Response to the Department of Health Consultation: Making a fair contribution

Introduction

This response is submitted by concerned health professionals working in Greater Manchester (and two associates in Liverpool), including: Dr. Pip Fisher, GP Locum and Senior Lecturer; Dr. Sam Campbell, GP at the Alexandra Practice, Whalley Range; Cath Maffia, retired Health Visitor and trainer at TS4SE Cooperative; Dr. Rebecca Farrington, GPwSI at GMW and Lecturer at University of Manchester; Dr. Zalan Allam, GP; Alison Ricketts, Public Health Nurse: asylum seekers and refugees, gypsies and travellers, Stockport MBC; Michael Pullet, Senior Medical Student at University of Manchester; Siobhan O'Sullivan, Senior Medical Student at University of Manchester; Dr Sepeedeh Saleh, Public Health registrar, Health Education North West; Dr Ayman S Jundi, Consultant in Emergency Medicine, Lancashire Teaching Hospital NHS Foundation Trust; Lesley Briscoe, Lead for Midwifery Research and Enterprise, Edge Hill University; and Susan Rixon, Asylum Seeker & Refugee Midwife Liverpool Women's Hospital.

While we recognise it is important to manage the finite resources of the NHS and to recoup expenditure where possible, we do not consider that extending the secondary care charging regime to primary care, as laid out in these proposals, will save money. We think that the proposals will in fact lead to greater spending in the long term as opportunities to deliver more cost-effective preventative care and early interventions will be missed. We also believe that charging for primary care, in whatever manner it is implemented, will increase barriers for the most vulnerable in our society. We are of the opinion that restricting access to primary and emergency care is not only harmful to individuals; it is detrimental to public health and social cohesion. We do not agree that the secondary charging regime should be applied to primary care or emergency care. In answering the consultation questions we hope that the reasons for this will be made clear.

As a group, we have extensive experience of working with asylum seeking and refugee communities (including refused asylum seekers), and we are particularly concerned about the impact these proposals will have on them. Our comments are therefore principally concerned with this group, though they do, in many cases, also apply to other vulnerable migrants.

Asylum seekers in Greater Manchester:

Regional data on asylum seekers are limited but indicate that the North West of England receives the highest numbers of asylum seekers of all UK regions: approximately 24% of those receiving section 95 support from the Home Office in the UK are in the North West.[1] Home Office data report 5, 431 asylum seekers receiving section 95 support in Greater Manchester. Figures for those asylum seekers in receipt of section 4 support from the Home Office are not available at a regional level, but tend to be much lower.

It is impossible to know how many destitute refused asylum seekers live in Greater Manchester at any time given the often transient and socially marginalised nature of this group. A recent report estimated that there are more than 2, 000 destitute asylum seekers and refugees in Greater Manchester, reporting that between 300 and 400 refugees and asylum seekers are helped by non-governmental organisations each week in the area. [2]

[1] Home Office, 2015a. Immigration statistics, January to March 2015. *Statistics- national statistics*. Available at: https://www.gov.uk/government/publications/immigration-statistics-january-to-march-2015/immigration-statistics-january-to-march-2015 [Accessed July 3, 2015].

[2] British Red Cross, 2014. A Decade of Destitution: time to make a change, Manchester.

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

Strongly agree

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

As medical professionals, we strongly assert that the NHS should provide a comprehensive service to all. We abide by the NHS constitution and adhere to the NHS principles. Since its foundation sixty years ago, the NHS has been based on three core principles:

- that it meets the needs of everyone
- that it be free at the point of delivery
- that it be based on clinical need, not ability to pay

Looked at in more detail, the first core principle is about ensuring the NHS provides a comprehensive service available to all. "This principle applies irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to diagnose, treat and improve both physical and mental health. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population."[3]

We are deeply concerned that the charging regime undermines the founding principles of the NHS and undercuts efforts to reduce health inequalities.

2.1 Barriers to primary care increase health inequalities:

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". It further stated that: "From a public health perspective there are many vital services which are accessed through primary care, including infectious disease clinics, national screening programmes, childhood primary vaccination and adult catch-up vaccination. 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."[4]

In the current 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 GPs and practice nurses free; and providing clear guidance to NHS staff.

While we welcome and 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. Our concerns can be summarised as follows:

[3] Principle 1 of the NHS: http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx

[4] 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, para 54.

2.2 Barriers to primary care further disadvantage vulnerable groups:
Refugees, people seeking asylum, vulnerable migrants, gypsies and travellers, and homeless persons already experience significant barriers to accessing healthcare.

There is currently very clear guidance to NHS staff regarding entitlement to primary care. In recognition of the importance and benefit of everyone registering with a GP and in acknowledgement of the barriers faced by vulnerable groups, the latest guidance on GP registration from NHS England, issued in November 2015, emphasises that *"*Inability by a patient to provide identification or proof of address would not be considered reasonable grounds to refuse to register a patient".[5] The guidance was developed in response to the concerns many advocates have raised about the current system and how it excludes asylum seekers from care. It states "The reason for issuing this guidance now is evidence of an increasing number of patients finding it difficult to register with some GP Practices [...] The guidance is designed to clarify the position for all patients, in particular though this issue is affecting migrants and asylum seekers who do not have ready access to documents." Despite this and earlier efforts to enable registration, many vulnerable individuals are wrongly refused access to GP services and the healthcare they need due to confusion over entitlement. We suggest that there are unknown numbers of people already unable to register with a GP.

The guidance clearly provides answers for the GP practices that have for many years been requesting clarity about registration of 'overseas visitors' and people unable to provide specific documentation. We are aware that some practices have been wrongly applying some of the eligibility criteria for secondary care to their registration process. A new set of rules and criteria will inevitably add to the confusion and lead to further exclusions.

Many asylum seekers experience poor health due to a combination of experiences pre-exile, during difficult and frightening or prolonged journeys and through post-exile stressors. They also face psychological challenges associated with claiming asylum in the UK, including being separated from family, friends and culture, and spending long periods waiting to hear the outcome of their application for asylum. On top of this, they invariably experience poverty (living on just £5.28 per day provided by the Home Office) and may go through periods of utter destitution following the refusal of their case, which seriously undermines their health. Asylum seekers may also experience hostility, discrimination or racism within the community, which is an additional source of stress. Finally, people seeking asylum may experience additional language barriers that prevent them from easily accessing health services and making their needs known once access is gained. This, in turn, can lead to delays in diagnosis and gaps in treatment for chronic disease, disability and long term conditions, leading to increased complications. These issues will be compounded by having to check eligibility (which itself has costs in terms of staff time and interpretation), leaving this group exposed to increased health inequalities. In this context, inequality against the wider population that is eligible for free healthcare will inevitably increase.

We would like to highlight the risks of excluding refused asylum seekers – who cannot safely return to their home country – from access to free primary and emergency care. Visitors to the UK generally have a choice, and the means to return home. Refused asylum seekers do not have this choice. Many may have no safe route of passage and some are stateless, others remain fearful for their lives and that of their families were they to return. For those who do wish to return, it can be difficult to access travel documents. Decision-making can be seriously impaired by cognitive deficits that accompany PTSD and other serious mental health problems. It is unfair to the patient and runs counter to doctors' training to refuse treatment on this basis.

