

*Eligibility of Immigrants
for Health Care Services*

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Executive Summary

1. This research studies the eligibility of immigrants for health care services in the state of New York (New York) of the United States of America (US), the province of Ontario (Ontario) of Canada, the United Kingdom (UK) and Hong Kong in terms of availability of public health care, eligibility for free or subsidized public health care, and other relevant health care policies relating to immigrants.

Availability of public health care

2. The four jurisdictions studied have adopted different approaches with respect to the availability of public health care services to immigrants as well as determining their eligibility for free or subsidized public health care services. In Ontario, Hong Kong, and the UK, health care coverage is universal and available to all legal immigrants, regardless of their age, disability, or income and resources of a household. On the other hand, New York does not have a universal health care programme for qualified immigrants.

3. In Ontario, residence in the province is the basic requirement for coverage under the Ontario Health Insurance Program for landed immigrants, who receive the same health care benefits as citizens. Similarly, in Hong Kong, residence is the only requirement for the receipt of public health care services for non-permanent residents, who receive the same range and quality of services as permanent residents. In the UK, legal immigrants are eligible for free access to National Health Service immediately after their arrival in the UK.

4. In New York, apart from basic health care coverage, free or subsidized public health care is not available to all qualified immigrants. Age, income intake, assets and resources are part of the test for eligibility for free or subsidized public health care services which are available only to designated groups of qualified immigrants.

Eligibility for free or subsidized public health care

5. In both Ontario and the UK, legal immigrants are eligible for free public health care services, with the services funded by tax revenue. In Ontario, both immigration and residence statuses are required for eligibility, while in the UK, residence status is the only determining factor. On the contrary, in New York, only selected groups of qualified immigrants are eligible for public health care services free of charge or at a subsidized rate: Medicare for the elderly and the disabled, Medicaid and Family Health Plus for low-income households, and Child Health Plus for children.

6. In Hong Kong, public health care services are available to all but are provided on a fee-for-service basis. Depending on the residence status of the individual, he or she is categorized into Eligible Persons and Non-eligible Persons whereby only the former is qualified for subsidized public rates. One Way Permit holders and other non-permanent residents, who are holders of Hong Kong Identity Card, are considered Eligible Persons and therefore qualified for subsidized rates.

Responsibility for immigrants' health care expenses

7. In Ontario and the UK, sponsors of immigrants are not required to reimburse the government for the provision of public health care services to immigrants. Similarly, in Hong Kong, residents whose family members have settled in Hong Kong via the One Way Permit Scheme are not required to reimburse the Government for the provision of public health care services to them. Only New York has enacted legislation on sponsor deeming¹ and sponsor liability². However, the legislation is yet to be implemented and discussion is underway regarding its enforcement.

¹ For the definition of sponsor deeming, please refer to paragraph 5.2.4a.

² For the definition of sponsor liability, please refer to paragraph 5.2.4b.

Eligibility of Immigrants for Health Care Services

Chapter 1 - Introduction

1.1 Background

1.1.1 The Panel on Health Services (the Panel), at its meeting on 10 March 2003, requested the Research and Library Services Division (RLSD) to conduct a research on the eligibility of immigrants for health care services in overseas jurisdictions.

1.1.2 The jurisdictions that RLSD originally proposed to study were the state of New York (New York) of the United States of America (US), the province of Ontario (Ontario) of Canada, and Australia. The Panel further suggested to include the United Kingdom (UK), Singapore and Japan in the study. After conducting preliminary research on these six jurisdictions, it is found that the health care service policy for immigrants in Australia is similar to that of Canada, with the federal government setting and administering the national health care standards, and the state governments being responsible for planning and implementing the individual state systems. Considering the similarities between Australia and Canada, only Ontario is included in the study. With respect to Singapore and Japan, limited information is available on the topic. Enquires were sent to the relevant authorities in Singapore and Japan, but no response has been received as at the publication of this report. Due to insufficient relevant information, these two jurisdictions are not included in the research report.

1.1.3 The overseas jurisdictions selected for this research report are New York, Ontario and the UK. These three jurisdictions exhibit fundamental differences in the provision of public health care to immigrants. In New York, free or subsidized public health care is only available to low-income immigrant families, whereas public health care in both the UK and Ontario is not only free, but universal and available to all immigrants. For immigrants who are eligible for health care services, they receive the same benefits as citizens in all three jurisdictions. Access to public health care is free in the UK and Ontario, whereas in New York, payment for public health care services depends on age, income intake and treatment received.

1.2 Scope of research

1.2.1 The scope of research covers:

- (a) an overview of health care policies;
- (b) health care policies relating to immigrants; and
- (c) implementation of health care policies relating to immigrants.

1.3 Methodology

1.3.1 This research adopts a desk research method which involves Internet research, literature review and analysis, and correspondence with related authorities. Information for this research is obtained from government reports, the Internet and relevant reference sources. Enquiries were also sent to the relevant authorities in Hong Kong and overseas jurisdictions. As at the publication of this report, RLSD has received response from only some of the authorities.

Chapter 2 - Hong Kong

2.1 Introduction

2.1.1 The policy of the Government of the Hong Kong Special Administrative Region (HKSAR) on health care is to safeguard and promote general public health of the community as a whole and to ensure the provision of medical and health care services for its population. The provision of health care services is stipulated in Article 138 of the Basic Law which states that the Government shall, "*on its own, formulate policies [...] to improve medical and health services. Community organizations and individuals may provide various medical and health services in accordance with law.*"

2.1.2 In Hong Kong, the responsibility for public health care management is shared among three government agencies:

- (a) Health, Welfare and Food Bureau (HWFB) is responsible for policy matters relating to medical and health care services, including review of health care delivery and financing systems, development of primary health care services, prevention of communicable and non-communicable diseases, and provision of hospital services;
- (b) Department of Health (DH) is the Government's official health advisor and agency to execute health care policies and statutory functions. It safeguards community health through promotional, preventive, curative and rehabilitative services; and
- (c) Hospital Authority (HA) is an independent statutory body established on 1 December 1990 under the Hospital Authority Ordinance to manage all public hospitals in Hong Kong. It provides medical treatment and rehabilitation services to patients through hospitals, specialist clinics and outreaching services.

Universality of public health care

2.1.3 Public health care services are available to all those in need, regardless of their residence status.³ The guiding principle of health care service policies in Hong Kong is that "*no one should be prevented, through lack of means, from obtaining adequate medical treatment*".⁴ There is no distinction in the scope and quality of services provided to each individual.

2.1.4 Public health care services are delivered on a fee-for-service basis. Depending on the residence and immigration statuses of an individual, there are two different rates for public health care services - rates for Eligible Persons (subsidized public rates) and Non-eligible Persons.

2.1.5 For illegal immigrants, public health care services are provided only when there is an urgent need, and the patients will be reported to the police.⁵

2.2 Policies relating to health care coverage for immigrants⁶

Definition of "resident"

2.2.1 Under Article 24 of the Basic Law, residents of HKSAR include permanent residents and non-permanent residents. Permanent residents include persons who are born in Hong Kong or have ordinarily resided in Hong Kong for a continuous period of not less than seven years, and children born outside Hong Kong of permanent residents.⁷ Non-permanent residents are persons who are qualified to obtain Hong Kong Identity Cards in accordance with the laws of HKSAR but have no right of abode.

One Way Permit holders

2.2.2 One Way Permit (OWP) holders are residents from the Mainland who have come to Hong Kong for settlement. Depending on whether they have the right of abode in Hong Kong, OWP holders can be either permanent residents or non-permanent residents of Hong Kong.⁸ At present, the daily quota of OWP is 150, with priority given to eligible children and spouses of Hong Kong residents.⁹

³ Information provided by HWFB.

⁴ This principle is incorporated in section 4(d) of the Hospital Authority Ordinance.

⁵ Information provided by HWFB.

⁶ In this report, immigrants refer to those non-permanent residents who have the right of abode in Hong Kong but have not yet attained the status of permanent residence.

⁷ For the full definition of permanent residents, please refer to Appendix I.

⁸ Information provided by the Immigration Department.

⁹ Information available at the website of the Immigration Department.

Responsibility for immigrants' health care expenses

2.2.3 Hong Kong residents whose family members have settled in Hong Kong via the OWP Scheme are not required to reimburse the Government for the provision of public health care services to these immigrants. The Government collects fees directly from immigrants only but not from their family members.¹⁰

2.3 Task Force on Population Policy

2.3.1 In February 2003, the Chief Secretary for Administration presented the Report of the Task Force on Population Policy (the Report). The Task Force was set up in September 2002 to develop a population policy as pledged by the Chief Executive in his second Inaugural Speech delivered in July 2002. The Report analyzed the demographic characteristics of the Hong Kong population, identified major challenges and concerns arising from demographic trends, and proposed a set of policies to be adopted.

