**Department of Health Consultation on Extending for Primary and Emergency Healthcare**

*I’ve used the notes from meetings in Leeds (22nd January) and Sheffield (8th February) to inform the responses for each consultation question. They include the main points that were covered in the meetings, alongside the key messages that have become clear over the past few weeks. My proposed responses have been supplemented by information from Still Human Still Here.*

***All organisations and groups are encouraged to become a signatory to this consultation response. Please let me know by Friday 4th March if you would like to be added as a signatory.***

If you want to refer to the full consultation paper, it can be found here: <https://www.gov.uk/government/consultations/overseas-visitors-and-migrants-extending-charges-for-nhs-services> .

The Home Office has also published an [Impact Assessment](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482648/Impact_Assessment.pdf) on the proposals which includes detailed information and costings for the proposals.

**DEADLINE FOR RESPONSES: Monday 7th March, 11.45pm.**

**Responses should be sent to:** **nhscostrecovery@dgh.gsi.gov.uk**

**Summary of the Consultation**

Legislation passed under the **Immigration Act 2014** and subsequent secondary legislation has made significant changes to how overseas visitors and migrants are identified and charged for their use of the NHS in England. This included the introduction of the **Immigration Health Surcharge** for nationals of countries outside the European Economic Area who intend to stay in the UK longer than six months. New ways to **identify and recover debt from** **chargeable patients at secondary care level** were also introduced.

The Department of Health has announced a new consultation on their plans to extend charging of overseas visitors and migrants who use the NHS. The changes outlined in this consultation include **proposals to introduce charging in primary care, ambulance services and A&E.**

Under these new proposals, **anybody who is does not have Indefinite Leave to Remain in the UK will become chargeable** for all the care they receive from the NHS, **apart from GP and nurse consultations,** unless they have paid the Immigration Health Surcharge**.** This will include introducing charges in primary care, community care and emergency care (including ambulance services, A&E and walk in centres).

For more information about the proposed policies, have a look at our briefing [here](https://gallery.mailchimp.com/441297605b29ad4bef83ce44d/files/RAA_Briefing_on_Department_of_Health_Consultation_on_Charging_Final.pdf).

**What are our key messages?**

1. **The current charging system is already deterring people seeking asylum and refugees from accessing the healthcare they need and are fully entitled to**There is strong evidence to suggest that current NHS charging procedures in secondary care – regardless of the exemptions - are already deterring vulnerable people from accessing the care that they need, with significant consequences for individual health and wellbeing**. It is unwise to replicate the charging mechanisms into primary and emergency healthcare if they are not working.**
2. **Restricting access to primary and emergency healthcare is economically and ethically unjustified**Access to primary care is crucial for the provision of timely and cost-effective preventative treatment, as well as an important gateway into specialist care for expecting mothers, those with non-urgent mental health needs, and other conditions. Creating further barriers to accessing primary healthcare will result in increased presentation at A&E, as chargeable patients will let their conditions deteriorate to a critical level to avoid primary care charges. **Considering the existing pressures faced by A&E services across the country, the provision of preventative care is all the more important.**
3. **Many chargeable patients will not be able to pay for the healthcare that they need**Refused asylum seekers do not have permission to work in the UK and, with any financial support and housing from the Home Office withdrawn, they are often entirely destitute. Despite being especially vulnerable to poor physical and mental health, destitute refused asylum seekers would have no means to pay for the healthcare they may need. **We expect that the administrative costs of chasing chargeable patients will far outweigh any recouped charges.**
4. **The proposed policies will worsen health inequalities and damage public health**

We are concerned that any new charging procedures will create significant barriers to healthcare for refugees and asylum seekers, as well as the general population. In order to avoid discrimination, healthcare providers will be duty bound to frequently request the immigration status of all NHS patients. We are concerned that this may result in racial profiling and discrimination that contravenes the Equality Act 2010. **Many vulnerable people – including the elderly, the homeless, those living with mental health conditions and others – will struggle to prove their entitlement to free care.**

**What are our key recommendations?**

1. We strongly recommend that the Department of Health do not extend charging mechanisms into primary, emergency, and other parts of NHS care.
2. If the Department do extend charging mechanisms into all parts of NHS care, we recommend that the Department of Health expand their list of vulnerable groups which are exempt from charges to include children and pregnant women, as well as ensuring that community mental health services are excluded from charging on both public health and cost efficiency grounds.
3. We also encourage the Department of Health to reiterate that those who have been granted people seeking asylum and those with refugee status, humanitarian protection or discretionary leave to remain will continue to be exempt from NHS charging regulations.
4. We also urge the Department of Health to exempt all asylum seekers from the charging system irrespective of their status as this will protect a vulnerable group, simplify procedures and reduce costs.
5. Health professionals should have the power to waive a charge when they consider it cost effective to do so, or where not providing care would risk public health.

DRAFT Consultation Response, February 2016

**1. We propose to apply the existing secondary care charging exemptions to primary care and emergency care. Do you agree?**

***Proposed Policy****Currently, overseas visitors and migrants can be charged for healthcare provided in a secondary care setting. However, there are a number of patient-based exemptions from charging including: asylum seekers, refugees, children who are looked after by a local authority, victims of human trafficking, treatment required for a physical or mental health condition caused by torture, FGM, domestic violence, sexual violence, treatment required under the Mental Health Act 1983, prisoners and immigration detainees. There are also a number of treatment-based exemptions from charging that apply to all patients for public health and public protection reasons, including: family planning services (not including a termination of pregnancy), diagnosis and treatment of specified infectious diseases, diagnosis and treatment of sexually transmitted infections.*

*This question asks whether these exemptions from charging should apply to primary care and emergency care (if charging were to be expanded into these areas).*

Whilst we strongly disagree with the proposal to introduce charging for primary and emergency healthcare, if charges are introduced, we strongly agree with the above proposal to carry existing charging exemptions set out at primary care into primary care and emergency care settings.

**2. Do you have any views on how the proposals in the consultation should be implemented so as to avoid impact on: people with protected characteristics (as defined under the Equality Act 2010), health inequalities and vulnerable groups**

**Proposed Policy***This question is an opportunity to explore whether the introduction of charging for primary and emergency healthcare will adversely affect certain groups of people and to raise general concerns about the potential impact of the changes to healthcare entitlements on refugees and people seeking asylum.*

We believe that the policy proposals outlined in [*Making a Fair Contribution: A Consultation on the Extension of Charging Overseas Visitors and Migrants Using the NHS in England*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/483870/NHS_charging_acc.pdf)will negatively impact on people with protected characteristics, worsen existing health inequalities and increase barriers to healthcare for an increasingly large group of vulnerable people.

