# Liverpool Joint Response to Department of Health Consultation 'Making a Fair Contribution: A Consultation on the Extension of Charging Overseas Visitors and Migrants Using the NHS in England'

**About Us**
This response has been developed by experienced professionals working with refugee and asylum seeking communities in Liverpool. We are advisers, social workers, doctors, counsellors and researchers. Contributing organisations include:

**Sahir House** (offers HIV support, information and training, with a specialist service for people seeking asylum). **Family Refugee Support Project** (improves the mental and physical health of families by offering counselling and therapeutic horticultural activities). **Four Wings** (a support service for marginalised or vulnerable women across Merseyside). **MRANG** (working with pre and post natal refugees and asylum seekers, plus women at other stages in the asylum process). **Asylum Link** (runs a drop-in centre providing friendship, help and advice to people seeking asylum). **Merseyside Refugee Support Network** (provides an information and support service for local refugee communities as well as for those organisations working with and for refugees and asylum seekers). **Cross-cultural Communication Group** (comprising a Professor of Primary Medical Care, University of Liverpool and a senior lecturer in Mental Health Nursing, Liverpool John Moores University). **Regional Asylum Activism Project** (informing and changing attitudes about asylum seekers and refugees, and campaigning for positive change to the asylum system).

In our response we have focused especially on the impact of these proposals on refugees and people seeking asylum.

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## Equalities and Health Inequalities

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

**QUESTION 2: Do you have any views on how the proposals in this consultation should be implemented so as to avoid impact on:**
- people with protected characteristics as defined under the Equality Act 2010;
- health inequalities; or
- vulnerable groups?

**Existing barriers to healthcare leading to health inequalities:**
2.1 **We are very concerned by the impact of the *current* charging regime on vulnerable asylum seekers and refugees.** We feel the secondary healthcare charging regime should be reconsidered and strongly urge the Department of Health not to pursue plans to introduce charging to primary and emergency care settings, though if this goes ahead, we would want to see the same exemptions applied plus an additional exemption for all asylum seekers, regardless of status (further details below).

2.2 Many of our clients and service users are already experiencing barriers to accessing the healthcare they need. Most of them are fully entitled to healthcare under the current system, but are met with receptionists and healthcare professionals who query their entitlements or they have heard from other people in the asylum seeking community that they will be charged, and so are put off from accessing

services. TB is a particular health risk example, where fear of being charged for treatment may prevent people seeking treatment.

2.3 Extending the charging regime will deter people from using health services unless it is a life or death matter. At this point, the cost and complexity of treatment may be much higher than if they were able to get care earlier on (whether for physical or mental ill health). We also believe more people will be so afraid of going to the hospital that they will die at home. This state of affairs could also lead to major public safety issues, putting pressure on other public services such as the police.

2.4 We have clients who have been charged for secondary healthcare under the current system. They are mostly people whose applications for asylum have been refused by the Home Office. It is important that the Department of Health understand being refused asylum in the UK doesn't mean a person does not need protection. Unreliable decision-making by the authorities and limited access to good legal advice means many people who seek asylum in the UK reach the end of the process without their protection needs being recognised. At this point, they lose access to the accommodation and support provided by the Home Office (they are made destitute), unless they agree to return home. They also do not have permission to work, so have no means of supporting themselves. However, many people remain in the UK because they continue to fear what might happen if they return home and/or the Home Office leave them destitute without proceeding with removal instructions. As an illustration of the unreliability of Home Office decision making, roughly a quarter of Home Office decisions to refuse asylum are overturned on appeal. Evidence abounds of the Home Office's failure to make reliable decisions on Lesbian, Gay, Bisexual, Trans and Intersex asylum claims.[1] Further down the line, a significant number of people whose asylum claims have been fully refused later submit fresh evidence and are granted refugee protection; roughly fifty percent of people who apply for asylum eventually get some form of leave to remain in the UK.

2.5 Despite being especially vulnerable to poor health and mental health, destitute refused asylum seekers are currently chargeable for secondary healthcare. The asylum decision making system is far from water-tight and we are therefore very concerned that the Department of Health is intending to rely on this for determining who is chargeable.

2.6 We are already seeing how the way HC2 forms are administered is leading to miscommunication between the Home Office and NHS. NASS issued HC2 certificates are not registering on NHS system (where they begin with "9"), hence clients are being sent automatic charging letters for prescriptions saying they have no valid HC2 form. This has been witnessed by Family Refugee Support Project and Merseyside Refugee Support Network. The letter informs clients that if they don't pay the fee within a set amount of days, they could face a fine. However, the clients are still in the asylum process and should not be charged. This puts pressure on advocates to contact health services to explain that the client is exempt from charging and/or get their HC2 form recognised on the NHS system. This is leading to confusion and resulting in undue stress and anxiety for people seeking asylum. This would only increase if charging for primary and emergency care were introduced.