2.3.2 The Task Force reviewed the eligibility for subsidized public services and, in particular, suggested recommendations relating to the provision of subsidized public health care services. At present, the Government subsidizes many public services, with some up to the rate of 96%.¹¹ The rising public expenditure has become a major concern to the Government. Unlike other subsidized services such as public rental housing and social security benefits which require applicants to meet a certain length of residence in Hong Kong¹², public health care services do not have such requirements.

¹⁰ Information provided by HWFB.

¹¹ The speech of the Secretary for Health, Welfare and Food in the motion debate on assisting low-income earners and the poor elderly in the Legislative Council on 22 January 2003.

¹² Regarding subsidized housing, one of the eligibility criteria for the allocation of public housing is that at the time of allocation, at least half of the family members included in the application must have lived in Hong Kong for seven years and remain living in Hong Kong. All children under the age of 18, regardless of their place of birth, will be deemed as having satisfied the seven-year residence rule provided that one of their parents has lived in Hong Kong for seven years.

Regarding social security benefits, on 3 June 2003, the Government announced a new proposal which required that applicants had to be Hong Kong residents for at least seven years and to live in Hong Kong continuously for at least one year immediately prior to application before they were eligible to apply for financial assistance under Comprehensive Social Security Assistance (CSSA) and Social Security Allowance (SSA comprising the Old Age Allowance and Disability Allowance (DA)) Schemes. Children under the age of 18 would be exempted from any prior residence requirement for CSSA and DA. The Finance Committee of the Legislative Council approved the proposal on 27 June 2003, and the new seven-year residence rule will come into effect on 1 January 2004.

2.3.3 Currently, public health care services are not only available to the general population, but also to the transient population as well.¹³ With regard to persons residing in Hong Kong for less than seven years (including OWP holders), the Task Force proposed the application of a uniform seven-year residence rule when providing heavily subsidized public health care benefits. The Government has initially applied the seven-year residence requirement to the combined category of Two Way Permit (TWP) holders¹⁴ and other visitors¹⁵. Except for the attendance at Tuberculosis and Chest Clinics, which will continue to be provided free of charge, patients belonging to the combined category will be charged as Non-eligible Persons¹⁶ for the full cost for all other public health care services. This arrangement has been effective since 1 April 2003.

2.3.4 HWFB will conduct an in-depth study to assess the impact of the policy before deciding its implementation on the rest of the affected population (including OWP holders) in the longer term.

2.4 Health care programme for immigrants

Regulatory authority

2.4.1 HWFB is responsible for formulating policies regarding the provision of health care services to both permanent and non-permanent residents of HKSAR.

Eligibility

2.4.2 Public health care services are provided on a fee-for-service basis, and are available to all those in need, regardless of their residence status. However, only individuals who fall into the following categories of Eligible Persons are qualified for subsidized public rates for health care services:

- (a) holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance;
- (b) children who are Hong Kong residents and under 11 years of age; and
- (c) other persons approved by the Director of Health.

¹³ The transient population includes foreign domestic helpers, migrant workers and Two Way Permit (TWP) holders who are spouses or children under 11 years of age of Hong Kong Identity Card holders. [Pending information from HWFB regarding whether tourists are considered part of the transient population.]

¹⁴ TWPs are issued by the Mainland authorities for Mainland visitors who come to Hong Kong for sightseeing or visiting their relatives from seven days to three months.

¹⁵ Examples of other visitors include those non-Hong Kong residents who have no close family link in Hong Kong.

¹⁶ For the definition of Non-eligible Persons and associated cost of public health care services, please refer to paragraph 2.4.4.

2.4.3 Under paragraphs 2.4.2(a) and (b), both permanent and non-permanent residents of HKSAR (including OWP holders) are qualified for Eligible Persons rates for public health care services. "Other persons" in paragraph 2.4.2(c) above refer to Vietnamese refugees and their dependents under 11 years of age.¹⁷

2.4.4 For those who do not fall into the categories of Eligible Persons (for instance, TWP holders), the rates of charges applicable to Non-eligible Persons apply. Table 1 illustrates some example fees for public health care services for both Eligible and Non-eligible Persons.

Table 1 - Fees for Public Health Care Services for Eligible and Non-eligible Persons[#]

Health Care Services	Eligible Persons* (HKD)	Non-eligible Persons (HKD)
Attendance at Tuberculosis and Chest Clinics	No charge	No charge
Attendance at a General Clinic	\$45	\$215
Accident & Emergency	\$100	\$570
Attendance at Maternal and Child Health Centres	No charge	Family Planning Services \$235 Child Health Services \$365 Maternal Health Services \$700
Attendance at a Specialist Clinic		\$700 (include drug cost)
Attendance at a Human Immuno-deficiency Virus Clinic	\$100 first attendance \$60 subsequent attendance \$10 per drug item	\$1,910 plus cost of drug and pathology
Attendance at a Child Assessment Centre		\$3,460 (include drug cost)

Sources:

1. *Hong Kong Government Gazette*, Government Notice (Extraordinary) 13 of 2003; and
2. Hospital Authority, "Fees and Charges of Public Health Care Services".

Notes:

- [#] The fees were revised by HWFB on 1 April 2003 while the charge for Accident & Emergency services was introduced earlier on 29 November 2002.
- ^{*} The subsidized level for health care services for Eligible Persons ranges from 82% to 96% of cost. (HWFB, "Legislative Council Brief, Restructuring of Fees and Charges for Public Health Care Services", HWF CR/13/2/3921/96(01) Pt.7, November 2002.)

¹⁷ Information provided by HWFB.

Coverage

2.4.5 In Hong Kong, public health care services are provided by both DH and HA. The types of health care services provided by DH include, but not limited to:

- (a) Personal Health Services, including family health services and general out-patient services;
- (b) Non-regionalized Services, including child assessment services, disease prevention and control division, elderly health services, and tuberculosis and chest services;
- (c) Special Health Services, including pharmaceutical services and radiation health unit; and
- (d) Dental Services.

2.4.6 The types of health care services provided by HA include, but not limited to:

- (a) Accident & Emergency services;
- (b) laboratory services, including microbiology, tuberculosis and radiology laboratory services;
- (c) community psychiatric services, community geriatric assessment services and community nursing services; and
- (d) hospital services, including surgery, obstetrics and gynaecology services, neonatal services, cardiology services, and prosthetic and orthotic services.

Fee Waiver Mechanism

2.4.7 To ensure that no one will be denied adequate medical care due to lack of means, the Government has introduced a fee waiver mechanism to aid the poor and needy. For recipients of Comprehensive Social Security Assistance (CSSA), for which non-permanent residents are eligible to apply¹⁸, payment of their public health care expenses is waived. Non-CSSA recipients, who cannot afford medical fees, can apply for fee waiver at public hospitals and clinics. Application for fee waiver is assessed according to a set of criteria by a Medical Social Worker of the Social Welfare Department.¹⁹

¹⁸ See footnote 12.

¹⁹ For details on the fee waiver mechanism, please refer to Appendix II.

2.5 Verification of eligibility for subsidized public health care services

2.5.1 The eligibility of patients for Eligible Person rates is assessed by either DH or HA on the availability of the Hong Kong Identity Card or valid travel documents showing their permitted condition of stay.²⁰ However, there have been cases where the patients, both Eligible and Non-eligible Persons, did not pay the medical fees due. For instance, in years 1999-2000, 2000-2001 and 2001-2002, the fee income written off by HA (before CSSA and non-CSSA waiver) amounted to 2.2%, 2.3% and 1.4% of the gross fee income respectively.²¹

²⁰ Information provided by HWFB.

²¹ Hospital Authority, "Fee Income Written Off by the Hospital Authority in the Past 3 Years", 11 November 2002, LC Paper CB(2)338/02-03(01).

Chapter 3 - The Province of Ontario in Canada

3.1 Introduction

3.1.1 Canada has a national health insurance programme, namely Medicare, which is implemented through a series of 13 independent provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage with minor differences. Medicare is designed to ensure that all residents of Canada have access to medically-necessary hospital and physician care on a prepaid basis. In 1984, the federal government enacted the Canada Health Act (the Act), which consolidated the previous health insurance legislation and became the legislative basis of the current Medicare programme.

3.1.2 The federal government sets and administers national standards for Medicare, while each provincial or territorial government is responsible for financing, planning, administering and evaluating its own health care systems.

3.1.3 Each province operates its own Medicare programme. In Ontario, the programme is known as the Ontario Health Insurance Program (OHIP), a provincial health insurance programme which provides free health care services to its enrollees. Under the Act, the health care coverage for hospital and physician services is similar across provinces and territories, but minor differences in coverage do exist. Provinces and territories also offer "additional benefits" under their respective health insurance plans, at their discretion and on their own terms and conditions.

