

REVIEW OF ACCESS TO THE NHS FOR FOREIGN NATIONALS February 2010

Consultation Response Form

We would prefer this form to be returned to us electronically as an email attachment. The email address for responses or queries is overseasvisitorsconsultation@dh.gsi.gov.uk. You can provide a covering letter by email if you wish.

Postal responses can be sent to:

**NHS Overseas Visitors Policy Team
Department of Health
Room 4W04 Quarry House
Quarry Hill
Leeds LS2 7UE**

Email responses to the consultation will receive an acknowledgement of receipt. Postal responses will not receive an acknowledgement.

The consultation closes on Wednesday 30 June 2010.

YOUR CONTACT DETAILS

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I do not wish my response to be passed to other UK Health Departments (please mark with an 'x').

I do not wish my response to be published in a summary of responses

About You

Please delete as appropriate. I am responding:

- on behalf of an organisation

If you are responding as a professional, please supply the following details:

Area of work:

NHS	
Social Care	
Private Health	
Third Sector	
Regulatory Body	
Professional Body	
Education	
Trade Union	
Local Authority	
Trade Body	
Other (Please give details)	
Independent Contractor to NHS [
Manufacturer	
Supplier	
Other (where relevant)	

If you are responding on behalf of an organisation, please indicate which type of organisation you represent:

NHS	
Social Care	
Private Health/Independent Sector	
Third Sector	x
Regulatory Body	
Professional Body	
Education	
Trade Union	
Local Authority	
Trade Body	
Other (Please give details)	

In which of the following areas do you live:
(please tick one box only)

North East	
North West	
West Midlands	
South East	
London	x
Humberside/Yorkshire	
East Midlands	
East of England	
South West	
No answer	

Please provide us with some information about yourself. This will help us to determine whether we have captured the views of everyone. All the information you provide will be kept completely confidential. No identifiable information about you, will be passed to on to any other bodies, members of the public or press.

1. What is your sex? *(Tick one box only)*

Male Female

2. Which age group do you belong to?
(Tick one box only)

0-15 yrs
16-24 yrs
25-34 yrs
35-44 yrs
45-54 yrs
55-64 yrs
65-74 yrs
75-84 yrs
85 yrs and over

3a. Do you have a disability as defined by the Disability Discrimination Act (DDA)?
(Tick one box only)

Yes No

The Disability Discrimination Act (DDA) defines a person with a disability as "someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities".

b. If yes, please tick all which apply

Partial or total loss of hearing
Partial or total loss of vision
Speech impediment or impairment
Other communication difficulty
Mobility impairment or difficulty moving around
Learning difficulty or learning disability
Mental health condition or disorder
Severe physical disfigurement
A longstanding illness or disease
Other medical condition or impairment (please specify)

4. What is your ethnic group? *(Tick one box only)*

A White

British
Irish
Any other White Background, please write below

B Mixed

White and Black Caribbean
White and Black African
White and Asian
Any other Mixed Background, please write below

C Asian or Asian British

Indian
Pakistani
Bangladeshi
Any other Asian Background, please write below

D Black or Black British

Caribbean
African
Any other Black Background, please write below

E Chinese or other ethnic group

Chinese
Any other, please write below

5. What is your religion or belief? *(Tick one box only)*

- Christian
 - Buddhist
 - Hindu
 - Jewish
 - Muslim
 - Sikh
 - None
 - Other (please write below)
-

6. Which of the following best describes your sexual orientation? *(Tick one box only)*

Only answer this question if you are aged 16 years or over.

- Heterosexual/Straight
- Lesbian/Gay
- Bisexual
- Other
- Prefer not to answer

REVIEW OF ACCESS TO THE NHS FOR FOREIGN NATIONALS

Consultation Questions

Please mark your answers with an “x” as necessary.

Chapter 2: The Charging Regulations and Guidance

Q1- Do you agree that the draft new consolidated Regulations provide a clearer, accurate and more succinct reflection of the existing Regulations?

 Yes No

Comments

The new regulations contain some changes to the existing regulations which are likely to cause some confusion.

