migrants the right to healthcare under the same conditions as those with citizenship. The new Health Minister stated at the time that 'it is a fallacy to say that excluding migrants benefits the system.'⁶⁸

While a positive step, the new legislation still requires migrants to register and obtain a health care card – a practice known to create barriers to access.

Resistance and opposition

The Royal Decree in 2012 sparked widespread opposition, due both to moral arguments about the right to healthcare and to the bypassing of democratic processes in the change of the law. Helena Legido-Quigley argues that 'the absence of clear economic justification' also sparked resistance, 'with critics also pointing to Spain's relatively low expenditure on health'.⁶⁹ Concerns about undermining migrant rights to health were exacerbated by wider changes to the health system that affected those with citizenship, including coverage restrictions, increased co-payments for care and increasing privatisation of care provision.⁷⁰

Popular discontent

'No es una crisis, es una estafa' (It's not a crisis, it's a rip-off).'

The wider package of austerity in Spain, of which the Royal Decree forms a major part, sparked the 15-M movement. The protestors, referred to as *Indignados* (the outraged), argued against the imposition of austerity and the excesses of banks and corporations.

The *Indignados* staged demonstrations against the dismantling of the Spanish healthcare system and its founding principles. The *Marea Blanca* (white tide), as the healthcare campaign came to be known, started in Madrid and spread across Spain with thousands of healthcare professionals and citizens taking part in marches.

Conscientious objection and civil society pressure

Yo Si Sanidad Universal, a health-professional-led campaign for universal access, emerged out of the *Indignados* movement and an assembly organised after the 2012 Royal Decree. It aimed to ensure that everyone would have access to healthcare within the public system, despite the Royal Decree, and to pressure the government into revoking the law.

Their tactics involved two main complementary strategies. The first was to organise and support conscientious objection by healthcare workers. They developed guides and workshops to demonstrate how to continue to treat migrants, and legal guidance and support for professionals accused of doing so illegally. Alongside this, they organised and trained neighbourhood groups to accompany migrants to GPs, hospitals, and other healthcare settings to support them to access the care they needed.

This approach started in Madrid, with accompaniment groups operating in 20 different neighbourhoods. It was taken up and adapted by others throughout the rest of Spain, eventually covering most of the autonomous regions. Over 3,000 Spanish doctors and nurses signed up to conscientiously object to the policy.

Soon after the Royal Decree, over 300 civil society organisations signed up to the Network for Reporting and Resisting the Royal Decree Law (REDER, *Red de Denuncia y Resistencia al RDL 16/2012*), with an objective to overturn the law and reinstate a universal right to healthcare. Members of the network collected the stories of individuals denied care and refuted myths peddled by the government,

‘[...] demonstrating publicly the incoherence and injustice of making migrants scapegoats for the policies of austerity that are cutting back social spending and rights has been the objective of campaigns such as #NadieDesechado (Médicos del Mundo), #YoElijoSerHumano (Red Acoge), or #5MentirasQueDuelen (REDER).’⁷¹

The Spanish Primary Care Physicians Forum publicly condemned the Royal Decree policies as inefficient and in conflict with medical ethics and international law. Doctors of the World launched a campaign promoting conscientious objection and advocating for reversal of the law.

The UN Committee on Social Rights strongly condemned the measures:

‘...the economic crisis should not have as a consequence the reduction of the protection of the rights recognized by the Charter. Hence, governments are bound to take all necessary steps to ensure that the rights of the Charter are effectively guaranteed at a period of time when the beneficiaries need the protection most...’⁷²

Regional resistance

Some autonomous regions refused to comply with the Royal Decree, instead continuing to provide services on a universal basis, free of charge. In 2013, the Andalusian regional government passed legislation that guaranteed access to free care for all migrants irrespective of legal status, arguing that excluding migrants from the health system would undermine basic rights and public health, and result in an increase of costs. The central government took several regions to court over the issue. The Spanish Constitutional Court upheld the right of the autonomous regions to provide free services to undocumented migrants, prioritising rights to health over public finances and citing a lack of evidence that the policy would result in savings.⁷³ By 2015, Castilla-La Mancha was the only autonomous region fully implementing the Royal Decree.

ACCESS TO HEALTHCARE IN ITALY**Summary**

- Asylum seekers and refugees are entitled to the same level of healthcare as Italian citizens. Undocumented migrants have restricted access compared to citizens, although coverage is wide by international standards.
- The law is ambiguous, however, resulting in regional inequalities of access. Non-medical terms used to stipulate levels of entitlement, such as 'urgent' and 'essential', have been interpreted differently. Many regional authorities have expanded entitlement, while others have restricted it. In some regions, the law is interpreted unevenly by different health professionals because of a lack of clear guidance.
- In 2009, the government attempted to revoke a law that prevented health professionals from having to report undocumented migrants to immigration authorities. The 'We are doctors and nurses, not spies!' campaign united health professionals and civil society who demonstrated against the policy, preventing the proposals from passing through the Senate.

Access to healthcare**BOX C: THE HEALTHCARE SYSTEM IN ITALY**

The Italian Servizio Sanitario Nazionale (SSN) is a Beveridge model of healthcare, funded predominantly out of taxation. The Italian constitution protects health as a right and guarantees free medical care.

Private insurance plays a limited role nationally, but co-payments for care – where patients are required to pay a proportion of the cost of care out of pocket – are more common than the UK. In 2015, 22% of total health spending was paid out of pocket, mainly for drugs not covered by the public system and for dental care.

