Health Economics, Policy and Law (2018), **13**, 107–117 © Cambridge University Press 2018
doi:10.1017/S1744133117000251

Perspective

Creating a 'hostile environment for migrants': the British government's use of health service data to restrict immigration is a very bad idea

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Abstract: In January 2017, the UK Government made public a Memorandum of Understanding (MoU) between the Department of Health, National Health Service (NHS) Digital and the Home Office. This Memorandum allows for the more expedited sharing of a patient's non-clinical data, specifically from the NHS England to the Home Office. The Government justified the MoU as in the 'public interest to support effective immigration enforcement'. In this review, we seek to unpack this justification by providing, first, a background to the MoU, placing it in the context of creating a 'hostile environment' for migrants – a project initially sought by Theresa May in her time as Home Secretary. We then explore the potential impact of data sharing on individual health, public health and on health professionals. We conclude that the MoU could threaten both individual and public health, while placing health professionals in an unworkable position both practically and in terms of their duties to patients around confidentiality. As such, we agree with colleagues' position that it should be suspended, at least until a full consultation and health impact assessment can be carried out.

Submitted 16 August 2017; revised 3 September 2017; accepted 5 September 2017; first published online 8 January 2018

Introduction

In 2017, a fire in a tower block – Grenfell Tower – in which at least 80 people died, revealed a deep divide in the UK's population (McKee, 2017). Councillors in one

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of the wealthiest parts of the country had ignored safety concerns long voiced by some of their poorest residents, many of whom were migrants (Royal Borough of Kensington and Chelsea, 2017). In the aftermath of the fire, the deep divisions became further apparent, as some of these migrants declined health care and other public services, fearful of the threat of detention and deportation (Gordon, 2017). Such fears were likely influenced by several very public changes to health care and public services, in which the British Government overtly targeted migrants in order to reduce overall net immigration. These changes included the extension of charges for using the National Health Service (NHS) (Steele *et al*., 2014), as well as a recent Memorandum of Understanding (MoU) allowing NHS Digital – the provider of information, data and IT systems to the NHS in England – to share data on individuals with the Home Office. The announcement, by British Prime Minister Theresa May, of a year-long amnesty for undocumented migrants did little to assuage fears, and charities across London responded by establishing support and even a temporary health care clinic for those in need, safe from immigration authorities (Adamson, 2017; Doctors of the World, 2017; Hiam, 2017).

While the impact of the new charging regime is explored elsewhere (Steele *et al*., 2014; Britz and McKee, 2016; Hiam and McKee, 2016), we seek to understand the possible consequences of the MoU and resulting data disclosure. Casla *et al*. (2017) recently highlighted some of these concerns, including the right of health to all. Here we explore these in more detail, beginning by placing it in the context of the Government's other policies on access to health care, before examining the effects it may have on the health of the individual, the population and on health care professionals. We concur with Casla *et al*. that there is a need for more detailed consideration of the MoU, and call for its suspension until a full public consultation and reassessment of its impacts is undertaken.

Background to the memorandum

While eligibility for free treatment by the NHS has never been absolute or universal, in recent years, the UK Government has increasingly enforced the principle that the service is only available to those 'ordinarily resident' in the United Kingdom. In April 2015, the Government changed how the NHS in England charges migrants, visitors and former residents of the United Kingdom for hospital treatment. First, an immigration health charge (or 'surcharge') payable by non-European Economic Area (EEA) nationals who apply for a visa to enter or remain in the United Kingdom for more than 6 months was introduced, and subsequently increased in cost. Second, the Government also increased the scale and scope of charging for NHS services for those not eligible for free-at-the-point-of-use care. Those who are not 'ordinarily resident' – that is, those who are not 'broadly, living in the UK on a lawful, voluntary and properly settled basis for the time being' (NHS, 2017a) – who have not paid the levy are to be charged for non-urgent secondary care, including non-emergency hospital services, mental health and community care. From October 2017, non-NHS providers of NHS care, such as charities, will be required to charge for such care, and a requirement of upfront charging will be introduced, unless this would delay urgent or immediately necessary care (NHS, 2017b).