First, there is a shift from charging for services provided at or by a hospital to charging for all non-primary care services. Without a definition of “primary medical services”, much will be left to interpretation and this is likely to lead to confusion and inconsistent application of the charging regulations..

Second, the new Regulations have broadened the responsibility to make and recover charges across the NHS so that it now extends to Strategic and Special Health Authorities. In addition, anyone providing potentially chargeable services, including GPs and Community Mental Health Teams, must inform the relevant NHS body that a patient who appears to be an overseas visitor has received chargeable treatment.

Both the above are likely to result in confusion as to what is a chargeable service and who has legal responsibility to make and recover charges. It is likely to lead to marginalised groups being deterred from accessing services or being wrongly refused treatment by individuals who do not have a detailed understanding of the regulations and associated guidance.

Q2- Do you agree that the consolidated Regulations do not imply any material change in policy?

Yes No
 X

Comments

See above

Q3- Does the new draft guidance clearly and comprehensively explain how the consolidated regulations should be interpreted and applied?

 Yes No

Comments

Q4- Does Chapter 3 of the new Guidance document fully and clearly explain the NHS's obligations and requisite processes to ensure the provision of immediately necessary and urgent treatment to chargeable patients who are unable to pay prior to the treatment needing to be provided?

 Yes No
 X

Comments

The current draft guidelines have sought to clarify when immediately necessary and urgent treatment should be provided to patients who cannot pay. This was also one of the aims of issuing interim guidance on 2 April 2009, in which it was clearly stated that urgent and immediately necessary treatment, including maternity care and cancer treatment, must never be withheld or delayed. Despite the issuing of the interim guidance, Still Human Still Here's research, *At the end of the line* (February 2010), still found that there was widespread confusion about entitlement amongst healthcare professionals and documented numerous cases where urgent and immediately necessary treatment had been denied to refused asylum seekers.

This confusion extended to entitlement to primary care even though there has been no change in the regulations and GPs have complete discretion as to whether to register a patient, regardless of their immigration status. An analysis of policies operated by London Primary Care Trusts (PCTs) on the registration of overseas visitors with GPs found that 13 of the PCTs contacted had policies which they send to GPs detailing who should be allowed to register with a GP surgery. Of these, 12 state that patients are entitled to NHS treatment if they are ordinarily resident in the UK. No distinction is made between primary and secondary care and many GPs have consequently curtailed entitlement to primary care for refused asylum seekers.¹

Even though the current draft guidance is an improvement on the interim guidance the complexity of the regulations means that there is likely to be a continued lack of clarity regarding how they should be interpreted and applied, particularly now that certain refused asylum seekers are excluded from charges, but others are not.

Still Human Still Here urges the Government to reinstate free access to secondary healthcare for all refused asylum seekers, as was the position prior to 2004, as this would greatly simplify the regulations and ensure that they are properly applied. Failing this we would propose the following specific amendments to the guidance:

1. Introduce a paragraph at the beginning of Chapter 3 (directly after paragraph 3.1) which states that "The guidance in this chapter **only** relates to access to secondary healthcare. There is no change to the entitlement to free primary healthcare and General Practitioners maintain their discretion to register any overseas visitor for access to free NHS primary healthcare services."

2. The Model Request for Advice from Doctors/Dentists form (Appendix 2) describes immediately necessary treatment as that required in order "to save the patient's life". This is inaccurate and should be amended to read "to save the patient's life, prevent a condition from becoming immediately life threatening or to prevent permanent serious damage from occurring" as is stated elsewhere in the guidance.

Still Human has concerns about making clinicians sign an administrative form, but if this is to be implemented it would be important to add in an additional paragraph to the form which gives the practitioner the opportunity to select an option which states that the patient requires further investigation to establish whether the treatment is immediately necessary or urgent. The diagnosis of serious illness is a key part of secondary healthcare and practitioners should not be discouraged in any way from undertaking further investigations to ascertain the cause of symptoms or the severity of a particular condition.

¹ Research by Adam Hundt, Pierce Glynn Solicitors, 2009. Quoted in Still Human Still Here, *At the end of the line*, London, 2010, page 58.

