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Children's Legal Centre

Making a fair contribution: A consultation on the extension of charging overseas visitors and migrants using the NHS in England

Coram Children's Legal Centre Response

Coram Children's Legal Centre (CCLC), part of the Coram group of charities, is an independent charity working in the United Kingdom and around the world to protect and promote the rights of children, through the provision of direct legal services; the publication of free legal information online and in guides; research and policy work; law reform; training; and international consultancy on child rights. Founded in 1981, CCLC has over 30 years' experience in providing legal advice and representation to children, their parents and carers and professionals throughout the UK. The CCLC's legal practice specialises in education, family and immigration law and CCLC operates several free advice phone lines including the Child Law Advice Line and the Migrant Children's Project Advice Line. The Migrant Children's Project at CCLC provides specialist advice and legal representation to migrant and refugee children and young people on issues such as access to support and services. As part of CCLC's work to promote the implementation of children's rights, CCLC has undertaken amicus curiae interventions in a number of significant cases, including in the European Court of Human Rights, the Supreme Court and the Court of Appeal, providing assistance to the court on matters of children's rights and best interests.

Q1: We propose to apply the existing secondary care charging exemptions to primary care and emergency care. Do you agree?

Strongly agree. We also believe that these charging exemptions should be broadened to include all children and pregnant women and all failed asylum seekers – see our response to Q2 below.

Q2: 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?

Coram Children's Legal Centre is extremely concerned about the impact that the proposed changes to access to primary healthcare will have on migrant children, especially those with 'irregular' immigration status (hereafter referred to as 'undocumented'). The Department of Health (DoH) itself has recognised that undocumented migrants, who have no recourse to public funds, are most vulnerable to ill health, are the least likely to have any health insurance, and are the least likely to be able to pay for their own care.[1] Independent research has highlighted the extent to which they are marginalised, vulnerable to abuse and exploitation, and have poor health outcomes.[2]

[1] This is outlined in the Department of Health's 2012 Review of overseas visitors charging policy: Summary Report, at paras 47 -48

2 Prederi. Quantitative Assessment of Visitor and Migrant use of the NHS in England: Exploring the data. London: Prederi, 2013; Britz JB, McKee M. Charging migrants for health care could compromise public health and increase costs for the NHS. European Pub Health 2015; doi: 10.1093/pubmed/fdv043; Poduval S et al. Experiences Among Undocumented Migrants Accessing Healthcare in the UK. International Journal of Health Services; April 2015 vol. 45no. 2 320-333

There are many routes to becoming 'undocumented', which might be summarised by the following:

1. Entering the UK unlawfully and never acquiring any form of regular immigration status (some in this situation may have never come to the attention of the authorities, others may have made an application to regularise their status but had this refused);
2. Coming to the UK on a form of visa (for example, as a visitor or student) and remaining in the UK beyond the date at which that leave expires (individuals in this situation are often referred to as 'overstayers');
3. Making an asylum claim which is unsuccessful and exhausting all possible appeals (often known as 'appeal rights exhausted'); and
4. Being born in the UK to parents with irregular immigration status (a child born in the UK does not automatically acquire British citizenship so there are a significant number of undocumented children who were born in the UK).

A May 2012, the University of Oxford report put the number of undocumented migrant children in the UK at 120,000, with over half born in the UK.[3]

Many undocumented migrants who do not have valid leave in the UK nevertheless cannot leave the UK. There are some situations in which voluntary return is not an option and situations in which someone cannot be forcibly removed from the UK by the government. This may be because there are barriers to their return to their country of origin, such as problems with documentation, their non-acceptance by the relevant national authorities, no feasible route of return, or a medical condition that means they are unable to travel.[4] Or they may have very strong legal claims to remain in the UK, but face obstacles to regularising their status. These obstacles include:

- Lack of knowledge about their legal rights
- Inability to understand the extremely complex Immigration Rules
- Lack of access to legal advice and representation, including the absence of legal aid for non-protection immigration cases and inability to pay privately for legal representation
- Unaffordable application fees for Home Office applications
- Lack of co-operation by partners, including in situations of abuse and domestic violence.[5]

The consultation states that 'it is fair that people who are in the country for a short time, and are not ordinarily resident here, should meet the costs of all NHS healthcare they receive. Our health system as it stands is still overly generous to those who only have a temporary relationship with the UK'.[6] This completely ignores the situation faced by those who have lived in the UK for many years, and may have even been born here and whose relationship with the UK is anything but temporary, but are not 'ordinarily resident' (the definition of which requires the residence to be 'lawful') because they have been unable to take steps to regularise their status. A 'long-term commitment' to the UK is not only evidenced by those who have indefinite leave to remain. CCLC works with a number of

[3] N. Sigona and V. Hughes, No Way Out, No Way In: Irregular migrant children and families in the UK, 2012 at: http://www.compas.ox.ac.uk/fileadmin/files/Publications/Reports/NO_WAY_OUT_NO_WAY_IN_FINAL.pdf