Universality of public health care

3.1.4 Similar to Hong Kong, public health care services in Ontario are available to those in need, regardless of their immigration status. However, the scope of services and charges vary among different groups of persons in respect of their immigration status.

3.1.5 Landed immigrants and Convention refugees receive the same package of health care services as citizens under OHIP free of charge. Meanwhile, refugees during waiting period²² and asylum seekers are covered by the Interim Federal Health Program (IFHP), a different federal health care programme unrelated to Medicare, which provides free health care services as well.

3.1.6 Illegal immigrants are ineligible for OHIP or IFHP benefits, and are financially liable for all medical services they receive in Ontario.²³

²² There is a minimum waiting period of three-month for refugees prior to their qualification for OHIP.

²³ Information provided by the Ministry of Health and Long-Term Care.

3.2 Policies relating to health care coverage for immigrants

Definition of "landed immigrant"

3.2.1 A landed immigrant is a person who has been granted the right to live in Canada permanently by immigration authorities. A landed immigrant is also known as a permanent resident.

Responsibility for immigrants' health care expenses

3.2.2 The Canadian government allows Canadian citizens and permanent residents to sponsor persons, who are family members living outside Canada, to immigrate to the country.

3.2.3 In Canada, provincial health insurance programmes are not considered as social assistance²⁴, which otherwise would require reimbursement by the sponsors for benefits claimed by the immigrants.²⁵ In any event, since immigrants residing in Ontario are covered by OHIP, which is free, their sponsors are not required to reimburse the government for the provision of OHIP services to them.

3.3 Health care programmes for immigrants

3.3.1 In Ontario, landed immigrants and Convention refugees receive health care services under OHIP, while refugees during waiting period and asylum seekers are covered under IFHP. The details of each programme are described below.

Ontario Health Insurance Program

3.3.2 The establishment of OHIP under the Ontario Health Insurance Act is to provide residents, including landed immigrants, with insurance in respect of the cost of insured services provided in hospitals and health facilities, and by physician and other health practitioners.

²⁴ Social assistance refers to any benefit, whether money, goods or services, provided to or on behalf of a person by a province. It includes assistance for food, shelter, clothing, fuel, utilities, household supplies, personal requirements and health care not provided by public health care.

²⁵ Information provided by the Citizenship and Immigration Canada.

Regulatory Authority

3.3.3 OHIP is administered on a non-profit basis by the Ministry of Health and Long-Term Care. The Ministry is responsible for providing health care programmes to the Ontario public through health insurance, drug benefits, care for mentally ill, home care, community support services, public health and disease prevention. It also regulates and funds hospitals and long-term care facilities, operates psychiatric hospitals and medical laboratories, and co-ordinates emergency health care services.

Eligibility

- 3.3.4 Landed immigrants are eligible for OHIP if they meet the following criteria:
- (a) making their permanent and principal homes in Ontario; and
 - (b) present in Ontario for at least 153 days in any 12-month period.

Fees

3.3.5 A landed immigrant pays no premium for OHIP, which is funded by federal and provincial taxes. The coverage is based solely on residence and is not determined by age, income level or employment status of the individual.

Coverage

3.3.6 OHIP coverage includes in-patient and out-patient hospital services, physician services, surgical-dental services, long-term care services, mental health services, and the residential component of the Homes for Special Care programme.²⁶ OHIP does not cover prescription medications.

Verification of eligibility under the Ontario Health Insurance Program

3.3.7 A Health Card is required to prove eligibility of OHIP benefits. To obtain a Health Card, a landed immigrant must produce three different documents to prove his or her identity, residence in Ontario, and Canadian immigration status.²⁷

²⁶ For details of services provided under OHIP, please refer to Appendix III.

²⁷ For details of verification of OHIP eligibility, please refer to Appendix IV.

Interim Federal Health Program

3.3.8 The purpose of IFHP is put in place for humanitarian reasons to allow Convention refugees, refugee claimants, and members of the humanitarian designated classes²⁸ to receive temporary medical coverage during their settlement period in Canada, prior to their qualification for provincial health care, such as OHIP. IFHP is not meant to replace provincial health care and does not provide the same extent of coverage for landed immigrants. The operation of the programme is the same in Ontario as in the other 12 provinces and territories in Canada.

Regulatory authority

3.3.9 The federal department of Citizenship and Immigration Canada is responsible for administering IFHP.

Coverage

3.3.10 The coverage of IFHP is limited to:

- (a) essential health care services for the treatment and prevention of serious medical/dental conditions (including immunizations and other vital preventative medical care);
- (b) essential prescription medications;
- (c) contraception, prenatal and obstetrical care; and
- (d) immigration medical examination, only if the refugee is unable to pay.

²⁸ On 1 May 1997, regulations were introduced to create two new humanitarian designated classes: the Country of Asylum Class and the Source Country Class. The Country of Asylum Class includes people who are outside their countries of citizenship or habitual residence, and are seriously and personally affected by civil wars, armed conflicts, or massive violations of human rights. The Source Country Class includes people who would meet the definition of a Convention refugee but who are still in their countries of citizenship or habitual residence, and have been detained or imprisoned and are suffering from serious deprivations of the right of freedom of expression, the right of dissent, or the right to engage in trade union activity.

3.3.11 Prior approval is required for a complete physical examination, diagnostic services (unless short-term complications are observed), ongoing psychiatrist's care, and psychotherapy/counselling, among others. Alternative and over-the-counter medications and root canals, among some other treatments, are expressly not covered.

Verification of eligibility under the Interim Federal Health Program

3.3.12 To determine whether a refugee claimant qualifies for IFHP, an officer at Citizenship and Immigration Canada will ascertain the status of the claim, ask the claimant whether he or she is in a position to pay for health care, or is eligible for private or public health insurance. If the claimant indicates a need for coverage and the immigration officer satisfies that the applicant qualifies, eligibility will be given without further investigation.

Summary of health care programmes available to non-citizens

3.3.13 Table 2 summarizes the various types of health care programmes available to non-citizens in Ontario.

Table 2 - Health Care Programmes Available to Non-Citizens in Ontario

Immigration Status	Health Care Programmes	Fee
Landed immigrants	Covered by OHIP; no coverage during waiting period.	Free.
Convention refugees	Covered by OHIP; waiting period covered by IFHP.	Free.
Refugee claimants / Asylum seekers	Covered by IFHP.	Free.
Illegal immigrants	Not applicable.	Financially liable for all medical services received.

Chapter 4 - The United Kingdom

4.1 Introduction

4.1.1 The public health care system in the UK is serviced by the National Health Service (NHS), which provides cradle-to-grave care to all in need. NHS is funded by the central government from tax revenue, and basic public health care services are free of charge to all individuals at the point of service. Furthermore, eligible persons are entitled to full NHS services for free.²⁹

4.1.2 NHS is made up of a wide range of health professionals, support workers and organizations. The aim of NHS is to bring about the highest level of physical and mental health to its population, within the resources available, by:

- (a) promoting health and preventing ill-health;
- (b) diagnosing and treating injuries and diseases; and
- (c) caring for those with a long-term illness and disability.

Reform of the National Health Service

4.1.3 At present, NHS is facing mounting pressure from the public with regard to its shortfall in the standard of services provided to patients, such as under-staffed hospitals and clinics, inadequate beds, and long waiting time for surgery³⁰. Established in the 1940s, NHS has systematic problems to cope with the provision of health care in the 21st century. The system is currently under-funded and there is a lack of national standards, clear incentives and levers to improve performance among NHS Trusts³¹.

²⁹ Except for prescription, dentistry, sight tests, glasses and contact lenses, wigs and fabric support (spinal or abdominal support), NHS services are free of charge to eligible persons. (Information provided by the Department of Health (DH)).

³⁰ In 2000, the total number of people on the hospital waiting lists in England exceeded 1.11 million, and the waiting time for a number of patients have exceeded the 18-month maximum set by the government.

³¹ NHS Trusts are regional or national centres of medical expertise for specialized health care.

4.1.4 In July 2000, Prime Minister Tony Blair called for a 10-year reform plan - the NHS Plan - to improve health care services and health outcomes. Specific targets and achievements in health care services are set as part of the NHS reform. One of the goals of the NHS Plan is to develop sustainable funding to increase national health spending to the same level as other member states of the European Union (EU).³² The NHS Plan promises:

- (a) more power and information for patients;
- (b) more hospitals and beds;
- (c) more doctors and nurses,
- (d) much shorter waiting times for hospital and doctor appointments;
and
- (e) tougher standards for NHS organizations and better rewards for the best.

Universality of public health care

4.1.5 NHS is available to all those in need, regardless of their immigration status. However, only individuals who have the status of ordinarily resident³³ or exempt overseas visitor³⁴ are eligible for full NHS access free of charge, while all others are considered non-exempt persons who enjoy basic NHS services for free but are liable for the full cost of non-basic health care services. The former category comprises a broad spectrum of people, including legal immigrants who have just arrived in the UK, and illegal immigrants who have resided in the UK for more than 12 months. In the light of the NHS reform, the Department of Health (DH) is in the process of reviewing and revamping the legislation on the universality of public health care to prevent abuse of the regulation on free NHS access. Further details are discussed in paragraph 4.5.1.