4. In paragraph 3.17 it would be useful to give examples of circumstances which will make it unlikely that a refused asylum seekers can return home in the near future (e.g. conditions in their country of origin are too dangerous to allow them to return, they do not have a passport, or they have a legal challenge pending).

The guidance states that when it is unclear when a patient will be able to return home, an estimated return date of six months should be used and an assessment made as to whether there would be an unacceptable deterioration in the patient's health during this time. In the case of refused asylum seekers, the National Audit Office report, *Returning failed asylum seekers*, found that it took on average 403 days to remove a refused asylum seeker. On this basis we believe that one year would be the right timeframe for making this health assessment.

In addition to the above, the new guidance on how the regulations should be applied needs to be better publicised and more widely distributed than the interim guidance. Frontline healthcare professionals, patients and relevant agencies and NGOs understand how the rules should be interpreted and ensure that those asylum seekers in need and entitled to care do receive it.

Chapter 3: Proposals for Change to the Charging Regulations.

Q5- Do you agree with the proposal to exempt Section 4 and Section 95 failed asylum seekers from charges for NHS hospital treatment?

Yes

X

No

Comments

Still Human Still Here strongly supports the proposals to exempt refused asylum seekers on Section 4 and Section 95 support from charges for HNS hospital treatment.

Asylum seekers often have specific health needs which arise from trauma and deprivation in their country of origin, but in many cases these are compounded by their isolation and destitution in the UK. The Royal College of Psychiatrists found that "The psychological health of refugees and asylum seekers currently worsens on contact with the UK asylum system" and concluded that the full range of social and medical care services "should be available at all times throughout the asylum process, including (for) those whose claims have failed, whilst they remain legally in the UK."²

By exempting refused asylum seekers on Sections 4 and 95 from charges the Government will relieve the suffering of this small group of particularly vulnerable individuals who are either unable to leave the UK through no fault of their own or are families with children.

This policy also has a number of benefits beyond the protection of the health of the individuals who will be able to access free secondary healthcare:

² The Royal College of Psychiatrists (RCP), *Improving services for refugees and asylum seekers: position statement*, Summer 2007.

1. It will help protect the health of the wider community as charging for healthcare, even when treatment is not delayed in order to secure payment, discourages people from seeking care and creates serious public health risks as these people may not come forward for inoculations, screening or treatment for communicable diseases. This was confirmed by the Joint Committee on Human Rights which concluded in 2007 that “The threat of incurring high charges has resulted in some people with life-threatening illnesses or disturbing mental health conditions being denied, or failing to seek, treatment.”

2. It will deliver efficiency savings within the NHS as the current charging system is difficult to administer. The new guidelines issued with the consultation will not solve this problem as healthcare professionals will still have to assess when a patient is likely to return home and whether waiting until that time would lead to an unacceptable deterioration in the patient’s condition. This assessment is both a difficult and time consuming task.

It is also a more efficient use of NHS resources to provide free treatment that prevents or cures illnesses rather than waiting for a condition to deteriorate until it reaches the threshold of immediately necessary or urgent treatment which cannot wait until the person is expected to return home. The Government review itself recognised that many refused asylum seekers do not have the means to pay for treatment they need and that the administrative costs of pursuing these debts are unlikely to be recovered.

These points around cost and efficiency are equally relevant for all refused asylum seekers still in the UK. Therefore, while strongly supporting the proposal to exempt refused asylum seekers on Sections 4 and 95 from charges, we urge the Government to restore all refused asylum seekers’ access to free secondary healthcare.

Drawing a distinction between those refused asylum seekers who are supported by UKBA and those who are not is problematic because there are often long delays in processing applications and providing support to refused asylum seekers who are entitled to it. Furthermore, many refused asylum seekers are wrongly denied support by UKBA and only receive it on appeal. In both these cases, individuals may have to wait weeks or months before receiving the support which would allow them to access healthcare that they were previously entitled to. During this time their health may deteriorate making treatment more difficult and expensive or, in some cases, making it impossible for the refused asylum seeker to return home because they are too ill to travel.