Asylum seekers and refugees have the same entitlement to healthcare as Italian citizens and can register for the SSN.

Except for children, undocumented migrants cannot register with the SSN as Italian citizens do. However, the law does entitle undocumented migrants to access 'urgent' and 'essential' preventative, maternity, primary, secondary, and emergency care, provided they sign up using a special code, called an STP code, with the local healthcare provider. The code lasts six months but is renewable. Urgent care is care that cannot be deferred without damaging a person's health. Essential care is the treatment of illnesses that are non-life-threatening in the short term but can cause greater damage in the longer term. To qualify for the STP code, undocumented migrants must declare poverty. While some services are provided free of charge, others are only provided on the payment of a 'ticket', a fee that is set regionally. This fee is also paid by nationals and those with regular residency status.

There is evidence of fear among migrant communities of being reported to immigration authorities by healthcare institutions, even though it is illegal for healthcare institutions to do so.⁷⁴ In addition, the ticket fee for some services, while also a requirement of residents, can prevent access to services for the many migrants in precarious economic situations.⁷⁵

The terms 'urgent' and 'essential' have been open to interpretation, resulting in inconsistent application.⁷⁶ In addition, there is a lack of knowledge of entitlements from both providers and migrants themselves, who are often not aware of their rights.⁷⁷

Several regional governments in Italy were providing wider access to care than national standards stipulate. The regional governments of Puglia and Tuscany enacted measures in 2009 to grant undocumented migrants full access to health care. Another 10 regional governments have since expanded healthcare entitlements to varying degrees.⁷⁸

In 2010, the Italian government challenged the policy of the Puglian and Tuscany governments in court as unconstitutional, arguing that it was the national government's remit to grant widened access to care. The Constitutional Court ruled the claims against both regional governments inadmissible.⁷⁹

The measures in Puglia and Tuscany stand in stark contrast to regions like Lombardy, where access to healthcare for undocumented migrants largely depends on the discretion of individual doctors.⁸⁰ Due to a lack of guidance, doctors are unsure about their obligations and frequently deny access to basic care.⁸¹ Lorenzi Piccoli argues that this regional disparity of practice can be explained by the presence of regional coalitions of advocacy organisations with historical ties to regional governments.⁸² Regional governments with strong institutional links to NGOs 'generally acknowledge the de facto legitimacy of undocumented migrants to be part of the regional civil community based on their actual residence rather than on their possession of a legal citizenship status'.⁸³ PICUM note that 'in practice, access to health care appears less guaranteed in towns where the immigrant population or the pressure of NGOs is relatively low'.⁸⁴

'In areas where there are not so many immigrants, many civil servants are familiar with the "STP system" resulting in extremely restrictive interpretations of the terms "urgent and essential care"'.⁸⁵

In 2011, the Health Commission of the Conference of Regions was established to attempt to harmonise practice across Italy. After two years, the Committee produced and approved guidance on a consistent definition of the law. However, only eight regions have ratified the guidance and practice is still not consistent: regional inequalities of access persist as a result. In 2013, the Lombardy government rejected parts of the guidance that mandated a right to a paediatrician for undocumented children, for instance.⁸⁶

Movements for change

The law in Italy currently prohibits hospitals from notifying authorities about patients whatever their nationality or legal status, except when they suspect a crime has been committed. In 2009, the Italian government sought to pass legislation that would require health professionals to report undocumented migrants to immigration authorities if they sought care.

In response, Società Italiana di Medicina delle Migrazioni (SIMM), Médecins Sans Frontières (MSF), Associazione Studi Giuridici immigrazioni (ASGi), and Osservatorio Italiano sulla Salute Globale (OiSG) launched a joint statement entitled 'We are doctors and nurses, not spies!' (*Siamo medici ed infermieri, non siamo spie!*), arguing that the policies would marginalise migrants and create alternative, underground health provision that would not fall under the supervision or control of Italian authorities.

The statement, which was sent to senators, was signed by health professionals, including all the unions and health professional bodies and over 50 civil society organisations. The policy was not implemented.

BOX D: LETTER EXTRACT FROM 'WE ARE DOCTORS AND NURSES, NOT SPIES!'⁸⁷

We therefore consider the measure useless and harmful because

- it will push some of the migrant population towards invisibility, thus lacking any health protection.
- it will encourage the spread of alternative and potentially unsafe healthcare provision, outside of public control (such as backstreet abortions).
- it will exacerbate health conditions since migrants cannot access services except in urgent situations.
- it will have repercussions on public health and risk spreading outbreaks of communicable diseases, due to care being unavailable or delayed.
- it will produce a significant increase in costs, as people unable to access healthcare may find that their health worsens, and they require more long-term, complex and expensive treatment.

ACCESS TO HEALTHCARE IN GERMANY**Summary**

- Access to care for asylum seekers and undocumented migrants is heavily restricted in Germany. The terms of entitlement are ambiguous, leading to inequalities of access. The legal duty on public bodies to report migrants undermines the meagre health entitlements that migrants have, as fear of immigration enforcement is hardwired into the system.
- These restrictions have dire consequences, with illnesses remaining untreated, leading to acute, life-threatening emergencies.
- Robust studies have shown that the impact goes beyond harm to individuals, with the health system paying higher costs in the long term. The policy is failing on its own terms.