³² The public health care expenditure as a percentage of GDP for the UK is 6.2%. By 2007-2008, the goal is to increase the UK health spending to 9.4% of GDP compared with the current EU average of around 8%. For details of public health care expenditure for other jurisdictions, please refer to Table 4.

³³ For the definition of the ordinarily resident status, please refer to paragraph 4.3.1.

³⁴ For the definition of the exempt overseas visitor, please refer to paragraph 4.3.5.

4.2 Policies relating to health care coverage for immigrants

Definition of "immigrant"

4.2.1 An immigrant is any person, irrespective of his or her skin colour or other physical appearance, who arrives in the country with the intention of settling or who, after arriving with the intention of staying temporarily, eventually becomes a permanent resident.

Responsibility for immigrants' health care expenses

4.2.2 A person can sponsor his or her family member(s) to settle in the UK. Family members include husband, wife, fiancé or fiancée, unmarried partner, children, adopted children, parents, grandparents or other dependent relatives. In the UK, the receipt of health care services is not considered as claiming public funds³⁵, and therefore sponsors of immigrants are not required to reimburse the government for the provision of public health care services to the immigrants.

4.3 Health care programmes for immigrants

4.3.1 In the UK, immigrants are eligible for NHS coverage since access to NHS is not based on UK citizenship, or the past or present payment of National Insurance contributions or UK taxes.³⁶ Instead, it is based on whether the individual concerned has the ordinarily resident status in the UK. The general principle of NHS is that it is free at the point of use, but the Secretary of State for Health has the power to charge anyone who does not have the ordinarily resident status for any NHS hospital treatment he or she receives under Section 121 of the National Health Service Act 1977.

³⁵ The Immigration Act requires that immigrants who wish to settle in the UK must be supported and accommodated without claiming public funds through

- (a) Income Support/Jobseekers Allowance;
- (b) Housing and Homelessness Allowance;
- (c) Housing Benefit and Council Tax Benefit;
- (d) Working Families Tax Credit;
- (e) Social Fund Payment;
- (f) Child Benefit; and/or
- (g) Disability Allowance.

³⁶ Information provided by DH.

4.3.2 There is no statutory definition of "ordinarily resident", although the guidelines published by DH in 1988 state that *"a person should be accepted as ordinarily resident if he is lawfully living in the UK voluntarily and for settled purposes as part of the regular order of his life for the time being"*³⁷. The guidelines go on to suggest that:

"[The person] must have an identifiable purpose for his residence here and that purpose must have a sufficient degree of continuity to be properly described as "settled". This will depend on the facts of each individual case but we advise that a person who is intending to stay here for less than six months should not usually be regarded as ordinarily resident and eligible for free treatment."

Regulatory authority

4.3.3 DH, being in charge of the provision of NHS, formulates the overall health care policies in the UK, including health care policies for immigrants as well.

Eligibility

4.3.4 Individuals having the ordinarily resident status are eligible for free NHS health care services. Therefore, legal immigrants, who normally meet the requirement of ordinarily resident, are eligible for NHS services free of charge. Eligibility commences immediately after the legal immigrants arrive in the UK.³⁸

4.3.5 In addition, the *National Health Service (Charges to Overseas Visitors) Regulations 1989* (the Regulations) specifies certain categories of overseas visitors, which include both legal and illegal immigrants, to be exempted from the payment of NHS services. For instance, the following groups of people, together with their spouses and children, are entitled to free NHS treatment:³⁹

- (a) anyone who has been in the UK for 12 months immediately prior to treatment;
- (b) anyone who has come to reside permanently in the UK;
- (c) anyone coming to the UK for employment (including self-employed people); and
- (d) anyone who is a refugee or asylum seeker.

³⁷ DH, "NHS Treatment of Overseas Visitors: Manual of Guidance", 1988. However, it should be noted that the guidelines have no statutory force. Therefore, whether a person is "ordinarily resident" is determined by DH on the facts of each individual case.

³⁸ Information provided by DH.

³⁹ Ibid.

Fees

4.3.6 There is no charge for NHS services for legal immigrants, who are eligible immediately after arriving in the UK, and for illegal immigrants who have resided in the UK for more than 12 months.⁴⁰

Coverage

4.3.7 NHS does not distinguish between "lawful" and "unlawful" residence. Illegal immigrants who have resided in the UK for more than 12 months fall into the overseas visitor exempt category under paragraph 4.3.5(a). However, if the health care service recipient has been resident for less than 12 months, and is found by the Home Office to be residing in the UK unlawfully, he or she would become liable for charges.⁴¹

4.3.8 Nonetheless, certain basic NHS services are exempted from charges and are free to a patient regardless of whether he or she has the status of ordinarily resident or exempt overseas visitor:

- (a) treatment in Accident and Emergency departments;⁴²
- (b) diagnosis and treatment of certain communicable diseases, including sexually transmitted diseases;⁴³
- (c) compulsory psychiatric treatment (i.e. when the patient is detained, or when it is a condition of a probation order that the patient should receive psychiatric treatment);
- (d) midwifery;
- (e) emergency ambulance service; and
- (f) family planning services.

⁴⁰ Information provided by DH.

⁴¹ Ibid.

⁴² A patient who is admitted to a hospital as an in-patient, even from an Accident and Emergency department as would generally happen for serious injuries, is liable to be charged, as would be patients referred to an out-patient clinic.

⁴³ For a patient who has HIV/AIDS, free treatment is only limited to a diagnostic test for the evidence of infection with HIV and counselling associated with that test or its result performed at a special clinic for treatment of sexually transmitted diseases. Referrals to a hospital from such a clinic will be liable for charges, as is the dispensary of drug or medicine for the treatment of HIV.

4.4 Verification of eligibility under the National Health Service

4.4.1 It is for individual hospitals or health clinics to determine whether a patient is eligible for free NHS services. The responsibility for establishing entitlement to health care services lies with the individual, who is expected to provide documentation that supports the claim of ordinarily resident or exempt overseas visitor. It is up to the individual to decide what to supply. Based on the evidence provided, the hospitals or health clinics will make a decision on eligibility.

4.5 Current development

4.5.1 In July 2003, DH proposed amendments to the Regulations and issued a consultation paper⁴⁴ to invite comments from Primary Care Trusts (PCTs)⁴⁵ and NHS Trusts. The aims of the amendments are to protect finite NHS resources by closing loopholes since it has been identified that certain parts of the Regulations are open to abuse, and also to provide greater clarity to enable PCTs and NHS Trusts to apply them more effectively. The proposed amendments include:

- (a) exemption from charges should only be applied to the individual himself or herself. Spouse and children are only exempted if they are living with the exempt person on a permanent basis⁴⁶;
- (b) exemption should be restricted to only those people who are engaging in employment which is based in the UK⁴⁷; and
- (c) any person whose primary purpose for being in the UK is to seek privately funded treatment, and anyone who is identified as being in the UK without proper authority, should be excluded from the 12-month residence exemption⁴⁸.

⁴⁴ The consultation period ended on 31 October 2003. The title of the consultation paper is "Proposed Amendments to the National Health Service (Charges to Overseas Visitors) Regulations 1989, A Consultation", DH, 28 July 2003.

⁴⁵ PCTs are local centres of general practitioners who provide primary health care services to local communities.

⁴⁶ DH reported a case where a woman had flown in just days before she was due to give birth, presented at an Emergency & Accident department in labour so that the hospital had no choice but to look after her, and then flown home again shortly after being discharged.

⁴⁷ DH reported a case where a foreign sports commentator came to the UK for a month to cover an international event. He brought his son with him and was able, under the current exemption, to obtain at no charge very complex and expensive treatment for the child that he would have to pay for in his own country.

⁴⁸ DH reported cases where:

- (a) someone who have been granted leave to enter the UK specifically to undergo privately funded medical treatment need only remain for 12 months, after which they, and their spouses and children, become entitled to access free NHS treatment; and
- (b) those who are living in the UK without proper authority can access free NHS treatment once they have been in the country for 12 months. These people include failed asylum seekers, overstayers, and illegal immigrants.

Chapter 5 - The State of New York in the United States

5.1 Introduction

5.1.1 The US has the least universal health care system among developed countries, with over 40 million people not covered by any public health care programmes or private insurance, out of a total population of almost 300 million.⁴⁹ Public health care coverage is only provided to certain groups of the population: the elderly and some of the poor with the enactment of Medicare and Medicaid in 1965; and children of low-income households with the State Children Health Insurance Program introduced in 1997.