[5] NHS England, *Patient Registration: Standard operating practice for primary medical care*, November 2015. https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf

A recent piece of qualitative research conducted with asylum seekers in Manchester found that factors such as fear, uncertainty and stigma are central to asylum seekers experiences and very often have serious adverse impacts on their post-migratory physical and mental health. Most asylum seekers have very limited knowledge of health and social care systems on arrival in the UK.[6] This, combined with uncertainties around the complex asylum system and the overwhelming fear than many asylum seekers have of being returned to a country where they are in danger, means that charges would act as a strong deterrent for asylum seekers (even those who may be exempt) from accessing much needed care. This, in a group already experiencing significant disadvantages in terms of health and wellbeing compared with the rest of the UK population,[7] [8] would risk greatly widening existing health inequalities: running counter to both the founding principles of the National Health Service and the recent 'Five Year Forward View' set out by NHS England (2014).[9]

Many studies, including the qualitative research based in Manchester, noted above, have revealed inconsistencies in health care access for asylum seeker populations, reflecting a need for widespread education of those involved in health care provision about asylum seeker eligibility to medical care. [10] [11] Such confusion, and resulting issues surrounding lack of healthcare access and health inequalities, can only be expected to increase if new healthcare charges are introduced to the system.

Indeed, one GP has witnessed frightened, anxious people with poor levels of English attempt to register and being told to "come back with proof of address and ID." This is a missed opportunity to engage with that person; a hard to reach patient who is eligible for treatment. In many cases the person may never return to the surgery. Even if the guidance for registration states "inability by a patient to provide identification or proof of address…" there is still an understanding that this is a deviation from the standard proof required and this is serving as a barrier for a group with protected characteristics (race, for example in this case).

Even when a person does have documents from the Home Office, they may struggle to understand what these documents say or what they entitle them to due to variation in levels of educational attainment and literacy. Likewise, those who have Home Office documentation verifying their status are also turned away because receptionists do not recognise or understand this documentation. One GP has seen a patient turned away with a slip of paper on which it said "you cannot register because you do not speak English."

Community research on 'Access to GP Services for Refugees and People Seeking Asylum in Salford' conducted in 2013 found that the majority (63%) of people seeking asylum who took part in this research found the process of registering with their GP not very easy or not at all easy. The main reason for not finding it easy was difficulties in finding acceptable proof of address. The vast majority of asylum seekers (73%) also found the process of booking a GP appointment not very easy or not at all easy. The most

[6] Crawley, H., 2010. Refugee Council Chance or choice?, London.
[7] Nyiri, J. & Eling, P., 2012. A specialist clinic for destitute asylum seekers and refugees in London. *British Journal of General Practice*, 62(604), pp.599–600. Available at: http://bjgp.org/content/62/604/599.abstract.
[8] Ramaswami, R., 2012. Why migrant mothers die in childbirth in the UK. *openDemocracy*. Available at: https://www.opendemocracy.net/5050/ramya-ramaswami/why-migrant-mothers-die-in-childbirth-in-uk [Accessed October 22, 2014].
[9] NHS England, 2014. Five Year Forward View, London.
[10] Hooper, B., 2014. Healthcare for all? *MPS Casebook September 2014*. Available at: http://www.medicalprotection.org/uk/casebook/casebook-september-2014/healthcare-for-all [Accessed July 23, 2015].
[11] Poduval, S. et al., 2015. Experiences Among Undocumented Migrants Accessing Primary Care In The United Kingdom: A Qualitative Study. *International Journal of Health Services*, 45(2), pp.320–333. Available at: http://joh.sagepub.com/lookup/doi/10.1177/0020731414568511.

common reason for this was the telephone booking and triage system, particularly difficulties asking for an interpreter.[12]

We believe the new charging regime will add barriers to access for patients and add further levels of complexity for the practice staff implementing it. A critical issue is that many individuals will choose not to register with a GP or access primary care because they think they will be charged and cannot afford to pay, or because they fear accruing unpayable debt, potentially jeopardising their future or that of their families in the UK. We are also concerned that individuals will not be able to show evidence of entitlement to free care and/or NHS staff will wrongly refuse access to healthcare.

Despite the Department of Health's welcome commitment to retain free consultations with GPs and primary care nurses, we are certain that individuals will still be deterred from accessing any care because of a worry that they will not have the means to pay for any diagnostic costs or medicines required to treat their illness. Whether this group comprises only people whose asylum claim has been refused and who find themselves destitute or also people with an ongoing claim to asylum, this is a group who we health professionals would clearly recognise as a section of the population in need of "particular attention" as defined by Principle 1 of the NHS (see page 1), not least around the mental health needs caused by displacement, family separation, destitution and loss of status.

The practical challenges of establishing a person's immigration status and applying exemptions designed to protect vulnerable groups are explored in answers 6.4 and 6.3 below.

2.3 Increased risk of health inequalities for people with 'protected characteristics':
Many people are fearful of volunteering information about their sexuality, race or religion, so GP practices will not be empowered to mitigate the effects on patients with protected characteristics in the face of increased access barriers caused by the charging regime, and inequalities will be increased. If there is increased sharing of information about eligibility between GP practices and the Home Office, people will understandably be less willing to disclose a protected characteristic, which may, in turn, jeopardise the quality of clinical care they receive. Concealing sexual orientation for example would have considerable impact on sexual health including HIV and also potentially mental health conditions. For many, the stigma of disability they have experienced in their home country may prevent disclosure (epilepsy is a commonly hidden diagnosis in some African communities, for instance), and revealing religious beliefs may have been an underlying factor in persecution pre-exile, leading to mistrust of who they can disclose to in the UK.

People with existing health needs and/ or a disability could be doubly disadvantaged, as could pregnant women, who already suffer from health inequalities and are especially vulnerable to health complications during pregnancy. Shockingly, 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.[13] It is our experience that women who have been sexually assaulted - arriving in the UK pregnant as a consequence - are high risk for physical and mental health complications. Interruption or delay of antenatal care through being relocated within the UK must be avoided; however, without a GP and midwife as their advocates to stay in an area it is hard for asylum seekers to challenge such a move.

Currently, midwives experience problems in supporting asylum seeking women when Home Office asylum support is delayed. For example, women who's access to section 4 is delayed have to stay in hospital until

[12] Access to GP Services for Refugees and People Seeking Asylum in Salford - Exec Summary: https://regionalasylumactivism.files.wordpress.com/2014/01/access-to-gp-services-for-refugees-and-people-seeking-asylum-in-salford-exec-summary.pdf
[13] Centre for Maternal and Child Enquiries (CMACE), 2011, *Perinatal Mortality 2009: United Kingdom*, London: CMACE

the midwife is reassured that the mother will have a place to look after her baby. This becomes a safeguarding issue if there is no accommodation, or the accommodation is not habitable or unsuitable for a baby to be cared for in. This situation may occur more frequently if asylum seekers are charged for care.

Another poorly served group who experienced discrimination and may experience increased inequalities under the proposed charging regime are transgender people. A recent New Internationalist magazine edition on transgender reports that the human rights of transgender people are routinely abused in many countries across the globe, with high rates of violence and homophobic attacks. It is important that people undergoing hormone replacement therapy do not have interruptions in their treatment. This could happen if people who have fled to the UK are subject to charges.[14]

There will be a negative effect on members of certain settled BME communities (who are eligible for free care), who share certain characteristics with people who may be chargeable. They will face additional barriers and stigma as a result of the charging regime. 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.

Vulnerable sections of the British population who already face obstacles to accessing healthcare (e.g. homeless people and those with mental health or addiction problems) will also find it even more difficult to prove entitlement to care if charging is introduced for primary healthcare.

Primary care charging could reinforce prejudices of staff and local communities and create unnecessary tension with newcomers. For example, at a 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.

The practical challenges of applying exemptions designed to mitigate the effect of the charging regime on groups with 'protected characteristics' are explored in answer 6.4 below.