Access to healthcare**BOX E: THE HEALTHCARE
SYSTEM IN GERMANY**

Healthcare in Germany is based on the Bismarkian model, whereby health services are funded by mandatory health insurance payments by employees and employers. Most are enrolled in the statutory health insurance scheme called sickness funds, but some opt out of the statutory scheme and choose private health insurance instead.

Unlike in most European countries, asylum seekers and refugees living in Germany do not have the same access to healthcare as nationals.⁸⁸ For 15 months after first arriving in Germany, they are only entitled to basic healthcare services for acute or painful conditions. After 15 months, asylum seekers and refugees are entitled to access to healthcare under the same conditions that apply to German citizens.⁸⁹

Undocumented people are also only entitled to basic healthcare services for acute illness and pain, as well as maternity care. To access most forms of care, however, they must apply for access at the local social welfare office. These offices have a duty to report those without residency permits to the immigration authorities.⁹⁰ In practice, this renders migrants' entitlements worthless as undocumented

migrants face a stark choice between accessing care or being deported. Only in emergency situations can undocumented migrants access care directly, avoiding risks of denouncement.⁹¹

There is no explicit definition of in which circumstances healthcare is covered for undocumented migrants, asylum seekers, and refugees. Authors of a UN report note that 'the definition of medical emergency varies greatly depending on the federal state or municipality. In addition, not many people are familiar with the regulation.'⁹²

As in England, the main argument for restricting access to healthcare is made on the grounds of cost.⁹³ This has been proved wrong by research. Policy changes between 1994 and 2013 created a natural experiment that was used to isolate the effects of restricting access to healthcare for migrants. The authors of the study compared health expenditure incurred by those with restricted access to those with regular access. They found that it cost more to cover people with restricted access to care and calculated that the policy of restriction had cost the German health system over a billion euro.

'[O]ur results support claims that the restrictions may have ultimately increased costs e.g. due to delayed care, focus on treatment of acute conditions instead of prevention and health promotion, reliance on expert opinion of public health officials on decisions whether treatments are "medically indicated" [...] and higher administrative costs entailed by the restrictive parallel system with its own funding, purchasing, and reimbursement schemes.'⁹⁴

In 2018, the UN Committee on Economic, Social and Cultural Rights raised serious concerns about the implementation of the right to health for non-nationals in Germany.⁹⁵ Médecins du Monde note that migrants have...

'.... no or very limited access to medical care. This means that illnesses remain untreated and can lead to acute, life-threatening emergencies. In particular, when chronic conditions go untreated or are not treated early enough, and people go without preventative care, the negative effects go beyond harm to the individual. The health care system is also put under strain.'⁹⁶

Opposition and resistance

A network of voluntary medical clinics, called *Medinetz* or *Medburo*, have been set up across the country to support undocumented migrants to access healthcare in their locality. They provide weekly consultations for those with health concerns and arrange appointments with doctors working free of charge.

Several cities have attempted to improve access to care, primarily through attempts to work with and support volunteer-run clinics. The Department of Health Frankfurt, for instance, has been working with NGOs to provide care for undocumented migrants. To overcome barriers, healthcare is provided anonymously to avoid fear of denouncement. Several other cities have followed Frankfurt's lead by supporting anonymous, alternative, volunteer-led healthcare initiatives.

However, as MSF notes, across Germany 'voluntary doctors and civil society organisations are doing the work of the state. But the primary care they offer is not the same as adequate outpatient diagnostics and treatment. If the barriers to access were removed, this would mean lower costs for the health care systems.'⁹⁷ The limited nature of advocacy only seeks to replace state provision, rather than challenging the restrictive nature of the system itself.

ACCESS TO HEALTHCARE IN SWEDEN

Summary

- Access to care for asylum seekers and undocumented migrants is restricted to care 'that cannot be deferred', and so is not provided on the same basis as those with citizenship.
- Health professionals lack knowledge about the law and the policy has been interpreted differently in different contexts, resulting in access inconsistencies.
- Over the last decade, care entitlements for undocumented migrants have improved. Prior to 2013, undocumented migrants were only able to access emergency care. The impacts of this level of restriction were wide ranging, including harm to the health of migrants and higher healthcare costs due to a lack of access to preventative care.

- Changes were brought about through pressure from multiple angles, including a coordinated campaign by health professionals and a network of civil society organisations, international criticism and improvements in practice at a local level.

Access to healthcare

BOX F: THE HEALTHCARE SYSTEM IN SWEDEN

Sweden's healthcare system, like the NHS, is based on a Beveridge model. All legal residents have automatic and universal healthcare coverage, predominantly paid for by taxation. Where the Swedish system differs from the NHS is that user charges or co-payments – such as a charge per day for hospital stays – are more prevalent.

Unlike most European countries, asylum seekers are not entitled to the same healthcare access as those with citizenship. Asylum seekers are entitled to subsidised healthcare for treatment that 'cannot be postponed', contraceptive advice, pregnancy termination, and maternity care. Asylum seekers under 18 are entitled to a broader scope of care.⁹⁸

Undocumented people's inclusion within the Swedish healthcare system has changed considerably over the last decade. When PICUM published their comparison of European countries in 2007, undocumented migrants lacked basic rights to healthcare.⁹⁹ They only had access to emergency care which they were liable to pay for, in full, after treatment. PICUM notes that undocumented pregnant women were expected to pay a fee of around £5,000 to give birth. The policy was less severe for undocumented children, where the government paid a fixed amount to cover the cost of their care.

