Department of Health

Questionnaire: Consultation on making a fair contribution

A consultation on the extension of charging overseas visitors and migrants using the NHS in England

Complete the questions below and email this form to:
nhscostrecovery@dh.gsi.gov.uk

Or alternatively, please write to:

Cost Recovery Programme

Department of Health

506 Richmond House

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London SW1A 2NS

QUESTION 1: We propose to apply the existing secondary care charging exemptions to primary medical care and emergency care.

Do you agree?

Agree

QUESTION 2: Do you have any views on how the proposals in this consultation should be implemented so as to avoid impact on:

- people with protected characteristics as defined under the Equality Act 2010
- health inequalities
- vulnerable groups?

Yes

If yes, please explain.

Our group is made up of elected members who lead on asylum issues for Oldham council (Cllr Susan Dearden) and Bury council (Cllr Rishi Shori), and local voluntary sector partners (Oldham Unity, Eagles Wing and Regional Asylum Activism). We have come together to identify solutions to asylum and refugee-related destitution in our communities. As such, we are particularly concerned about the potential effect of these proposals on the vulnerable asylum seekers and refugees we support.

Increased health inequalities:

We are concerned that the extension of charges into primary care, A&E and community healthcare settings will increase health inequalities by creating additional barriers, preventing vulnerable groups to access care. Many of the asylum seekers and refugees with whom we work are already experiencing significant barriers to accessing the healthcare they need, creating health inequalities with the settled population. Most asylum seekers are fully entitled to healthcare under the current system, but are met with receptionists and healthcare professionals who query their entitlements, or they have heard from other people in the asylum seeking community that they will be charged, and so are deterred from accessing services. We believe this will become worse for all asylum seekers and refugees (not just refused asylum seekers) if these propoals are implemented.

There is currently very clear guidance to NHS staff regarding entitlement to primary care, but this has not prevented many vulnerable individuals being wrongly refused access to GP services and the healthcare they need. This is illustrated by the Oldham Unity survey (about which more below), which found that 23% of destitute asylum seekers were not registered with a GP, often because they could not supply proof of address or suitable ID, though recent guidance from NHS England explicitly says this should not prevent registration.

The Department of Health noted in its response to the last consultation on charging that the proposal to extend charging to primary care had generated “significant concerns that this would

increase inequalities". In 'Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England, December 2013,' the Department of Health states in para 54 "From a public health perspective there are many vital services which are accessed through primary care, including infectious disease clinics, screening and childhood vaccination programmes. Even if these continued to be free to all, the threat of a fee could dissuade those who are unsure of their status from seeking care."

In the consultation document, the Department of Health stresses the mitigating steps it has taken to ensure that the charging regime does not increase health inequalities or negatively impact on vulnerable groups. These measures include: ensuring that immediately necessary and urgent treatment is always provided; establishing exemptions from charging for vulnerable groups; keeping consultations with doctors or nurses free; and providing clear guidance to NHS staff. While we welcome and strongly support all these measures, we do not believe that they will adequately address the increasing barriers to accessing services that vulnerable groups will face as a result of extending charges to primary and other healthcare settings or that they will prevent an increase in health inequalities.

We welcome the decision noted within the consulatation to exempt certain groups from charging, including asylum seekers; individuals receiving support under section 95 of the Immigration and Asylum Act 1999 (the 1999 Act) from the Home Office; failed asylum seekers receiving support under section 4(2) of the 1999 Act from the Home Office or those receiving support from a Local Authority; children who are looked after by a Local Authority; victims, and suspected victims, of human trafficking, as determined by the UK Human Trafficking Centre or the Home Office, plus their spouse/civil partner and any children under 18 provided they are lawfully present in the UK; and treatment required for a physical or mental condition caused by: torture; female genital mutilation; domestic violence; or sexual violence. However, we are gravely concerned that all asylum seekers - regardless of status - are not included in this list. Neither are those with Discretionary Leave to Remain and Humanitarian Protection mentioned. We strongly recommend that all asylum seekers - regardless of status - are exempt from charging, along with those with Discretionary Leave to Remain and Humanitarian Protection are exempt from charging.