In the Department of Health’s response to the last consultation in 2013, they noted that their proposal to extend charging to primary and emergency care had triggered “significant concerns that this would increase inequalities.”[[1]](#footnote-1) The government response also identified concerns from respondents about the policy’s potential to encourage discrimination in healthcare settings, dissuade vulnerable people (eligible or otherwise) from seeking help, and also shift demand towards A&E.[[2]](#footnote-2) The policy proposals and mitigations outlined in the new Consultation document and accompanying impact assessment do not, in our opinion, fully address the serious concerns raised in the 2013 consultation, nor do they meet the current consultation’s own ‘overarching principles.’[[3]](#footnote-3)

**i) A system that ensures access for all in need**

The proposals are complex for both patients and practitioners, resulting in a potentially impenetrable system which will disadvantage vulnerable patients both from migrant backgrounds, and vulnerable residents with particular additional needs arising from dementia, mental health conditions, homelessness, learning difficulties and others.

**ii) A system where everybody makes a fair contribution to the NHS**

The proposals outlined are designed to charge short-term visitors to the UK for their use of the NHS. However, since the introduction of the health surcharge, direct charges target an increasingly small group of irregular migrants, many of whom are not ‘visitors’ in the terms suggested by these proposals. More often than not, they are long-term residents in the UK.

This increasingly small chargeable group are likely to be totally unable to pay for any care, and in many cases, the cost of pursuing any charges is bound to outweigh any revenue recovered. For some, including destitute refused asylum seekers, they will not have permission to work in the UK or access to public funds.

We are not convinced that the potentially recouped charges will outweigh the costs of initiating this new charging regime. With the health surcharge in place, many of those who are chargeable under these rules are not ‘visitors’ in the sense of temporary residence in the UK. They are often long-term residents in the UK who are in a vulnerable position, even if

The administrative costs alone of chasing patients for charges they are unable to pay will render the process untenable.

**iii) A system that is workable and efficient**

Following on from the above comment, attempting to recoup charges from an increasingly small group of vulnerable migrants without the means to pay for their medical care will result in a system that is neither workable nor efficient.

Limiting access to primary healthcare will also reduce proactive healthcare-seeking activity, consequently reducing preventative interventions that help stop health conditions deteriorating. As highlighted in the 2013 consultation response, charging mechanisms at primary and emergency care could delay and deter everyone (eligible or ineligible) from accessing healthcare until conditions become critical. This is neither cost-effective, as preventative care is always cheaper, but also not workable, considering the immense pressures faced by A&E services already.

We also believe that the current healthcare charging system isn’t workable, or efficient. Fully entitled patients who come under a patient based-exemption for free care are routinely deterred from accessing healthcare due to confusions about entitlements. Many are refused registration with GP practices due to lack of photo ID, whilst others are wrongfully charged for secondary care provision despite being fully entitled to free care If the proposals are to be workable and efficient, it would be apt to evaluate the charging mechanisms in secondary care prior to extending them into primary and emergency healthcare settings.

The impact of these changes will also not be felt proportionately across the country. NHS Trusts and GP surgeries in metropolitan areas with high migrant BME and migrant populations will experience a significant increase in workload, whilst others will not. As healthcare services in areas with high population density and diverse communities are already under significant strain to deliver more services to a large patient-group, the added administrative workload of charging patients for care will not be workable or efficient.

**iv) A system that does not increase health inequalities**

Many of the vulnerable groups – including asylum seekers and refugees - who are set to be worse affected by these proposals already have significant and additional health needs and generally have poorer health outcomes than the rest of the population.
Refugees and people seeking asylum have significant and acute health needs that arise from their experiences of persecution, flight from persecution, and sometimes from their experiences of living in poverty and homelessness in the UK. We are concerned that further barriers to care will worsen the health inequalities already faced by those seeking refugee protection in the UK. [DATA]We also believe that the proposals outlined by the Department of Health could also have adverse effects on particularly vulnerable groups, including some people with protected characteristics.

**i) The proposals in the consultation are set to disproportionately impact on vulnerable pregnant mothers and children**Extending charging into all NHS settings is set to further dissuade chargeable migrant women from accessing maternity care when they fall pregnant. Mothers, faced with the prospect of an expensive bill for maternity care, may decide to delay presenting to medical professionals until very late in pregnancy. This has the potential to put both mother and baby at risk, and heightens the possibility of the child being born into ill health through no fault of their own.

Mothers disproportionately bear the costs of maternity care, as well as the subsequent care needed for new born children. Maternal deaths to women with irregular immigration status are already higher than the rest of the resident population.

**ii) Extensive identification of immigration status at all levels of NHS care opens the door to potential racial profiling and discrimination**In order to avoid discrimination, NHS staff at all levels of care will need to ask all patients about their immigration and residency status in order to define their eligibility for free care. Without clear guidelines, training and support, overt or covert discrimination towards particular groups of patients could propagate within the NHS. Mistakes made could result in costly legal challenges against NHS trusts.

**iii) The new proposals run counter to a number of cross-governmental objectives around FGM, Modern Day Slavery, Child Protection, and reducing violence against women and girls.**Healthcare providers, especially in primary care, are a crucial gateway to specialist services for vulnerable migrants in the UK. GPs and nurses have important roles to play in the early identification of FGM, torture, child abuse, and domestic violence that enable vulnerable individuals to access the care and support they desperately need. The threat of charging in primary care threatens to dissuade vulnerable individuals from accessing primary care providers, significantly limiting their avenues of support.

For asylum seekers, letters from GPs and specialist care providers can make the difference between destitution and the provision of Home Office support. Some refused asylum seekers will need to access healthcare whilst they are deemed to be chargeable, solely for the purpose of proving they are entitled to HO support and free NHS care due to a medical condition.

**3. We propose recovering costs from EEA nationals visiting the UK who do not have an EHIC (or PRC). Do you agree?**

***Proposed Policy****This question looks at the proposal to recover costs from EEA nationals visiting the UK who use the NHS but are unable to produce a valid EHIC - European Health Insurance Card -(or PRC).*

*Strongly disagree.*

**4. We propose recovering costs from non-EEA nationals and residents to whom the health surcharge arrangements do not apply. Do you agree?**

***Proposed Policy****This question looks at the proposal to recover costs from non-EEA nationals and residents who have not paid the health surcharge or for whom the health surcharge arrangements do not apply.*

*Strongly disagree.*

**5. We have proposed that GP and nurse consultations should remain free to all on public protection grounds. Do you agree?**

***Proposed Policy****As one of their key mitigations to combat a potential increase in health inequalities, the Department of Health has stated that all GP and nurse consultations should remain free to all, regardless of immigration status.*

*We strongly agree with the idea that GP and nurse consultations should remain free to all.*

**6. Do you have any comments on the implementation of the primary medical care proposals?**

***Proposed Policy****GPs can currently only charge overseas visitors if the person is first offered the choice of being an NHS patient, but decides to pay to be treated as a private patient. Under the new proposals, chargeable care in primary care settings will be anything other than a GP or nurse consultation delivered in a GP practice, or on behalf of a GP practice. This includes: blood tests, x-rays, minor surgery and physiotherapy.*

*GP and Nurse consultations will remain free to all, and patient-based and treatment-based exemptions will still apply. GP surgeries will be expected to record the immigration status of patients.*

We have significant concerns about the potential impact of the primary medical care proposals. We believe that introducing charging into primary healthcare has the very real possibility of both denying and deterring vulnerable people from accessing the care they mean, with serious consequences for personal health and wellbeing as well as public health. We also do not believe that maintaining free GP and nurse consultations for all is a sufficient mitigation for protecting the health and wellbeing of vulnerable individuals.