An MSF report detailed the impact of the restrictive policy, finding that 'the failure on the part of the Swedish government to recognise [undocumented migrants] as a patient group has led to the near total exclusion of this group from accessing non-emergency and routine health care in Sweden at this time'.¹⁰⁰ The lack of access to primary and preventative healthcare had implications for migrant health, and led to a higher prevalence of patients presenting in a state of ill health at emergency services, requiring more costly inpatient care.



Right to Healthcare Initiative protests in Sweden. From IFMSA-Sweden (used with permission)

Paul Hunt, a UN Special Rapporteur on the Right to Health, visited Sweden in 2006 and sharply criticised limitations on health care for undocumented migrants, describing the practice as 'not consistent with international human rights law'.¹⁰¹

As a result of public pressure, the Swedish government introduced significant reforms to the health care system in 2013, entitling undocumented migrants to access to care 'that cannot be deferred' for a small fee (€5), bringing access for undocumented migrants up to the level of asylum seekers.¹⁰² The new reforms also grant undocumented children the same healthcare access as documented Swedish citizens and allow regions to offer wider health coverage up to the level of citizen entitlements at their discretion.¹⁰³

While undocumented migrants now have increased entitlement to care, both asylum seekers and undocumented migrants are still treated differently to those with citizenship, with restricted entitlements to care. In addition, healthcare professionals are often unaware of legal changes, resulting in unlawful charges or denial of care. In a report analysing the implementation and analysis of the new law, the Swedish Agency for Public Management found that 'seven out of ten doctors say that they have heard of the law, but do not know it very well'.¹⁰⁴ They found that the terminology 'care that cannot be deferred' has

proved problematic, as it is open to interpretation and has been implemented differently by health professionals in different settings.¹⁰⁵

Six regions have since chosen to offer undocumented migrants wider coverage: Sörmland, Västmanland, Östergötland, Västerbotten, Västernorrland, and Gävleborg.¹⁰⁶

Opposition and resistance

The expansion of provision for undocumented migrants in 2013 was the result of significant pressure placed on the government by multiple actors, including civil society, local and regional actors, and the international community.

NGOs and health professionals, working voluntarily, had previously set up alternative systems to deliver essential healthcare for asylum seekers and undocumented migrants. A coordinated campaign by the volunteer clinics highlighting the plight of migrants without healthcare entitlement, alongside the UN Special Rapporteur's 2006 report, sparked a public debate on the issue.

In 2008, The Right to Health Care Initiative (Rätt till vård-initiativet) was founded, bringing together a coalition of humanitarian organisations, religious organisations, trade unions and health care professional organisations.¹⁰⁷

The group argued that

‘it is not worthy of a solidarity and democratic society like the Swedish to limit the rights of vulnerable people to health care ... we urge the Swedish Government to assume its responsibility for ensuring that paperless and asylum seekers have access to health care on essentially the same terms as other residents. Legislation that specialises or excludes certain groups is incompatible with fundamental human rights on equal value and non-discrimination’.¹⁰⁸

By 2012, several county councils had widened entitlement and two councils provided care on the same level as for those with citizenship.¹⁰⁹

Reacting to the pressure from health professionals, the Right to Health Care Initiative, the UN report, and improved practice at a local level, the government launched an inquiry into reforming the law.¹¹⁰ This inquiry recommended that asylum seekers and undocumented migrants be provided with the same rights to health care as those with citizenship, citing human rights commitments, professional ethics, and the difficult working environment imposed on health professionals.¹¹¹

Henry Ascher, a Swedish doctor from the Right to Health Care Initiative, cites a number of factors that drove the successful change in the law, including pressure from multiple angles, Sweden’s high aspirations for human rights, a humanitarian public opinion, and a positive attitude among journalists.¹¹²

The Right to Health Care Initiative have now turned their attention to challenging the disparities that still exist after the 2013 reforms, arguing that the term ‘care that cannot be deferred’ is ‘medically unserviceable and unethical’.¹¹³

‘We call on the Swedish Parliament and Government to immediately ensure that asylum seekers, undocumented migrants and vulnerable EU citizens residing in Sweden are entitled to healthcare as needed and on equal terms regardless of origin or legal status. We expect more coherent legislation and a clarification of how the legislation is to be applied at the national level.

‘Sweden has a long tradition of solidarity with vulnerable peoples and communities. In this spirit, it is consequential, right and decent that a rich, humanitarian and democratic society does not limit vulnerable people’s right to the best possible health through healthcare or dental care on equal terms.’¹¹⁴

The campaign continues to challenge these restrictions.

LEARNING FROM INTERNATIONAL POLICY AND PRACTICE

This section draws together policy and practice themes from across the case study countries. Throughout, we highlight the similarities with, and learning for, policy and practice in the England—including what the international case studies tell us about what might happen in England if we continue to restrict access to healthcare through the hostile environment.

HOW HEALTHCARE IS RESTRICTED

Across each case study country, migrants face a range of barriers to accessing care. Broadly, these are the result of (1) restrictive national policy, (2) the integration of healthcare and immigration enforcement, and (3) the administration of healthcare in practice.

1. National policy varies both between countries and within countries over time; however, it is common for countries to have some level of restriction on subsidised or free-at-the-point-of-use services for migrants – most frequently for those undocumented. These restrictions create economic obstacles that are impossible for many migrants to overcome.