It should be stressed that in both Wales and Scotland all refused asylum seekers have access to free secondary healthcare and there is no evidence that this has created any increased demand for services from refused asylum seekers or put undue stress on NHS resources in these areas. Indeed, in 2009, the Royal College of General Practitioners concluded: “There is no evidence that asylum seekers enter the country because they wish to benefit from free health care.”³ At present Belgium, France, Italy, the Netherlands, Portugal and Spain are among the EU countries that provide full, free healthcare access to refused asylum seekers.⁴

³ The Royal College of General Practitioners, Position Statement: Failed asylum seekers/vulnerable migrants and access to primary care, 13 February 2009.

⁴ HUMA Network, *Access to healthcare for undocumented migrants and asylum seekers in 10 EU countries: Law and practice*, 2009.

Q6- Do you agree with the proposal that any unaccompanied non-resident Children should be exempted from NHS treatment charges?

Yes

No

Comments

Still Human fully supports the proposal that all unaccompanied non-resident children should be exempted from NHS charges. This is a humane policy that will safeguard the future health and development of this group of children and ensure that the Government meets its obligations under the UN Convention on the Rights of the Child and its own Every Child Matters policy. On this basis we would urge the Government to consider exempting all children present in the UK from charges for hospital treatment.

The proposed exemption is also a practical policy as only a negligible percentage of unaccompanied children will be able to pay for the treatment. However, Still Human would once again underline the point that if the Government reinstated free access to secondary healthcare for all refused asylum seekers, this would simplify the system and avoid complications arising around issues like whether an unaccompanied child's treatment should end when they become 18 or whether free treatment should be provided to an unaccompanied child whose age is disputed.

Q7- Do you agree that UK residents may be absent from the UK for up to six months in a year before potentially being liable for charges for NHS treatment under the Charging Regulations?

Yes

No

Comments

Q8- In respect of the proposals referred to in Questions 5-7 are you able to provide any additional data that may inform the calculations of costs and benefits?

Yes

No

Comments

Having reviewed the Department of Health's "Impact assessment of exemptions for failed asylum seekers" (10 December 2009), Still Human believes that the identified benefits of the proposals are not properly represented in the Impact Assessment or the full consultation document and that there are substantial additional benefits associated with the proposals in Q5 and Q6 which have not been taken into account.

In relation to the first point, the Impact Assessment states that the proposed changes would have "an overall social cost" (paragraph 38, page 8) when in actual fact there is a net social benefit as clearly shown in the summary analysis on page 2.

Furthermore, while the consultation document states that the additional costs to the NHS budget would be £9 million a year (page 11), it does not highlight the fact that there is net annual benefit of £12 million derived from extending free treatment to some refused asylum seekers under the current proposal. Still Human is concerned that some of those who respond to the consultation may oppose this proposal because they have wrongly concluded that it is cost ineffective based only on what they have read in the consultation document.

There are also additional benefits from the proposals which should be considered. One element included in the total costs is loss of charging revenue to the NHS. The impact assessment calculates that 10 per cent of costs are recoverable and that they would therefore lose revenue of £0.8 million a year by not charging refused asylum seekers who are on S4 or S95 for secondary healthcare. This is not the case as S4 and S95 support is only available to those asylum seekers who the Government has already assessed as destitute. These people will be unable to pay charges and consequently there will not be any loss of charging revenues to the NHS. On the contrary, a significant amount of time and money will be saved by not seeking to recover the costs of treatment from refused asylum seekers who do not have the means to pay these bills. On this point alone the average annual cost will be around £0.8 million less than the estimated £9 million (this does not include the administrative savings identified above).