2.4 Human Rights and Dignity:

A recent Lancet editorial on 'Health as a Human Right' stated: "it is clear that denial of the fundamental right to health is an urgent and recurring theme that must be addressed by the global community."[15] The proposals outlined in this consultation threaten to compromise this right to health for some of the most vulnerable groups in our community. This would have far-reaching consequences for the UK health service, and our society.

We believe the introduction of new charges would risk serious compromise to human dignity and human rights. With regard to such questions in the past, the Department of Health has officially acknowledged the government's responsibility to comply with the 1976 International Covenant on Economic, Social and Cultural Rights, which outlines the human right to healthcare. [16] This is a serious consideration for the proposed charging regulations, which threaten the human right to healthcare, particularly in areas such as maternity care and cases such as that described below.

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[14] New Internationalist magazine, October 2015. http://newint.org/issues/2015/10/01/

[15] Health—an explicit human right. The Lancet, Volume 387, Issue 10022 , 917.

[16] Department of Health (Equality and Human Rights Group) (2007) Human Rights in Healthcare - A Framework for Local Action. London: Department of Health and The British Institute of Human Rights.

In a recent piece of qualitative research based in Manchester, the following case was revealed: "One asylum seeker described being taken to hospital following a suicide attempt, only to be held outside the accident and emergency department in the ambulance while prolonged conversations were held between medical professionals about his eligibility for treatment." Such scenarios are clearly not in keeping with the founding principles of the NHS, and would increase in frequency if the proposed changes are introduced.

In 2008, the Independent Asylum Commission (IAC) concluded that: "Healthcare should be provided on the basis of need, and asylum seekers should be eligible for primary and secondary healthcare until their case is successful, or they leave the UK; in particular and specifically, that all perinatal healthcare should be free."[17] Any change to these recommendations would need to be Impact Assessed and reconsidered by such an independent panel.

The introduction of charges would, furthermore, require a race equality Impact Assessment to ensure impacts do not discriminate against certain ethnic groups (see points raised in 2.3 above). This, again, has been raised in past consultations and must be borne in mind here. [18]

2.5 Confidentiality - concern over information sharing deterring vulnerable people:
The new charging system will necessitate GP receptionists asking many more background questions than they do at present. This could be intimidating for asylum seekers or refugees, who may fear and mistrust officials as a result of their pre-exile experiences. Although the majority of them will be exempt from charging, this will not lessen the deterrent effect of them worrying about confidentiality, which may go on for many years after getting status in the UK.

One GP works with a refugee doctor who is currently re-qualifying in the UK. The refugee doctor was unwilling to go to an Occupational Health appointment as he feared they would share his details with the Home Office. This demonstrates the level of fear surrounding the sharing of information with the Home Office. In this case, the man was well educated and had status in the UK. The deterrent effect would be even higher for somebody whose status is not yet confirmed.

Many individuals believe they will be reported to the Home Office if they access NHS services. This fear has increased following public reports that 7,766 requests for traces from UKBA were approved by HSCIS in 2010-13.

Another case illustrates the complications caused by fear of disclosing a person's status. One patient who explained she was an asylum seeker had a test that revealed she was HIV positive, and was provided with treatment in hospital. During the antenatal period it was disclosed that she did not have accommodation but was sleeping on a friend's couch. She did not return to the hospital for treatment after this was disclosed. This case shows how difficult it is to keep track of homeless asylum seekers who have been refused and do not have a permanent residence. The risks to the baby are clear in this circumstance.

The Hippocratic Oath states: "I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know." As doctors we have committed to acting in our patient's best interest and to not pass information to a third party. We wholeheartedly reject proposals to enable data sharing

[17] Independent Asylum Commission (IAC) (2008c) Deserving Dignity: The Independent Asylum Commission's third report of conclusions and recommendations. London: IAC and the Citizen Organising Foundation.
[18] Aspinall, P. & Watters, C., 2010. *Refugees and asylum seekers. A review from an equality and human rights perspective*, Manchester. Available at: http://kar.kent.ac.uk/24337/1/refugees_and_asylum_seekers_research_report.pdf.

between the NHS and the Home Office as part of the new charging regime and believe this would lead to increased health inequalities.

In summary, we believe all of the obstacles to care outlined 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.[19] We further believe these obstacles will as put at risk public protection measures. The risks to public health are outlined in more detail in answer 6.5 below.

We do not believe it is possible to implement the proposals in the consultation without having a negative impact on health inequalities because the introduction of a charging system into primary healthcare will further discourage vulnerable groups from accessing the care they need, even where they are entitled to free treatment. The practical measures and resources required within the GP surgery will be considerable and risk leading to racial tension within communities and discrimination under the Equality Act 2010.

We recommend that the following groups also be added to the list of those exempt from charging: refused asylum seekers, pregnant women, children, people of transgender or gender dysphoria conditions and people with long-term medical conditions, including severe and enduring mental health problems, and those with drug or alcohol dependencies.

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?

6.1 Challenges of practical and fair implementation:
We strongly agree with the proposal that GP and nurse consultations should remain free to all on public protection grounds. However, we would highlight the concern outlined in answer 6.7 below that public protection will be jeopardised by the barriers imposed by having to establish eligibility for prescriptions, investigations and further care, and that clinicians will find themselves in the impractical position (within the currently strained limitations on time and resources) of determining eligibility before being able to conclude any clinical assessment. As doctors we perceive that this conflicts with our ethical duty of care which is underpinned by the founding principle of the NHS; care that meets the needs of everybody and is free at the point of delivery.

[19] Research by the National Audit Office confirmed that early diagnosis and intervention provides significant long term savings (31 January 2013, HC683 Session 2012-13).

We are already well aware that the charging regime for secondary care is complex; the 131 page guidance reflects this. The Department of Health "strongly recommends that each relevant NHS body has a designated person to oversee the implementation of the charging regulations."[20] The guidance has been around for many years but we can cite numerous examples where it was inadequately or injudiciously applied. The guidance itself is continually being updated, further complicating its administration. When large organisations such as hospital trusts are struggling to administer the charging regulations fairly, it is unrealistic to anticipate that GP practices, small companies or, for example, independent pharmacies and dental practices would be able to do so.

We are concerned that doctors cannot fulfil their duties as set out in GMC's 'duties of a doctor guidelines' if the charging regime is brought in.[21]

GPs are already under tremendous pressure to see a great volume of patients, with British Medical Association GP leader Dr Chaand Nagpaul recently stating that doctors were having to rush patients to keep up. He has admitted this could be potentially dangerous in terms of identifying cancer and getting medicines right.[22]

We believe that for already over-worked general practitioners, the new charging proposals could be 'the straw that breaks the camel's back.' We are unable to see that how these changes will contribute to protecting NHS finances. In terms of the administration of GP practices, and addressing the health needs of patients, our specific concerns are as follows:

6.2 The hidden costs of administering the charging system:
The Department of Health stated in response to the last consultation that "the administrative cost may outweigh the recoverable charges for frequently used but relatively inexpensive services, but we will examine this in detail in the implementation impact assessment.[23] We regret that no further information has been provided in relation to this and believe that if charging is extended to primary care it would be cost effective to implement a policy along these lines.

It is our understanding that the Healthcare Surcharge was intended to establish a person's eligibility for free healthcare at the point of entry into the country. In our view, health service providers should not be given the responsibility of establishing eligibility 'in-country'. Making GP practices take on this role will simply serve to reinforce mistrust of authority for people who are already vulnerable and will deter people from accessing services, while at the same time putting undue administrative and financial burdens on practices.