[4] For example, The Refugee Council (2012) Between a Rock and a Hard Place recently illustrated examples of the protection gap for nationals from the Democratic Republic of Congo, Eritrea, Somalia, Sudan, and Zimbabwe who have been refused asylum but may still have a well-founded fear of return

[5] K.Dorling, Growing up in a hostile environment: The rights of undocumented migrant children in the UK, Coram Children's Legal Centre, November 2013

[6] Para 1.19

children and families who will have been living in the UK for a number of years in a variety of circumstances and may make an application to remain in the UK on the basis of Article 8 of the European Convention on Human Rights, which protects their right to respect for family and private life. There is no question that these are children whose lives are rooted in the UK and whose future lies in the UK, and they have strong legal claims to remain although may not have been able to do so due to the barriers listed above.

Lack of a child impact assessment

As was the case prior to the 2013 consultations by the Home Office and the Department of Health,[7] no Child Impact Assessment has been carried out in advance of this consultation being launched. The government has an obligation, under the UN Convention on the Rights of the Child (UNCRC), to 'undertake all appropriate legislative, administrative, and other measures for the implementation of the rights' contained in the Convention,[8] and to ensure that, in all actions concerning children, their best interests shall be a primary consideration. This fundamental principle applies whether the actions are taken by 'public or private social welfare institutions, courts of law, administrative authorities or legislative bodies'.[9] This extends to the formation of government policy and legislation, and, according to the UN Committee on the Rights of the Child and the Joint Committee on Human Rights, [10] child impact assessments are key to fulfilling this obligation and to ensuring that government decision-making centres on the needs and interests of children.[11]

The Supreme Court has held that the UNCRC imposes binding international legal obligations on the UK,[12] and as such, in all actions involving children, the UK must take full account of its obligations under this treaty. The current government has also reaffirmed the commitment made by the Coalition Government in 2010 to give due consideration to the UNCRC when making new policy and legislation. [13] Yet, the consultation makes no reference to children's rights, nor the UNCRC, Article 24 of which recognises the right of a child to 'the enjoyment of the highest attainable standard of

[7] Department of Health consultation 'Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England', August 2013; Home Office consultation 'Controlling immigration – Regulating Migrant Access to Health Services in the UK'

[8] Article 4, UN Convention on the Rights of the Child 1989

[9] Article 3, UN Convention on the Rights of the Child 1989

[10] General Comment No. 5, *General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para. 6)* CRC/GC/2003/5 at paragraph 45.

[11] Joint Committee on Human Rights, *The UN Convention on the Rights of the Child: Tenth Report of Session 2002-03* at paragraph 27.

[12] *ZH (Tanzania) v Secretary of State for the Home Department* [2011] UKSC 4 para 23

[13] **Written parliamentary question (HL1585):**
To ask Her Majesty's Government whether they have any plans to renew the commitment made in 2010 by the Coalition Government to give due consideration to the United Nations Convention on the Rights of the Child when making new policy and legislation, as recommended by the Joint Committee on Human Rights in its report *The UK's compliance with the UN Convention on the Rights of the Child* (8th Report, Session 2014–15, HL Paper 144). (HL1585)
Tabled on: 16 July 2015
Answer - Lord Nash:
The government remains committed to giving due consideration to the United Nations Convention on the Rights of the Child (UNCRC) when developing new policy and legislation and the commitment given by the coalition government stands. We believe that embedding children's rights in government policy can strengthen services and improve outcomes for children.

health'.[14] Article 2 of the same Convention clearly states that the rights within the Convention should be respected for all children within the state party's jurisdiction, 'without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status'.[15]

The UN Committee on the Rights of the Child has outlined that '*children are entitled to quality health services, including prevention, promotion, treatment, rehabilitation and palliative care services. At the primary level, these services must be available in sufficient quantity and quality, functional, within the physical and financial reach of all sections of the child population, and acceptable to all*.' [16] Article 24 on the UNCRC imposes '*a strong duty of action by States parties to ensure that health and other relevant services are available and accessible to all children, with special attention to under-served areas and populations. It requires a comprehensive primary health-care system... [and] barriers to children's access to health services, including financial, institutional and cultural barriers, should be identified and eliminated*.'[17] The Committee urges states to place children's best interests at the centre of all decisions affecting their health and development, including the allocation of resources, and the development and implementation of policies and interventions that affect the underlying determinants of their health.[18]

The duties to safeguard and promote the welfare of children are outlined in domestic law under section 11 of the Children Act 2004 and section 55 of the Borders, Citizenship; and Immigration Act 2009. The November 2010 White Paper, 'Healthy Lives, Healthy People: Our strategy for public health in England', emphasised the importance of 'giving every child in every community the best start in life' and expressed the government's intention that 'high-quality universal services will form the foundations to ensure the strongest outcomes for children and their parents'.[19]

In short, under both domestic law and policy and international legal obligations, every child present in the UK should be entitled to the same healthcare services as nationals.