2.7 In one case where a family was potentially chargeable, Family Refugee Support Project witnessed how charging for healthcare services impacts on the mental health of the whole family, with parents losing

[1] UK Lesbian & Gay Immigration Group. *Failing the Grade: Home Office initial decisions on lesbian and gay claims for asylum*, 2010. Available at: http://uklgig.org.uk/wp-content/uploads/2014/04/Failing-the-Grade.pdf (accessed July 2015).
UK Lesbian & Gay Immigration Group. *Missing the Mark: Decision making on Lesbian, Gay (Bisexual, Trans and Intersex) Asylum Claims*, 2013. Available at: www.uklgig.org.uk/docs/publications/Missing_the_Mark.pdf
Independent Chief Inspector of Borders and Immigration. *An Investigation into the Home Office's Handling of Asylum Claims Made on the Grounds of Sexual Orientation*, 2014. Available at: http://icinspector.independent.gov.uk/wp-content/uploads/2014/10/Investigation-into-the-Handling-of-Asylum-Claims-Final-Web.pdf (accessed July 2015).

sleep over unpaid bills. In this case, the family did not have a valid HC2 certificate, though they were eligible for one. They did not ultimately have to pay, but reported that they would have been forced into the arms of loan sharks if they had been billed.

2.8 Family Refugee Support Project has also witnessed cases in which the mum or dad have a life-long illness and are not accessing support, which undermines their ability to care for their children. This, in turn, has a knock-on effect on schools and social services, as more input and support is needed for the family as a whole. The costs of the charging regime may therefore be felt by other statutory services.

2.9 Based on our collective experience of supporting refused asylum seeker clients, we feel the cost of introducing the administrative system necessary for identifying chargeable patients, and the costs of pursuing chargeable patients via debt collection agencies or through the courts would far outstrip the value of the small number of debts successfully recovered.

2.10 If a refused asylum seeker has a serious health condition and has no other way of paying for the healthcare they need, it is conceivable that they may commit a crime in order to be detained and receive free healthcare. Again, this is an example of where the proposed charging regime could have unintended financial impacts on other statutory services and on community cohesion.

2.11 We are concerned that if patients are unable to pay their healthcare charge or outstanding fine, it could be on their Home Office file forever. This could affect their chances of seeking asylum if they ever try to come back to the UK. This is particularly concerning for people who come from politically volatile countries where the situation can deteriorate rapidly.

2.12 **In light of the above points, we recommend that all asylum seekers - regardless of status - should be exempt from healthcare charges while they remain in the UK.**

**Practical barriers to applying exemptions, and the need for additional exemptions to protect vulnerable groups:**

2.13 The Immigration Bill 2015-16, which is currently passing through parliament, includes proposals that will make substantial changes to the asylum support system and could lead to many more people being left without Home Office or Local Authority support, therefore becoming chargeable for healthcare under these proposals. Currently, families with children who have had their asylum claims refused remain on Section 95 support (if their child was born prior to the final refusal of asylum), until their immigration status is regularised or until they leave the country. The Bill proposes to withdraw Section 95 support from refused asylum seeking families and replace it with a new form of support (Section 10A). We are concerned that families may go through a period of being supported by neither the Home Office nor the Local Authority following a refusal due to administrative delays and/or disputes over which body is responsible for providing support. During this period vulnerable families would be chargeable for healthcare and experience significant health inequalities as a result.

2.14 The dangers of a delay in accessing support are powerfully illustrated by a 2012 Serious Case Review into the death of a mother (Mrs G) and child (EG) in 2010. In this tragic case the mother had been granted asylum but delays obtaining mainstream benefits and secure housing left her relying on ad hoc payments from local authorities. The general lack of support prevented her from caring for her vulnerable children and put additional pressure on local professional agencies. Her infant son starved to death as Mrs G was left unconscious due to a severe brain infection, from which she later died.

2.15 The Immigration Bill will remove Section 4 support for refused asylum seekers who temporarily cannot be returned to their home country (replacing it with Section 95A). The Bill also proposes to remove

the right of appeal against Home Office decisions to refuse or withdraw asylum support. If the Immigration Bill becomes law we can expect to see many more asylum seekers being refused support and therefore becoming chargeable for healthcare, despite having no means of paying for this.