The Impact Assessment estimates it will take 1.5 mins extra time to check eligibility, but we are certain this is an underestimate. Even if this were an accurate estimation, it would need to be applied to all patients or a GP practice will risk accusations of discrimination. If wrongly applied, this could undermine equality. Therefore, the only way to check eligibility for free NHS services in a way which does not contravene equality law is to check everyone. Reviewing patient's 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

[20] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/496951/Overseas_visitor_hospital_charging_accs.pdf

[21] General Medical Councils 'duties of a doctor guidelines' http://www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp

[22] GP pressures: We are failing patients - doctors' leader: http://www.bbc.co.uk/news/health-35479749

[23] 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, para 106.

can be avoided as service providers will have to ensure that a patient's residency status in the UK has not changed over time. An asylum seeker's eligibility may change from month to month. In many cases an interpreter would need to be used to complete the eligibility test, at extra cost. We believe non-medical appointments with the practice manager will also need to be factored in in order to allow them to explain charging criteria to patients.

It is unclear from the consultation document how this will be funded, and although the cost to administer this is hard to estimate accurately, considering that there are estimated to be 300,000 – 400,000 general practice consultations each year in England[24], and approximately 57 million people registered with a GP in England,[25] this cost is likely to be considerable. We question whether this is practical to deliver with current staffing levels and the state of General Practice, which is reaching breaking point with 81% of GPs saying General Practice does not have sufficient resources to deliver high quality patient care as things stand currently.[26] In addition, it should be noted that vulnerable migrants, and particularly asylum seekers housed under the Government's COMPASS accommodation contract, live in deprived areas where services are particularly over-stretched.

In many instances, the GP will be the only person with the right level of information to be able to establish whether a person is chargeable (and to identify those who are exempt on the grounds of FGM, human trafficking etc). In these cases, appointment times would inevitably be extended for further clarity and then again in the event that any diagnostic tests, referrals or medications that would incur a charge needed to be discussed with the patient. The use of interpreters would be required in most cases.

Extensive training of practice administrative and clinical staff would need to be provided, especially to ensure adherence to the Equality Act 2010 with the considerable risks outlined in our response to Question 2.

A GP who works for a TIER II service addressing the mental health needs of people seeking asylum had a patient who was so worried following being wrongly charged for an ECG and subsequent harassment from a debt collection agency that two extra appointments were needed to talk through his concerns. This man had so little money he was struggling to buy a basic primary school uniform for his son from a supermarket. He then delayed and had to be convinced to go for a chest x-ray to exclude TB because he was so worried about being billed again. This demonstrates the difficulties under the current charging system and we can anticipate many more problems of this nature if primary and emergency care also become chargeable.

For cases where exemptions apply, we believe a lot of valuable GP time will be wasted challenging charges applied elsewhere in the health service. For example, one GP who had referred a patient to hospital for a test found her patient had been charged, even though it was part of an investigation in primary care. It took the GP many hours to challenge this and get the charges dropped.

As well as the direct costs to primary care services outlined above, we believe there will be many wider unanticipated costs as a consequence of the charging regulations. For example, barriers to accessing healthcare for families can lead to extra costs for health visitors, school nurses etc. If the health service is squeezed at one end it will inevitably impact on other services. It will also undermine organisational goodwill.

[24] http://www.rcgp.org.uk/campaign-home/~/media/Files/PPF/Deloitte%20Report_Under%20Pressure.ashx#page=12
[25] http://www.hscic.gov.uk/catalogue/PUB18762
[26] http://www.rcgp.org.uk/policy/~/media/Files/Policy/Fair%20Funding%20for%20General%20Practice/Fair%20Funding%20for%20General%20Practice.ashx

As explored in answer 6.5 below, there will be medicolegal costs arising from litigation against practices and clinicians over their implementation of the eligibility assessment and racial discrimination risks, or due to failure to arrange a test when the clinician was under the impression that the person was ineligible when in fact they were entitled to that test. These costs will be financial. They will be felt indirectly through increased indemnity costs for GPs, and through increased pressure on the workforce while an investigation is carried out or staff are absent due to the stress caused by a malpractice investigation.

It is important the Department of Health recognise how much asylum seekers are moved around via asylum dispersal, and how this disrupts their care. When the deterrent effect of fear of charging despite entitlement is added to delayed appointments and disrupted medication as a result of frequent moves, the impact on care and the cost of delivering it is profound. For example, a GP working in an A&E setting met a couple from the Caucasus who had claimed asylum in the UK and had recently been allocated a house by the Home Office and were waiting for a registration appointment with their new GP. The male had had a chest infection for the last two months, while his wife required a prescription for the contraceptive pill. They had been told it would take them three weeks to get an appointment, so they were forced to present at A&E. We foresee a greater burden and higher financial cost on emergency care if additional barriers to primary care are introduced.

Reduced health investment often leads to increased social care costs and more fragmentation. Charging vulnerable people who have no means of paying will have the same effect. It will undermine preventative approaches to healthcare and undermine community and individual resilience. Greater Manchester is embracing the opportunities the new GM Health and Social Care Devolution agenda presents. Yet the proposed charging regime could seriously undermine the efforts to focus on preventative care and the cost savings associated with this.

Examples from around the globe tell us that charging for health services does not improve health or indeed reduce the cost of healthcare across the board: “User fees are not a perfect solution to the inadequate funding for the health care sector. User charges have proven to be ineffective as a stand-alone policy. The countries that experienced a raise in revenue flow from user charges have at the same time experienced drastic reduction in care utilization and no improvement in the quality of care. The countries that still maintain the user charge programs have slowly substituted additional health initiatives to help poor people who cannot afford to pay.”[27]

Likewise, there is evidence that charging for dental care has caused increased GP work load. We can therefore extrapolate that charging for other aspects of care will similarly impinge on GP workload and the cost of delivering primary care. 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.[28]

6.3 Uncertain immigration status:
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. In this context, we are concerned to see that those who have been granted refugee status, humanitarian protection or discretionary leave for protection purposes in the UK do not appear in the list of exemptions from the NHS charging regulations.

[27] User Fees as a Form of Cost Sharing In Developing World: http://www.cwru.edu/med/epidbio/mphp439/user_fees.pdf
[28] ‘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

A commitment was made by the Department of Health in response to the previous charging consultation 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."[29] We believe these groups do 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.

We would draw attention to the fact the listed exemption for refused asylum seekers receiving support under Section 4 (2) will need to be updated to reflect the changes proposed in the current Immigration Bill. The Bill also proposes changes to the support received by refused asylum seeking families and those leaving care at 18, meaning the eligibility criteria for free healthcare will need to be updated to reflect this.

The constantly changing and complex nature of immigration law makes it difficult for health professionals to accurately identify who is chargeable under the current regulations and who is exempt, particularly when the immigration status of individuals and their eligibility for free healthcare regularly changes over time.

Also, it is very hard for GPs to establish the status of an asylum seeker patient. Torture can leave some asylum seekers cognitively impaired, which makes it doubly hard to find out what's happening. Others find talking about their claim too re-traumatising to be able to disclose. Those with an ongoing case at the Home Office could therefore be wrongly excluded from care.

6.4 Impracticality of applying exemptions:
There is a lack of clarity over what 'ongoing treatment' means under the current secondary healthcare charging regime and it is not clear whether this will be any easier to interpret under the proposed new charging regime. For example, one patient who had been shot in the face had had several reconstructive surgeries already and was refused asylum. The hospital then argued that the next surgery would be chargeable as it was a new episode of care. It took the GP who was working with him a great deal of time to establish his eligibility on the basis of ongoing treatment.