On top of this, the costings do not take account of the changes to the criteria for accessing S4 (most asylum seekers making further submissions will no longer be able to access S4 while their submissions are being considered). The number of decisions to grant S4 has dramatically declined since this change was introduced, down by 55% in the last quarter of 2009 as compared with the third quarter. The number of people on Section 4 at the end of the first quarter of 2010 is already 10% below that used to estimate the costs of these proposals and this trend is likely to continue. Even on a conservative estimate the number of people in receipt of S4 is likely to be down 25% on this figure by the end of 2010. A decrease of 25% in the numbers of refused asylum seekers on S4 support would lead to a decrease in annual costs of £7.5 million a year, according to calculations contained in the impact assessment.⁵

In addition to the above, there is a substantial cost benefit of removing the administratively burdensome process of having to assess entitlement to healthcare from refused asylum seekers on S4 or S95 and unaccompanied children. The charging policy is bureaucratic and time consuming as it requires healthcare professionals to assess when a patient is likely to return home and whether waiting until that time would lead to an unacceptable deterioration in the patient's condition. This is an extremely difficult task. Even immigration lawyers will often be hard

⁵ Based on the calculation (on page 8 of the Impact Assessment) that if S4 applications increase by 5%, then annual total costs would increase by £1.5 million (from year two and including opportunity costs).

pressed to say when a judicial review will be heard or when an individual may be removed from the UK. Healthcare professionals are obviously ill equipped to make these assessments and this may lead to treatment being denied when it should not be. No estimate has been made of this cost benefit.

Furthermore, treatment that prevents or cures illnesses is obviously more cost efficient than waiting for a condition to deteriorate until it becomes an emergency or reaches the threshold of urgent or immediately necessary. This is recognised in paragraph 25, page 6 of the impact assessment, but no estimate has been made of this cost benefit.

While this is difficult to estimate, there is no doubt that there are significant savings to be made from the early intervention and the avoidance of more costly treatment when a condition deteriorates. For example, a prompt referral to a medical consultant based in a hospital costs £163 per patient related hour and outpatient attendance at a hospital for a face to face meeting (non-consultant led) would cost £55 for the first attendance and £71 for follow up appointments (national averages).⁶ Compare this with the cost of treating someone when a condition is allowed to deteriorate until it is an emergency or care is immediately necessary. The average cost per journey in an emergency ambulance is £263 (or £344 in a paramedic unit). If surgery is required the cost for a doctor (surgical consultant) to perform an operation is £388 per hour operating.⁷

The same is true in relation to mental health issues. Once the treatment becomes immediately necessary then costs are much higher. For example, hospital inpatient attendance for those requiring mental health services are £532 for intensive care, £268 for acute care and £257 for rehabilitation (all costs are national averages per bed day). Compare this against the cost of NHS Trust day care for people with mental health problems which averages £65 per day (not including evenings) or weekly Cognitive Behavioural Therapy session which costs £58 per session and is generally preventative.⁸

Charging for access to healthcare is likely to undermine the effectiveness of the fight against communicable diseases because it discourages refused asylum seekers from seeking out medical advice or coming forward for screening for diseases like TB or HIV/AIDS (despite the fact that they have a right to free treatment for the former). A recent Government review of health inequalities, noted that making access to social protection difficult for asylum seekers is counterproductive and can endanger the health of the host community.⁹ Conversely, allowing refused asylum seekers free access to healthcare will make it easier for the authorities and health workers to identify, engage and treat this vulnerable group of people and consequently save considerable resources by preventing the spread of communicable diseases. In this context, Still Human strongly urges the Government to include HIV/AIDS as one of the infectious diseases which is exempt from charging.

As the above indicates, providing refused asylum seekers with free access to secondary healthcare will save a significant amount of healthcare professionals' time, NHS financial resources and also helps protect the wider community from

⁶ Lesley Curtis, *Unit costs of health and social care 2008*, Personal Social Services Research Unit, University of Kent, 2008, pages 159 and 81.

⁷ Lesley Curtis, *op. cit.*, pages 82 and 160.

⁸ Lesley Curtis, *op. cit.*, pages 81, 53 and 57.

⁹ *Reducing the Risks to Health: The role of social protection*, Report of the Social Protection Task Group for the Strategic Review of Health Inequalities in England Post 2010, <http://sticerd.lse.ac.uk/dps/case/cp/CASEpaper139.pdf>

public health risks. Still Human Still Here estimates that the proposed policy would save several million pounds each year over and above the net annual benefit of £12 million already identified in the impact assessment.

Chapter 4: Tackling NHS Debt and Misuse

Q9- Do you agree with the proposal to require an overseas visitor receiving chargeable NHS treatment to provide personal information to aid subsequent recovery of charges?