In Germany, asylum seekers and refugees are only entitled to basic healthcare services during their first 15 months, and undocumented migrants are only eligible for basic healthcare services for acute illness and pain. In Sweden, while entitlements have significantly improved since PICUM's research in 2007, access to care for asylum seekers and undocumented migrants is restricted to care 'that cannot be deferred' rather than provided on the same basis as those with citizenship. In Italy, asylum seekers and refugees are entitled to the same level of health care as Italian citizens, but undocumented migrants have restricted access to urgent and essential care.

Spain is the only case study without national level restrictions, where migrants are entitled to healthcare on the same basis as those with citizenship. This, however, is a recent development, with the country's Popular Party implementing severe restrictions on migrant healthcare access between 2012 and 2018.

In countries where migrants do not have the same entitlements as those with citizenship, national policy restricting access is frequently ambiguous, using non-medical terms which are open to interpretation and misunderstanding. The result is migrants under-utilising services to which they are entitled; health professionals incorrectly denying care to migrants with entitlements; and an inconsistent application of the law depending on the actions and policies of individual health professionals, healthcare organisations, or regions.

2. In a minority of the countries studied, immigration enforcement has been hardwired into the healthcare system, and health professionals are required to report migrants using health services to immigration authorities. This effectively renders any entitlements null and void, forcing people to risk deportation in order to seek care. In Germany, a 'duty to denounce' placed on public servants undermines undocumented migrants' already meagre healthcare entitlements.
3. Migrants often face many practical barriers created by health system administration, even in countries with both wide national entitlements and effective firewalls between the health system and immigration authorities. Most commonly, administrative systems that require documentation, such as ID or proof of address, deter migrants from registering and seeking care, as this can be hard for some to produce and can exacerbate fears of denouncement even when the law prevents it or no such practices are evident.

There are many examples from across the four case study countries of cities and regions taking steps to proactively adapt health systems to overcome barriers to inclusion in practice. In the Spanish region of Andalusia, for instance, direct access to healthcare bypassed the requirement to sign up for a health card with a public authority, which was causing fear of deportation and undermining access to care.

All three of these barriers to care are currently present in England, with severe policy restrictions based on non-medical terms such as ‘urgent’ and ‘immediately necessary’, data-sharing mechanisms between NHS England and the Home Office, and administrative barriers to care in practice. Congruent with emerging evidence in the UK, these international examples suggest that these barriers are likely to lead to unequal application of the law, with migrants unable to seek even the healthcare they are entitled to under current policy.

HOW RESTRICTED HEALTHCARE IS JUSTIFIED

When governments introduce or maintain policy restrictions on migrants’ access to healthcare, justifications centre on the notions of so-called health tourism, the cost of providing care to migrants, and the need to ensure fiscal sustainability. Restrictions have been introduced at the same time as austerity measures, with drastic cuts to health systems, public health systems, and public services more broadly. Restrictions in Spain have also been used to undermine the universal basis of a health system, and to introduce a contributory principle whereby healthcare is restricted to those paying insurance. Governments rarely evidence claims that restricting healthcare access saves money, nor do they commission research to understand the effects of restrictive policies on healthcare expenditure. Rarer still do governments monitor the overall costs of implementing restrictive policies.

International arguments used to justify restricting access to care are remarkably similar to the arguments used in the UK, with restrictions advanced on the basis of cost at the same time as funding for services is cut, without – or contrary to – available evidence. The experience in Spain demonstrates the danger that restrictive policies present to the universalist principle in healthcare, giving credence to arguments made by campaign groups such as Docs Not Cops in the UK that migrant charging is the thin-end of the wedge in the privatisation of healthcare.

THE OUTCOMES OF RESTRICTIVE HEALTHCARE

Across all four case study countries, there is evidence that restrictions at a national policy level harm migrant health. The evidence is largely gathered through qualitative research and surveys of those affected, as well as case studies collected

by NGOs. This invariably shows that restrictions lead to people going without preventative or timely care, illnesses remaining untreated, and a resultant increase in life-threatening emergencies.

Researchers in Spain quantitatively assessed the full impact of policy restrictions introduced in the country, finding them responsible for an estimated 15% rise in mortality amongst undocumented migrant groups over the three years after implementation.¹¹⁵ It should be noted this 15% figure is an average over those years, with mortality rising to 22.6% in the third year. This is despite regional resistance to the policy, which is likely to have significantly softened its impact.

While governments frequently point to cost to justify restrictive policy, there is evidence that restrictions cost, rather than save, money. The negative effects of a lack of access to timely care noted herein go beyond harm to the individual, putting the health system itself under strain. Across countries, restrictions lead to a higher prevalence of patients presenting in a state of ill health at emergency services, requiring more costly acute care services.

The most robust assessment of the full effect of restricting access to care on cost comes from Germany, where researchers quantified the effects of policy changes between 1994 and 2013, concluding that the net cost of the restrictions for the health system were over a billion euro.¹¹⁶ The research suggests that restrictions increase cost due to delayed care and a focus on the treatment of acute conditions, rather than preventing harm and promoting health.