5.1.2 While the federal government primarily provides funding and policy directions of public health care services, the operation of health care programmes is the responsibility of individual states, including New York. Each state has the flexibility to design its own health care programme under the guidelines provided by the federal government.

5.1.3 In August 1996, as a result of the welfare reform, the federal government enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which has a profound effect on the entitlement of immigrants to health care services. PRWORA draws distinction between pre-enactment immigrants (legally admitted before 22 August 1996) and post-enactment immigrants (legally admitted on or after 22 August 1996) by barring the latter group from receiving the federally-funded health care programme, Medicaid, during their first five years of residence.

5.1.4 However, in June 2001, the ruling on differentiating immigrants based on their arrival dates for health care benefits under PRWORA was overturned by the New York State Court of Appeals, citing violations of both the New York and US Constitutions. The resulting *Aliessa v. Novello* decision⁵⁰ has subsequently restored health care benefits of immigrants to its pre-welfare reform status.

⁴⁹ Bodenheimer, Thomas S., and Kevin Grumbach, *Understanding Health Policy: A Clinical Approach*, Third Edition, The McGraw-Hill Companies, 2002.

⁵⁰ *Aliessa v. Novello*, 96 N.Y. 2d at 418 (2001).

Universality of public health care

5.1.5 In New York, public health care services are available to all qualified immigrants⁵¹ in need. Depending on age, income level and employment status, qualified immigrants meeting such criteria are entitled to different public health care programmes (or a combination of them) under Medicaid, Medicare, Child Health Plus (CHPlus), and Family Health Plus (FHPlus) under which they are not required to pay, or only pay for a fraction of the cost of treatment.

5.1.6 Unqualified immigrants⁵², except immigrants formerly considered "Permanently Residing under Color of Law" (PRUCOL)⁵³ and children under the age of 19, are only eligible for emergency services, prenatal services under the Medicaid-funded Prenatal Care Assistance Program (PCAP)⁵⁴, immunizations, and testing and treatment for symptoms of communicable diseases (regardless of whether those diseases turn out to be present).⁵⁵ These services are available for free.

5.1.7 With respect to the exempt unqualified immigrants, PRUCOL immigrants are eligible for full Medicaid services free of charge. For unqualified immigrants under the age of 19, they are eligible for CHPlus and the monthly premium depends on the income of the family.

5.2 Policies relating to health care coverage for immigrants

Definition of "immigrant"

5.2.1 Immigrants are classified into two groups: qualified and unqualified immigrants.

⁵¹ For the definition of qualified immigrants, please refer to paragraph 5.2.2.

⁵² For the definition of unqualified immigrants, please refer to paragraph 5.2.3.

⁵³ 8 US Codes §1613(a), §1611(a), and §1641(b). PRUCOL is not an official immigration status for the purpose of entering the US. Instead, it is used to refer to a number of immigrant classifications. Generally, a PRUCOL immigrant is a non-citizen who has resided in the US for an indefinite period of time with the knowledge of Immigration and Naturalization Services (INS) and whose departure INS does not contemplate enforcing.

⁵⁴ PCAP is a Medicaid-funded programme for pregnant women with incomes up to 200% Federal Poverty Level. PCAP offers routine pregnancy check-ups, hospital care during pregnancy and delivery, full health care for pregnant women until at least two months after delivery, and full health care coverage for the baby up to one year of age.

⁵⁵ Section 401(b)(1) of PRWORA, Public Law 104-193, August 1996.

Qualified immigrants

- 5.2.2 Under 8 US Code §1641, qualified immigrants include:
- (a) lawful permanent residents⁵⁶;
 - (b) refugees and asylees;
 - (c) persons paroled into the US for at least one year; and
 - (d) battered spouses and children (with a pending or approved spousal visa or a petition for relief under the Violence Against Women Act).

Unqualified immigrants

5.2.3 All other immigrants are considered unqualified. This group includes undocumented immigrants, asylum applicants, PRUCOL immigrants, and those with permission to remain in the US but without legal permanent resident status.

Responsibility for immigrants' health care expenses

- 5.2.4 New York has enacted two pieces of legislation on sponsorship:
- (a) "sponsor deeming", which deems the income and resources of an immigrant's sponsor as those of the immigrant when he or she applies for Medicaid (except for emergency care)⁵⁷; and
 - (b) "sponsor liability", which requires local social service districts to request reimbursement by the sponsor for any medical expenses (other than emergency care) that the state or federal government incurs on behalf of the immigrant.⁵⁸

⁵⁶ According to the Bureau of Citizenship and Immigration Services, a permanent resident is any person who is not a citizen of the US but is residing in the US under legally recognized and lawfully recorded permanent residence. In 2002, the total number of immigrants admitted in the US is 1.063 million, with the percentage of family-sponsored immigrants being 18%. Most family-sponsored immigrants belong to the category of lawful permanent residents.

⁵⁷ 8 US Codes §§ 1631, 1613(c); New York Social Services Law § 122(4).

⁵⁸ 8 US Code § 1183a(b); New York Social Services Law § 122(5). An affidavit of support has been put into use since 19 December 1997 to legally enforce the agreement between the sponsor and the government whereby the sponsor agrees to provide sufficient support to maintain an immigrant at 125% Federal Poverty Level. The affidavit enables federal, state and local agencies to sue the sponsor for any benefits received. The government has up to 10 years from the date on which an immigrant last receives the public benefit to bring an action for repayment against the sponsor.

5.2.5 Although the legislation has been enacted, according to the New York State Department of Family Assistance, it has not been enforced. In other words, the New York Medicaid programme does not count the sponsor's income towards the immigrant applying for health care coverage, and does not pursue the sponsor to reimburse Medicaid for services used by the immigrant.⁵⁹ The enforcement of the legislation is being discussed among state health officials.

5.3 Health care programmes for immigrants

5.3.1 The regulatory authority, eligibility criteria, coverage and fees for the four health care programmes available to qualified immigrants in New York (aforementioned in paragraph 5.1.5) all exhibit some degree of differences.

5.3.2 Medicaid is for immigrants who have limited income and resources. Health care services are delivered free of charge under the programme. For those who do not have health insurance but have incomes too high to be qualified for Medicaid, they are eligible for free FHPlus services if they meet the age and income level criteria. Children, including unqualified immigrants, are eligible for CHPlus and the monthly premium charge for CHPlus depends on family income.

5.3.3 Contrary to Medicaid, FHPlus and CHPlus, Medicare requires qualified immigrants or their families to make social security contributions in order to be eligible for the plan. Immigrants who are at least 65 years of age and have worked for at least 10 years in Medicare-covered employment are eligible.

Medicaid

5.3.4 Medicaid is a public assistance programme that does not require recipients to make contributions. The programme was established by the federal government in 1965 as part of the Social Security Act to provide health care services to certain groups of low-income immigrants.

5.3.5 Medicaid is operated jointly by the federal and state governments. The federal government shares the cost of the programme with the states, and sets the basic rules concerning eligibility, scope of coverage, quality and administration. Within this framework, the states, including New York, have flexibility to individualize their Medicaid programmes and, under certain circumstances, can obtain waivers from some of the federal requirements.

⁵⁹ Information available from the website of the New York State Department of Family Assistance, <http://www.dfa.state.ny.us/ohrd/powerpoints/370.pdf>, 9 January 2003.

Regulatory authority

5.3.6 At the federal level, the agency responsible for the administration of the Medicaid programme is the Centers for Medicare & Medicaid Services (CMS), a federal government agency under the Department of Health & Human Services.⁶⁰ In New York, the programme is administered by the New York State Department of Health.

Eligibility

5.3.7 The New York State Department of Health has the discretion in determining the groups of people its Medicaid programme covers. Qualified immigrants and PRUCOL immigrants are eligible for full Medicaid services if they fulfil the income and resources requirements set up by the New York State Department of Health.⁶¹

Coverage

5.3.8 The New York Medicaid programme provides a basic package of health care services, which include:

- (a) treatment and preventive health and dental care;
- (b) hospital in-patient and out-patient services;
- (c) family planning services;
- (d) medicines, supplies, medical equipment and appliances; and
- (e) prenatal care.

Fees

5.3.9 The New York Medicaid programme is provided free of charge.

⁶⁰ Prior to 1 July 2001, CMS was known as the Health Care Financing Administration.

⁶¹ For details on the eligibility requirements for New York Medicaid, please refer to Appendix V.

Child Health Plus

5.3.10 In 1990, New York established its own state-sponsored health insurance programme for low-income children, known as CHPlus, which has different eligibility criteria compared to the federal programme, the State Children Health Insurance Program (SCHIP)⁶². Both qualified and unqualified immigrants are eligible for CHPlus.

Regulatory authority

5.3.11 CHPlus is administered by the New York State Department of Health.

Eligibility

5.3.12 Children who are residents of New York and under the age of 19 are eligible to enrol in CHPlus, regardless of their immigration status or date of arrival. There is no income requirement, with the monthly premium directly proportional to family incomes.