We are concerned to see that community mental health services are not listed as being exempt from charges. Access to primary mental health support is very important for vulnerable asylum seekers.
We are also concerned that in practice it will be very difficult to apply the exemptions to charging, leaving vulnerable people without care, and those with 'protected characteristics' experiencing increased health inequalities. The exemptions - which are largely designed to mitigate the effects on vulnerable groups or enable the treatment of health conditions that could be injurious to public health - are based on the assumption the patient already has a diagnosis. It often takes many tests to establish this, which cannot be completed if the patient will not present at the GPs due to fear of being charged. Many of the listed exemptions will therefore not work in practice.

Introducing charging to primary care settings creates additional barriers that could prevent people from disclosing experiences of torture, sexual violence, FGM etc. This presents three problems: firstly, they cannot make a case for their eligibility for free healthcare; secondly, it could stop them getting the healthcare they need; and thirdly, this could prevent them from accessing vital medical evidence to support their claim for protection. In the current system it is already reported that charging for letters describing scarring and other consequences of ill treatment prevents asylum seekers from being able to follow up medical evidence which could lead their solicitors to commission independent reports.

[29] 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, para 97.

It is unclear from the consultation whether referrals to specialists for safeguarding purposes will be charged for. For example, would a referral to an FGM specialist be exempt from charging? It is also unclear whether access to community mental health teams and psychological therapies would be chargeable. It becomes increasingly difficult for the GP to know how to act in their patients' best interest against the backdrop of this uncertainty.

Destitute people are often forced into exploitative or inappropriate relationships and vulnerable to domestic violence and sexual violence. As their immigration status makes them chargeable for care, they would face many barriers to being recognised as exempt on the basis of sexual violence. It is vital that evidence of sexual violence is collected straight away to enable a prosecution. The practical barriers introduced by the charging regime could prevent this from happening.

Many people get refugee status after having initially been refused asylum and finally presenting additional evidence. They may spend many years in the interim without Home Office support, and, under the proposed new charging regulations, would be chargeable for healthcare. We are not clear whether these costs would be repaid to them if they do finally get refugee status or another form of protection in the UK. It may be extremely impractical to reimburse costs at this stage. Receipts may have been lost, or the individual may have refused treatment due to having no means of paying, with likely increased cost to the individual and to the NHS when treatment is then implemented later and when complications have developed.

6.5 Ethical and legal challenges for GPs:
The new charging regime could be ethically compromising for doctors, particularly if the prohibitive costs of diagnostic tests means they must work 'blind' with a patient, or spend much more time convincing them to have a test carried out. A GP working with a refused asylum seeker patient with fragile mental health may decide not to push for tests if they know the patient will be charged. Drug monitoring for certain antipsychotic medication known to help with PTSD involves regular blood tests to check for complications. Not undertaking these tests when a patient is unable to afford them would place the GP at risk of criticism for continuing to prescribe the medication.

The charging regime may also leave a GP managing serious conditions in a primary care setting that should be addressed in secondary care. If a patient refuses admission to the hospital, how hard should a GP insist? There is clinical risk to the GP involved in trying to manage conditions outside of the hospital, which could leave them open to medical legal challenges. This could also have a negative effect on the stress levels and mental health of the GP.

All of this can engender direct and indirect costs to practices, as outlined in answer 6.2.

6.6 Risk to individual health:
People with refugee status or discretionary leave to remain often experience high levels of stress over money. The charging regime could add to this, leading to a deterioration in mental health and suicide risk. Even when the person is eligible for free care, fear of being charged or confusion over entitlement could have the same effect.

If charging for prescription medication is introduced, chargeable patients may be tempted to obtain medication by other means, for example, getting relatives to post it from abroad or buying it on the black-market. This could leave clinicians unable to prescribe other drugs safely as there may be interactions. Moreover, medications sent from home may not have been subject to quality control, may be ineffective, deleterious for health or may have deteriorated due to conditions during transit. For example, deteriorated antibiotics will increase antibiotic resistance. We also anticipate the risk of an increase in

back-street abortions because reproductive health and terminations are not included in the list of exemptions.

A fee-based system at primary care level may lead to patients demanding certain types of care that are not in their best interests, but may be cheaper or appear to 'fix' the problem more straightforwardly. We already know that GPs over-prescribe antibiotics against their better judgements in response to pressure from patients. We could see this effect in other areas of care as a result of the charging regime.

One GP who works with a consultant who deals with TB reported that the consultant saw a new patient diagnosed with TB who had been a NATO interpreter in Afghanistan. He was placed in a house with seven other men by the Home Office. The consultant knew she should be screening for other infectious diseases, and that there was a risk of transfer to the other residents, but recognised they didn't have the resources at the patient's local surgery – which was in a deprived community and operating on a stretched budget - to carry out all the tests. This is clearly a case where financial concerns overrode medical need.

We strongly oppose the extension of charging into primary healthcare. 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 drug monitoring, and that community mental health services are exempt from charging, as this will help to ensure that vulnerable individuals are not deterred from accessing the healthcare they need.

6.7 Risk to public health:

On 12 November 2013, the Minister for Immigration, Mark Harper MP, stressed that the Government "will not do anything that will worsen public health. Of course it is important for those who are in the United Kingdom, even if they are not here legally, to have access to public health treatment, because it has an impact not just on them, but on the rest of the community."[30] However, we see many aspects of the proposed charging regime that will compromise public health.

Access to primary medical care is an essential tenet of good public health. GPs are pivotal in the diagnosis and treatment of infectious diseases and mental health conditions. They are a gateway to maternity and sexual health services. Preventing access to these services will have a negative impact on individual and public health. It is likely to lead to substantial additional costs as treatment is more expensive than prevention and early management.

One example would be vaccination programmes. A recent audit of the immunisation of children who are either asylum seekers or visa holders at a central Manchester GP practice found a complete lack or significant gaps in their immunisation history. [31] This GP practice serves a population from the most deprived decile of deprivation (Index of Multiple Deprivation, 2015) and with an estimated 57.6% of people from non-white ethnic groups.[32] About 8100 people are registered as patients at this surgery, and 158 of these are coded as visa holders and 34 are coded as asylum seekers. Coding these characteristics is not obligated at a GP surgery and may therefore underrepresent the actual numbers from these groups.

Thirty children were included in this audit: 24 (80%) were visa holders and 6 (20%) were asylum seekers. The mean age of the participants was 8.9 years (range 0-15). Only 8 (27%) children were completely up-to-date with their vaccinations. 16 (53%) children had no record of any vaccinations and 6 (20%) were only

[30] Immigration Bill, Committee Stage, House of Commons, 9th Session, 12 November 2013.

[31] 'An audit of the immunisation of children who are asylum seekers or visa holders at the Range Medical Centre': http://bit.ly/range-audit.

[32] http://fingertips.phe.org.uk/profile/general-practice/data - mod,2,pyr,2015,pat,19,par,E38000032,are,P84039,sid1,2000005,ind1,639-4,sid2,-,ind2,-

partially vaccinated. The audit also found that the coverage for the MenC vaccination was lower than for other immunisations (of the six children who were only partially vaccinated, all lacked a MenC containing vaccine).

This audit indicates that children who are asylum seekers or visa holders can be insufficiently covered in terms of immunisations, and this has serious implications for public health as clusters of unimmunised individuals are a threat to herd immunity, thereby reducing protection from diseases such as measles, whooping cough and meningitis to the wider community. Any additional barriers to accessing primary care would certainly worsen this situation.