In not assessing the impact on children at all, the consultation document invariably does not analyse the effect that the proposals will have on different groups of children and young people, including children with disabilities, BME children, children with mental health conditions and so on. In CCLC's view, the introduction of the policy will have a disproportionate impact on BME children, and this should be analysed in detail before any proposals are brought forward.

Under the Health and Social Care Act 2012 there is a legal duty on the Secretary of State and NHS England to reduce inequalities by improving the health outcomes of groups including the

[14] UN Convention on the Rights of the Child, at http://www.unicef.org.uk/Documents/Publication-pdfs/UNCRC_summary.pdf
[15] Article 3, UN Convention on the Rights of the Child
[16] UN Committee on the Rights of the Child, *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*[*] , 17th April 2013, CRC/C/GC/15 para 25
[17] ibid, para 28-9
[18] ibid, para 13
[19] 'Healthy Lives, Healthy People: Our strategy for public health in England', at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

marginalised and vulnerable.[20] Instead these proposals will only serve further to exclude already marginalised groups from accessing care and in doing so increase inequalities, both among the population whose eligibility is limited by the proposals and the British or settled persons, EEA and foreign nationals entitled to access to the NHS. Furthermore, they may lead to discrimination in frontline service delivery as BME patients or those who do not speak English fluently may be particularly targeted for checks. The government is obliged to consider such potential impacts in accordance with its duties under section 149 of the Equality Act 2010.

Impact of proposals and effectiveness of measures to protect vulnerable groups

The current measures proposed by the DoH to protect vulnerable groups include keeping consultations with doctors or nurses free; establishing exemptions from charging for vulnerable groups; ensuring that immediately necessary and urgent treatment is always provided; and providing clear guidance to NHS staff. We do not believe that as they currently stand these will go far enough to protect children. We consider that the proposals will result in persons who are entitled to at least some health care, even if this is only on an emergency basis or an initial consultation with a GP, not accessing the health services at all, including not taking their children to the health services.

The risk of this negative impact has been identified by the DoH and they have committed to evaluate this on a number of occasions. In the Equality Analysis accompanying the 2015 charging regulations it is stated 'the Department will consider on how best to undertake review of the potential unintended consequences on vulnerable groups once the Regulations come into force'.[21] However, no evaluation was made available as part of this consultation.

Notwithstanding the 'safeguard' of keeping initial GP and nurse consultations free, implementing a system whereby patients' immigration status will have to be checked and migrants who have lived in the UK for many years will be charged for primary care will not only create a costly administrative burden for GPs; it will also result in many families, young people and children not accessing healthcare at all due to fear and confusion.

Under the current arrangements access to primary care is already challenging for migrants.[22] This is due to a number of factors including perceived barriers, administrative difficulties (no formal proof of address or ID), lack of understanding of how to access the health system, language barriers and fear of arrest. In 2014 DOTW recorded 109 instances where a GP surgery asked DOTW about someone's immigration status and refused to register them on this basis despite them being fully entitled to do so. CCLC highlighted this problem in its response to the DoH consultation 'Sustaining services, ensuring fairness' in 2013, and continues to see cases where access issues are faced not only for those who would be chargeable under current proposals but also those vulnerable groups who would be exempt such as asylum seekers, refugees and children in care.

[20] Section 1C Health and Social Care Act 2012.

21 Department of Health, Equality analysis: The National Health Service (Charges to Overseas Visitors) Regulations 2015, at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/474853/equality-analysis-charges-ovs-visitors-acc.pdf

[22] in 2014 97% of people of people coming to the Doctors of the World (DOTW) clinic experienced barriers in accessing healthcare and 83% were not registered with a GP https://www.doctorsoftheworld.org.uk/files/uk_report_2014_web.pdf

Case study:

An MCP advice line caseworker spoke to a professional working with a 14 year old, T, in August 2015. T was in the care of social services under section 20, but his social worker had been unable to register him with his GP as the practice was demanding documentation from the Home Office. T was considering making an asylum claim and had an upcoming appointment with a solicitor to discuss this, but did not want to make his decision without legal advice. Capacity issues meant his initial appointment with a solicitor was being delayed by several weeks. His social worker was rightly prioritising his immediate safety and wellbeing, and a health check was integral to urgent concerns regarding his safeguarding. However, health professionals were blocking his access, despite evidence provided by social services of his identity and his status as a looked-after child.