As a result, NHS bodies are now obliged both to check the status of a patient presenting to their service against flags placed on the patient file indicating status, while obtaining from the patient information about their residency status to identify whether they should be charged and, if they incur debts, to pass this information back to the Home Office (Department of Health, 2012). An outstanding NHS debt of £500 is now a basis for refusal of right to remain, and potentially leading to removal from the UK according to amendments to Appendix FM to the Immigration Rules (UK Government, 2016; Home Office, Department of Health, NHS Digital, 2017). In this way, charging for NHS services is now linked to immigration enforcement. In addition, responsibility for surveillance of migrants has been dispersed throughout the public sector, and among landlords and banks, amongst others, who must determine residence status before providing services (UK Government, 2013).

In practice, however, numerous issues with departmental sharing of information for the purposes of immigration enforcement have been identified. First, the system for transferring information between various NHS bodies and the Home Office was dysfunctional, plagued by burdensome administrative processes. Prior to January 2017, NHS Digital only identified the area in which the individual was registered as a patient, while the Home Office had to contact local NHS organisations to obtain their contact information (Gordon, 2017). This required a series of actions by many different parties, using several systems.

The MoU sought to simplify this situation, allowing NHS Digital to trace the personal data of the individual and supply it directly to the Home Office, thereby cutting out the need to contact local NHS bodies for information (Gordon, 2017). The Government justified the MoU on the basis that there is a 'substantial public interest in sharing this non-clinical information to support effective immigration enforcement' and for protection of people who might be at risk (Gordon, 2017). The agreement came into force on 1 January 2017, without a public consultation ever taking place. The Government only undertook a limited stakeholder review, justifying the lack of consultation and review on the basis that the MoU was only for the 'operationalisation of existing functions' (Gordon, 2017).

These functions are grounded in Section 261 of the Health and Social Care Act 2012. Section 261(5)(e) allows disclosure in connection with investigation of a criminal offence. Section 261(5)(d) permits disclosure where it is necessary, or expedient, for the NHS to have information for the purpose of exercising its functions under or by virtue of any provision of any Act. Section 261(5)(c) allows disclosure where it is necessary or expedient for the purposes of protecting the welfare of the individual. Any disclosure of data is subject to consideration of individual circumstances, the person to whom the information is disclosed, and the purpose of the disclosure. NHS digital is required, by Section 261(5)(e), to take account of common law that would otherwise prohibit or restrict the disclosure, weighing the public interest in favour and/or against disclosure. It must do this on a case-by-case basis. The public interest justification offered for breaching confidentiality is for 'maintaining effective immigration controls', as 'it is in the public interest that limited UK resources and public services (including the NHS, jobs, schools, housing) are protected from unnecessary financial and resource pressures' (Home Office, 2017).

However, on closer inspection, this statement is somewhat problematic. First, it ignores mounting evidence that problems facing many public services, particularly health and social care, reflect cuts in public funding under the guise of austerity (Loopstra *et al.*, 2015, 2016; Hiam *et al.*, 2017). In fact, although difficult to assess the estimated cost to the NHS of EEA and non-EEA visitors is ~1.8% of the total NHS England spend (Appleby, 2013). It also ignores any public interest in protecting public health, and having a health system that preserves confidentiality and is trusted.

The Government has acknowledged that 'the increased transparency enabled by the MoU and Review may itself have an effect [of deterring immigrants seeking health services]' (Gordon, 2017). This view is shared by many health care workers, who have refused to co-operate with data collection obligations that facilitate charging (Bulman, 2017). In response, the National Audit Office has advised on mechanisms to encourage enforcement (National Audit Office, 2016). In these circumstances, we ask whether the MoU could harm patients, the public at large, and health practitioners? If so, what should be done?

Issues for individual patients

The Government justifies the sharing of data with the Home Office on the basis that it 'is potentially able to bring suspected immigration offenders back into contact, to either regularise their stay or work towards their removal' (Gordon, 2017). It also states that it 'is particularly important in respect of safeguarding responsibilities towards vulnerable children and adults who may be at risk'. However, as the Government has noted, there is a risk that migrants, fearful of the consequences of data sharing, may not seek health care (Department of Health, 2015). Public Health England has asserted that there is a lack of statistical evidence to suggest that this is happening, as there is a dearth of research. It has, however, conceded that:

> [i]f patients have concerns that their personal information, even simple identifiers, could be shared with law enforcement or immigration enforcement agencies for the purposes of pursuing them for actual or alleged breaches of law or immigration rules, then this risks creating a real barrier to their engagement. Any barriers, actual or perceived, to patients accessing healthcare can have serious consequences. In particular this may impact upon asylum seekers, refugees and undocumented migrants or migrant groups legally in the UK

who may be distrustful of sharing personal information for fear that it could be accessed by migration enforcement to locate them or their friends and family (Public Health England, 2017).