Vulnerable Groups:

Despite being especially vulnerable to poor health and mental health, destitute refused asylum seekers are currently chargeable for secondary healthcare and would be chargeable for primary and emergency care under these proposals. These individuals would have no means of paying, so the NHS would waste valuable resources pursuing debts it cannot recover. Moreover, failing to treat refused asylum seekers could pose a threat to public health, which as councils we have a duty to prevent.

Oldham Unity is one of a number of local projects providing food support for destitute asylum seekers as part of the Greater Manchester wide Red Cross destitution project. They recently carried out a survey of the health needs of destitute service users. The survey is based on 26 responsese. It found that 23% of respondents were not registered with a GP. These were principally people who had been destitute for more than twelve months. The respondents mentioned that, particularly as they often had no fixed address, it was difficult to register with a doctor and some believed that completing a registration form would mean that information would be shared with the Home Office.

All the destitute asylum seekers who were not registered with a GP had attended A&E in the last 12 months. This demonstrates the extra pressure that emergency services are put under when vulnerable people are deterred from accessing care at an earlier stage.

Unreliable decision-making by the authorities ('A question of credibility: Why so many initial asylum decisions are overturned on appeal in the UK,' Amnesty International and Still Human Still Here, April 2013), coupled with limited access to good legal advice means many people who seek asylum in the UK reach the end of the process without their protection needs being recognised. At this point, they lose access to the accommodation and support provided by the Home Office (they are made destitute), unless they agree to return home. They also do not have permission to workin the UK, so have no means of supporting themselves. However, many people remain in the UK because they continue to fear what might happen if they return home.

Oldham Unity regularly see destitute refused asylum seekers who are charged for secondary healthcare. Being issued with a bill that you have no means of paying is highly distressing for the individual, while advocacy to challenge charges and demonstrate the person has no means of paying also takes up a lot of volunteer and staff time. However, by far the most damaging element is that it prevents that individual from seeking care the next time they need it.

According to the 'Guidance on implementing the overseas visitor hospital charging regulations 2015' (pp 118 - 119), hospitals have the power to write off the debt for accountancy purposes where: "given the NHS chargeable patient's financial circumstances, it would not be cost effective to pursue it (e.g. they are a destitute illegal migrant or are genuinely without access to any funds or other resources to pay their debt)." This is invariably the case for refused asylum seekers.

The charging letters sent to people in this situation warn that if payment is not made, the account will be referred to a debt collection agency. They further state: "We register the debt with your Embassy which will result in future visa applications to enter the UK being rejected […] We will take you to Court and under the County Court Act 1984 Section 69 you will be charged interest on the debt and will be required to pay any court costs […] You will be put on a register of people with County Court Judgements (CCJs) and will find it difficult to get loans or credit of any kind for over six years."

A significant number of people whose asylum claims have been fully refused later submit fresh evidence and are granted refugee protection. Roughly fifty percent of people who apply for asylum eventually get some form of leave to remain in the UK. We are concerned that the charging regime jeopardises their future changes in the UK and is a barrier to integration.

We therefore re-state the need to make all asylum seekers - regardless of status - exempt from charging for primary and emergency care.

Furthermore, we recommend that the Department of Health seeks to work with the Home Office to improve accommodation options for destitute asylum seekers who are to be discharged from hospital. Eagles Wing (an asylum seeker drop-in based in Bury) have supported a destitute asylum seeker for 12 months following her release from hospital, where she spent 3 months and received a bill for £15,000 for treatment, for which she has no means of paying. No one stays in hospital for 3 months unless they are genuinely in need of nursing care. However, her stay in hosptal was further

prolonged because she had no home to return to. 'Bed blocking' costs the NHS a huge amount of money, which in this particular case would not be recoverable. We therefore urge the Home Office to explore housing options that may releave this pressure on the NHS, and the unnecessary costs it engenders.

Risks to public health:

The commitment to exempt from charges tests and treatment for sexually transmitted infections and communicable diseases will be undermined by the introduction of charging to primary healthcare as evidence shows that patients do not proactively seek such screening but have it recommended as part of a routine GP visit. This has significant implications for the wider community as, for example, around 17 per cent of people living with HIV in the UK do not yet know they have it.

It deterrant effect of introducing charging for primary care will also prevent parents from registering their children with a GP and being part of immunisation programmes (see below).