In this context, access to primary healthcare is likely to worsen under the DoH's proposals. This would have serious consequences for these individuals and for society at large. Primary care services are at the front line of early detection of diseases that, if untreated, worsen or become more complicated to treat and require expensive secondary or emergency care. Decisions about whether to present for healthcare will be made on the basis of self-diagnosis, with a strong incentive for vulnerable individuals to struggle on rather than access health services. The longer someone has an untreated infection, the greater the likelihood that they may unwittingly pass it to others. The greater the number of children without access to immunisation schemes, the less effective such schemes will be.

CCLC believes that charging for primary care would create a further barrier to promoting the health and well-being of children and undermine the government's own commitment to an effective childhood immunisation programme with an aim to reduce the incidence of childhood infections.[23] Health protection is normally afforded to children, via surveillance, screening and immunisation in the primary care setting and NICE has already highlighted several groups as being at particular risk of not being immunised including 'those from some minority ethnic groups, those from non-English speaking families, and vulnerable children, such as those whose families are travellers, asylum seekers or are homeless'.[24] Large scale vaccination programmes are made effective through herd immunity. Where a proportion of the childhood population do not access healthcare and to not receive routine childhood vaccinations, herd immunity is reduced for the majority.

Limiting access to primary care will be detrimental for individual and public health, will increase health inequalities in many areas, will damage doctor/patient relationships and will cost far more to enforce than the NHS is likely to recoup.

In short, the proposals to extend questions about immigration status and charging into primary care will increase confusion and fear, and decrease the amount of vulnerable people who will access doctor and nurse consultations.

[23] This commitment is emphasised in the government strategy for children and young people's health (DH 2009a) and the 'National service framework for children, young people and maternity services' (DH 2004).
[24] NICE: *Reducing differences in the uptake of immunisations* at http://publications.nice.org.uk/reducing-differences-in-the-uptake-of-immunisations-ph21/public-health-need-and-practice

Exemptions for vulnerable groups

We believe the list of vulnerable groups to be exempt from charges is not sufficiently comprehensive, leaving vulnerable people being changed for healthcare or are put off accessing healthcare because they fear charges. The following groups should be added to the exemption applied to the existing charging regime and any proposed extended charging regime:

***All* refused asylum seekers:**

Many refused asylum seekers face a genuine obstacle to their departure from the UK. They have very limited access to welfare support or housing, which is likely to be reduced further by the Immigration Bill, and homelessness is common. Refused asylum seekers are exempt from healthcare charges in Wales, Northern Ireland and Scotland (which have similar charging systems to England) because of their vulnerable nature.

Children:

CCLC believes that all children, not only those in local authority care, should be exempt from charges, as is consistent with the UK's obligations under the UN Convention on the Rights of the Child. Studies have pointed to a higher prevalence of unmet health needs among migrant children, often related to reduced use of healthcare services and delayed or inadequate preventative medicine[25]. This is a situation that would only be worsened by creating barriers to accessing care through charging for children. In its response to the 2013 consultation on migrant access to the NHS the DoH highlighted that '*all major NHS stakeholders and professionals from health and public health expressed concern that deterring people from accessing care through GPs would have a significant and negative impact on individual and public health and costs to the service of delayed treatment. In particular they provided evidence regarding the needs of children, pregnant women and women more generally, as groups who would be disproportionately affected by the proposals.*'[26]

Whilst we would encourage the government to exempt all children from any new charging policy, it is important to note that this exemption alone would not satisfactorily protect children. Charging adults, including pregnant mothers and parents of children, will still impact on and potentially restrict access for children, with negative consequences for their health. In order to be true to its commitment to the UK's humanitarian obligations and international obligations, any measures need to ensure that *all* children are still able to access primary and secondary healthcare.

The current exemption from NHS charges for victims of trafficking only applies to those formally accepted as victims or potential victims by the National Referral Mechanism. Whilst CCLC supports this exemption we also want to raise concerns around the limited nature of this category. Children who are suspected of having been trafficked can be referred by agencies to Competent Authorities through the National Referral Mechanism (NRM). However, research has shown there are in practice

25 IOM. Maternal and Child Healthcare for Immigrant Populations. Background Paper. Brussels: International Organization for Migration, 2009

[26] Department of Health. Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England. London: Stationery Office; 2013

a number of obstacles to getting a referral to the NRM process and shortcomings in the identification of people – including children – who have been trafficked. The National Crime Agency makes clear when reporting on this issue that the number of victims of human trafficking is likely to be higher than the number currently identified by the system, as not all potential victims of trafficking were not referred to the NRM[27] and the real number of trafficked children is likely to be far higher than that reported. Thus, very many victims, including those not yet identified, face NHS charges for those healthcare services to which charges to overseas visitors apply[28]. This, and further proposals to charge for primary care, runs contrary to the Government's commitment to address trafficking and modern day slavery. The Minister for Public Health, Jane Ellison said: 'The NHS may be the one public agency to which a victim can turn for assistance not only to address their health needs, but also to seek care and protection from this abhorrent practice'[29]. That victims have access to healthcare is of special importance both to protect their health and because it offers an opportunity whereby they may secure advice and support to escape their abuse. NHS staff are uniquely placed to spot, treat and support victims of trafficking. These staff will, however, likely no longer come into contact with many victims of trafficking if the proposals are introduced, since most will be undocumented and therefore considered as 'illegal', falling outside the scope of entitlement proposed in this consultation. This narrowly defined exemption as it stands therefore undermines attempts by the Department of Health to make progress in supporting trafficking victims, and illustrates the clear need to exempt all children.