**i) GPs are the most common referral route for the diagnosis and treatment of infectious diseases and mental health issues, as well as for accessing maternity services.**Primary care is crucial for the identification and treatment of ailments before they deteriorate into critical, chronic conditions. Whilst we welcome the fact that GP and Nurse consultations will remain free to all, we are concerned that fears of being charged, having to divulge your immigration status upon registration with a GP, and confusions about exemptions may result in refugees and asylum seekers not accessing important preventative care in a primary care setting. Patients too afraid to access primary care will let conditions worsen until they reach a critical point and need to access emergency care in an A&E setting.

**Public Health:** Proactive health-seeking behaviour, especially in a primary healthcare setting, is pivotal to the identification and treatment of infectious and communicable diseases. Whilst we welcome the fact that certain infectious diseases remain on the treatment-based exemption list, we remain concerned that vulnerable patients may be dissuaded from accessing primary healthcare for fear of charging and a lack of knowledge about what conditions may or may not be exempt from charges.

Put plainly, if chargeable patients have less routine engagement with healthcare providers, it will be more difficult to both diagnose certain conditions, even if the final treatment of infectious and communicable diseases is exempt.

Establishing barriers to primary care provision for vulnerable migrant groups will also make it increasingly difficult for local authorities and health providers to protect public health. If communities – due to fears of charging, or the reality of being charged – do not access primary care providers, communicable and infectious diseases will be much harder to diagnose prior to a wider outbreak.

[HEP A CASE STUDY]

**Children and Immunisations:** Despite significant concerns raised in the previous 2013 consultation[[4]](#footnote-4) and subsequent research from Demos[[5]](#footnote-5), there is still no general exemption for children in need of NHS care. In the words of the Department of Health, “if the child is subject to immigration control, then they will also need to have indefinite leave to remain at the time of receiving treatment to be considered ordinarily resident.”[[6]](#footnote-6)

Children are currently only exempt if they are under the care of the local authority. Children born to exempt parents are only considered exempt from charging for the first 3 months of their lives, by which point their parents are expected to have regularised their child’s immigration status in the UK. It is unclear from the consultation whether or not a child born to a non-exempt parent would also be considered exempt for 3 months after the birth date.

Making children chargeable for healthcare, especially at primary care level, could deter parents from ensuring their children have the full set of childhood vaccinations. A large number of childhood vaccinations are due after three months and many require ‘boosters’ or top ups over the first year or two of the child’s life.[[7]](#footnote-7) This could have significant consequences for the health of vulnerable children, but also could have adverse impacts on public health more generally.

**Mental Health:** People seeking asylum are also vulnerable to significant mental health challenges, including post-traumatic stress disorder, severe depression, and anxiety. Refugees and asylum seekers are also among the highest risk categories for suicide in the UK[[8]](#footnote-8) and the Royal College of Psychiatrists has even noted that “the psychological health of refugees and asylum seekers currently worsens on contact with the UK asylum system.”[[9]](#footnote-9)

Charging for non-crisis mental health care is both economically and ethically unjustified. Only exempting crisis mental health care – either subject to a court order or sectioning – means that low-level mental health conditions will only be addressed once they escalate to a critical condition. This is neither cost effective, nor ethically justified in terms of providing adequate healthcare to those in need. It is important that those suffering from mental health challenges are able to access preventative, early-intervention care without fear of charges.

**ii) Current operational guidance is not being enacted in practice, and vulnerable people are being denied access to healthcare they are fully entitled to**Despite new guidance being issued in November 2015[[10]](#footnote-10), refugees, people seeking asylum and other migrants continue to struggle to register with GPs despite being fully entitled to free care. This can result in pregnant mothers struggling to access antenatal care, immunisations, as well people being wrongly informed of their rights and entitlements to NHS care whilst in the UK.

From the experiences of those feeding in to this consolation response – third sector and healthcare professionals alike – there is a huge amount of confusion about who is entitled to free NHS care. Organisations advocating for the rights of refugees and people seeking asylum frequently report difficulties registering their clients with GP surgeries, whilst many healthcare providers report confusion over what documentation individuals need to prove entitlement to free NHS. In fact, the trigger for the NHS England guidance for patient registration with GPs was “evidence of an increasing number of patients finding it difficult to register with some GP practices […] in particular though this issue is affecting migrants and asylum seekers who do not have ready access to documents.”[[11]](#footnote-11) General barriers to healthcare for undocumented migrants – including refugees and asylum seekers – have been continually raised by Doctors of the World.[[12]](#footnote-12)

This is particularly worrying within primary care, as the current regulations clearly state that everyone – regardless of immigration status – is eligible to register with a GP and receive free NHS care (unless the patient opts to be treated as a private patient).[[13]](#footnote-13) Our experiences, and the experiences of refugees and asylum seekers across Yorkshire and Humberside, suggest that this guidance is not being followed and is sometimes being contradicted by conflicting information from other governmental teams looking at fraud.

**Case Study, Leeds, January 2016:**
*In January, a worker at a Children’s Centre in Leeds accompanied two recently arrived asylum seeking women to register with their local GP. One of the women had a four week old baby with a heart problem. They were told by the receptionist that they could not register because they had no photo ID.*

*They then tried to register at a second GP practice nearby. The receptionist at this practice stated that “there were too many of these people in the area to take any more” and that “they took three times as long to deal with as other patients.”*

*The worker has since registered both women at a different GP surgery which is nearly double the distance from their accommodation.*

We believe that it would be particularly unwise to introduce a more complex registration and identification system in primary care when there are significant problems in operating the current guidance.

**iii) Access to primary care is incredibly important for refused asylum seekers**

Whilst there are exemptions from charging for refused asylum seekers who are in receipt of Section 4, Section 95 and Part 1 of the Care Act 2014, fully refused destitute asylum seekers are expected to pay for their healthcare. It is our understanding that under the new proposals, this will be extended into primary care.

Just because someone is refused asylum, it does not mean that they do not have a protection need. Poor decision making by the Home Office combined with a lack of good local advice and support can mean that many people reach the end of the process without their protection needs being recognised. Roughly 50% of all asylum applicants end up with some form of leave to remain in the UK.

Accessing primary care is particularly important for people seeking asylum in order to access additional state-provided support for newly born children whilst they wait for a decision on their claim for refugee protection, or receive temporary support whilst they arrange to return to their country of origin. Individuals applying for additional maternity payments (under Section 95) will need to provide a letter from a GP or midwife confirming that the patient is pregnant and her expectant due date. Those applying for temporary support (Section 4) will need a letter from a GP or health professional stating that, due to their medical conditions, they are unfit to fly. Without this supporting information, vulnerable people seeking refugee protection could be left destitution, without access to accommodation or financial support, despite being fully eligible for it. For refused asylum seekers applying for temporary Section 4 support, technically they will be chargeable for all NHS care received (unless it meets a treatment-based exemption) until their application for Section 4 support is successful (and they then meet one of the patient-based exemptions). Under these proposals, a refused asylum seeker who needs to prove his medical condition in order to access Section 4 support and subsequent exemption from NHS charges may have to pay for care in order to prove his exemption.