People with protected characteristics:

We are concerned that pregnant women and children are not included within the list of exemptions. A recent survey amongst women with children attending the Oldham Unity destitition project showed that 40% had accessed maternity care while in the UK. To charge for maternity care would increase the risks (and attendant costs) to an already vulnerable group of women (Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature. Soc Sci Med; 2009;68(3):452–6). Moreover, the Royal College of Obstetricians and Gynaecologists noted that pregnant asylum seeking women are seven times more likely to develop complications during childbirth and three times more likely to die than the general population (Centre for Maternal and Child Enquiries (CMACE), 2011, Perinatal Mortality 2009: United Kingdom, London: CMACE). For these reasons, we believe that pregnant women should be added to the list of vulnerable groups which are exempt from charging.

As noted above, the Department of Health already appears to have ackowledged that limiting access to primary care for children would have effects on both prevention and treatment (Sustaining Services, Ensuring Fairness December 2013). Changes to asylum support outlined in the current Immigration Bill could leave the children of parents whose asylum application has been refused without support from the Home Office or Local Authority. As such, they may go through a period of not being eligible for free healthcare under the proposals outlined in this consultation.

We are particularly concerned that vulnerable children will not be covered under vaccination programmes. Drastic cuts to Local Authority public health budgets could leave gaps in the vaccination programme (http://www.ilkleygazette.co.uk/news/14287102.Leeds_to_lose_millions_of_pounds_in__quot_brutal_quot__cuts_to_preventative_health_care/). It is our understanding that children born to a mother that meets one of the patient-based exemptions are only themselves exempt for 3 months. The parent then has to regularise their child's immigration status (including paying the health surcharge) in order for the child to continue to be exempt from charges. (see page 41: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/496951/Overseas_visitor_hospital_charging_accs.pdf). While this is clearly a worry for individual children and their

parents, we are also concerned that creating such gaps within the vaccination programme could seriously jeopardise public health and undermine the investment already made. We stronly recommend that children are made exempt from charging.

All of the above will result in late diagnosis and treatment amongst groups most at risk, with significant long-term costs to the NHS because preventive or early treatment is extremely cost effective, particularly when compared with emergency interventions undertaken after an individual's health has deteriorated and they require urgent or immediately necessary treatment.

Racial profiling and risks to community cohesion:

It must also be stressed that the only way to check eligibility for free NHS services in a way which does not contravene equality law is to check everyone. Reviewing patients' immigration status will be time consuming, costly to administer and frustrating for both patients and NHS staff. It is difficult to see how repeat eligibility checks can be avoided as service providers will have to ensure that a patient's residency status in the UK has not changed over time. The Race Equality Foundation has stressed that the requirement to prove eligibility in order to access healthcare is likely to lead to profiling which will impact disproportionately on BME communities.

Oldham is an extrememly diverse community which has experienced significant cohesion and racial tension issues over the years. We are proud that this has largely been overcome through concerted efforts to build bridges and mutual understanding between communities. Yet primary care charging could reinforce prejudices of staff and local communities and create unnecessary tension with newcomers. For example, at one practice in Oldham with high deprivation levels and many newly arrived migrants and asylum seekers, a lot of extra staff time needs to be spent explaining how the health system works. This draws attention to certain patients and makes regular patients question the newcomers' entitlement to care. Some practices will inevitably take a bigger burden of chargeable patients due to the asylum housing contracts and other factors affecting the distribution of migrants in the UK. The Department of Health and Home Office both need to be aware of the effect a charging regime could have on community cohesion and racial tension.

For all of the reasons outlined above, we do not believe it is possible to implement the proposals in the consultation without having a negative impact on health inequalities, groups with protected characteristics, and vulnerable groups. Not only will the charging regime have a negative effect on the health of an already vulnerable group, but there is no evidence presented to show that they will be cost effective. We therefore urge the Department of Health not to implement these proposals.

QUESTION 3: We propose recovering costs from EEA residents visiting the UK who do not have an EHIC (or PRC).

Do you agree?

Strongly disagree

QUESTION 4: We propose recovering costs from non-EEA nationals and residents to whom health surcharge arrangements do not apply.

Do you agree?

Strongly disagree

QUESTION 5: We have proposed that GP and nurse consultations should remain free to all on public protection grounds.

Do you agree?