Coverage

5.3.13 CHPlus is divided into two components: CHP A and CHP B. CHP A is Medicaid for children. CHP B provides subsidized health care coverage for children with family incomes of up to 250% Federal Poverty Level (FPL)⁶³.

Fees

5.3.14 There is no monthly premium for families whose income is less than 160% FPL. For families whose income is between 160% and 250% FPL, they pay a monthly premium of US\$9 to US\$15 a month per child, depending on their income and family size. The monthly fee is capped at three children. For families whose income is more than 250% FPL, they have to pay the full monthly premium. There are no co-payments for services under CHPlus.

⁶² SCHIP is available to pre-enactment qualified immigrants. Post-enactment qualified immigrants are ineligible for SCHIP during their first five years of residence.

⁶³ Section 423 of PRWORA, Public Law 104-193, August 1996, and Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Public Law 104-208, September 1996. Federal Poverty Level (FPL) is a poverty measure issued each year by the Department of Health and Human Services for administrative purposes, such as determining the financial eligibility for certain federal programmes. Please refer to Appendix VI for specific FPL guidelines.

Family Health Plus

5.3.15 Based on the success of CHPlus, New York launched a Medicaid-funded health insurance programme known as FHPlus in 2000 for adults aged 19-64 who do not have health insurance but have incomes too high to qualify for Medicaid. FHPlus is available to qualified immigrants who are single adults, couples without children, and parents with limited income residing in New York. The programme provides comprehensive coverage, including prevention, primary care, hospitalization, prescriptions and other services.

Regulatory authority

5.3.16 FHPlus is administered by the New York State Department of Health.

Eligibility

5.3.17 Qualified immigrants meeting the following criteria are eligible to enrol in FHPlus:

- (a) residing in New York;
- (b) aged 19-64;
- (c) individuals without dependent children in their households with gross incomes up to 100% FPL, or parents living with a child under the age of 21 with gross family income up to 150% FPL as of 1 October 2002; and
- (d) not in receipt of equivalent health care coverage or insurance, as defined under the Health Insurance Portability and Accountability Act.

5.3.18 While the majority of Medicaid eligibility standards and rules apply, FHPlus allows several waivers to encourage participation and ease of enrolment. There is no asset or resource test for the programme.⁶⁴ The existing Medicaid fair hearing and notice process is used for eligibility determination under FHPlus. Enrolees are guaranteed an initial six months of coverage regardless of changes in circumstances.

⁶⁴ New York Social Services Law § 369-ee (2)(b).

Fees

5.3.19 There is no co-payment, premium or other type of cost sharing under FHPlus.

Medicare

5.3.20 Contrary to Medicaid, FHPlus and CHPlus which are available for free for immigrants who qualify, Medicare is a social insurance programme, requiring immigrants or their families to make social security contributions in order to gain eligibility to the plan.

Regulatory authority

5.3.21 Medicare is administered by CMS and the operation of this federal programme is the same in all states within the US, including New York.

Eligibility

5.3.22 Permanent residents are eligible for Medicare if they are at least 65 years old and have worked for at least 10 years in Medicare-covered employment. A younger person with disability or with end-stage renal disease can be eligible for coverage as well.

Coverage

5.3.23 Medicare has two parts: Part A for Hospital Insurance and Part B for Medical Insurance. Medicare Part A covers inpatient care in hospitals, skilled nursing facility care, hospice care and some home health care.

5.3.24 Medicare Part B covers doctors' services, outpatient medical and surgical services and supplies, diagnostic tests, and durable medical equipment (such as wheelchairs and hospital beds). It also covers those medical services that are not covered by Part A but deemed medically-necessary, such as some of the services of physical and occupation therapists, and home health care.

Fees

5.3.25 No premium or deductible is required for Medicare Part A. Participants only pay a percentage of the service charges. For Medicare Part B, the premium is US\$58.70 per month as of 2003, and participants are required to pay US\$100 deductible once per calendar year and a percentage of the service charges.

Summary of health care programmes available to non-citizens

5.3.26 Table 3 summarizes the various types of health care programmes available to non-citizens in New York.

Table 3 - Health Care Programmes Available to Non-Citizens in New York

Immigration Status	Health Care Programmes	Fee
Qualified immigrants	Medicaid	Free.
	FHPlus	Free.
	CHPlus	Monthly fee depending on family income.
	Medicare	Premium, deductible, and % of service charge.
Unqualified immigrants	PRUCOL Immigrants	
	Medicaid	Free.
	Children Under 19 of Age	
	CHPlus	Monthly fee depending on family income.
	All Other Unqualified Immigrants	
	Emergency services	Free.
	Prenatal services	Free.
	Immunizations	Free.
	Testing and treatment of communicable diseases	Free.

5.4 Verification of eligibility for Medicaid, Family Health Plus and Child Health Plus

5.4.1 For the verification of eligibility for Medicaid, FHPlus or CHPlus in New York, an applicant is required to document his or her residence, income, family composition, and lawful immigration status (for Medicaid and FHPlus).

5.4.2 The immigrant must be subject to an in-person interview at the Human Resources Administration (HRA) in New York City (or a local district social services office if they live outside of New York City), complete the application, and provide significant documentation, including four consecutive pay stubs and proof of age, identity, immigration status, residence, and social security number.

5.4.3 In some instances, New York uses fraud detection systems, such as Eligibility Verification Review⁶⁵ and applicant finger imaging, to identify applicants who do not qualify for coverage.⁶⁶

Appeals and hearing

5.4.4 If the applicant is dissatisfied with the decision made by HRA or the local social service office, he or she can request a conference with the agency, or appeal to the New York State Office of Temporary and Disability Assistance and request a fair hearing.

Eligibility and access

5.4.5 Immigrants who are eligible for Medicaid, FHPlus or CHPlus may choose not to apply for the programmes due to the complex and constantly changing eligibility rules that have left some of them confused about whether they are eligible for assistance. Moreover, there are fear and misinformation among immigrants about the consequences of Medicaid enrolment. Many believe that the receipt of any public benefits will render them a "public charge"⁶⁷ and jeopardize their immigration status. This belief has prevailed despite the Immigration and Naturalization Services' clarification in 1999 that the receipt of Medicaid (except for long-term care) should not result in a public charge determination that would jeopardize an immigrant's residence status.⁶⁸

⁶⁵ The Eligibility Verification Review system, implemented in 1995, assesses applicants' eligibility for public assistance, including Medicaid, through office interviews, home visits, and data matching with state and federal databases to verify applicants' income, identity and resources.

⁶⁶ Under both federal and state laws, New York can verify an applicant's eligibility for public health care programmes by comparing answers on the application with federal and state databases, such as the Income and Eligibility Verification System and the Systematic Alien Verification System. (New York Social Services Law §366-1 (8))

⁶⁷ "Public charge" means that an alien has become (for deportation purposes) or is likely to become (for admission/adjustment purposes) primarily dependent on the government for subsistence.

⁶⁸ *Federal Register*, 64 FR 28689-93, "Field Guidance on Deportability and Inadmissibility on Public Charge Grounds", Department of Justice, 26 May 1999.

Chapter 6 - Analysis

6.1 Introduction

6.1.1 The comparison of the health care policies for immigrants in the selected overseas jurisdictions and Hong Kong is summarized in Table 4. The following issues are highlighted in this chapter:

- (a) availability of public health care;
- (b) eligibility for free or subsidized public health care ;
- (c) verification of eligibility for free or subsidized public health care services; and
- (d) responsibility for immigrants' health care expenses.

6.2 Availability of public health care

6.2.1 Ontario, New York, Hong Kong and the UK have adopted different approaches with respect to the availability of public health care services to immigrants as well as determining their eligibility for free or subsidized public health care services. Among the four jurisdictions studied, Ontario, Hong Kong and the UK have centrally-managed health care systems which cater to immigrants of all ages and income levels. In contrast, New York has different health care programmes available to different sectors of the immigrant population. In any event, the basic health care coverage provided by the health care programmes in the four jurisdictions are similar in terms of the types of services provided.

6.2.2 In Ontario, Hong Kong and the UK, public health care is available to all legal immigrants, regardless of their age, disability, or income and resources of a household, but there are slight variations on the eligibility requirements among the three jurisdictions. In particular, Hong Kong provides subsidized services to eligible persons, while public health care services are free in Ontario and the UK for eligible immigrants. In New York, apart from basic health care coverage, free or subsidized public health care is not available to all qualified immigrants, but only to a selected few.

6.2.3 In Ontario, landed immigrants receive the same health care benefits as citizens under OHIP as long as they fulfil the provincial residence requirement. In Hong Kong, residence is the only requirement for the receipt of public health care services for OWP holders and other non-permanent residents who, as holders of Hong Kong Identity Card, receive the same range and quality of public health care services as permanent residents.