Accessing healthcare services are a primary source of identifying women and girls who have had, or are at risk of, female genital mutilation. The Government Multi-Agency Practise Guidelines on FGM state that "Health professionals are key to providing essential support to women with FGM and intervening to prevent girls and women at risk of FGM from being harmed"[30] The Department of Health has a £3million national FGM Prevention Programme underway[31], which will inevitably be hindered where girls do not access healthcare because of fears over costs. This is contradictory to the public statement from the government that the UK would "demonstrate to the world that we are doing all we can to eliminate FGM from our shores"[32]

Care-leavers and families with no recourse to public funds receiving support from a local authority:

In addition, care leavers, who have been looked after by a local authority and a receiving ongoing support, should be exempt from charges. The government should also consider the situation of

[27] http://www.nationalcrimeagency.gov.uk/publications/656-nca-strategic-assessment-the-nature-and-scale-of-human-trafficking-in-2014/file

[28] . (In 2012, around two-thirds of trafficking victims identified by the Serious Organised Crime Agency (SOCA) had not been referred to the National Referral Mechanism (additionally, we assume, victims not identified by SOCA had also not been referred): see SOCA, A Strategic Assessment on the Nature and Scale of Human Trafficking in 2012, August 2013, p6 (paragraph 8) available at http://tinyurl.com/ojfa8e8).

[29] https://www.gov.uk/government/news/supporting-victims-of-modern-slavery-through-healthcare-services

[30] HM Government, Multi Agency Practice Guidelines: Female Genital Mutilation, November 2014, p32

[31] UK Government, Progress on tackling female genital mutilation and child, early and forced marriage since girl summit 2014, July 2015 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/447578/160722_Cross-Govt_declaration_GS_one_year_on__final___2_.pdf)

[32]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384349/FGMresponseWeb.pdf

families receiving support from a local authority under section 17 of the Children Act 1989. Children in these families are owed duties by the local authority as 'children in need'. To charge them for access to healthcare would potentially shift costs onto local authorities, who would be obliged to meet the child's needs but who are unable to bear this additional financial burden.

Pregnant women:

All women receiving maternity services should be exempt from charge. A DOTW report from 2014 on the experiences of pregnant migrant women in the UK highlighted the deterrent effect of charging and entitlement checks in a population with little access to primary care.[33] Antenatal care is frequently received late and often does not meet the minimum standards for care and subsequently puts women and their unborn children at increased risk of costly pregnancy-associated complications. Fear of costs and language barriers were cited by service users as the main barriers for accessing antenatal care.

While the Government asserts that the NHS is 'overly generous to those who have only a temporary relationship with the UK'[2], these proposed changes will make the NHS one of the most restrictive healthcare systems in Europe for undocumented migrants.[34] In a number of EU member states, for example, undocumented children are explicitly entitled to the same level of care as regularly residing and citizen children in their legal framework. These include Cyprus, France, Italy, Spain and Sweden. In Portugal, the law explicitly provides equal access until the age of 16, and broad access after 90 days of residence.[35]

Q3: We propose recovering costs from EEA nationals visiting the UK who do not have an EHIC (or PRC). Do you agree?

Strongly disagree

Q4: We propose recovering costs from non-EEA nationals and residents to whom the health surcharge arrangements do not apply. Do you agree?

Strongly disagree

Q5: We have proposed that GP and nurse consultations should remain free to all on public protection grounds

Strongly agree

Q6: Do you have any comments on the implementation of the primary medical care proposals?

[33] http://www.doctorsoftheworld.co.uk/page/-/DOTW%20Maternity%20Report%202015_FINAL3.pdf
[34] Aleksic D. Provision of Maternity Services for Undocumented Migrants in the United Kingdom and six European Countries: Maternity Action, 2013; Medecins du Monde. Legal report on access to healthcare in 12 countries: Doctors of the World – Médecins du Monde International Network, 2015
[35] http://picum.org/picum.org/uploads/publication/Protecting%20undocumented%20children-Promising%20policies%20and%20practices%20from%20governments.pdf

We welcome the proposal to retain free access to GP and nurse consultations for all and the recognition of the important role of primary care in maintaining access to healthcare for vulnerable groups, reducing health inequalities and protecting public health. However, it is CCLC's views that the proposal to introduce eligibility checks and charging into primary care services will deter vulnerable groups from accessing primary care altogether, undermining the 'safeguard' of maintaining free GP and nurse consultations. Furthermore, we do not believe that it is cost-effective, and workable. See our answer to question 2 for more information.