Previous research supports these concerns. In the United States, fear of disclosure of undocumented status can both reduce or delay health-seeking behaviour for several diseases, including tuberculosis (Asch *et al*., 1994; Martinez *et al*., 2015). In the UK a fear of deportation does influence testing for communicable diseases, including HIV (Dodds *et al*., 2008; Thomas *et al*., 2010), although migrants do not carry a high burden of infectious disease. Victims of human trafficking have been shown to be particularly vulnerable to worries about disclosure, even when legal protections are offered to them (Kings College London, 2017). These findings are borne out by accounts not only from the scene of the Grenfell Tower fire, with reports of individuals assessed by volunteer doctors as requiring hospital treatment, for example, for head injuries, refusing it (Gentleman, 2017a), but across the country, where many, including pregnant women, are too afraid to go to hospital, despite the clear medical need (Gentleman, 2017a, 2017b).

While such outcomes may on face appear clearly undesirable to the United Kingdom, it is critical to consider the context in which they have been implemented; the MoU is situated within a series of Government policies designed to create a ‘hostile environment’ for migrants (Steele *et al*., 2014). It was recently revealed that the Government had acquired data on distribution and needs of rough sleepers – data intended to allow for the allocation of services and to protect this vulnerable group – and then used it to target areas for immigration enforcement against homeless migrants, including specifically EEA nationals (Townsend, 2017). The fears that these actions generate clearly jeopardise the health of individual migrants and, as the next section shows, also the health of the population at large.

Issues for the public at large

Although most migrants arrive in good health, exhibiting the ‘healthy migrant effect’, and are at low risk of infectious diseases (European Centre for Disease Prevention and Control, 2015), undiagnosed and untreated infections, and lack of routine immunisations, can result in issues for the local population and communities into which migrants are received (Legido-Quigley *et al*., 2013; Kentikelenis *et al*., 2014). Failure to treat non-communicable diseases, such as diabetes and hypertension, may increase future health care needs and costs and burdens on health services, as well as impairing the ability of the individual to contribute to the economy (Bozorgmehr and Razum, 2015). Thus, any measurable impact on the health care-seeking behaviour of individuals risks impacting on public health more widely.

Issues for health care workers

When taking the Hippocratic Oath, new doctors swear that 'whatsoever I shall see or hear in the course of my profession … I will never divulge, holding such things to be holy secrets' (Miles, 2005). As a result, patient confidentiality remains a core obligation for all in the medical profession. The General Medical Council (GMC) provides guidance on how to operationalise this requirement in daily practice, and, in *Good Medical Practice*, it makes it clear that 'patients have a right to expect that their personal information will be held in confidence by their doctors' (GMC, 2013). In April 2017, the GMC re-emphasised that '[a]sking for a patient's consent to disclose information shows respect, and is part of good communication …' (GMC, 2017).

As detailed above, the expectation of confidentiality is not absolute. Disclosure of a patients' personal information may be necessary to support the direct care of the individual, for the protection of patients and others, or for other purposes covered by statutory obligations designed to protect the public interest. In all these cases, the objective is to prevent harm to the patient or others. Doctors who fail to follow GMC's guidance on confidentiality and disclosure and who exhibit serious or persistent failures put their registration at risk.

Balancing confidentiality with disclosure of information involves challenges for practitioners. The GMC states that, for a disclosure to take place, it must be clear that 'the benefits to an individual or to society of the disclosure must outweigh both the patient's and the public interest in keeping the information confidential'. Considerations to be taken into account are listed in Box 1.

Looking at these in turn, it is self-evident that disclosure will bring harm or distress to the patient and, as noted above, there is now evidence from several countries that disclosure of immigration status will impede the future engagement with treatment of

Box 1. Considerations in deciding whether disclosure is justified

a) The potential harm or distress to the patient arising from the disclosure – for example, in terms of their future engagement with treatment and their overall health
b) The potential harm to trust in doctors generally – for example, if it is widely perceived that doctors will readily disclose information about patients without consent
c) The potential harm to others (whether to a specific person or people, or to the public more broadly) if the information is not disclosed
d) The potential benefits to an individual or to society arising from the release of the information
e) The nature of the information to be disclosed, and any views expressed by the patient
f) Whether the harms can be avoided or benefits gained without breaching the patient's privacy or, if not, what is the minimum intrusion

Source: General Medical Council.

some people in some circumstances. Second, there is also clear evidence from the events following Grenfell Tower that such measures can erode trust in doctors. In both of these cases, the offer of an amnesty by the government can be considered an implicit acceptance of these arguments. Third, where disclosure concerns risks of communicable disease transmission or terrorism, the risk of harm from non-disclosure are relatively clear, assuming that the information on which disclosure is based is accurate and non-discriminatory. However, this is far from clear in relation to immigration, where any theoretical benefits to society are very far from certain.