6.2.4 In the UK, NHS is available free of charge to individuals who have the status of ordinarily resident or exempt overseas visitor. In this respect, legal immigrants, who fulfil both residence requirements, enjoy free access to NHS, which is available to them immediately after their arrival in the country.

6.2.5 In contrast, in New York, the government does not have a compulsory and universal health insurance programme for qualified immigrants. Age, income intake, assets and resources are part of the test for eligibility for free or subsidized public health care services, which are available only to designated groups of qualified immigrants.

6.2.6 With respect to illegal immigrants, the UK has the most generous public health care programme among the four jurisdictions. In the UK, illegal immigrants can receive full NHS coverage for free under the overseas visitor exempt category as long as they have resided in the UK for more than 12 months. If the health care service recipient is found by the Home Office to be a resident for less than 12 months and is residing in the UK unlawfully, he or she would be liable for charges. Nevertheless, the UK is currently considering revamping this provision to prevent abuse of the legislation on NHS access.

6.2.7 In New York, except for PRUCOL immigrants and children under the age of 19, unqualified immigrants are only eligible for emergency services, prenatal services, immunizations, and testing and treatment for symptoms of communicable diseases. These services are provided free of charge.

6.2.8 In Hong Kong, illegal immigrants are provided with health care services only if they are in urgent need, whereas in Ontario, illegal immigrants are not eligible for OHIP benefits and are financially liable for all medical services they receive.

6.3 Eligibility for free or subsidized public health care

6.3.1 In both Ontario and the UK, legal immigrants are eligible for free public health care services, with the services funded by tax revenue. In Ontario, both immigration and residence statuses are required for eligibility, while in the UK, the eligibility of public health care services is comparatively lax since residence status is the only determining factor. In contrast, free or subsidized public health care services in New York are only available to selected groups of qualified immigrants: Medicare for the elderly and the disabled, Medicaid and Family Health Plus for low-income households, and Child Health Plus for children.

6.3.2 In Hong Kong, public health care services are available to all. However, the services are provided on a fixed fee-for-service basis and charges vary according to the immigration and residence statuses of an individual. Hong Kong is the only jurisdiction in this study where fees on public health care services are imposed regardless of eligibility, but the fees are heavily subsidized by the Government for those who are eligible.

6.3.3 At present, only recipients of CSSA are exempted from the payment of their medical services. For non-CSSA recipients, depending on their residence status, there are two different charging rates on public health care services - Eligible Persons rates (heavily subsidized public rates) and Non-eligible Persons rates. Since OWP holders and other non-permanent residents are Hong Kong Identity Card holders, they are considered Eligible Persons and are qualified for subsidized rates.

6.4 Verification of eligibility for public health care services

6.4.1 The UK has a different policy for verification of eligibility for health care services compared to the other three jurisdictions. In the UK, there is no official list of documents for establishing entitlement to health care services. It is up to the individual to decide on what relevant documents to submit. However, in New York, Ontario and Hong Kong, the regulatory authorities have established fixed guidelines in terms of application procedures and specific documents required for establishing claims to health care services.

6.5 Responsibility for immigrants' health care expenses

6.5.1 Among the four jurisdictions, only New York has enacted legislation on sponsor deeming and sponsor liability. However, the legislation is yet to be implemented and discussion is still underway regarding its enforcement.

6.5.2 In Ontario and the UK, sponsors of immigrants are not required to reimburse the government for the provision of public health care services to immigrants. In Canada, provincial health insurance programmes, such as OHIP, are not considered as social assistance, which otherwise would require reimbursement by the sponsors for benefits claimed by the immigrants. Similarly, in the UK, the receipt of NHS services is not considered as claiming public funds, and therefore sponsors are not required to reimburse the government for the provision of NHS to immigrants.

6.5.3 In Hong Kong, residents whose family members have settled in Hong Kong via the OWP Scheme are not required to reimburse the Government for the provision of public health care services to the immigrants. The Government collects fees directly from the immigrants only.

Table 4 - Comparison of Health Care Coverage of Immigrants in New York, Ontario, the United Kingdom and Hong Kong

	New York	Ontario	The United Kingdom	Hong Kong
Public health care expenditure as % of GDP (in 2001)	Information not available. #	Information not available.*	6.2%.	2.7%.
Health care framework	Free or subsidized public health care services available only to designated groups of qualified immigrants.	Universal health care.	Universal health care.	Subsidized public health care services available to eligible persons only.
Programmes for which legal immigrants are eligible	Medicare - for the disabled or elderly aged 65 or above; Medicaid - for low-income households with members of all ages; FHPlus - for low-income households with members aged 19 to 64; and CHPlus - for children aged 19 or below.	Ontario Health Insurance Program for all ages.	National Health Service for all ages.	Public health care services for all ages.

Sources:

1. OECD Health Data 2003.
2. Hong Kong Department of Health.

Notes:

- # While the information on public health care expenditure of New York is not available, the public health care expenditure as a percentage of GDP of the US is 6.2%.
- * While the information on public health care expenditure of Ontario is not available, the public health care expenditure as a percentage of GDP of Canada is 6.9%.

Table 4 - Comparison of Health Care Coverage of Immigrants in New York, Ontario, the United Kingdom and Hong Kong (cont'd)

	New York	Ontario	The United Kingdom	Hong Kong
Regulatory authority	Medicaid - Centers for Medicare & Medicaid Services and New York State Department of Health. FHPlus - New York State Department of Health. CHPlus - New York State Department of Health. Medicare - Centers for Medicare & Medicaid Services.	Ontario Ministry of Health and Long-Term Care.	Department of Health.	Health, Welfare, and Food Bureau.
Fees	Medicaid - Free. FHPlus - Free. CHPlus - Monthly fee depending on family income. Medicare - Premium, deductible, and percentage of service charge.	Free.	Free.	Fixed fee for services with different Eligible Persons rates and Non-eligible Persons rates.
Responsibility for immigrants' health care expenses	New York has enacted legislation on sponsor deeming and sponsor liability. The legislation is yet to be implemented, and discussion is still underway regarding its enforcement.	Sponsors of immigrants are not required to reimburse the government for the provision of public health care services to immigrants.		Residents whose family members have settled in Hong Kong via the OWP Scheme are not required to reimburse the Government for the provision of public health care services to the immigrants.

Table 4 - Comparison of Health Care Coverage of Immigrants in New York, Ontario, the United Kingdom and Hong Kong (cont'd)

	New York	Ontario	The United Kingdom	Hong Kong
Eligibility criteria	<p>Medicaid:</p> <ul style="list-style-type: none"> • low-income qualified immigrants and PRUCOL immigrants; and • residents of New York. <p>FHPlus:</p> <ul style="list-style-type: none"> • low- income qualified immigrants; • residents of New York; and • not in receipt of equivalent health care coverage or insurance. <p>CHPlus:</p> <ul style="list-style-type: none"> • both qualified and unqualified immigrants; and • residents of New York. <p>Medicare:</p> <ul style="list-style-type: none"> • qualified immigrants who have worked for 10 years; or • younger persons with disability or renal disease. 	<ul style="list-style-type: none"> • Landed immigrants and Convention refugees; • making a permanent and principal home in Ontario, and • present in Ontario for at least 153 days in any 12-month period. 	<ul style="list-style-type: none"> • Individuals classified as: <ul style="list-style-type: none"> (a) ordinarily resident; or (b) exempt overseas visitor. 	<ul style="list-style-type: none"> • Holders of Hong Kong Identity Card issued under the Registration of Persons Ordinance; • children who are Hong Kong residents and under 11 years of age; and • other persons approved by the Director of Health.

Appendix I

Definition of Permanent Residents of the Hong Kong Special Administrative Region

- A1.1 Under Article 24 of the Basic Law, permanent residents of the Hong Kong Special Administrative Region shall be:
- (a) Chinese citizens born in Hong Kong before or after the establishment of HKSAR;
 - (b) Chinese citizens who have ordinarily resided in Hong Kong for a continuous period of not less than seven years before or after the establishment of HKSAR;
 - (c) Persons of Chinese nationality born outside Hong Kong of those residents listed in categories (a) and (b);
 - (d) Persons not of Chinese nationality who have entered Hong Kong with valid travel documents, have ordinarily resided in Hong Kong for a continuous period of not less than seven years and have taken Hong Kong as their place of permanent residence before or after the establishment of HKSAR;
 - (e) Persons under 21 years of age born in Hong Kong of those residents listed in category (d) before or after the establishment of HKSAR; and
 - (f) Persons other than those residents listed in categories (a) to (e), who, before the establishment of HKSAR, had the right of abode in Hong Kong only.

Appendix II

Fee Waiving Mechanism in Hong Kong

A2.1 Recipients of Comprehensive Social Security Assistance (CSSA) are currently exempted from the payment of public health care services. For patients who are not CSSA recipients, they can apply for fee waivers.