The DoH 2013 consultation response found 'all major NHS stakeholders and professionals from health and public health expressed concern that deterring people from accessing care through GPs would have a significant and negative impact on individual and public health and costs to the service of delayed treatment.' [36] It is not clear what has changed in the period between that consultation response and this consultation to allay those concerns.

Maintaining universal access to primary care is vital to both individual and public health. Unlike secondary care services, which is restricted to only those with specific, identified needs, the purpose of primary care is to assess the broadest range of health needs and identify how best to meet them. Breaking down components of activity that take place in a GP surgery into chargeable and not chargeable is extremely difficult and likely to lead to confusion and discrimination.

It is not workable to apply to exemptions to diagnostics tests in primary care. It is not clear how tests required to determine whether care is immediately necessary or urgent would be managed. It is not clear whether immunisations would be charged for. If someone goes to a GP but is unable to have diagnostic tests or prescription medication , the value of primary care in preventative and early intervention medicine will be highly limited. Furthermore, the impact assessment could not quantify the savings to be gained from charging for primary medical care services and described that it was likely to make up a small proportion of costs in primary care. This reflects the complexity in unpicking diagnostic tests from general primary care and without an estimate of the likely savings it cannot be demonstrated that it is cost effective to proceed.

Administrative difficulties

Given that the current system is relatively straightforward compared to what is envisaged, under these proposals it is safe to predict that confusion and mistakes will increase significantly. Those responsible for providing primary healthcare will not be experienced in reviewing an individual's immigration status, which can be very complex and often requires a comprehensive understanding of immigration legislation, policy and case law. This will make the screening process slow and resource-intensive and is extremely likely to result in some people being wrongly refused free healthcare, with a consequent impact on their health as well as financial and legal implications for the NHS.

Furthermore, many migrants with the required leave will be unable to show this and prove their entitlement. For example, not all British citizens have a passport or driving licence. There are already

[36] Department of Health. Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England. London: Stationery Office; 2013

existing problems faced by refugees in accessing welfare benefits when they receive status and are moved off Home Office asylum support – these problems would apply in the healthcare context also.

Conversely, refused asylum-seekers who cannot register/are de-registered from their GP's surgery will not be able to obtain the appropriate medical verification that they are too sick to travel (and thereby access section 4 support) or that they are in poor health and should have their reporting requirements to the Home Office reduced or temporarily suspended. Similarly, victims of domestic violence who are seeking permission to remain in the UK after the breakdown of a relationship with a partner who sponsored them will also need evidence of that violence, which will usually come from a GP.

Reviewing patients' immigration status will be time-consuming and frustrating for both patients and NHS staff. In addition, immigration status does not remain stagnant and 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 or the coverage afforded by payment/exemption from the Immigration Healthcare Surcharge has not expired. Such checks are likely to undermine the doctor-patient relationship. In particular, it is likely to discourage vulnerable groups from accessing primary healthcare, because they are concerned about their immigration status or because they cannot afford to pay for a consultation. Creating obstacles to primary health care fundamentally undermines the objective of providing an efficient and effective healthcare system.

The consultation and impact assessment did not describe how primary care would be able to maintain up to date information on a patient's chargeable status's over time but it did describe that they would require a new IT system which has not yet been scoped. Given the very limited cost savings described, the current pressures already existing in primary care and the track record of introducing new IT projects in the NHS, it is difficult to see that implementation of a new IT system would be cost effective.

A research study published in September 2015 found that providing access to regular preventive healthcare for migrants in an irregular situation would be cost-saving for governments[37]. Restricting access to primary care will increase the pressure on parts of the NHS which already struggle with demand and are far more expensive to run.

If people are barred from free access to GPs and are unable to meet the cost of care themselves, they will be left with no choice but to seek care at A&E services. This places unnecessary pressure and costs on emergency services and limits their ability to deal effectively with emergency cases.

Late presentation is particularly concerning when one considers the importance of early treatment for:

- Infectious diseases: Treatment for HIV and TB is free and can prevent onward transmission but this benefit can only be gained if the infection is first diagnosed. Primary care is also

37 EU Agency for Fundamental Human Rights, Cost of exclusion from healthcare 2015

the site of immunisation programmes, for example for MMR, where 95% herd immunity is needed.

- Maternity care: Women who commence antenatal care early in their pregnancy have better maternal and child health outcomes that those commencing care later and reduced need for costly interventions.
- Progressive conditions: There are considerable efforts to improve the ability of GPs to diagnose cancer early, when it can be treated more effectively. When detected early, diabetes can be treated inexpensively, compared to treating complications arising from unmanaged diabetes.