Given both the pre-existing evidence about the negative impact of implementing healthcare restrictions in the UK, and the international evidence outlined in this report, it is damning that the UK government continues to pursue these policies. Despite the government’s rhetoric, both the domestic and international evidence strongly suggests that policies designed to restrict access to healthcare not only harm migrant health, but result in higher costs for health systems – thus failing on their own terms. Unless the government repeals the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2015 and 2017, these healthcare restrictions are likely to cause damage to both health and the health system.

DRIVERS OF CHANGE

While policy and practice in the countries studied have waxed and waned significantly in recent years, and while there is still some way to go – as our discussion demonstrates – the general trend across countries is towards more inclusive health coverage, with migrants better able to access healthcare and enjoy their rights. This change has not occurred because of national governments voluntarily responding to the evidence, but rather is the result of multifaceted opposition and pressure from city and regional governments, healthcare workers, civil society, NGOs, international organisations, and wider publics.

What is clear is that when governments attempt to restrict access to healthcare, or when a country's policy and practice are already inadequate, strong coalitions have been created, employing a variety of tactics to mitigate, resist, and demand change. In Sweden, for instance, the Right to Health Care campaign was influential in the government's decision to set up an inquiry and eventually widen entitlements for undocumented migrants at a national level. In Spain, meanwhile, the White Tide movement, the campaign coordinated by Yo Si Sanidad Universal and the REDER network of civil society organisations, were instrumental in the government's decision to widen migrant access to care in 2018. It is the lessons learned from these campaigns for change that we turn to in the next section.

LEARNING FROM INTERNATIONAL OPPOSITION AND RESISTANCE

This section draws together the themes from across case studies showing how change has been driven and achieved. Throughout, we reflect on the international opposition to restrictive national policies, and how this compares to efforts to oppose the Hostile Environment for migrants in the NHS. Our aim is to examine the applicability of strategies and tactics from elsewhere to the UK context. We hope that this will be instructive to health professionals, healthcare bodies, unions, and campaigners here in the UK, and help to inform collective organising against the Hostile Environment.

- Successful campaigns have used several common arguments, strategies, and tactics to create change, including:
- Combination of individual casework support and mitigation measures with broader campaigning against policies.
- Mass public campaigns and non-compliance by healthcare workers.
- Resistance from local and regional governments.
- Strategies directed at wholesale policy reversal, rather than simply expanding exemption criteria.
- Arguments made on both cost and moral grounds.
- Broad-based campaigning, including across faith institutions, trade unions, community organisations and NGOs.

To frame the discussion, we have developed a simple typology of strategies evident across the countries studied: mitigation, resistance, and

policy-change strategies. It is important to note that successful oppositions have combined strategies from across the typology to create change, so they should be viewed as complementary rather than mutually exclusive.

MITIGATION AND ALTERNATIVE CARE PROVISION

In the shorter term, strategies to oppose restrictive national policies and practices have focused on limiting their negative effects on migrant populations; however, there are differences in terms of how this has been done across countries.

Mitigation seeks to limit harm by setting up alternative healthcare systems to treat migrants. In Germany, for instance, a network of voluntary medical clinics, called *Medinetz* or *Medburo*, have been set up across the country to support undocumented migrants to access healthcare in their locality.

While this may go some way in limiting the damages caused by restrictive mainstream health systems, the provision of alternative care outside of the mainstream in this way runs the risk of creating substandard structures of care for migrants. Further, by picking up the slack left by governments, this approach may create a perverse incentive for further healthcare restrictions.

Most alternative systems of support, however, do not exist in isolation and have been run concurrently with campaigning actions to change national policy. In Sweden, for instance, the Right to Healthcare Initiative emerged out of the voluntary clinics that were providing healthcare to undocumented migrants shut out of the country's health system.

In the UK, NGOs like Doctors of the World and others do vital work across the country to provide healthcare to many migrants who are excluded, and crucially, continue to campaign for a reversal of the policy whilst doing so.

RESISTANCE IN HEALTHCARE SETTINGS

The resistance approach involves attempting to continue to treat migrants within mainstream health systems, despite exclusionary national policy.

Mass non-compliance by healthcare workers.

When the Spanish government issued a Royal Decree restricting access to healthcare in 2012, *Yo Si Sanidad Universal* – a health-professional-led campaign for universal access – supported healthcare workers in Madrid to conscientiously object to the policy and continue to treat migrants. To support this, the campaign developed guides and workshops to demonstrate how to continue to treat migrants, and to provide legal support for professionals accused of doing so. They also organised and trained neighbourhood groups to accompany migrants to health care settings. The model spread throughout the country, with over 3,000 Spanish doctors and nurses signing up to object to the policy.

City or regional governmental resistance.

Where policy has regressed, cities and regions – often those with higher numbers of migrants and strong institutional links between humanitarian NGOs and regional government – have led the way in challenging healthcare restrictions by implementing alternative systems locally. After the Royal Decree in Spain, for instance, many regional governments across the country chose not to implement the policy. This is thought to have substantially reduced the harm caused by the policies implementation.

Resisting national policy change has the advantage of avoiding the pitfalls of setting up alternative healthcare systems for migrants and contributing to efforts to overturn national policies by making them difficult to implement in practice.

There is scope for opposition in the UK to apply some of the strategies and tactics used internationally to resist the Environment in the NHS in various ways, including both local level resistance and conscientious objection.