Financial consideration

A2.2 Individuals are eligible to apply for a fee waiver if they meet both of the following financial criteria:

- (a) the individual's monthly household income does not exceed 75% of the Median Monthly Domestic Household Income (MMDHI) applicable to the individual's household size (see Table 5); and
- (b) the value of the individual's household asset is within a certain limit applicable to the household (see Table 6). It should be noted that the value of the individual's residence does not count towards this asset limit.

A2.3 For individuals whose monthly household income does not exceed the average monthly CSSA payment applicable to their household size (at present, it is approximately at the level of 50% of MMDHI) and who pass the asset limit test, they will be considered for a full waiver of their medical fees at public clinics/hospitals.

A2.4 For individuals whose monthly household income is between 50% and 75% of MMDHI applicable to their household size and who pass the asset limit test, Medical Social Workers will consider their applications (as well as whether a waiver valid for a defined period of time or a one-off, full or partial waiver should be granted) on a case-by-case basis.

Appendix II (cont'd)Non-financial consideration

A2.5 The following non-financial factors are also considered:

- (a) the patient's clinical condition, as defined by the patient's frequency of use of the various public medical services, and severity of the illness;
- (b) whether the patient is a disabled person, single parent with dependent children, or belongs to other vulnerable groups;
- (c) whether a fee waiver could provide incentive and support to solve the patient's family problems;
- (d) whether a patient has any special expenses that make it difficult for him or her to pay for the medical fees at public clinics/hospitals; or
- (e) other justifiable social factors.

**Table 5 - Median Monthly Domestic Household Income (MMDHI)
By Household Size - Third Quarter 2002**

Household Size	Median Monthly Domestic Household Income (HK\$)	75% of MMDHI (HK\$)	50% of MMDHI (HK\$)
1	6,000	4,500	3,000
2	12,700	9,525	6,350
3	16,000	12,000	8,000
4	19,400	14,500	9,700
5	24,300	18,225	12,150
6 or above	25,300	18,975	12,650

Source:

Health, Welfare and Food Bureau, "LegCo Panel on Health Services - Enhanced Medical Fee Waiver Mechanism", February 2003, LC Paper CB(2)1245/02-03(15).

Appendix II (cont'd)

Table 6 - Asset Limit for Waiving of Medical Charges

Household Size	Asset Limit in HK\$ (with <u>no</u> elderly member)	Asset Limit in HK\$ (with <u>1</u> elderly member)	Asset Limit in HK\$ (with <u>2</u> elderly members)
1	30,000	80,000	-
2	60,000	110,000	160,000
3	90,000	140,000	190,000
4	120,000	170,000	220,000
5 or above	150,000	200,000	250,000

Source:

Health, Welfare and Food Bureau, "LegCo Panel on Health Services - Enhanced Medical Fee Waiver Mechanism", February 2003, LC Paper CB(2)1245/02-03(15).

Note:

The asset limit is raised by HK\$50,000 for each elderly member (i.e. age ≥ 65) in the patient's family, e.g. a 5-person family with three elderly members has an asset limit of HK\$300,000 instead of HK\$150,000.

Appendix III

Coverage under the Ontario Health Insurance Program

Insured in-patient hospital services

A3.1 Under Regulation 522 of the Ontario Health Insurance Act, insured in-patient hospital services include:

- (a) accommodation and meals at the standard ward level;
- (b) necessary nursing services;
- (c) laboratory, radiological and other diagnostic procedures;
- (d) drugs, biological and related preparations; and
- (e) use of operating rooms, obstetrical delivery rooms and anaesthetic facilities.

Insured out-patient hospital services

A3.2 Insured out-patient hospital services include:

- (a) laboratory, radiological and other diagnostic procedures;
- (b) use of radiotherapy, occupational therapy, physiotherapy and speech therapy facilities, where available;
- (c) use of diet counselling services;
- (d) use of home renal dialysis and home hyperalimentation equipment, supplies and medication;
- (e) provision of equipment, supplies and medication to haemophiliac patients for use at home; and
- (f) biosynthetic human growth hormone to patients with endogenous growth hormone deficiency.

Appendix III (cont'd)Insured physician services

A3.3 Under Regulation 552 of the Ontario Health Insurance Act, a service rendered by a physician in Ontario is an insured service if it is medically-necessary, and is contained in the Schedule of Benefits and rendered in such circumstances as outlined in the Schedule of Benefits. These services include:

- (a) diagnosis and treatment of medical disabilities and conditions;
- (b) medical examinations and tests;
- (c) surgical procedures;
- (d) maternity care;
- (e) anaesthesia, radiology and laboratory services in approved facilities;
and
- (f) immunizations, injections and tests.

Insured surgical-dental services

A3.4 Insured surgical-dental services that are medically-necessary can be rendered in hospital under Regulation 552 of the Ontario Health Insurance Act. These include:

- (a) repair of traumatic injuries;
- (b) surgical incisions;
- (c) excision of tumours and cysts;
- (d) treatment of fractures;
- (e) homeografts;
- (f) implants; and
- (g) alloplastic reconstructions.

Appendix IV**Verification of Eligibility under the Ontario Health Insurance Program**

- A4.1 To obtain a Health Card to prove OHIP eligibility, a landed immigrant must:
- (a) prove his or her Canadian immigration status by showing an original document which can be:
 - (i) a Immigrant Visa and Record of Landing;
 - (ii) a Confirmation of Permanent Residence;
 - (iii) a Permanent Resident Card; or
 - (iv) a Canadian Immigration Identification Card.

 - (b) prove his or her residence in Ontario by showing an original document which can be:
 - (i) a valid Ontario driver's licence or temporary driver's licence;
 - (ii) a bank account statement;
 - (iii) an utility bill; or
 - (iv) an employer record;

 - (c) prove his or her identity by showing an original document which can be:
 - (i) a valid Ontario driver's licence or temporary driver's licence;
 - (ii) a social insurance number card;
 - (iii) a Canadian Immigration Identification Card; or
 - (iv) a Permanent Resident Card.⁶⁹

⁶⁹ A document cannot be used more than once. For example, a person cannot use his or her Permanent Resident Card for proof of immigration status and also for proof of identity.

Appendix V**Eligibility for New York Medicaid Programme**

A5.1 Some examples of Medicaid-eligible groups for both citizens and immigrants are:

- (a) low-income families with children. Table 7 shows the amount of income a family of qualified immigrant or PRUCOL immigrant can receive and the amount of resources it can retain and still qualify for Medicaid. Certain groups, including pregnant women, children and disabled persons, are allowed to have higher income with no resource limits and still be eligible for Medicaid. For instance, pregnant women and infants up to one year old can have income limit up to 200% Federal Poverty Level;
- (b) infants born to Medicaid-eligible pregnant women. Medicaid eligibility continues throughout the first year of life as long as the infant remains in the mother's household and she remains eligible;
- (c) recipients of adoption assistance and foster care under the Social Security Act;
- (d) low-income Medicare beneficiaries. Medicaid pays for their out-of-pocket medical expenses and supplements Medicare coverage by providing services and supplies, such as nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses and hearing aids; and
- (e) special protected groups who can keep Medicaid for a period of time. Examples are families who are provided with six to 12 months of Medicaid coverage following loss of eligibility due to increase in earnings, or four months of Medicaid coverage following loss of eligibility due to an increase in child or spousal support.

Table 7 - 2003 Income & Resource Levels*

Number of Family Members	Monthly Income (US\$)	Resources (US\$)
1	642	3,850
2	934	5,600
3	942	5,650
4	950	5,700
5	992	5,950
6	1,134	6,800
7	1,275	7,650
8	1,417	8,500
For each additional person, add:	142	850

Source:

The New York State Department of Health.

Note:

* Income and resource levels are subject to yearly adjustments.

Appendix VI

Table 8 - 2003 Federal Poverty Level Guidelines for All States (except Alaska and Hawaii)

Family Size	Percent of Poverty (Annual Income in US\$)						
	100%	125%	133%	150%	160%	200%	250%
1	8,980	11,225	11,943	13,470	14,368	17,960	22,450
2	12,120	15,150	16,120	18,180	19,392	24,240	30,300
3	15,260	19,075	20,296	22,890	24,416	30,520	38,150
4	18,400	23,000	24,472	27,600	29,440	36,800	46,000
5	21,540	26,925	28,648	32,310	34,464	43,080	53,850
6	24,680	30,850	32,824	37,020	39,488	49,360	61,700
7	27,820	34,775	37,001	41,730	44,512	55,640	69,550
8	30,960	38,700	41,177	46,440	49,536	61,920	77,400

Notes:

1. For family units of more than eight members, add US\$ 3,140 for each additional member.
2. Income levels are subject to yearly adjustments.
3. Published in the Federal Register on 7 February 2003

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