There is significant existing confusion around eligibility in primary care with patients who are entitled access being denied it as detailed under question 2. This will only increase if charges are applied for some services.

Q7: 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 card. Do you agree?

Strongly disagree

Q8: 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 three. Do you agree?

Strongly disagree

Q9: Do you have any comments on implementation of the NHS prescription proposals?

The consultation proposals mean that all pregnant women, children and destitute people living in the UK who are undocumented would be required to pay a prescription charge. This will leave many vulnerable people unable to access prescription medication.

The consultation document does not describe how this proposal can be implemented in a way that is simple and cost effective. The current proposal describes that implementation would require primary care and other prescribers to maintain up to date information on a person's chargeable status and have access to this when issuing a prescription. There is a high risk of discrimination as questions would have to be asked of each patient as to their chargeable status, and each prescribing clinician would need to be trained to ensure the proposals did not result in discrimination. See our response to question 6 for more information.

Q10: We propose reclaiming the balance of the cost 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

Q11: 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

Q12: Do you have any comments on implementation of the primary NHS dental care proposals?

Oral health has an important role in the general health and well-being of individuals and should be recognised as a key part of health services. The consultation proposals would mean that all pregnant women, children and destitute people living in the UK who are undocumented would be required to pay dental charges. This will mean many vulnerable people are unable to access dental care.

Access to preventative dental care is particularly important for children and pregnant women who are more susceptible to problems[38].

The impact assessment attributes only £500,000 of savings of which 86% of income comes from EHIC claims. Most free dental care is preventative and if not provided, people's dental health will deteriorate and they will require more expensive, invasive treatment and admission via A&E and there will be a risk to their health.

This proposal will require each dental receptionist to assess the entitlement of every patient that presents for care. The impact assessment does not quantify the risk of discrimination and the cost of training staff to ask these questions in a non-discriminatory way. Some dental care will meet the definition of immediately necessary and urgent care which must be provided but may be charged for afterwards and again reception staff must be knowledgeable in applying this definition.

Q13: 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

Q14: Do you have any comments on implementation of the NHS ophthalmic services proposals?

The consultation proposals mean that all pregnant women, children and destitute people living in the UK who are migrants would be required to pay for sight tests. This will mean many vulnerable people are unable to access sight tests.

The impact assessment clearly demonstrates this proposal would be far from cost effective given that it would actually *cost* the NHS an estimated £32.7 million over 5 years.

[38] (https://www.rcseng.ac.uk/fds/policy/documents/fds-report-on-the-state-of-childrens-oral-health

Most free optical care is preventative, if not provided people's eye health will deteriorate and they will require more expensive, invasive treatment and there will be a risk to their health. Sight tests include a diagnostic element to identify disease; access to this should be available to everyone.

Q15: 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

Q16: If you disagree or strongly disagree with the proposals in Q15, 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

Q17: 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)

N/A

Q18: Do you have any comments on implementation of the A&E proposals?

Trying to assess entitlement at A&E and whether treatment is urgent or immediately necessary is likely to increase delays, put individuals' lives at risk, and may lead to people being wrongly charged or discriminated against as staff seek to make quick decisions because of resource pressures. 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.

Access to A&E is also an essential part of the public health protection system where people with symptoms of a potentially infectious disease can have them investigated and begin treatment.

The proposal to roll out charging to A&E is not cost effective. The impact assessment calculates a likely return of £5.7 million over 5 years, this represents a tiny proportion of the NHS budget and does not take into account the impact upon clinical staff and the cost of delaying care/people not presenting with infectious diseases.

Q19: 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

Q20: Do you agree that the Government should charge individuals who receive care by air ambulance?

Strongly disagree

Q21: Do you have any comments on implementation of the ambulance service charging proposals?

We do not believe charges for ambulance services should be implemented. It is unlikely this could be implemented in a cost-effective, non-discriminatory way as every patient receiving ambulance care would have to be advised that they might be charged and have their identity and status reviewed. Access to ambulance services for all provide a critical safeguarding role for victims of modern day slavery, trafficking and children.

Q22: Our proposal for 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?

N/A

Q23: 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?

N/A

Q24: Are there any other services that you think we should consider removing access to for those who have paid the health surcharge?

No

Q25: 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

N/A

Q26: 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.

Strongly disagree

Q27: Are there any non-NHS providers that should be exempt from a requirement to apply the Charging Regulations

All non-NHS providers should be exempt from charging regulations. The majority of non-NHS providers provide out of hospital care which is preventative, providing early intervention and community based support. These providers include charities, voluntary and community organisations, local authorities and providers who are established as social enterprises. Charging should not be extended to third party providers such as those highlighted above as these bodies are often providing crucial services to 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. 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.

Sexual assault referral centres (SARCs) and paediatric sexual assault referral centres function as both centres of healthcare and evidence gathering. Provision for victims of sexual assault and rape is a public health provision commissioned by NHS England. These centres are commissioned jointly by the Department of Health, police, clinical commissioning groups and local authorities. Victims may be referred as a police case to the centre, or may make a self-referral.