Strongly disagree

QUESTION 6: Do you have any comments on implementation of the primary medical care proposals?

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

Yes

If yes, please explain.

The Faculty of Public Health (Health Needs of Asylum Seekers. Faculty of Public Health 2008) has pointed out that whilst many asylum seekers do arrive in the UK in relatively good physical health, health problems can rapidly develop whilst they are in the UK (British Medical Association. 2002: Asylum seekers meeting their healthcare needs.London: British Medical Association). Some asylum seekers can have increased health needs relative to other new migrants, such as mental health problems including PTSD, chronic illness, such as diabetes and hypertension and dental disorders. Others have problems related to injury and/or torture. (Burnett & Fassilo 2000 Meeting the health needs of refugees and asylum seekers. London Department of Health)

The proposals do not appear to be in accordance with the Department of Health's commitment in 2013 that "Vulnerable groups such as asylum seekers, refugees,

humanitarian protection cases and victims of human trafficking will also continue to have free access to the NHS.” We believe these groups need to be listed as they will be granted leave to remain rather than Indefinite Leave to Remain and therefore will not automatically qualify for free health care (Department of Health, Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England, December 2013). We believe that the existing charging exemptions should also be applied to any charging regime introduced into primary or A&E care in order to protect some of the most vulnerable groups in our society.

The aforementioned survey carried out by Oldham Unity shows that 62% of people had been treated for anxiety or depression during the last twelve months. GPs are the primary route for identifying and addressing mental health issues. A particular concern is that there is no reference in the document to community mental health services.Lack of access to mental health support could have a negative effect on a person's family and support network and the public at large.

Eagles Wing was recently involved in a meeting of child care professionals and school staff concerned for the mental health of the child of a refused asylum seeker. They were told that the mother needed psychological care, counselling and therapy but that as this was deemed to be secondary health care, she was not entitled to it. This lady is still suffering and her children are being affected by her being refused care.

We therefore believe that community mental health services should be excluded from charging, on health and public safety grounds, as well as for economic reasons.

The survey also found that 43% of destitute asylum seekers take 4 or more daily medications. GPs play a vital role in prescribing medication for managing long-term conditions. This avenue of support would be interrupted if these proposals are implemented. Barriers to effectively managing long-term conditions will increase the cost to the NHS as the person's condition deteriorates, becoming more acute and expensive to treat.

The Royal College of General Practitioners stated that "Despite the Department of Health’s welcome commitment to retain free consultations with doctors and nurses, individuals will still be deterred from accessing care because they will see little point in taking advantage of a free consultation with a healthcare professional when they do not have the means to pay for any diagnostic costs or medicines required to treat their illness." (Evidence to the Immigration Bill Standing Committee, October 2013). We share the concern that the decision not to make diagnostic testing exempt from charging will be an added deterrant. Access to diagnostic tests is often essential both to diagnosis of medical conditions and the monitoring of chronic problems. There are potential risks to personal and public health if there is lack of access to

free tests. We strongly recommend that diagnostic tests for all patients remain free of charge.

We are aware of increasing demands on general practice, with the possible consequences of an increased use of walk-in centres and A&E departments (Meeting need or fuelling unnecessary demand, Nuffield Trust, 2014). Introducing a charging system would be costly financially and in terms of time. The Department of Health's own pilot study of primary care reception staff asking for EHIC cards found this added an extra 30 minutes a day to staff workload and lengthened each registration by 1-2 minutes (www.gov.uk/government/uploads/system/uploads/attachment_data/file/268630/Sustaining_services__ensuring_fairness__Government_response_to_consultation).

As noted in our response to question 2, to comply with equality leglislation, every patient will have to prove eligibility for free care.The extra staff time noted above will increase dramatically if practices screen every patient.

It would take extra staff time to explain eligibility for free prescriptions if the exemptions outlined in the consultation are implemented. A patients' eligibility for free care would need to be checked each time a prescription is needed as immigration status changes over time. A lot of training - both initial and ongoing - would be required by all staff (receptionists, practice managers, nurses and doctors) in order to operate the proposed system. Interpreters are also likely to be needed, at additional cost.