We believe that children should be added to the list of those exempt from charging in order to ensure that they do not face any barriers to accessing the care they need. The Department of Health itself recognised the value of this when it noted that "anything that limits access to primary care will have a disproportionate effect on children as they are heavily reliant on primary care services for both prevention services (surveillance, screening and immunization) and treatment."[33]

The incidence of Tuberculosis (TB) is disproportionately high in the UK compared with most other Western European countries. It is concentrated in large urban centres such as London and Manchester, where rates are more than three times the national average.[34] Almost three quarters of all cases of TB occur in people born abroad, and the disease also disproportionately affects deprived communities (a category into which almost all asylum seekers fall: particularly those not receiving government support). Late diagnosis of TB is of particular concern locally in Manchester as well as nationally. A proactive approach to TB diagnosis and treatment, as well as vaccination where appropriate, is central to reducing TB rates in the UK.[35] There is a real risk, in introducing further charges for groups of asylum seekers, of increasing existing barriers to healthcare access for everybody in the asylum system through fear of eliciting charges - which asylum seekers are unlikely to be able to pay -[36] or through fear of deportation.

Many people have latent TB; this means that they have been in contact with the disease at some time in their past, but they do not have active TB and are not ill or infectious. If the individual is healthy, well nourished, has warm shelter and is not significantly stressed, the disease is very unlikely to activate. However, where there is poverty, homelessness, a shortage of nourishing food and the extreme stress that vulnerable migrants often experience, it is very likely that the TB will become active and the individual become ill.

People seeking asylum are a high risk population, even if coming from areas of low incidence of TB, due to close confinement and overcrowded living conditions in refugee camps and in transit, where they may be temporarily living with people of multiple nationalities. This may also be exacerbated by close contact in Initial Accommodation centres or detention centres while in the UK.

The Charging guidelines are complex, and it is very unlikely that asylum seekers and people in the situation of vulnerable migrants will understand that TB treatment is free, while that for an ordinary chest infection, for example, is chargeable. They are unlikely to access health care until they are acutely ill and have to go

[33] 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

[34] Public Health England. 2014. *Tuberculosis in the UK 2014 report*, London. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/360335/TB_Annual_report__4_0_300914.pdf.

[35] Manchester City Council Public Health, 2013. *Joint Strategic Needs Assessment In-depth Report on Tuberculosis (TB)*, Manchester. Available at: http://www.manchester.gov.uk/info/500230/joint_strategic_needs_assessment/6355/tuberculosis/2.

[36] Poduval, S. et al., 2015. Experiences Among Undocumented Migrants Accessing Primary Care In The United Kingdom: A Qualitative Study. *International Journal of Health Services*, 45(2), pp.320–333. Available at: http://joh.sagepub.com/lookup/doi/10.1177/0020731414568511

to A&E. Until this point they will be infectious, creating a public health risk. Treatment for TB is lengthy; people with chaotic lifestyles and greater worries than their health may not comply fully with treatment, leading to an increase in drug-resistant TB. Tracing and maintaining contact with this group of people will be very complicated and therefore expensive.

The proposal to introduce charges is therefore inadvisable from a Public Health perspective, both in terms of increasing health inequalities, and due to compromise of current efforts to counter the continuing threat of TB in the UK.

Similarly, the commitment to exempt from charges tests and treatment for sexually transmitted infections and communicable diseases will also 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% of people living with HIV in the UK do not yet know they have it.

While we welcome the fact that consultations with GPs and practice nurses will remain free, we are concerned the current consultation makes no reference to community mental health services and strongly recommend that these services are also excluded from charging on both public health and cost efficiency grounds. If mental health services are exempt from charging it will avoid situations which put the health of individuals at risk.

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?
As outlined in our responses to Questions 2 and 6, despite the fact that they are one of the exempt groups, asylum seekers already experience multiple barriers to accessing primary care. Asylum seekers are already challenging patients to work with in terms of prescription medication because of frequent moves and unfamiliarity with the health system. It takes a long time for notes to arrive. Asylum seekers also struggle to get hold of repeat prescriptions as they do not understand the system and often leave it until they have run out to re-order. This breaks continuity of care. Adding charging for prescriptions to this will only exacerbate the situation.

An example of this is one patient who had eight GPs in six years due to frequent Home Office moves. It took weeks for their notes to arrive with their new doctor. They were on antidepressants and the doses had to be adjusted without reference to their previous notes. A sudden halt in medication or a sharp decline in the dose is a serious matter that could lead to risk of suicide.

It is also time consuming for GPs to check repeat prescription requests. Often the checks need to be more regular for asylum seekers for the reasons outlined above. One GP has already heard that asylum seekers view GPs to be “acting as a guard” and an additional barrier to getting the prescriptions they need.

As noted in answer 6.2 above, there are significant costs associated with training NHS staff to properly assess entitlement and the prescribing clinician would need to check this for every patient. This proposal would also necessitate the use of two prescription pads.

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.

HC2 certificates can take 6-8 weeks to arrive. Currently, some pharmacies ask for evidence a person has a valid HC2 certificate, while others don't. If the proposed charging regime is introduced, this could present a real barrier to newly arrived asylum seekers - who would be exempt from the proposed charging regime - but would struggle to prove it. We are also concerned some pharmacies could be tempted to charge an additional admin fee as it will be resource intensive to process payments and judge entitlement. This would be a further cost that vulnerable people have to bear.

Fees for prescriptions have been known elsewhere to lead to misuse of medications. For example, in the USA, patients choose to underuse medications because they cannot afford to pay for them all.[37] This clearly undermines the effectiveness of the medication and a GPs' ability to satisfactorily manage a person's condition. In the case of incorrect use of antibiotics, this can lead to anti-microbial resistance, with consequences for all.

If patients are given a choice between a range of treatment options they are likely to select the least expensive, not the one which will have best results. Experience tells us it is hard to persuade some patients to try a new treatment at the best of times. It will be doubly hard if they will also have to pay for it.

Torture survivors have increased risk of hypertension, diabetes and dementia. The cost of diagnostic tests and prescriptions could lead to vulnerable people relying on short-term fixes, rather than addressing their health needs in the round. They are also more likely to end up in A&E if these conditions go untreated. Pain management is another difficulty. It often takes multiple consultations and complex, expensive treatment to manage pain effectively, which chargeable patients could be deterred from paying for. Under the proposals outlined in this consultation, torture survivors would be eligible for free care. However, as outlined in our response to question 2, there are many reasons why a person may not disclose that they have been subject to torture, so they cannot always be identified by health practitioners.

We are concerned that inability to get hold of prescription medications will lead to self-medication with drugs and alcohol for those with mental health issues.

In view of the above, we wholeheartedly disagree with proposals to change the charge exemption criteria for prescriptions. However, if the Department of Health pushes forward with these proposals, charges for NHS prescriptions should only be applied if it can be demonstrated that the proposals are cost effective and can be implemented in a non-discriminatory way.

In addition, 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

[37] 'Are your patients being forced to choose between food and medications?' May 07, 2014, Medical Economics: http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/cost-related-medication-underuse/are-your-patients-being-forced-choos.

medical condition who hold a valid exemption certificate; prescriptions for contraceptives and other listed medication; and for those in receipt of certain benefits (listed in Annex D).

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?
We consider that, in the same way as for GP practices, the administrative task of checking all patients for exemption criteria documentation would be an immense burden for dental practices. It will also put practitioners at risk of falling foul of discrimination legislation.

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.

We are concerned that this proposal will add to GP workloads. 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.[38] Patients with dental problems present challenges to GPs who report concerns about their ability to manage such conditions. Despite this, many reported frequently prescribing antibiotics for patients with dental conditions. This may contribute to both patient morbidity and the emergence of antimicrobial resistance, with serious public health consequences. 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. Moreover, it is important to note that dental trauma is often seen as a consequence of torture.

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?
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. As noted above, there are additional associated costs in relation to training NHS opticians to properly assess entitlement to these services. On costs grounds alone the ophthalmic proposals should not be taken forward.