Yes

No

X

Comments

While Still Human accepts that the NHS should seek to recover costs from appropriate chargeable overseas patients, we are concerned that in the case of refused asylum seekers the more personal information that is required, the more likely it is that that they will be deterred from accessing the healthcare they need.

In many cases, refused asylum seekers will not be able to give the information required (e.g. a passport or a permanent home address), and in seeking to obtain this data it is likely that the NHS will waste a good deal of valuable resources. In addition, the more agencies that are involved in obtaining or processing this data the more likelihood there is that there will be a breach of confidentiality with consequent legal and financial implications (these issues are also relevant for subsequent questions in the consultation).

For these reasons we believe that refused asylum seekers – who are extremely unlikely to be able to pay NHS charges – should be exempted from having to provide personal details beyond those that they have already provided to GPs as, in many cases, it is going to discourage, delay or prevent them from accessing healthcare because of the difficulties involved in providing the required information.

Q10- Do you agree with the proposal that NHS organisations must provide information relating to outstanding debt for NHS treatment to the Department of Health or to an appointed agency?

Yes

No

X

Comments

Still Human does not believe there should be a requirement on an NHS Trust to pass on information which may put it at risk of breaching a patient's confidentiality and we are concerned that this risk is increased each time an additional agency is given access to information relating to a patient.

Q11- What safeguards on the protection of personal information are needed beyond those described?

Comments

Specific safeguards should be introduced to limit who can access personal information held by the NHS Counter Fraud Service and in what circumstances.

Q12- Do you agree that the NHS Counter Fraud Service should transfer the data from the Department of Health's appointed agency to the UK Border Agency to support recovery and implement any agreed immigration sanctions under rules approved by parliament?

Yes

No

X

Comments

See answers to Qs 10 and 11 above.

Q13- Do you agree that the Secretary of State Directions to the NHS Business Services Authority should be amended to enable the NHS Counter Fraud Service to lawfully carry out the data transfer process?

Yes

No

X

Comments

See answers to Qs 10 and 11 above

Chapter 5: Health Insurance for Overseas Visitors

Q14- Do you support the principle that a requirement for chargeable overseas visitors to have health insurance should be introduced to cover the costs of any NHS treatment they may require during their stay?

Yes

No

Comments

Q15- What issues may arise from a system of either strongly recommended or mandatory health insurance for chargeable overseas visitors? How might these be overcome?

Comments

Q16- Do you support the principle that some overseas visitors who are currently exempted from charges should instead fund their treatment costs through health insurance?

 Yes **No**

Comments

Q17- What practical issues may arise if particular categories of overseas visitors or temporary residents were required to cover or insure their own healthcare costs rather than be entitled to free NHS treatment? How might these be overcome?

Comments

Please feel free to submit any further comments on these draft regulations below.

Further comments

In his 16 March 2010 report on the UK, the United Nations Special Rapporteur on Migrants specifically recommended that the UK Government “Address the concerns expressed by the Committee on Economic, Social and Cultural Rights regarding the low level of support and difficult access to health care for rejected asylum-seekers **by fully implementing the recommendations from the joint review carried out by the Department of Health and the Home Office on access to the National Health Service by foreign nationals**, and by ensuring that refused asylum-seekers are not left destitute while they remain in the United Kingdom.” (A/HRC/14/30/Add.3, paragraph 81b)

Still Human strongly endorses this view and hopes that the proposals in Q5 and Q6 will be implemented as quickly as possible and that treatment for HIV/AIDS will also be exempted from charging, as is the case for other infectious diseases.

However, Still Human firmly believes that charging any refused asylum seeker for healthcare, even when treatment is not delayed in order to secure payment, will discourage them from seeking care because they are worried about debt and also about immigration enforcement action which they associate with debt. The current charging arrangements have also given ample evidence of repeated and serious non-compliance with the guidelines, particularly in relation to maternity care. For these reasons we urge the Government to reconsider reinstating free access to secondary healthcare for all refused asylum seekers which would greatly simplify the regulations and help ensure their proper application while reducing the administrative burden on healthcare professionals.