As this example from local refugee support project, Eagles Wing shows, there is already a lot of confusion about who is eligible for free prescriptions:

"The Eagles Wing in Bury has recently been swamped by our members coming with worrying letters informing them they owe the NHS for recent primary care treatment. When we have phoned on their behalf there is no problem; the person answering the phone says that there is no clear link up between the NHS and the Home Office and so they don’t know, until we phone up, that the patient is an asylum seeker with a valid HC2. They then say there is no problem and ask us to reassure our member, that they have logged our information." However, this experience causes emotional distress for the person who has received the letter, and will deter them from seeking help in the future. It is also a real waste of time for NHS staff and the volunteers at refugee support organisations alike. If the person is a refused asylum seeker, then their HC2 may not be renewed and so the bill stands, despite them having no means to pay.We anticipate the same being true of consusion over who is eligible for free primary care if the proposed charging regulations are brought in.

The integration of databases, both current and proposed, will also be costly and, if past experiences are a guide, might be difficult to implement. There is no costing of this in the proposal.

Moreover, front-line primary care staff, particularly receptionists, could be faced with a potential ethical and legal dilemma regarding refusing access to care because of a wrong assessment of a person's status. Legal challenges could be a further cost to practices.

We strenuously oppose the extension of charging into primary care. However, if the Department of Health does decide to take this forward we would strongly recommend that no charges should be made for diagnostic testing and that the same exemptions as are currently applied to secondary care are also applied to primary care.

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

Do you agree?

Strongly agree

QUESTION 8: We propose removing prescription exemptions for non-EEA residents to whom surcharge arrangements do not apply and who are not in one of the charge-exempt categories identified in section three.

Do you agree?

Strongly disagree

QUESTION 9: Do you have any comments on implementation of the NHS prescriptions proposals?

Yes

If yes, please explain.

As noted above, 43% of destite asylum seekers in the Oldham Unity survey were taking 4 or more daily medications. According to the proposed charging regime, all of these individuals would have to pay for their medication, despite having no permission to work in the UK and no recourse to public funds.

As noted in our answer to question 6, there will be significant costs involved in training NHS staff to properly assess entitlement to free prescriptions. The prescribing clinician would need to check this for every patient. There is no assessment of the implications of this in the proposal. As most prescriptions will be for low cost medications for managing long-term conditions or preventing a deterioration in illness, it is likely to be cost ineffective to charge for them, particularly if by doing so the individual fails to access the medication they need and later needs urgent or immediately necessary care.

We recommend that vulnerable people should be able to access prescription medication. In particular, prescription exemptions should not be removed from children; pregnant women 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; those prescribed contraceptives and other listed medication; and those in receipt of certain benefits.

QUESTION 10: We propose reclaiming the balance of 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

QUESTION 11: We propose removing NHS dental charge exemptions 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 three.

Do you agree?

Strongly disagree

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

Yes

If yes, please explain.

We have a particular worry about dental health in children who would be affected by the proposals. The Faculty of Dental Surgery's recent report 'The State of Children's Oral Health in England' (January 2015) highlights the issues generally.

Oldham Unity have experience of adult asylum seekers who were unable to access NHS dental services having to attend A&E because of severe dental infections.

The British Medical Journal reports that most GPs report regularly managing patients with dental problems despite recognising that they are not trained or qualified to do so (General practitioners' attitudes towards the management of dental conditions and use of antibiotics in these consultations: a qualitative study: http://bmjopen.bmj.com/content/5/10/e008551.full). Removing NHS dental charge exemptions from non-EEA residents to whom surcharge arrangements do not apply and who are not in one of the charge exempt categories will increase the cohort of patients who are unable to access dental treatment and who rely inappropriately on GPs for assistance with dental problems.

Oldham Unity recently made representations to Oldham NHS Dental Services on behalf of a man who received dental treatment shortly after being granted refugee status. He was subsequently sent a bill and was threatened with a County Court

Judgement if he failed to pay. While an asylum seeker on Section 95 support he had a valid HC2 certificate, but there was some confusion as he switched between statuses in the 'move on' period following the Home Office's decision to grant him refugee status. His level of English was poor and he did not understand the steps he needed to take to complete a HC1 certificate for the interim period. This is an example of somebody who is eligible for free care being charged erroneously. The bill caused the man a great deal of distress, it took up time for an advocate to challenge this on his behalf and help him complete a HC1 certificate, it also created administrative costs for the detail practice, and the Court Judgement could potentially have jeopardised the man's future in the UK.