The SARCs are independent centres offering the full range of sexual health and counselling services together with forensic evidence gathering. The centres operate to allow victims to access these services, including evidence gathering, without reporting to the police. A victim who has undergone forensic evidence gathering at a SARC may then chose to make a report to the police at a different time and evidence may be stored for up to one year after examination. An alternative that required a sexual assault victim pay a fee before receiving these services would place the UK at odds with the Istanbul Convention, Article 50(2); although the UK has not ratified the Convention, as a signatory, the UK must not take steps that are in direct opposition to the aims and Articles of the Convention. Article 50(2) requires that in respect of evidence gathering:

> *2 Parties shall take the necessary legislative or other measures to ensure that the responsible law enforcement agencies engage promptly and appropriately in the prevention and protection against all forms of violence covered by the scope of this Convention, including the employment of preventive operational measures and the collection of evidence.*

It would be anomalous and contrary to the stated aims of the CPS, the refreshed Action Plan to End Violence Against Women and Girls if women and sexual assault victims were charged for evidence gathering, and it is unclear how services provided could be separated between evidence gathering and healthcare, and whether it would be desirous to charge for any services which may lead to the arrest, charge and conviction of a person guilty of offences under the Sexual Offences Act 2003.
If a victim of sexual assault faces a charge for the use of these services, it will diminish the quality of evidence that is available to the police and CPS to proceed to charge. In the *Stern Review*, forensic evidence was described as: *The medical examination is a vitally important part of the evidence gathering process: it can in some cases assist in putting together a case that can go through the system and in ensuring good care for victims*. [p64] While recommending that these services become part of the umbrella of NHS services due to poor clinical standards in some areas of the UK.

The signal that would be sent if these services were chargeable for migrants, even irregular migrants would be that justice is limited based on immigration status and the safety of women and girls, or victims of sexual violence would be compromised by the failure to gather all available evidence.

A SARC also provides information to assist in the prosecution of those responsible for human trafficking for the purpose of sexual exploitation and may therefore be attended by trafficking victims who have no immigration status. Under the Council of Europe Convention on Action Against Trafficking in Human Beings "the Trafficking Convention"; victims of human trafficking are entitled to protection and the aim of the Convention is to provide protection and assistance to all victims of human trafficking; as well as ensuring effective investigation and prosecution.

Q28: Are there any NHS funded services provided outside hospital that should be exempt from a requirement to apply the Charging Regulations

The following services should be exempt: mental health services, hospices, drug and alcohol related services, sexual and reproductive health services including termination of pregnancy, maternity and children's services, healthcare targeted at migrants with irregular status and/or with no recourse to public funds.

The case for exempting community mental health services - which are often delivered by hospital teams – is particularly strong. The individuals who are most likely to impact by the charges such as undocumented migrant, failed asylum seekers, victims of trafficking and torture, are particularly vulnerable to poor mental health. This exemption would avoid situations which put the health of individuals and the general public at risk.

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.

Q29: Are you aware of any data on the number of overseas visitors that access NHS funded care provided by non-NHS bodies, or outsider the hospital setting?

No

Q30: 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

Q31: Do you think NHS Continuing Healthcare or NHS funded Nursing Care should be covered by the NHS Charging Regulations?

No. Those patients requiring this type of care will not be 'short-term visitors'. They 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.

Q32: Our proposal for defining residency for EEA nationals is to exclude EEA nationals from being considered ordinarily resident in the UK for the purposes for 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

Q33: 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

Q34: 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

No

Q35: Our proposal for overseas visitors working on UK-registered ships to remove their exemption form NHS charges. Do you agree?

N/A

Q36: 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

Q37: Do you have any comments on the assumptions made in the impact assessment accompanying this consultation?

Yes.

The impact assessment accompanying this consultation recognises that 'the principal health risk of any policy that introduces charging for healthcare is that there will be a reduction in patients accessing the healthcare they need.' Yet the impact assessment makes the assumption that the current measures described by the DoH to protect vulnerable groups are sufficient, despite there having been no (published) evaluation of this.

The impact assessment does not consider the cost of individuals being deterred from seeking healthcare or wrongly turned away or charged, leading to late diagnosis and treatment of health problems.

The uncertainty around the implementation of key elements of the programme means that the impact upon NHS staff has not been fully quantified and as such the costs of implementation described in the impact assessment are likely to be insufficient and the savings overestimated.
Examples include the IT system in GP surgeries and the clinical time taken to assess eligibility in primary care and A&E.

In order to make the consultation fair, the Government should produce any and all evaluations or evidence that it has relevant to the cost effectiveness, the impact on public health, and the practical implementation of the current healthcare charging system and allow respondents time to consider this as part of the consultation.

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