Where the government does have a case is the Home Office contention that this involves disclosure that is at or close to the level of minimum intrusion. In this they are supported by a ruling in the Court of Appeal in which four non-UK residents challenged the transmission of information identifying them from the Department of Health to the Home Office (Court of Appeal, 2015), in an appeal that was joined by the British Medical Association. The Court held that such information was ‘less intrusive’ than disclosure of detailed information about an individual’s medical condition and treatment. While noting that this did not mean that it was not intrusive at all, or that the information was not inherently private, it was held that it meant that it would be easier to justify disclosure. However, that judgement was on issues of data protection and did not take into account the other issues included in the GMC criteria.

Taking these criteria as a whole, it is unsurprising that many British doctors have asked whether their professional ethics conflict with the policy of their Government, in this case a policy promulgated by an MoU and not even by primary legislation that has undergone parliamentary scrutiny. Of course, this is a quandary that is faced by doctors in many countries now and in the past, sometimes even involving judicial and extra-judicial attacks on doctors treating individuals deemed unworthy by governments (Arie, 2014; Vlassov, 2014).

Also, it must be remembered that many health care staff are themselves migrants. The data from the GMC reveals that 30,472 doctors come from the EU and other countries in the EEA, while 71,139 were trained elsewhere in the world, outside the UK. Data collected by the House of Commons library show that, in December 2016, 22,081 nurses working in NHS hospital or community services had an EU nationality, accounting for 7% of the total (Baker, 2017). Creating an environment where these health care workers are reminded daily that migrants are seen as a burden on the United Kingdom, and current migration levels are undesirable, may have significant impacts on morale and their on-going contribution to the NHS. Troublingly, a haemorrhaging of foreign staff from the NHS was noted after Brexit, with EU staff leaving in large numbers, while the numbers of registrations simultaneously dropped dramatically (Boffey, 2017). A critical decline in foreign staff and overseas-trained doctors in the NHS will in fact affect the sustainability of the service, threatening the quality of health care for the population at large. Accompanied by a reduction in applications for training places in shortage in fields like nursing and midwifery, there are real reasons for the public to be concerned about the staffing of the NHS, and therefore wait times, as well as safe and excellent care.

Conclusion

The British Government, while presenting the MoU as justified, has acknowledged that its impacts must be appraised more fully, yet it suggests this can safely be done after implementation. It has delegated this task to Public Health England, to be completed within the next 2 years. However, there are already strong grounds to believe that the MoU threatens individual and public health, while placing health professionals in an invidious position. Consequently, we support the calls by Doctors of the World, the National AIDS Trust and Liberty, to suspend it until there has been a detailed consultation on its impacts (Doctors of the World, National AIDS Trust 2017), especially on migrants, and, if implemented, it should be as a pilot in a few areas and rigorously evaluated. This measure could change the doctor–patient relationship potentially irreparably, while driving even more staff to feel unwelcome in the United Kingdom, shifting their health care expertise elsewhere. Once again, the government has steam-rolled significant changes to the NHS, without consulting those forced to impose them: the health profession.

Conflicts of Interest

Dr Hiam is a health advisor at Doctors of the World.

References

Adamson, M. (2017), ‘The Red Cross’s priority is to help every victim of the Grenfell Tower fire’. *The Guardian*, https://www.theguardian.com/commentisfree/2017/jun/20/british-red-cross-responds-grenfell [25 August 2017].

Appleby, J. (2013), ‘Migrants’ healthcare: who pays?’, *BMJ*, **347**: f6483.

Arie, S. (2014), ‘New Turkish law forbids medical treatment of injured protesters without state permission’, *BMJ*, **348**: g82.

Asch, S., B. Leake and L. Gelberg (1994), ‘Does fear of immigration authorities deter tuberculosis patients from seeking care?’, *Western Journal of Medicine*, **161**(4): 373–376.

Baker, C. (2017), *NHS Staff From Overseas: Statistics*, London: House of Commons Library.