2.16 Asylum Link Merseyside currently has 250 destitute Asylum Seekers registered with the centre. Around 100 of these have become destitute during the past 12 months. However, this figure does not accurately reflect the annual number of refusals in the Liverpool area and the true number is likely to be much higher. A Freedom of Information request to the Home Office in October 2015 asked how many asylum seekers were refused in Liverpool each year with no ongoing support. To date, despite an internal review, no answer has been forthcoming, indicating that the Home Office either do not know, or will not say. Information on the destitute group is at best sketchy and the total figure will increase every year with no clear indication of how people are able to make their way in life.

2.17 This raises two issues for the proposals in this consultation: firstly, that the list of exemptions must be updated to reflect the new support streams that may be created by the bill, and secondly, that the number of refused asylum seekers who would theoretically be chargeable will grow, as will health inequalities against the rest of the population.

2.18 **In light of this, we recommend that the list of charging exemptions be updated to include the newly created categories of support if the Immigration Bill 2015-16 becomes law (Section 95A of the Immigration and Asylum Act 1999, and new paragraphs 10A and 10B of Schedule 3 of the 2002 Nationality, Immigration and Asylum Act).**

2.19 **We recommend that all asylum seekers and their dependents - regardless of status - should be exempt from charges. This would mean adults and children that are refused asylum should continue to receive free primary and emergency healthcare. We further recommend that secondary healthcare charging exemptions should also be introduced for this group in light of the costs involved in recovering these debts and the unlikelihood that these individuals would be able to pay.**

2.20 **We are concerned that those who have been granted refugee status, Humanitarian Protection or Discretionary Leave to Remain for protection purposes in the UK do not appear in the list of exemptions from the NHS charging regime, and we strongly recommend that they are added to the list.** These groups would be granted leave to remain rather than Indefinite Leave to Remain and therefore would not automatically qualify for free healthcare.

2.21 The UK asylum process worsens people's mental and physical health. What we observe on the ground in Liverpool is backed up by research by the Royal College of Psychiatrists, which notes that "the psychological health of refugees and asylum seekers currently worsens on contact with the UK asylum system". Surely the primary aim of the Department of Health should be to improve health and reduce health inequalities. Yet we cannot see how the proposals to extend charging can possibly make vulnerable people's health better.

2.22 Research with the University of Central Lancashire in 2009 indicated that 50% of the sample group experienced moderate to severe levels of depression.[2] Subsequent informal observations lead to similar conclusions. The proposed system of charging will not improve access to the treatments people require, instead letting them deteriorate to the point of crisis, a move away from a preventative model.

[2] http://iccm.org.uk/the-last-gambados/wp-content/uploads/Executive-Summary-CSIP-Community-Mental-Health-Research-Report.pdf
http://healthycities.org.uk/uploads/files/003_asylum_seeker_mental_health_modernisation_group___liverpool.pdf

2.23 Refused, destitute asylum seekers live in extreme poverty, with no access to secure housing, food and other essentials. They are susceptible to poor health resulting from exposure, poor nutrition etc. They are also extremely socially isolated and thus vulnerable to poor mental health and psychological/sexual exploitation. Preventing them from accessing emergency health services and some primary care services will only exacerbate these underlying vulnerabilities. As noted above, there is no way of measuring the scale of this problem as very few accurate figures are available.

2.24 Although treatment for HIV is listed amongst the exemptions, we are concerned that barriers to accessing primary care may prevent people from learning that they are HIV positive in the first place, and for those patients who already have a diagnosis, these barriers may leave them exposed to other opportunistic infections. If these infections aren't controlled, they will put the public at risk. In our experience, this is a special risk for minors who may have been exposed to sexual abuse/violence.

2.25 We welcome the inclusion of victims of torture and sexual violence within the list of people who will be exempt from healthcare charging. However, we are concerned that it will be impossible for these groups to be identified if access to health services is further restricted via the charging regime. It takes time and a great deal of trust to volunteer information about torture or rape to a healthcare professional. This is unlikely to happen at an initial appointment with a GP or nurse. Rather, it may be that through the treatment/ investigation of another condition (depression, anxiety, panic attacks, headache etc) that experience of torture or sexual violence comes to light. Closing off access to certain health services precludes such confidences from being made.

2.26 These barriers may also prevent vulnerable people from being able to get evidence of the torture or sexual violence they may have experienced. Medical reports are a vital mechanism in substantiating asylum claims based on torture, and we are concerned that the barriers introduced by the charging scheme (whether real or imagined) will prevent asylum seekers from getting this evidence.

2.27 We are also concerned that Home Office data will be relied upon to identify asylum seekers who are eligible for free healthcare, and those who are refused and therefore chargeable. Home Office decision making is unreliable, with roughly a quarter of all decisions to refuse asylum later overturned on appeal. A key flaw in the decision making process is in the assessment of credibility and the treatment of evidence. Home Office case workers regularly reject medical evidence pointing towards torture. As such, we do not have faith that Home Office data can reliably be used to determine who should have access to healthcare. Relying on this will, in our view, risk excluding vulnerable people, including victims of torture and sexual violence, with disastrous consequences for health and mental health.