The consequences of refused asylum seekers not being able to access adequate support are destitution and poverty. The experience of homelessness worsens health and wellbeing, and the practical consequences of having nowhere to stay and no funds to support yourself or your family means that your ability to engage with early-stage preventative care is limited. Those who are of no fixed abode seek help at a much later stage in an illness than the general population, usually through A&E departments. It is well documented that acute conditions are more expensive to treat and emergency care is far more costly than preventative care.

Homelessness contributes significantly to secondary healthcare costs, which are estimated to be around £1,575 per person per year higher than for the general population. If the proposed policy results in an additional 2,500 asylum seekers and their dependents becoming destitute each year, this would result in nearly £4 million in additional secondary healthcare costs each year (a conservative estimate). Costs will be borne by hospitals and trusts in local authorities to which asylum seekers are dispersed, and therefore not evenly spread throughout the NHS.

**iv) Lack of clarity over full exemptions for refugees, those with humanitarian protection or discretionary leave to remain**Alongside the current concerns we have around access to primary care for those that are already exempt, and our fears at the impact any charging regime in primary care may have on vulnerable refugees, asylum seekers and wider communities, we also are concerned about the lack of clarity over full exemptions for those granted limited leave to remain in the UK.

People granted refugee status are only granted 5 years leave to remain in the UK (not indefinite leave to remain), and many individuals with other forms of protection needs are granted humanitarian protection, discretionary leave to remain and limited leave to remain in the UK. Despite being granted full legal right to remain in the UK, it is unclear from this consultation whether they will be exempt from charges at primary care.

The entitlements of those granted discretionary leave to remain (DLR) are particularly unclear. Individuals who have been granted DLR are often given two and a half years leave to remain in the UK. At this point, they are not asked to pay the health surcharge, but are also not included on a patient-based exemption set out at primary care. When individuals apply for an extension on their discretionary leave to remain, they are then asked to pay the health surcharge on top of the cost of renewing their leave. Whilst it is possible for individuals to apply for a waiver of the leave renewal fee costs, it is unclear whether this covers the costs of the health surcharge.

We believe that charging people whose protection needs have been recognised – be that through refugee status, humanitarian protection, or discretionary leave to remain – would be both economically and morally wrong.

**v) Lack of administrative capacity or structure to carry out charging in primary care settings**Primary care settings do not have the same administrative capacity to deal with charging patients on site as secondary healthcare providers. Without the expertise of overseas visitors managers, the responsibility for assessing a patient’s eligibility for free NHS care will fall directly on the registration staff.

The consultation document refers to a pilot run in 9 GP practices to in 2015 to assess the collection and processing of European Health Insurance Card (EHIC) data in primary medical care settings. According to this pilot, collecting the additional data at the point of registration added an extra minute or two per patient.[[14]](#footnote-14) This pilot, however, does not account for the additional time needed to assess more the more complicated documentation needed to prove other forms of immigration status in the UK.

As outlined earlier in this consultation, Trusts and practices in certain parts of the country will be disproportionately impacted by the proposed changes. Practices in highly populated and diverse areas will be faced with a significant strain on their administrative capacity to fairly and fully register patients. We are concerned that this may lead to discrimination and racial profiling at the point of registration.

**vi) Compromising the patient-doctor relationship**A second consequence of the lack of administrative capacity within primary healthcare services to fairly and efficiently enact the charging regulations is the potential for additional stress on staff.

Healthcare professionals involved in the two focus groups which inform this consultation submission raised concerns that practice staff – both at registration and in clinical positions – may be faced with difficult conversations about their entitlement to free care. Individuals reported concerns about staff safety and security, as well as the potential adverse impact these situations may have on the mental health and wellbeing of staff. Finally, many felt that the introduction of charging in primary healthcare services would threaten their ability to provide free healthcare based on a patients’ need rather than their ability to pay.

The difficulty of balancing the provision of healthcare with the collection of personal patient data necessary to establish chargeable status has already been raised within maternity care. Midwives in Hull reported concerns at OV1 forms being included in the first set of documentation to take to a new patient at their booking in appointment. The midwives were not made aware of what the OV1 forms were for and found themselves fielding difficult questions from patients, and being asked to support patients in completing the form. Not only did this add extra work onto the midwives’ already busy schedule, but also complicated the relationship between the midwife and patient. (?!?)

Many people seeking asylum – refused or in process – have difficulties trusting statutory bodies. Due to their experiences of persecution in their country of origin, many do not feel comfortable divulging personal information to people who are seen to be in positions of authority. [CONCERNS ABOUT DATA SHARING]

In conclusion, we are concerned that these proposals facilitate a primary care system where immigration status threatens to trump the provision of healthcare based on clinical need, and not someone’s ability to pay. These proposals will have an adverse effect on patient and public health – as well as the efficiency and sustainability of the NHS.

**7. We propose reclaiming the balance of the cost of drugs and appliances provided to EEA residents who hold an EHIC card (or PRC) (over and above the prescription charge paid by the patient) from the EEA country that issued the EHIC/PRC car. Do you agree?**

*Strongly disagree.*

**8. We propose removing prescription exemptions from non-EEA residents to whom the surcharge arrangements do not apply and who are not in one of the charge-exempt categories identified in section 3. Do you agree?**

*Strongly disagree.*

**9. Do you have any comments on the implementation of the NHS prescription proposals?**

***Policy Proposals****These two questions focus on eligibility for free prescriptions. The new proposals plan to change prescription exemptions so that all chargeable patients will be expected to pay the NHS prescription charge unless the patient meets one of the* [*current criteria for exemption*](http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Prescriptioncosts.aspx) *(i.e. low-income, under 16 or over 60 years old), as well as one of the patient-based exemptions outlined at secondary care (i.e. victim of human trafficking, asylum seeker).*

We strongly disagree with the prescription proposals outlined in the consultation document. We believe that there are significant costs associated with training relevant NHS staff to properly assess entitlement to exemptions from prescription charges. Prescribing clinicians would also have to further check this for every patient. This would result in the need for two different prescription pads to be used by the prescribing clinicians, in order to identify who is chargeable, and who is exempt. As most prescribed medications are for managing long-term conditions, or preventing a condition from deterioration, it is likely to be cost ineffective to charge for them, particularly if patients cannot afford to access preventative medication and later needs urgent or immediately necessary care.

There are already significant problems with access to prescription charge exemptions via the HC2 form. Refugee-support organisations across Yorkshire and Humberside have reported a series of incidents whereby the NHS has wrongly pursued people seeking asylum for prescription charges and a penalty fee due to issues with verifying the HC2 form.

Case Study, Bradford:
Between June 2015 – February 2016, one refugee-support service saw 27 different clients with letters from the NHS advising them that they had claimed to be on a HC2 but that this could not be verified so they would have to pay the prescription fee and a penalty charge. All 27 of these clients had valid HC2 and were either in receipt of S95 or S4 support. In each case, this involved a phone call to give the HC2 details and get the charge cancelled. This created additional work for the voluntary sector and a great deal of stress for each individual client.