While the health system in England is more centralised than the countries where city and regional action was strongest, there is nonetheless much that NHS Trusts can do at a local level. Trusts have been asked to implement the policy with little consideration as to how it diminishes their ability to meet conflicting demands – such as cost-effectiveness and public health considerations – or how the policy might be in conflict with other important legal obligations – including

their obligations under the Human Rights Act, the Equalities Act, and healthcare workers' legal obligations under their duty of care to patients.

Mass health worker resistance has remained relatively subdued due to the operation of the policy, which creates an atmosphere of uncertainty for healthcare workers. Many are not aware of their rights, or the rights of their patients, and have been told that they must abide by the charging regulations irrespective of the potential for a conflict with their duty of care as a healthcare professional. Furthermore, the data-sharing arrangements between the NHS and the Home Office render individual acts of conscientious objection ineffective. For this strategy to successfully challenge the policy, health workers and institutions must collectively refuse to participate in these policies.

This is the arena in which engagement and intervention by trade unions holds considerable promise. Healthcare workers' opposition to the policy must be strengthened by advice from their unions and representative bodies as to their rights and obligations considering the charging duties.

PUBLIC PERCEPTION AND POLICY CHANGE

Opposition in most of the countries examined have set their long-term strategic sights on national policy change and have done so using several common tactics, often simultaneously. Most commonly, tactics have included large public demonstrations against restrictions and the mobilisation of a broad base of actors to exert pressure; demanding universal access, rather than exemptions; and broadening the argument beyond economics. Each of these is now discussed in turn.

Public demonstrations and opposition. Across countries, successful oppositions have used large public demonstrations against restrictions and the mobilisation of a broad base of actors – from local government and healthcare bodies to faith institutions, unions, NGOs, and the UN – to exert pressure. Across all the reviewed countries taking this form of opposition, action has been initiated and led by healthcare professionals. The prominence of healthcare workers in such campaigns plays an important part in gaining public trust and sympathy to the cause.

In Spain, for instance, the *Indignados* staged demonstrations against the dismantling of the Spanish healthcare system and its founding principles, starting in Madrid and spreading across the country with thousands of health professionals taking part. Meanwhile, over 300 civil society organisations signed up to REDER, publicly denouncing the government's restrictive policy and advocating for a reinstated universal right to healthcare.

A broad-based opposition has two key advantages. First, it builds a critical mass with the force to bring about change in the face of concerted opposition from the state. The success of campaigns often comes down to their ability to coerce, rather than convince, governments into reversing the policies. This requires that movements be created with the power to force the government's hand, made possible by broad-based mobilising. Secondly, the mobilisation of different sectors allows for tactical flexibility. Where one group's voice could be more influential, or a particular approach more effective, movements could mobilise them to create multiple pressure points as part of an overall strategy.

Many of these tactics are currently evident in the campaign against the Hostile Environment in the NHS, which began with a series of public actions by Docs Not Cops, including public letters, actions outside the Home Office and the Department of Health, the distribution of materials to healthcare workers, and a number of media stunts and stories. Meanwhile, healthcare unions and Royal Colleges have released statements in opposition to the charging policy.

The current campaign has a broad base of groups now engaged in challenging the policy in their different arenas. However, there remain areas of development, especially in the engagement of frontline migrant organisations and the creation of campaigns around affected individuals. Here opposition is muted by the fear in migrant communities who worry that campaigning will have negative ramifications for their immigration status, and the sheer amount of casework to support individuals that is currently overwhelming migrant organisations, making it difficult for them to engage in longer-term and more upstream campaigning.

Centring universal access. Importantly, demands raised by successful campaigns have focused on the overall objective of achieving universal access, regardless of immigration status, rather than on exemptions or entitlements for particular migrant groups (eg campaigning for children to be exempt from charges). Demands for exemptions have the potential to reinforce ideas of 'deserving' and 'undeserving' migrants and thereby weaken collective resistance to restrictive policies as a whole and leave some groups without access to adequate care.

In the UK similarly, the main demand has been for a wholesale reversal of the policy. Organisers within the Patients not Passports campaign have been careful to ensure that demands for policy changes have not been diverted into requests only for exemptions. The overriding concern has remained removing the policy altogether, on the understanding that there is no version of the policy that will not inflict considerable harm on migrant communities.

Beyond the economic argument. While international campaigns and movements have sought to undermine the inaccurate cost arguments made by governments, they have also attempted to move the debate beyond a narrow focus on economics to include a wider range of considerations, often including a mix of humanitarianism, human rights, medical ethics, and public health.

In Spain, the REDER network published and disseminated myth busting documents debunking government claims about so-called health tourism; however, campaigners were wary about focusing too much on cost. As one member of the Yo Si Sanidad Universal notes, 'even if it were [cost saving], we still don't think this should be happening. We, as a society, don't want to reject people because it's cheaper to do so.' As well as economics, the movement in Spain centred on the right to healthcare and medical ethics. Arguments about the right to healthcare were strengthened by concerns about wider changes to the health system affecting those with citizenship at the same time – including increased co-payments, the introduction of a contributory principle into the health system, and an increased role for private health organisations.

In Sweden, the campaign focused on migrants' right to healthcare by appealing to Sweden's high aspirations for human rights and humanitarian public opinion. In Italy, the 'We are Doctors and Nurses, Not Spies' campaign framed proposed changes as 'useless and harmful', by increasing costs while undermining health protection, creating dangerous parallel health care, increasing demand for emergency care, and damaging the collective health of the population.