[38] '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

In addition, it should be noted that most free optical care is preventative and, in some cases, if not provided will have serious implications for the individual's eye and general health (e.g. failure to pick up diabetes). This is especially true of children's eyesight and its importance during a child's education.

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)
We believe *all* services provided within an NHS A&E setting should be exempt from the requirement to apply the Charging Regulations. By definition, these services are "immediately necessary and urgent", and should be available irrespective of the ability to pay. Enforcing a charge will deter the most vulnerable from seeking the care they need. In fact, it will undoubtedly also deter many of those who are entitled to free healthcare (including refugees and asylum seekers). This group of vulnerable individuals will already be confused and overwhelmed by the dizzying array of rules and regulations, cultural and social pressures, as well as profound communication problems they meet with in the UK.

It is worth noting that defining "Core A&E Services" is an ongoing matter of debate, particularly when commissioning and allocation of services are under consideration. Furthermore, that definition varies widely across the country, and even within the same region. That in itself adds to the confusion experienced by all in this vulnerable group, be they refugees, asylum seekers, or refused asylum seekers.

It is already documented that 2014-2015 has witnessed an increase of 356,000 patient episodes. There is no information within the consultation document indicating whether there are applicable and validated models to predict the impact of refugees, asylum seekers and refused asylum seekers on the number of attendances to A&E Departments that may result from restrictions in access to primary care or walk-in centres.

Implementing charges for Primary Care but not for A&E will naturally cause increased A&E attendances. We therefore recommend that no charges should be levied for any primary care, urgent care, or emergency care, whether these are delivered through a GP Practice, a Walk-In Centre, an Urgent Care Centre, or an Emergency Department.

Q18 Do you have any comments on implementation of the A&E proposals?
The workload of GPs will be increased if people cannot access walk-in centres. There will also be an increase in ambulance call-outs. We believe the proposed new charging regime will lead to a lot of patients accessing care at an inappropriate point in the NHS. Seeing a GP with access to your full notes is cheaper and easier. Duplication of care will increase, as patients who present at A&E will be advised to go back to their GP. We therefore reiterate the importance of exempting from charging whichever route those vulnerable people use, be that primary care, urgent care, or emergency care.

GPs will struggle to persuade some patients who are acutely ill to go to hospital. GPs often have to convince people who are very unwell to go into hospital when they are reluctant. The chances of getting these patients into hospital for essential treatment is further reduced if they fear the cost. This leaves GPs with the practical and ethical problem of inappropriately managing these conditions at primary care level.

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." [39] 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, homeless people currently attend A&E six times more often than the general population and stay in hospital three times as long as a result of the difficulties they have in accessing primary care. It will also 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.

It is already recognised that A&E is struggling to cope with its existing commitments. The Health Select Committee noted in July 2013 that staffing issues and rising attendances were among the main causes of problems in A&E treatment and that the four-hour waiting time target was missed by a total 94 out of 148 providers across the NHS from January to March. This operational standard was set in recognition of the fact that long waiting times in A&E compromise patient safety and reduce clinical effectiveness. The Committee also noted that more than 300,000 patients waited longer than they should have - a 39% rise on the previous year.[40]

It is not only the number of people attending A&E that has increased. More people are being admitted to hospital, with an additional 356,000 admissions from A&E in England in 2014-15. This in turn has further increased waiting times. In this context it is all the more important to ensure that individuals are not discouraged in any way from accessing GP surgeries as this is only likely to lead to late and emergency admission at A&E, which in turn will contribute to longer waiting times and further compromise patient safety.[41]

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 sufficient English to be able to explain their status. Even in these circumstances patients would be unlikely to be able to provide immediate 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, they are presented with a stressful ethical dilemma. In addition, 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,

[39] Department of Health, *2012 Review of overseas visitors charging policy, Summary report*, April 2012, para.28
[40] BBC, *A&E crisis plans "not good Enough" MPs say* , 4 July 2013, http://www.bbc.co.uk/news/health-23423796
[41] The King's Fund, *What's going on in A&E*, October 2015, accessed at: http://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters?gclid=COrWjdCt7ckCFcFAGwod8XgPZw

or the patient will not understand that they are eligible to return and their situation will further deteriorate. This is a high level of risk for a clinician to sanction.

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. It creates ethical concerns around charging someone who is unable to consent or refuse treatment due to serious illness/injury. For all the above reasons, we believe that charging should not be extended to A&E care.

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. We are also concerned that the charging regime will deter people from returning to A&E for follow up care, for example, to get stitches removed or get a plaster cast taken off. Rather, they will try to manage this at home.

The qualitative research undertaken with health professionals for the Department of Health in 2013 found that respondents "questioned whether a charge should be levied for genuine emergencies and very importantly, what the effect might be on patients who are unable to pay."[42] This is particularly noteworthy as the majority of individuals interviewed for this research were Overseas Visitor Officers, practice mangers, administrative staff and members of the Border Force. The Department of Health noted in its response to the consultation that: "Collectively the majority of responses were opposed to the proposals to extend charging into other services…Clinical concerns extended to charging for A&E, again associated with delay in treatment whilst eligibility was established and also with the ethical considerations."[43]

We would also question the balance of costs. An Overseas Visitor Officer's wage would have to be paid to chase bills for patients who often have no means of paying.

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 of ambulance services should be implemented. See answer to Q18 above for details.

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?

[42] Creative Research, *Qualitative Assessment of Visitor and Migrant use of the NHS in England*, 23 September 2013, page 27.
[43] 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, paras 53 & 56

Strongly disagree

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?

Strongly disagree

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

No. The Department of Health stated at the end of 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,"[44]

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 payees should be able to receive the same treatment as other UK residents. If it is decided that those who have paid the surcharge are to be excluded from fertility treatment, then 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)?

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

The proposal to require both partners to demonstrate they are ordinarily resident/have Indefinite Leave to Remain 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.

People often arrive as asylum seekers at the peak of their reproductive years. Long delays in Home Office decision making can lead to them missing their chance at having a family if they have fertility issues. This issue would affect so few people that it surely cannot be cost effective to include it within the charging regime.

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

[44] 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, para 95

Yes, charities, voluntary and community organisations and providers who are established as social enterprises. We consider that 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.

Drug and alcohol services; sexual health; physiotherapy; and interpreting are all currently commissioned separately. Forcing these providers to apply the charging regulations could undermine equality legislation. There is also a risk that private providers could discriminate against certain patients as failure to pay could eat into their profits. This would need to be mitigated via commissioning contracts.

Q28 Are there any NHS funded services provided outside hospital that should be exempt from a requirement to apply the Charging Regulations
Yes, mental health services, hospices, drug and alcohol related services, sexual and reproductive health services, maternity and children's services; healthcare targeted at migrants with irregular status and/or with no recourse to public funds. 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 be seriously ill or dying 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
We believe it is unreasonable to expect a third party to take on unlimited liability for unforeseen circumstances. An individual can commit to provide financial support for a visitor for a period of time who is unable to prove they have sufficient funds, but they 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 that this requirement may lead to vulnerable people – especially refused asylum seekers – getting into inappropriate relationships so they have a 'sponsor' who can pay for healthcare. This group is already at increased risk of sexual violence and domestic abuse.

Research carried out by a midwife who contributed to this response has identified that if a destitute refused asylum seeking woman seeks help from religious institutions she can sometimes be vulnerable to exploitation (Briscoe 2009). The research highlighted the experience of a woman from Rwanda who turned to a church and was made to feel intimidated and manipulated because she was destitute. This kind of situation could become more common if vulnerable refused asylum seekers are forced to find a third party willing to pay for their healthcare.