We do not believe that the NHS prescription proposals, in their current form, can be applied and implemented in a way which is cost-effective and non-discriminatory. We are also concerned that the NHS is already making mistakes relating to existing prescription charge exemptions, resulting in vulnerable groups being pursued for charges that they are fully exempt from paying. We believe it is unwise to expand charging mechanisms in prescriptions when the current exemption and charging mechanisms are not working.

In order to protect vulnerable groups and mitigate any adverse effects on health inequalities, we strongly recommend that prescription exemptions should not be removed for children; pregnant woman and women who have had a child in the previous month who hold a valid exemption certificate; people with a specified medical condition who hold a valid exemption certificate; prescribed contraceptives and other listed medication; and those in receipt of certain benefits.

 **10. We propose reclaiming the balance of the cost of NHS dental treatment provided to EEA residents with EHICs or PRCs (over and above the banded charge paid by the patient) from their home country. Do you agree?**

*Strongly disagree*

**11. We propose removing NHS dental charge exemptions from non-EEA residents whom surcharge arrangements do not apply and who are not in one of the charge exempt categories identified in Section 3. Do you agree?**

*Strongly disagree*

**12.Do you have any comments on the implementation of the primary NHS dental care proposals?**

 ***Policy Proposals****These questions focus on eligibility for free NHS dental care. Currently, you do not have to pay for NHS dental treatment if, when your treatment starts, you are in one of the overarching* [*exempt categories*](http://www.nhs.uk/chq/Pages/1786.aspx?CategoryID=74) *(i.e. low-income, under 18, pregnant). The new proposals plan to change entitlement to free NHS dental care so that all chargeable patients will be expected to pay for dental treatment unless the patient meets one of the current criteria for exemption, as well as one of the patient-based exemptions outlined at secondary care (i.e. victim of human trafficking, asylum seeker).*

We believe that exemptions from NHS dental charges should be retained for vulnerable groups or those with existing health conditions, including those on low incomes, pregnant women and children.

**13. We propose removing eligibility for an NHS sight test and optical voucher from non-EEA residents to whom surcharge arrangements do not apply and who are not in one of the charge exempt categories identified in section 3. Do you agree?**

*Strongly disagree*

**14. Do you have any comments on the implementation of the NHS ophthalmic services proposals?**

***Policy Proposals****These questions focus on eligibility for free NHS sight tests and optical vouchers. Currently, you do not have to pay for NHS sight tests if you are in one of the overarching* [*exempt categories*](http://www.nhs.uk/chq/pages/895.aspx?CategoryID=68&SubCategoryID=157) *(i.e. low-income, under 16 years of age, been diagnosed with diabetes). The new proposals plan to change entitlement for free NHS ophthalmic services so that all chargeable patients will be expected to pay for ophthalmic services unless the patient meets one of the current criteria for exemption, as well as one of the patient-based exemptions outlined at secondary care (i.e. victim of human trafficking, asylum seeker).*

The proposal to remove eligibility to free NHS ophthalmic services from non-EEA residents to whom surcharge arranges do not apply and who are not in one of the charge exempt categories will not be cost effective. The Impact Assessment shows that the cost of extending charging to eye care will cost the NHS £32.7 million over 5 years. On cost grounds alone, the ophthalmic proposals should not be taken forward.

**15. Our proposal for A&E is to extend charging of overseas visitors to cover all treatment provided within all NHS A&E settings, including Walk-In Centres , Urgent Care Centres and Minor Injuries Units. Do you agree?**

*Strongly disagree*

**16. If you disagree or strongly disagree with the proposals in A15, do you agree that charging should cover care given within an NHS A&E setting if an individual is subsequently admitted to hospital, or referred to an outpatient appointment?**

*No*

**17. Are there any NHS funded services provided within an NHS A&E setting that should be exempt from a requirement to apply the Charging Regulations (e.g. on public protection grounds?**

No comment

**18. Do you have any comments on implementation of the A&E proposals?**

***Policy Proposals****These questions focus on eligibility for free care within Emergency Care. Currently, charging regulations do not apply for A&E services. However, chargeable patients are charged for inpatient and outpatient appointments and treatment.*

*The new proposal plans to extend charging into all parts of emergency care, including A&E. Patient-based and treatment-based exemptions sets out at secondary care will still apply. Immediately necessary and urgent can cannot be withheld from chargeable patients, but hospitals will seek payment before treatment where appropriate. Chargeable patients will be charge at 150% of the tariff.*

We believe that the consultation’s proposals to extend charging into all A&E treatment – especially when considered alongside the proposals for primary care - are unworkable, uneconomic and not practically viable.

A&E is already under considerable pressures and is struggling to cope with its existing commitments. In 2013, the Health Select Committee note that staffing issues and raising attendances were among the main causes of problems in A&E treatment.[[15]](#footnote-15) The Committee also noted that more than 300,000 patients waited longer than they should have to be treated in A&E – a 39% rise on the previous year. This is accompanied by an increase in the number of people being admitted to hospital from A&E, with an additional 356,000 admissions in England in 2014 – 15.[[16]](#footnote-16)

In discussions about the increased pressures in A&E, commentators often reference ‘inappropriate’ use of the A&E services as a significant contributory factor. The Department of Health recognised in 2012 that “there is some evidence of higher and sometimes inappropriate use of A&E by short term visitors and others who may experience barriers to registering with a GP.”[[17]](#footnote-17) It is then fair to assume that by restricting free access to primary healthcare – either through fears of charging or the reality of being charged – we can expect increased use of A&E services once conditions reach a critical level.

In this context, it is all the more important to ensure that individuals are not discouraged in any way from accessing GP surgeries, as this will trigger late and emergency admissions at A&E, and in turn contribute to longer waiting times and further compromise patient safety. The proposals to limit access to primary care for certain groups of migrants are counter-productive to the general trajectory of the NHS towards promoting preventative care and early intervention.

Fundamentally, by the time a patient is admitted to A&E, it is unlikely that their treatment will either be routine or optional. However, chargeable patients in an A&E setting will need to have their condition assessed by a clinician in order to identify whether or not the treatment is immediately necessary or urgent (and therefore must be provided prior to payment), or whether it is routine or optional (and therefore must be paid for / deposit paid in advance of treatment). This places an extra administrative burden and ethical strain on clinicians in an already over-stretched department.

There are also a number of clear practical barriers and issues which raises questions about charging for emergency treatment. Firstly, it is very difficult to obtain information from a patient during a medical emergency, especially after an accident, or when they are acutely ill. It is difficult to see how Overseas Visitors Managers would be able to have informed, detailed conversations with patients in order to explain someone’s chargeable status when someone is in a critical condition. It is also unlikely that the individual patient will have brought with them proof of their immigration status in the UK.

Secondly, it will be increasingly difficult to obtain informed consent from patients who do not have adequate English, especially within an emergency setting. The time needed to fully discuss the possibility of being charged for care and allow for patients to make an informed decision on the healthcare they decide to access, has the potential to delay important and necessary treatment. It may also lead to cases whereby a lengthy assessment of eligibility for free care delays the provision of treatment, or where patients are discriminated against as staff seek to make quick decisions because of resource pressures.