We believe that exemption 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.

QUESTION 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 three.

Do you agree?

Strongly disagree

QUESTION 14: Do you have any comments on implementation of the primary NHS ophthalmic services proposals?

Yes

If yes, please explain.

There is a strong preventative element to free optical care, particularly for children. There is no economic argument given for this proposal. Again there would be training costs associated with implementing this proposal.

An optician's assessment may reveal signs of systemic disorders such as diabetes and hypertension. Early treatment of these problems is cost effective.

As the impact assessment makes clear, this proposal is not cost effective and would cost the NHS an estimated £32.7 million over 5 years. On costs grounds alone the ophthalmic proposals should not be taken forward.

QUESTION 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

QUESTION 16: If you disagree or strongly disagree with the proposals in question 15, 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?

Strongly disagree

QUESTION 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)?

Yes

If yes, please explain.

This is difficult to comment on because the services that would attract a charge are not specified.

QUESTION 18: Do you have any comments on implementation of the A&E proposals?

Yes

If yes, please explain.

Front-line secondary care staff, particularly receptionists, could face a potential ethical and legal dilemma if they refuse access to care because of an incorrect assessment of a person's status.

The effect of charging for primary care could lead to people not accessing care until late into an illness and this would place extra demands on an already overstretched secondary care services.

Late presentation, diagnosis and treatment of most illnesses is inevitably more expensive than early presentation and managment (A systematic rapid evidence assessment of late diagnosis. Caird, Hinds, Kwan &Thomas. EPPI-Centre Report: November 2012).

Conforming with legislation that denies free access to healthcare goes against the instincts of many doctors and healthcare workers and infringes international and domestic ethical codes as well as the Hippocratic Oath and GMC guidance for doctors.

The Department of Health itself 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” (Department of Health, 2012 Review of overseas visitors charging policy, Summary report, April 2012, para.28). The intention to introduce charges for primary healthcare treatment will deter a much greater number of short term visitors and vulnerable migrants from seeking timely treatment from GPs, resulting in these groups making greater use of A&E.

This will impose a considerable additional burden on A&E departments. For example, as a result of the difficulties they have in accessing primary care, homeless people currently attend A&E six times more often than the general population and stay in hospital three times as long. Similarly, as the Oldham Unity survey demonstrates, all the destitute asylum seekers who were not registered with a GP had attended A&E in the last 12 months.

These proposals will threaten the effectiveness of A&E care both for the individuals affected and for the general population, as these individuals will generally end up in A&E when their health has deteriorated and it is more difficult and costly to treat them. This, in turn, will increase pressure on A&E departments and increase waiting times.

Charging for emergency treatment also raises specific practical issues. Firstly, it is extremely difficult to obtain information from a patient during an emergency or when they are acutely ill. Trying to obtain detailed information on their immigration status would often be impractical even if NHS staff had the specialist knowledge required and the patient spoke adequate English to be able to explain their status. In these circumstances patients would also be unlikely to be able to provide evidence that they had Indefinite Leave to Remain.

Clinicians will often need to be involved in deciding whether a chargeable visitor who is unable to pay for care should still be treated because their condition requires immediately necessary or urgent care. Where a clinician identifies symptoms which could be life threatening, undertakes tests, but then does not treat the problem because it has not yet reached the threshold of urgent or immediately necessary, then administrative and clinical time is wasted. The migrant is likely to return to A&E when their health deteriorates, and the whole process will be repeated.

There is also a risk that follow-up checks and the pursuit of charges levied will further waste NHS resources, particularly as many people will be either wrongly charged or unable to pay.

In view of the above, we strongly recommend that charges are not introduced for emergency care.

QUESTION 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

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

Strongly disagree

QUESTION 21: Do you have any comments on implementation of the ambulance service charging proposals?

Yes

If yes, please explain.

Ambulance personnel would have the dilemma of making a decison that might deny access to health care. This would go against their clinical principles and would infringe international and domestic ethical codes. The same challenges around deciding whether the care is 'urgent and immediately necessary' outlined in our response to question 18 would apply.

We are also concerned that in an emergency situation - where a stranger may have called for an ambulance - a person who may be chargeable would not have the power to refuse care, subsequently leaving them facing a large bill that they are unable to pay.