Boffey, D. (2017), ‘Record numbers of EU nurses quit NHS’. *The Guardian*, https://www.theguardian.com/society/2017/mar/18/nhs-eu-nurses-quit-record-numbers [25 August 2017].

Bozorgmehr, K. and O. Razum (2015), ‘Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: a quasi-experimental study in Germany, 1994-2013’, *Public Library of Science One*, **10**(7): e0131483.

Britz, J. B. and M. McKee (2016), ‘Charging migrants for health care could compromise public health and increase costs for the NHS’, *Journal of Public Health*, **38**(2): 384–390.

Bulman, M. (2017), ‘Doctors fight against becoming “border guards” for Home Office immigration enforcement’. *The Independent*, http://www.independent.co.uk/news/uk/home-news/doctors-home-office-immigration-enforcement-border-guards-nhs-doctors-of-the-world-a7693461.html [25 August 2017].

Casla, K., P. Roderick and A. M. Pollock (2017), ‘Disclosure of patients’ data to the UK home office must stop’, *BMJ*, **358**: j361.

Court of Appeal. (2015), ‘EWCA Civ 1034 W, X, Y AND Z and The Secretary of State for Health’. England and Wales Court of Appeal, Civil Division.

Department of Health (2015), *Visitor and Migrant Cost Recovery – Extending Charging: Impact Assessment*, London: Department of Health.

Department of Health (2012), ‘Guidance on overseas visitors hospital charging regulations’, last updated on 22 August 2017, https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations [30 August 2017].

Doctors of the World (2017), ‘Doctors of the World launches clinic for Grenfell Tower survivors’. 29 June, https://www.doctorsoftheworld.org.uk/news/doctors-of-the-world-launches-clinic-for-grenfell-tower-survivors [30 June 2017].

Doctors of the World, National AIDS Trust (2017), ‘Briefing on patient information sharing with the Home Office’, https://www.doctorsoftheworld.org.uk/Handlers/Download.ashx?IDMF=32f18a4f-e84f-4df5-ade5-fe84bf7c92ff [7 April 2017].

Dodds, C., F. Hickson, P. Weatherburn, D. Reid, G. Hammond, K. Jessup and G. Adegbite (2008), *BASS Line 2007 Survey: Assessing the Sexual HIV Prevention Needs of African People in England*, London: Sigma Research.

European Centre for Disease Prevention and Control (2015), ‘Assessing the burden of key infectious diseases affecting migrant populations in the EU/EEA’. https://ecdc.europa.eu/en/publications-data/assessing-burden-key-infectious-diseases-affecting-migrant-populations-eueea [30 June 2017].

General Medical Council (GMC) (2013), ‘Good medical practice’, Updated 29 April 2014, http://www.gmc-uk.org/guidance/good_medical_practice.asp [30 June 2017].

General Medical Council (GMC) (2017), ‘Confidentiality guidance: disclosing information with consent 2009’, http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality_24_35_disclosing_information_with_consent.asp [7 April 2017].

Gentleman, A. (2017a), ‘Grenfell Tower survivors “too scared to seek help” because of immigration status’. *The Guardian*, https://www.theguardian.com/uk-news/2017/jun/22/grenfell-tower-survivors-too-scared-to-seek-help-because-of-immigration-status [31 July 2017].

Gentleman, A. (2017b), ‘Pregnant women without legal status “too afraid to seek NHS care”’. *The Guardian*, https://www.theguardian.com/uk-news/2017/mar/20/pregnant-asylum-seekers-refugees-afraid-seek-nhs-maternity-care [25 August 2017].

Gordon, N. (2017), ‘Letter from NHS Digital to Dr Sarah Wollaston MP 2017’, https://www.parliament.uk/documents/commons-committees/Health/Correspondence/2016-17/Correspondence-Memorandum-Understanding-NHS-Digital-Home-Office-Department-Health-data-sharing.pdf [20 July 2017].

Hiam, L. (2017), ‘Grenfell survivors shouldn’t be afraid to go to hospital’, *BMJ*, **358**: j3292.

Hiam, L. and M. McKee (2016), ‘Making a fair contribution: is charging migrants for healthcare in line with NHS principles?’, *Journal of Royal Society of Medicine*, **109**: 226–229.

Hiam, L., D. Dorling, D. Harrison and M. McKee (2017), ‘What caused the spike in mortality in England and Wales in January 2015?’, *Journal of Royal Society of Medicine*, **110**(4): 131–137.