Thirdly, organisations have already reported misinterpretations of charging regulations set out at secondary care. There are instances where patients – who meet patient-based exemptions to charging – have been wrongfully charged for secondary care, and are pursued for payment by hospital trusts. It often involves the intervention of a third party (often a charity or advocacy group) to rectify errors made. Wrongful charging of patients who meet an exemption primarily because of their vulnerability has significant impacts on the individual patient, as well as contributing to generalised fears of charging within healthcare. As articulated in other parts of this consultation, we do not believe it is appropriate to expand charging regulations into new parts of healthcare when the current regulations are not being accurately enforced.

Finally, concerns about extending charging into all areas of emergency care were raised in the 2013 consultation. A piece of qualitative research undertaken with health professionals for the Department of Health found that respondents “questioned whether a charge should be levied for genuine emergencies and very importantly, what the effect might be on patients who are unable to pay.”[[18]](#footnote-18) The Department of Health noted that in the consultation, “the majority of responses were opposed to the proposals to extend charging into other services … Clinical concerns extended to charging for A&E, again associated with delay in treatment whilst eligibility was established and also with the ethical considerations.”[[19]](#footnote-19)

Our concerns about the potential impact of extending charging into A&E remain have not changed since 2013. The confirmation from the Department of Health that immediately necessary and urgent treatment will continue to be provided regardless of a patient’s ability to pay does not fully compensate for the potential impact on patient health and wellbeing, public health and health inequalities. For all of the above reasons, we do not believe that charging should be extended to A&E care.

**19. Our proposal for ambulance services is to introduce charging for all treatment delivered by NHS Ambulance Trusts. This would include any cost incurred for treatment delivered by NHS paramedics, including at the site of an accident, any use of ambulance services, and any treatment carried out outside an A&E department or equivalent. Do you agree?**

*Strongly disagree*

**20. Do you agree that the Government should charge individuals who receive care by air ambulance?**

*Strongly disagree*

**21. Do you have any comments on implementation of the ambulance service charging proposals?**

***Policy Proposals****These questions focus on extending charging mechanisms into services provided by NHS Ambulance Trusts. Chargeable patients would be charged at 150% of the tariff for any care they receive from NHS paramedics and any use of ambulance services.*

We do not believe that the Department of Health should introduce charges for the use of ambulance services. The reasons we broadly oppose the introduction of charging into emergency care settings are set out in Q18. However, we have some concerns which are specific to the care provided by paramedics.

Firstly, care provided by ambulance services is not always urgent and immediately necessary; paramedics provide more than just emergency care. It is unclear whether paramedics will be expected to check the immigration status of individuals in order to assess whether they are duty bound to provide routine or non-urgent treatment, or need to first obtain payment or a deposit.

Secondly, it would be impossible to require paramedics to charge patients at the site of an incident or accident. They do not have the practical means to process payment, assess someone’s immigration status (and eligibility for free care) as well as provide care.

Finally, introducing charges for ambulance services for certain categories of migrants raises significant questions about who would be chargeable. If a passer-by calls an ambulance for a critical ill individual who turns out to be chargeable, is it fair for the patient to be charged for a service he did not choose to have? Similarly, when it comes to providing care at the site of an accident, the provision of care by paramedics is often a matter of life or death. Introducing charging into such a critical aspect of emergency care seems both unethical and impractical.

We recommend that charges are not extended into the provision of ambulance services.

**22. Our proposal assisted reproduction is to create a new mandatory residence requirement across England for access to fertility treatment where both partners will need to demonstrate they are ordinarily resident (in the case of non-EEA citizens this includes having ILR in the UK) in order for any treatment to begin. Do you agree?**

*Strongly disagree*

**23. We propose removing the right to access NHS funded fertility treatment from those who have paid the health surcharge. This will not affect any other care given by the NHS. Do you agree?**

Strongly disagree

**24. Are there any other services that you think we should consider removing access to for those who have paid the health surcharge?**

No. The Department of Health stated at the end of the 2013 that “on consideration, we believe that exclusions would be contrary to the principles of the surcharge and that all treatment should remain freely available on the basis of clinical need. We will not therefore apply any such exclusions when the surcharge is introduced and would only consider this in the future in the event of any exceptional and compelling specific justification.”[[20]](#footnote-20)

**25. Are there any other groups or individuals who you believe should continue to have access to NHS funded fertility treatment even if they are not OR or have ILR?**

***Policy Proposals****These questions focus on eligibility for NHS funded fertility treatment. It aims to restrict NHS funded fertility treatment to those who are ordinarily resident in the UK (in the case of non-EEA citizens this will include having indefinite leave to remain). Both partners will need to be ordinarily resident in order to be eligible for NHS funded fertility treatment. Those who paid the health surcharge will no longer be eligible for NHS funded fertility treatment.*

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**26. Our proposals for non-NHS providers and out-of-hospital care is to standardise the rules so that NHS funded care is chargeable to non-exempt overseas visitors wherever and by whomever it is provided.**

*Strongly disagree*

**27. Are there any non-NHS providers that should be exempt from a requirement to apply the Charging Regulations?**

Yes. Charities, voluntary and community organisations and providers who are established as social enterprises. We believe that charging should not be extended to third-party providers, as these bodies are often providing crucial services to hard to reach communities and vulnerable sections of society. It is in the best interests of these individuals and the wider community that they receive free treatment.

**28. Are there any NHS funded services provided outside hospital that should be exempt from a requirement to apply the charging regulations?**

***Policy Proposals****These questions focus on eligibility for NHS funded services provided outside hospital settings. Currently, no non-NHS body providing NHS-funded healthcare can apply charges to overseas visitors. However, new proposals plan to extend charges for non-exempt patients wherever, and by whomever, it is provided. Care will be charged at 150% of the tariff.*

Yes. Mental health services, hospices, drug and alcohol related services, sexual and reproductive health services, maternity and children’s services; healthcare targeted at migrants with irregular status and/or with no recourse to public funds. Mental health services are a perfect example where preventative care is significantly cheaper than crisis provision. DATA?

In areas with high numbers of dispersed asylum seekers, there are a number of specialist clinics that are funded by the local CCG to provide healthcare to people seeking asylum, refugees and irregular migrants. These clinics exist precisely because local CCGs have recognised the specific vulnerabilities and health inequalities faced by this patient-group. Clinics providing this service – as well as CCG funded 3rd sector services - must be exempt from applying the charging regulations.