QUESTION 22: Our proposal for assisted reproduction is to create a new mandatory residency requirement across England for access to fertility treatments where both partners will need to demonstrate they are ordinarily resident (in the case of non-EEA citizens this includes having Indefinite Leave to Remain in the UK) in order for any treatment to begin.

Do you agree?

Strongly disagree

QUESTION 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

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

No

If yes, please explain.

No. Treatment should be available on the basis of clinical needs. (Department of Health, Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England, December 2013).

The Department of Health stated at the end of 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.” We do not believe that there are any “exceptional and compelling specific justification” for removing fertility treatment from those who have paid the surcharge, let alone other services.

Once the surcharge is paid, it is our understanding that payees should be able to receive the same treatment as other UK residents. We can only assume the proposal to remove access to fertility from those who have paid the surcharge (as well as other groups) is on cost grounds and would warn of the 'slippery slope' effect where certain groups are excluded from expensive treatments. Indeed, what is to

prevent this then being extended to all other expensive treatments in the future (e.g. for cancer treatment where the costs are far greater than for IVF treatment)? How would this help reduce health inequalities?

QUESTION 25: Are there any groups of individuals who you believe should continue to have the right to access NHS funded fertility treatment, even if they are not ordinarily resident, and (in the case of non-EEA citizens), do not have Indefinite Leave to Remain in the UK?

Yes

If yes, please explain.

The proposal to require both partners to demonstrate they are ordinarily resident/have Indefinite Leave to Remain (ILR) in order to access fertility treatment is disproportionate and discriminatory as it will affect relatively few people, but will mean some British citizens will not be able to access fertility treatment purely because their partner is not a British national.

Furthermore, many individuals who are ordinarily resident and have made a substantial long term commitment to the UK will have to wait many years before they can apply for ILR and access fertility treatment, during which time they may lose the opportunity to have a family altogether as fertility problems are exacerbated as people get older. For example, a refugee would have to wait five years before they can even apply for ILR and most would have been in the UK for many months prior to being granted refugee status while their claims were being determined.

QUESTION 26: Our proposal 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.

Do you agree?

Strongly disagree

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

Yes

If yes, please explain.

We are aware that there are organisations that act as third party providers of care. They are often providing services to those in our society who might be termed 'vulnerable' and 'hard to reach'.

Charging should not be extended to third party providers such as Charities, voluntary and community organisations and social enterprises, as these bodies are often providing crucial services to these hard-to-reach and vulnerable sectors of society. It is in the best interests of these individuals and the wider community that they receive free treatment. Introducing charges for these services would increase health inequalities and potentially increase the risk to public health which Local Authorities have a duty to protect.

QUESTION 28: Are there any NHS-funded services provided outside hospital that should be exempt from a requirement to apply the Charging Regulations (e.g. on public protection grounds)?

Yes

If yes, please explain.

On the basis of people Oldham Unity have seen at the project since 2001, there is a need for non hospital-based NHS-funded services in the following areas: mental health services; children's services; maternity services; contraceptive services, drug and alcohol services, hospices, sexual health services; and services directed at 'hard to reach' groups such as homeless asylum seekers.

It must be stressed that a compelling case for charging for out-of-hospital care has not been made in the consultation and the cost of charging for these services is likely to greatly outweigh the net benefits of providing them for free.

QUESTION 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 (and when the providers of that care are not hospital employed or directed staff)?

No

If yes, please explain (anonymised information only).

QUESTION 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

If yes, please explain (anonymised information only).

QUESTION 31: Do you think NHS Continuing Healthcare and NHS-funded Nursing Care should be covered by the NHS Charging Regulations?

No

If yes, please explain.

Those patients requiring this type of care will be seriously ill and severely impacted if charging where introduced. Furthermore, no evidence has been provided to show that this is a significant problem for the NHS or that the proposal would be cost-effective.

Oldham Unity have not seen any evidence to suggest that this would be a cost-effective approach. A few of the people they have supported over the years have become seriously ill and clinically needed this type of care. If it had not been available, it could have led to a hospital admission, with subsequent higher costs.

QUESTION 32: Our proposal for defining residency 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?