Home Office, Department of Health, NHS Digital (2017), ‘Memorandum of understanding between Health and Social Care Information Centre and the Home Office and the Department of Health’, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585928/MOU_v3.pdf [30 June 2017].

Kentikelenis, A., M. Karanikolos, A. Reeves, M. McKee and D. Stuckler (2014), 'Greece's health crisis: from Austerity to Denialism', *Lancet*, **383**(9918): 748–753.

Kings College London (2017), 'Human Trafficking: improving the UK's health-care response', https://www.kcl.ac.uk/ioppn/depts/hspr/research/CEPH/wmh/projects/A-Z/protect-files/PolicyBrief-HEE-and-Royal-Colleges.pdf [20 July 2017].

Legido-Quigley, H., L. Otero, D. la Parra, C. Alvarez-Dardet, J. M. Martin-Moreno and M. McKee (2013), 'Will Austerity cuts dismantle the Spanish healthcare system?', *British Medical Journal*, **346**: f2363.

Loopstra, R., A. Reeves, D. Taylor-Robinson, B. Barr, M. McKee and D. Stuckler (2015), 'Austerity, sanctions, and the rise of food banks in the UK', *BMJ*, **350**: h1775.

Loopstra, R., M. McKee, S. V. Katikireddi, D. Taylor-Robinson, B. Barr and D. Stuckler (2016), 'Austerity and old-age mortality in England: a longitudinal cross-local area analysis, 2007-2013', *Journal of Royal Society of Medicine*, **109**(3): 109–116.

Martinez, O., E. Wu, T. Sandfort, B. Dodge, A. Carballo-Dieguez, R. Pinto, S. D. Rhodes, E. Moya and S. Chavez-Baray (2015), 'Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review', *Journal of Immigrant and Minority Health*, **17**(3): 947–970.

McKee, M. (2017), 'Grenfell Tower fire: why we cannot ignore the political determinants of health', *BMJ*, **357**: j2966.

Miles, S. H. (2005), *The Hippocratic Oath and the Ethics of Medicine*, Cary: Oxford University Press.

National Audit Office (2016), 'Recovering the cost of NHS treatment for overseas visitors'. https://www.nao.org.uk/wp-content/uploads/2016/10/Recovering-the-cost-of-NHS-treatment-for-overseas-visitors.pdf [24 August 2017].

National Health Service (NHS) (2017a), 'The National Health Service (charges to overseas visitors) (amendment) regulations 2017', 19 July, http://www.legislation.gov.uk/uksi/2017/756/pdfs/uksi_20170756_en.pdf [24 August 2017].

National Health Service (NHS) (2017b), 'NHS business definitions: ordinarily resident 2017', http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/o/ordinarily_resident_de.asp?shownav=1 [20 July 2017].

Public Health England (2017), 'NHS digital National Back Office (NBO) Review', http://www.parliament.uk/documents/commons-committees/Health/Correspondence/2016-17/Correspondence-Memorandum-Understanding-NHS-Digital-Home-Office-Department-Health-data-sharing.pdf [20 June 2017].

Royal Borough of Kensington and Chelsea (2017), 'Borough economic profile 2017', https://www.rbkc.gov.uk/business-and-enterprise/borough-economic-profile [13 July 2017].

Steele, S., D. Stuckler, M. McKee and A. M. Pollock (2014), 'The Immigration Bill: extending charging regimes and scapegoating the vulnerable will pose risks to public health', *Journal of Royal Society of Medicine*, **107**(4): 132–133.

Thomas, F., P. Aggleton and J. Anderson (2010), '"If I cannot access services, then there is no reason for me to test": the impacts of health service charges on HIV testing and treatment amongst migrants in England', *AIDS Care*, **22**(4): 526–531.

Townsend, M. (2017), 'Home Office used charity data map to deport rough sleepers'. *The Guardian*, https://www.theguardian.com/uk-news/2017/aug/19/home-office-secret-emails-data-homeless-eu-nationals [23 August 2017].

UK Government (2014), Immigration Act 2014. https://www.gov.uk/government/collections/immigration-bill [24 August 2017].

UK Government (2016), ‘Statement of changes in immigration rules’. Presented to Parliament pursuant to section 3(2) of the Immigration Act 1971, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564933/57079_-_HC_667_-_Web_Accessible.pdf [20 July 2017].

Vlassov, V. (2014), ‘Doctors are targeted by police while treating protesters in Kiev’, *BMJ*, **348**: g1169.