**29. Are you aware of any data on the number of overseas visitors that access NHS funded care provided by non-NHS bodies, or outside the hospital setting?**

*No*

**30. Are you aware of circumstances where someone who may not be ordinarily resident in the UK is receiving NHS Continuing Healthcare or NHS funded Nursing Care?**

*No*

**31. Do you think NHS Continuing Healthcare or NHS funded Nursing Care should be covered by the NHS Charging Regulations?**

*This area of the consultation falls outside of the remit of our work with refugees and people seeking asylum.*

**32. Our proposal for defining residence for EEA nationals is to exclude EEA nationals from being considered ordinarily resident in the UK for the purposes of receiving free NHS healthcare if another member state is the country of applicable legislation or otherwise responsible for funding their health care. Do you agree?**

*This area of the consultation falls outside of the remit of our work with refugees and people seeking asylum.*

**33. Our proposal for recovering NHS debt of visitors resident outside the EEA is that where NHS debt is incurred and is not repaid by a visitor, payment should be sought from the individual providing third party financial support of their application when the visitor can not otherwise show that they have sufficient funds available whilst they are in the UK. Do you agree?**

*Strongly disagree*

**34. Do you have any evidence on the impact of the proposal of recovering debt from a third party on NHS recovery or any comments on the implementation of this proposal?**

***Policy Proposals****These questions focus on cost recovery chargeable patients who are unable to meet their debts. The Department of Health proposes that charges can be recovered from the third party financial support of their application to visit the UK.*

**35. Our proposal for overseas visitors working on UK-registered ships to remove their exemption from NHS charges.**

*N/A*

**36. Do you think there are any other healthcare services not mentioned in this consultation that you feel we should consider for the extension of charging?**

*No*

**37. Do you have any comments on the assumptions made in the impact assessment accompanying this consultation?**

***Policy Proposals****Alongside the consultation, the Department of Health issued an impact assessment that aimed to look at the intended effect of the policy changes, the key risks and the key mitigations against those risks.*

*According to the Department of Health, the intended effect of the policy change is “for the NHS to receive a fairer contribution for the cost of healthcare it provides to individuals who are not resident in the UK.” The key risks identified are possible delays in the provision of care due to eligibility assessments, deterrence from accessing care, and that the costs of the new infrastructure would outweigh the benefits (or charges recouped). The Department of Health outlined two key mitigations to address these risks. Firstly, GP and Nurse Consultations will remain free. Secondly, immediately necessary and urgent treatment will continue to be provided regardless of a patients’ ability to pay.*

*This question is an opportunity to state whether you believe the policy proposals as a whole will meet the Department of Health’s own aims, and whether the mitigations and exemptions granted by the government are enough to minimise potential risks.*

We have a number of concerns about the assumptions made in the impact assessment accompanying this consultation. The impact assessment fails to address a number of concerns raised in the previous 2013 consultation as well as other concerns relating to the economic viability of the new policies, the impact on NHS staff, and wider public health concerns.

**i) Economics**According to the Department of Health, the intended effect of the proposed policy is for “the NHS to receive a fairer contribution for the cost of healthcare it provides to individuals who are not resident in the UK.”[[21]](#footnote-21) However, in the same document, it outlines the principle financial risk of extending charging into primary care and A&E is that “the costs significantly exceed what is expected and outweigh the benefits.”[[22]](#footnote-22)

Concerns about the financial inefficiency of the primary care and A&E proposals were raised in 2013 by the Chair of the BMA Council, the Chair of the Royal College of GPs, and in the Department of Health’s own qualitative research with health professionals.[[23]](#footnote-23) We do not believe that the Department of Health have provided any further evidence in the consultation document or impact assessment to address the concerns about cost efficiency.

We are particularly concerned that there is yet to be a full evaluation of the cost efficiency and practical application of the charging system set out in secondary care. In 2014, the Department of Health stated that “decisions about progressing with the later phases of the Programme will be based on, and contingent upon, demonstrated achievements in the earlier phases.”[[24]](#footnote-24) In the current impact assessment, the Department of Health refers to "significant achievements”[[25]](#footnote-25) made in the recovering of charges at secondary care; however they have not provided accompanying evidence to substantiate this statement. We believe it is unwise to replicate the system set out at secondary care into other parts of healthcare before fully establishing whether the current system is economically efficient and meets the healthcare needs of vulnerable people.

As explained earlier in this consultation response, there is a disjunct between the supposed subject of these policies and those who will be impacted by it. The consultation outlines a whole set of proposals designed to charge short term visitors to the UK, but after the introduction of the health surcharge, those that are now chargeable for care are more likely to be those who have been resident in the UK for a long time, but without indefinite leave to remain in the UK. Those with limited leave to remain or someone whose immigration status has changed following a termination of employment or other circumstances, will have paid towards their healthcare costs through general taxation. Treating long term residents – albeit with irregular status or limited to leave to remain – the same as short-term visitors in the same way is unfair.

The reality remains that many of those who are deemed to be chargeable under the current regulations set out a secondary care cannot afford to pay for the healthcare they receive. For irregular migrants – especially destitute refused asylum seekers – this is particularly true. They have no right to work and no recourse to public funds, leaving them without any means to pay charges accrued for healthcare. It is likely the costs incurred by NHS Trusts in pursuing chargeable patients may outweigh any recouped charges.

Health professionals should have the power to waive a charge when they consider it cost effective to do so (e.g. the patient does not have the means to pay and not treating them would most likely lead to them presenting again either at a GP’s surgery or at A&E once their illness requires urgent treatment). Similarly, health professionals should always have the ability to waive charges where it would risk public health not to treat the patient.

**ii) Assumptions about administrative capacity in primary and emergency healthcare settings**The impact assessment also makes a number of assumptions about the costs of identification, invoicing and charge collection rates in primary care: according to the Department of Health, the costs will be “equal to those in secondary care.”[[26]](#footnote-26) This is highly unlikely as this is the specific function of OVMs in secondary care, while GP surgeries do not have a dedicated resource for this work or the same administrative capacity to absorb the extra workload. It will fall to GP receptionists to undertake complex patient assessments to establish eligibility to free services. Considering the problems already faced by vulnerable migrants in registering for primary care services – when they are fully entitled to do so – due to misinformation amongst frontline staff, we are concerned that expecting a non-specialist to carry out this sensitive assessment alongside other duties will result in further mistakes and wrongful refusals of care. It is also improbably that non-specialists who are performing very different roles to OVMs will have the same identification, invoicing and charge collection rates.

We also believe that the assumption that each new patient registration will take an additional 1.5 minutes due to the addition of questions required to identify non-UK residents who are chargeable – based on a 2015 pilot determining whether patients had EHIC cards – underestimates the complexity of establishing the status and eligibility of non-EEA residents. Non-EEA residents will have to prove their immigration status with accompanying documents, which they may or may not have with them at the point of accessing either primary care or emergency care. The additional time needed to chase up patients, cross-check data, or query documents has not been factored in to this impact assessment. Indeed, in a screening exercise carried out by the Department of Health’s researchers in 15 trusts in 2013, the category of visitor could not be determined in over a third of cases and their nationality was unknown in 41% of these cases. The report for the Department of Health noted that administrators “may need to spend considerable time trying to establish the patient’s situation.”

Case Study, Bradford

*A lady arrived via family reunion heavily pregnant with twins. She spent some time in hospital in Manchester before moving in with her husband in Bradford. She was sent a bill from the hospital for the maternity care she had received.*

*The hospital trust would not accept evidence from the refugee support worker that the women was the wife of a refugee and insisted that the mother travelled to Manchester in person with the relevant documentation to prove her immigration status.*

*Once she had travelled to Manchester, the ID was accepted and the charges dropped.*

A number of refugee-support organisations have also reported instances where fully exempt patients are being wrongfully charged for care.