The international precedent of engaging with and broadening the argument matches the tactics used by the successful No Pass Laws campaign against charging introduced into the NHS in the 1980s. A key way in which campaigners and health workers challenged the charges was to demonstrate the faulty economic logic underlying them. A 1982 No Pass Laws newsletter suggested that 'the administration of the scheme was likely to actually cost more than the probable income from charges', while a Trade Union Congress report noted that 'the actual net saving to the National Health Service of introducing these fees would be extremely small. These savings in any event will be offset against the considerable indirect costs which will arise from the adverse effects implementation of the proposal would have on the international reputation of the NHS and exacerbation of racial difficulties in this country'.

Taking its name from the 'pass law' system of Apartheid South Africa, the campaign also argued that the charges 'were racist both in intent and operation and are likely to result in the harassment of black patients and to deter them from using the National Health Service'. Linking the introduction of NHS charges to the British Nationality Act 1981, the group critiqued the moral framing of the charges and instead understood them as part of a broader move to restrict citizenship and 'as an attempt by the Home Office to use the Health Service as an agent in its policing of the immigration rules'.

The group created and translated information leaflets on the charges and disseminated them to migrant community organisations, drafted model motions to be brought to trade union branches, organised workshops and conferences, and collected individual cases of charging that were being challenged by local law centres.

When the Patients not Passports campaign was initially launched in the UK, it became apparent that charging within the NHS was not cost effective, and campaigners focused their arguments heavily on the NHS's own estimate that only 0.3% of the NHS expenditure coming from overseas visitors.

However, many felt that this approach unduly accepted the economic logic put forward by the government, and failed to argue that the policy was wrong because of the harm it causes to migrant communities and the principles of the NHS. Campaigners made a choice to expand their arguments to include the humanitarian and human rights rationale for ensuring the NHS was free at the point of use for everybody.

More recently, campaigners have adapted this message to harness the positive public sentiment towards the NHS and its founding principles, focusing on the risk to the NHS that the charging regime creates and how it embeds costing and payment structures that can be readily expanded to other groups. It is thought that this language can help reach out to different groups of people and mobilise new groups of potential supporters.

The success of matching arguments to wider national interests and ethics beyond economics suggests that the campaign should continue to employ language that highlights both the moral and economic failing of the hostile environment, making the case that charging policies further undermines the universal principles of the NHS.

PRINCIPLES FOR TAKING THE MOVEMENT FORWARD

The examples in Europe, and previous movements in British history, provide interesting examples for how such policies can be resisted. These ideas, together with current status of campaigning in the UK, suggest the following key principles and ideas for taking the movement forward:

- Continue to employ language that highlights both the moral and economic failings of the policy, as well as its roots in an austerity agenda that further undermines the universalism of the NHS. This can help lay the groundwork for an accurate understanding of the policy, its dangers, and the need for collective resistance to overcome it.

- Ensure that local and individual advocacy is channelled into a campaign for wholesale reversal of the policy, rather than simply focusing on individual wins and exemptions that divide groups against each other and lead to further fragmentation.
- Undertake work that can remind NHS Trusts and local and regional governments of their legal obligations – under the Human Rights Act, the Equalities Act, and other duties – and that can facilitate them acting in defence of their local communities.
- Engage healthcare worker unions and the Medical Royal Colleges in developing guidance for their members that protect their rights and the rights of their patients, supporting them in opposing the policy on these grounds.
- Create opportunities and structures for frontline migrant organisations, often overwhelmed with casework, to develop campaigns around individual injustices that can highlight the egregious and widespread nature of the policy.

CONCLUSION

In this report, we set out to explore what can be learned from international practice, describing levels of migrant access to healthcare, the impact of different policies and practices, and the campaigns and movements that have successfully challenged barriers to accessing healthcare.

Despite differences in policy and context across the countries reviewed, there is a remarkable uniformity in terms of how restrictive policies are introduced and the arguments used to support them. While the evidence shows us that restrictive policies fail on economic, health, and humanitarian grounds, moves towards more inclusive healthcare systems have not occurred because of national governments voluntarily responding to this evidence. Rather, it is the result of multifaceted opposition and pressure from city and regional government, healthcare workers, civil society, NGOs, international organisations, and wider publics.

The similarities with the countries studied in this report, both in terms of the policies pursued by governments and the multifaceted resistance and opposition evident, demonstrate the need to recognise and remember that the struggle for universal healthcare is one that is international and part of a much broader anti-racist struggle for international solidarity. The biggest mistake we can make in campaigning is to not see the people organising alongside us right now, and to work with and learn from each other. We hope that the learning from the international movement highlighted in this report is instructive to health professionals, healthcare bodies, unions, and campaigners here in the UK, and helps to inform collective organising against the Hostile Environment.

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Registered charity number 1055254

COVER IMAGE BY:

Pieter Roden

PUBLISHED:

October 2020

NEF is a charitable think tank. We are wholly independent of political parties and committed to being transparent about how we are funded.

WRITTEN BY:

Daniel Button with Akram Salhab, James Skinner, Aliya Yule, and Kathryn Medien

The authors would like to thank: PICUM and Doctors of the World, whose research we drew upon throughout this report; Yo Si Sanidad Universal for their pictures and information; Docs not Cops, for allowing us access to their image library.

NEF worked alongside Medact and Migrants Organise as part of the Patients Not Passports campaign to support opposition from frontline healthcare workers and communities impacted by charging.