Strongly disagree

QUESTION 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

QUESTION 34: Do you have any evidence on the impact of this proposal on NHS cost recovery or any comments on the implementation of such a proposal?

Yes

If yes, please explain.

We believe it is unreasonable to expect a third party to take on unlimited liability for unforeseen circumstances. An individual should not be expected to take responsibility for an open ended amount of debt that has resulted from an unforeseen event (e.g. a car accident) and which could amount to many thousands of pounds.

We are also concerned this may force destitute asylum seekers into an exploitative relationship with somebody who can provide the required third party financial support.

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

Do you agree?

Please choose one

QUESTION 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

If yes, please explain.

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

Yes

If yes, please explain.

We are aware that the Department of Health's 'Impact assessment: Visitor and migrant cost recovery – extending charging, 2015' points out that the principal financial risk of extending charging into primary and A&E is that “the costs significantly exceed what is expected and outweigh the benefits." There are several aspects to the charging proposals considered in the Impact Assessment where this is clearly the case (for example, in relation to opthalmic services) and many other aspects of the charging proposals that would incur wider costs to other services and the public at large) than have been accounted for.

For instance, the legal consequences and subsequent legal costs of erroneously denying access to either primary or secondary care to someone who is eligible or who needs immediate and necessary treatment, have not been factored in.

There is also no evidence presented in the documentation to show that the system(s) proposed will be practical/workable or efficient. Neither is there data to suggest that the proposals will decrease health inequalities, reduce the workload of health care staff or even offer safer healthcare.

The Impact Assessment assumes that identification, invoicing and charge collection rates in primary care settings will be “equal to those in secondary care.” This seems highly unlikely as this is the specific function of OVMs, while GPs surgeries do not have a dedicated resource for this work. It will fall to GP’s receptionists to undertake these functions alongside their other duties. They have no experience in identifying immigration status and determining the eligibility of people to access services. If charging is expanded to cover primary care, the administrative burden on the NHS will increase significantly and it is improbable that non-specialists who are performing

very different roles to OVMs will have the same identification, invoicing and charge collection rates.

The Impact Assessment assumes 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 primary care pilot carried out in 2015. However, this pilot was only asking question to determine whether new patients had an EHIC card. While collecting the additional data for this purpose may only have taken 1.5 minutes on average, collecting information on the status and eligibility of non-EEA residents is likely to prove much more complicated and time consuming.

Staff in GPs' surgeries carrying out this work will need to be provided with training so that they can accurately identify a person's immigration status and their eligibility for free health. They may also need to attend regular courses so that they are aware of changes to the immigration rules which take place on a regular basis. These costs also do not appear to have been accounted for in the impact assessment.

It should be stressed that the Impact Assessment specifically identifies that the proposals relating to Community Care; NHS Continuing Healthcare; Ambulance and paramedics; changing sponsorship rules; overseas visitors working on UK registered ships; and assisted reproduction as being outside the scope of the assessment. In each case, the Impact Assessment notes that there is either "insufficient details to scope policy at this time" or "no data available and suspected to have a very small effect overall." It is therefore highly questionable whether these proposals are cost effective.

The impact on public health, and the dwindling budgets allocated to Local Authorities for addressing this, have not been taken into account. As our response to question 2 notes, children are likely to be excluded from immunisation programmes as a result of the charging proposals and vulnerable adults are likely to face barriers to accessing sexual health services. The lifetime costs of treating just one person who is infected because their partner did not access a GP when they were suffering from the symptoms of HIV is around £320,000 (Costings from National Aids Trust, Universal access to primary care: a gateway for HIV testing, treatment and prevention, November 2012). In view of this, the charging proposals do not make a convincing case on cost grounds.

We are also concerned about the extra pressure and costs in terms of staff time that the charging proposals will introduce for Local Authority advice services and voluntary and community organisations. As the case studies from Oldham Unity have demonstrated, a great deal of staff time is spent advocating for the health needs of vulnerable people under the current charging regime. This is only set to increase if these proposals are brought in. Crucially, this will prevent these services from delivering vital support to the community.

Finally, the costs involved in setting up and running the administrative and IT systems, along with the additional expenditure incurred from delayed treatment, pursuing debts and defending possible legal challenges, mean that the costs are likely to greatly outweigh any financial benefits and will put the health of individual patients and the wider community at risk.