Migrants, the National Health Service, and the threat of exclusion

David Stuckler and **Sarah Steele** point out that dog-whistle immigration politics are incompatible with the founding principles of the NHS

Brace yourself for another round of innuendo and ignorance about immigration, as the Office for National Statistics prepares to report data one year on from the lifting of restrictions on migrants arriving from Bulgaria and Romania, a January 2014 shift that saw 30,000 new migrants arrive in the first quarter of this year (Ross, 2014).

Amid the huffing and puffing will be the insidious suggestion that the first thing these new migrants will do, once they've signed up for a council house and weekly dole payments that is, will be to barge in front of hard-working Britons in the queue for healthcare.

No matter that this is clearly an inaccurate picture – for reasons we will discuss – the ill-feeling this sort of dog-whistling creates is in direct contravention of the principles by which the National Health Service (NHS) was originally established.

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The *Immigration Act 2014* radically reconfigures these foundational principles. The Act, which received Royal Assent on 14 May, permits an NHS levy on visas and extending charges for visitors and non-EEA temporary migrants (e.g. those from outside the European Economic Area) for NHS services, when these individuals do not fall into a handful of exemptions. When the Act comes into effect many migrants will likely face substantial treatment costs.

David Cameron and his Health Secretary Jeremy Hunt, among other members of the coalition, argue that the Act is a painful, yet necessary, step to ensuring the long-term viability of the NHS. They claim that the Act is essential to establish that the NHS is 'a national health service not an international health service', so as to 'wipe out abuse in the system' to 'make sure it is sustainable for years to come' (The Huffingham Post, 2013).

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There are three fundamental flaws in the Act. First, it will require the setting up of an elaborate system of charging that will require the Home Office and NHS to share data. But how do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? This will necessitate a new information system, along with staff training on how to use it. The Act is likely to increase NHS administration costs, bringing in less money from charging migrants than it costs to administer (Royal Society of Medicine, 2014).

Second, there is no data supporting the claim that migrants cost the system. Indeed, the evidence points to the contrary. A budgetary analysis found that non-EEA migrants contribute two per cent more than they take out during their time in the UK. This contribution offsets the less than two per cent of NHS expenditure spent on migrants (Dustmann and Frattini, 2013). At the same time, 36 per cent of doctors registered with the General Medical Council are trained abroad, so that the NHS workforce relies heavily on the contributions of migrants (General Medical Council, 2014).

Third, the Act is likely to cause harm to people. Apart from a few exceptions, migrants generally come to the UK in better health than the local population (Rechel et al., 2013). UK living and working conditions and diets, however, expose migrants to increased risk of non-communicable diseases. Screening and interventions are essential to reduce this risk and long-term healthcare costs. There is clear evidence from large randomised trials that introducing charges and user fees for care reduces both necessary and unnecessary healthcare utilisation, with direct consequences for health (Manning et al., 1987).

Thus, leaders of British Medical Association and Council of the Royal College of General Practitioners are speaking out against the reforms. The British Medical Association, for example, has voiced concern that

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the changes conflict with professional ethics and specifically doctors' duty to provide care. What will happen next? Many healthcare workers may be unwilling or simply refuse to implement the changes as a protest against them.

The Act could spur a wider movement bringing together nurses, doctors, and healthcare workers towards preserving the NHS' foundational principles, perhaps building upon the nascent National Health Action Party, whose main aim is to reverse the *Health and Social Care Act*.

Meanwhile the media and pressure groups, such as Migration Watch, will continue to raise the temperature of this debate.

If we do not intervene, it may not be long until the rest of the UK population is harmed. It doesn't bode well for the future. ■

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