Q35 Our proposal for overseas visitors working on UK-registered ships to remove their exemption form NHS charges
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?
As noted in the Department of Health's current Impact Assessment, 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."[45]

Following the previous consultation the Chair of BMA Council, described the proposed charges as "impractical, uneconomic and inefficient" and warned that they "could have an impact on the care all patients receive." [46] The Chair of the Royal College of GPs also noted that the costs of the proposed charging system, with its related set-up, transaction and collection costs, "would far outweigh" what would ever be recouped in charges. The Department of Health's qualitative research undertaken with health professionals in 2013 also found that there was concern that "the cost of setting up a new complex infrastructure may outweigh any increase in income." We share these concerns and consider that the full costs of the proposed system have been fully taken into account in the current Impact Assessment.

The Impact Assessment assumes that identification, invoicing and charge collection rates in primary care settings will be "equal to those in secondary care."[47] This seems highly unlikely as it is the specific function of OVMs to recover these debts, 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

[45] Department of Health, *Impact assessment: Visitor and migrant cost recovery – extending charging*, 5 November 2015. Page 11.
[46] BMA Press Release, *Government's migrant charging proposals are impractical, uneconomic and could damage the NHS, warns BMA*, 28 August 2013.
[47] Department of Health, *Impact assessment: Visitor and migrant cost recovery – extending charging*, 5 November 2015. Page 13.

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.[48] 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. As noted in our answer to question 6, we believe interpreters will also be needed to ensure patients understand the charging rules and know what documentation they are being asked for to prove entitlement.

In a screening exercise carried out by Department of Health's researchers in 15 Trusts in 2013, the category of visitor could not be determined in over a third of cases and their nationality was unknown in 41% of these cases. The report for the Department of Health noted that administrators "may need to spend considerable time trying to establish the patient's situation, for example, by writing to them asking for the necessary documents..."

As noted previously, the only way to check eligibility for NHS services in a way which does not contravene equality law is to check everyone. Regular repeat eligibility checks will also be required and records will have to be regularly updated as an individual's status changes. In the case of asylum seekers, their status could change from exempt to chargeable and back to exempt in a matter of weeks. It does not appear that the Impact Assessment has taken full account of the administrative time required to do this.

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.

The Impact Assessment does make clear that before a charging system can be introduced "a technical solution to improve NHS IT systems so that chargeable patients can be identified" needs to be found and states that "the precise specifications of the IT enhancements required to support this policy are uncertain." [49] There will be costs associated with keeping these databases populated, up to date and fit for purpose.

Furthermore, NHS systems will have to be properly integrated with Home Office systems and, crucially, all databases will have to have accurate and up to date systems that are able to communicate reliably with each other. There are also existing problems with getting hospital databases to communicate with those of GP practices. The delivery of functional IT systems to specification and the timely and accurate updating of records has historically been a particular challenge for the Home Office. In view of the above it is likely that IT costs will overrun the £5 million estimate and ongoing IT costs in relation to further upgrades and problem solving should also be budgeted for.

The introduction of charging into primary care will also require substantial expenditure in relation to set up costs, including having wi-fi installed in every GP practice, machinery to take payment by credit card, as well as the people and space in GP surgeries to carry out transactions and pursue payments. None of the

[48] Department of Health, *Impact assessment: Visitor and migrant cost recovery – extending charging*, 5 November 2015. Page 14.
[49] Department of Health, *Impact assessment: Visitor and migrant cost recovery – extending charging*, 5 November 2015. Page 13.

above seem to have been costed in the Impact Assessment. Refused asylum seekers will usually lack the means to pay, but on top of this, refused asylum seekers and irregular migrants find it very difficult to open bank accounts.

Identifying who is chargeable and who is not is extremely complicated. Many people will have difficulties proving entitlement, including vulnerable British residents (e.g. homeless people, those with mental health problems, etc.) or those who do not have a passport or other documentation.

The current Impact Assessment recognises that identifying an individual's status may be complicated and that "there is also a risk that care may be delayed while payment status is clarified." Despite this, it goes on to recognise that the financial implications of this have "not been explored in the consultation IA."[50]

Wrongly refusing access to care to someone who either has entitlement or is in need of urgent and immediately necessary treatment could have extremely serious consequences for that individual's health and may result in the practice being the subject of legal proceedings, as could the operation of eligibility procedures which are discriminatory in any way. No provision is made in the Impact Assessment for these costs.

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." [51] It is therefore highly questionable whether these proposals are cost effective.

The Impact Assessment does recognise 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."[52] As set out above, we are convinced that the mitigating measures taken by the Department of Health will not prevent this from happening and that individuals will be deterred from seeking treatment from a GP, leading to late diagnosis and treatment of health problems.

This in turn will result in very significant extra costs to the NHS as preventive or early treatment is much more effective than emergency interventions undertaken after an individual's health has deteriorated. Crucially, these costs have not been included in the impact assessment and are likely to run to tens of millions of pounds. For example, treating type II diabetes-related complications is around nine times more expensive when it has not been diagnosed and treated in a primary health setting)[53] and 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.[54]

Even where someone is identified as chargeable and does not have the means to pay, GPs will still have a duty to provide urgent or immediately necessary treatment. This is a clinical decision, but once a patient

[50] Department of Health, *Impact assessment: Visitor and migrant cost recovery – extending charging*, 5 November 2015. Page 11.
[51] Department of Health, *Impact assessment: Visitor and migrant cost recovery – extending charging*, 5 November 2015. Page 8.
[52] Department of Health, *Impact assessment: Visitor and migrant cost recovery – extending charging*, 5 November 2015. Page 11.
[53] Matrix Evidence, *Economic evaluation of extending entitlement to healthcare to irregular migrants,* Doctors of the World, October 2011.
[54] Costings from National Aids Trust, *Universal access to primary care: a gateway for HIV testing, treatment and prevention*, November 2012.

has been assessed it is likely to be more cost effective to treat any diagnosed illness rather than send them away until their condition deteriorates to the point that it does requires urgent treatment.

Where such treatment is required and is provided to irregular migrants, "charges cannot be waived and must be applied" even though, as recognised by the Department of Health, "it is unlikely that many will have the resources to pay."[55] In this way, practices are likely to waste time and money invoicing and pursuing debts that cannot be recovered.

Health professionals should have the power to waive a charge when they consider it cost effective to do so (e.g. the patient does not have the means to pay and not treating them would most likely lead to them presenting again either at a GP's surgery or at A&E once their illness requires urgent treatment). Similarly, health professionals should always have the ability to waive charges where it would risk public health not to treat the patient; however differences in interpretation of these discretionary aspects of care would lead to inequalities of care dependent on an individual practitioner. It leaves them open to confusion and potential criticism. Simplification of the system is crucial to fair implementation for all.

As outline above, we believe the Impact Assessment does not take account of the full costs of extending charging to primary and A&E care. We consider that the available evidence strongly indicates that charging those without ILR for primary healthcare will create additional barriers to accessing early and preventative treatment. Consequently, it will undermine some of the key overarching principles of the charging regime, in particular: that the system must be workable and efficient and must not increase inequalities, place undue burdens on staff or compromise the cost-effective and safe delivery of quality healthcare.

The costs involved in setting up and running the systems, along with the additional expenditure incurred from delayed treatment, pursuing debts and defending possible legal challenges, mean that the costs are highly likely to greatly outweigh any financial benefits and will put the health of individual patients and the wider community at risk. Doctors in the NHS are already facing workloads that are difficult to manage. The ethical dilemmas and practical difficulties charging migrants will pose for them can only contribute to their stress.

[55] 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, para 79.