Case Study, Bradford

*A new refugee sought support from a refugee support organisation in Bradford at the end of January 2016 with a letter from the NHS trust saying he owed £7,698.75 for treatment carried out in October – November 2015. The covering letter stated that he hadn’t paid and he must pay immediately or it could affect his immigration status if he has debts with the NHS. On further investigation by the refugee support organisation, it was discovered that he had his refugee status issued in June 2015.*

Fundamentally, identifying who is chargeable and who is not is extremely complicated. Many people will struggle to prove entitlement, including vulnerable British residents (e.g. homeless people, those with mental health problems) or those who do not have a passport or other documentation. Equally, the only way to check eligibility for NHS services in a way which does not contravene equality law is to check everyone. In the case of asylum seekers, their status could change from exempt to chargeable and back to exempt in a matter of weeks. Patients will need to have repeat eligibility checks in order to keep records up to date. The extent of administrative time needed to do this is underestimated in the impact assessment.

We are also acutely aware of the current proposals in the Immigration Bill 2015-2016 relating to support provision for refused asylum seekers. If these proposals become law later this year, the type of support refused asylum seekers are eligible for will change significantly. As a refused asylum seekers’ entitlement to free NHS care is dependent on whether or not their receive support from the Home Office, we encourage the Department of Health to ensure that any charging regulations and exemptions are updated to reflect the new support mechanisms for refused asylum seekers.

**iii) Expensive set up costs**

We also believe that the impact assessment has underestimated the costs of training NHS staff to fairly and efficiently identify chargeable patients. Staff across all levels of NHS care will need to be provided with training so they can accurately identify immigration status and their eligibility for free healthcare. This has not been accounted for in the impact assessment.

The impact of not providing sufficient training to NHS staff on migrant eligibility for NHS care in England is already evident in the existing barriers to care faced by vulnerable people. Members of the refugee sector already report numerous instances where wrongful charging or refusal of registration is only challenged once the individual seeks support from an advocate. The knock-on costs to the third sector organisations advocating for the healthcare rights of their clients has not been considered in this impact assessment.

Whilst the impact assessment does make clear that before a charging system can be introduced “a technical solution to improve NHS IT systems so that chargeable patients can be identified” needs to be found and states that “the precise specifications of the IT enhancement required to support this policy are uncertain.”[[27]](#footnote-27) In order for the systems to work, the NHS and Home Office will need to set up an integrated database, with accurate and up to date records. Historically, setting up efficient complex IT systems has been a particular challenge for the NHS and the Home Office. For this reason, we can expect the IT costs to exceed the £5 million estimate.

The introduction of charging into primary care will also require substantial expenditure in relation to set up costs, including setting up Wi-Fi in every practice, machinery to take payment, and creating the people and space in GP surgeries to carry out transactions and pursue payment.

**iv) Wider costs of barriers to early-intervention**The impact assessment does recognise that “the principle health risk of any policy that introduces charging for healthcare is that there will be a reduction in patients accessing the healthcare they need.”[[28]](#footnote-28) Whilst we welcome the Department of Health’s commitment to keeping GP and Nurse consultations free for all, we do not believe this is a sufficient mitigating measure to prevent vulnerable individuals from being deterred from seeking healthcare.

A reduction in proactive health-seeking behaviour will bring significant knock on costs for the wider community, local authorities and the NHS. Firstly, it is universally accepted that preventative and early-invention care is cheaper and more effective than emergency interventions after a condition has deteriorated. For example, treating type II diabetes-related complications is around 9 times more expensive when it has not been diagnosed and treated in a primary health setting.[[29]](#footnote-29) The potential increased costs of treating patients who have deferred treatment due to the threat or reality of being charged for treatment has not been factored into the impact assessment.

Health problems don’t disappear just because you don’t treat them. Establishing barriers to primary care will result in minor health conditions deteriorating into chronic, expensive to treat conditions which will be bottle-necked into emergency care. Leaving health conditions untreated at early stages also can have significant impacts on public health. Local authorities across the UK are currently experiencing significant cuts to public health budgets; £200 million has been cut from ring-fence Public Health grant nationally. For example, in 2016-2017, Leeds City Council will lose £3.9 million from its public health budget. In the words of Leeds’ executive member for health, wellbeing and adult services, “this is at a time when we know the future survival of the NHS depends on everyone’s health improving in our communities so that less demand is placed on hospitals and GPs.”[[30]](#footnote-30) Narrowing access to preventative healthcare whilst cutting public health budgets could create a perfect storm where health inequalities rise and the general health of the population declines.

We also have concerns about the potential proliferation of unregulated private healthcare providers and quack doctors if access to free healthcare in England is further restricted.

**Overarching final comment**- whole policy proposal runs counter to the self-stated principles at the beginning of the document
- also threatens some of the core values of the NHS
- dealing with an unquantified problem with dangerous proposals
- impact of this done badly is significant – deaths, and higher health inequalities
- costs will outweigh benefits
- unconvinced by economics, or ethics.

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2. *Ibid,* p.15 [↑](#footnote-ref-2)
3. [*Making a Fair Contribution: A Consultation on the extension of charging overseas visitors and migrants using the NHS in England,*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/483870/NHS_charging_acc.pdf)p.11 [↑](#footnote-ref-3)
4. [*Sustaining Services, Ensuring Fairness: Government Response to the consultation on migrant access and financial contribution to NHS provision in England*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268630/Sustaining_services__ensuring_fairness_-_Government_response_to_consultation.pdf), Department of Health (2014) p.14 [↑](#footnote-ref-4)
5. [*Ensuring fair use of the NHS efficiently and effectively: Do No Harm*](http://www.demos.co.uk/files/Demos_DoNoHarmREPORT.pdf?1413823102)*,* Demos (2014), p. 13 [↑](#footnote-ref-5)
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8. *First Do No Harm: Denying healthcare to people whose asylum claims have failed*, Refugee Council (2006), p.10 [↑](#footnote-ref-8)
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11. *Ibid,* p. 5 [↑](#footnote-ref-11)
12. Doctors of the World, 2015 [↑](#footnote-ref-12)
13. [*Patient Registration: Standard Operating Principles for Primary Medical Care (GP*](https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf)*),* NHS England (2015) [↑](#footnote-ref-13)
14. [*Making a Fair Contribution: A Consultation on the extension of charging overseas visitors and migrants using the NHS in England,*](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/483870/NHS_charging_acc.pdf)p.15 [↑](#footnote-ref-14)
15. BBC, *A&E crisis plans “not good enough” MPs say,* 4 July 2013, <http://www.bbc.co.uk/news/health-23423796> [↑](#footnote-ref-15)
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18. Creative Research, *Qualitative Assessment of Visitor and Migrant use of the NHS in England,* 23 September (2013), p.27 [↑](#footnote-ref-18)
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22. *Ibid,* p.11 [↑](#footnote-ref-22)
23. See BMA Press Release, *Government’s migrant charging proposals are impractical, uneconomic and could damage the NHS, warns BMA,* 28 August 2013. [↑](#footnote-ref-23)
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