2.28 We also welcome the decision to include "anyone receiving compulsory treatment under a court order or who is detained in an NHS hospital or deprived of their liberty (e.g. under the Mental Health Act 1983 or the Mental Capacity Act 2005)" within the list of those exempt from charging. However, we are concerned that with a charging regime restricting access to most primary care services, and all emergency services, many people with severe mental health issues (including those at risk of suicide) will simply not be recognised and would not be sectioned, though their state of mind may warrant it.

2.29 **There is no mention within the consultation document about ensuring community mental health services are freely available. We strongly recommend that these should be exempt from charging.**

2.30 One case study from the social worker at MRANG illustrates how vital it is that refused asylum seekers have free access to mental health services:

The social worker is working with A, a female asylum seeker who has been sectioned and had her children adopted. She has no support at all from mental health professionals and the social worker has had to advocate for her through her GP, particularly reminding them of her deterioration, booking appointments and accompanying her to appointments because she forgets easily. The community mental health nurses have very minimal visits to her home and A is just barely managing. Her asylum case has been refused with no rights of appeal. She has not been given notice to leave the accommodation yet but probably will very soon and she will be destitute. Her mental health is deteriorating and she still requires access to mental health services but would be chargeable for these.

**Impact on people with 'Protected characteristics':**

2.31 Looking exclusively at protected characteristics under the 2010 Equality Act, we believe the proposed charging regime is set to increase discrimination on the basis of race, and on the basis of pregnancy/ maternity.

**Race:**

2.32 Under the 2010 Equality Act, race "refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins."

2.33 Many asylum seekers hail from the Middle East and north and sub-Saharan Africa, because these are places experiencing widespread conflict and political/ social unrest. These are regions where certain health conditions are more prevalent. For example, according to the NHS, people of African origin are more likely to experience high blood pressure, diabetes, prostate cancer and sickle cell disorder. Likewise, the NHS also notes "People from African and African Caribbean communities are more likely than others to be admitted to hospital for mental illness. […] Everyday life has a big impact on mental health, and black communities in the UK are still more likely than others to face issues such as bad housing, unemployment, stress and racism, all of which can make people ill." This is especially true for people seeking asylum (see below). The proposal to make refused asylum seekers chargeable as part of the new charging regime would *de facto* increase health inequalities for this group.

2.34 There is already a lot of confusion amongst healthcare professionals and administrators about the entitlement to healthcare of certain groups. We are concerned that the new charging regime will increase this confusion and lead to race discrimination and reliance on racial profiling. Already, we suspect some GP practices tell asylum seeker clients their registration lists are full, simply because they do not want to deal with complicated patients. Local advice agencies, and a local refugee-led forum (Liverpool Asylum and Refugee Association) have uncovered evidence of hostile reception staff who erroneously inform people they are not entitled to register. This, in turn, feeds into negative social attitudes towards people seeking asylum and compounds the wider myth that they are undeserving and have come to the UK to take advantage of our 'generous' benefits system. Liverpool has been a well-established asylum-dispersal area for over fifteen years and yet these problems persist. Several new towns in the Merseyside area will soon become asylum dispersal areas as the reach of the COMPASS asylum accommodation contract is expanded. This raises significant concerns that the new charging regime, which asks un-trained GP receptionists and healthcare professionals to police entitlement, could lead to racial discrimination and hate crime. Aside from the effect on the health and mental health of individuals, this will also undermine community cohesion and put more pressure on other services such as the police.

**Pregnancy/ maternity:**

2.35 One woman supported by the Family Refugee Support Project was questioned excessively at the Liverpool Women's Hospital following an ante-natal appointment, when someone working there pulled her and her partner aside and said that they had checked with the Home Office and been told their case had ended in 2011. This was incorrect as they still have representations in with the Home Office. The family believed this signalled a notice of a refusal from the Home Office and it caused a huge amount of distress, with neither parent sleeping for three days. It also made them reluctant to return to the hospital. Family

Refugee Support Project had to put a lot of extra staff time and resources into counselling the family and advocating on their behalf as a result of this confusion.

2.36 Having eligibility for free maternity care questioned is a common experience for pregnant women and affects both those who are chargeable and those who are not, under the current charging regime. Appallingly, the Royal College of Obstetricians and Gynaecologists have reported that asylum seeking women are *three times more likely* to die in childbirth than the general population. This demonstrates a shocking level of health inequality which we believe the proposed new charging regime will not only do nothing to address, but is rather set to exacerbate. As news spreads that charges have been introduced for primary health care, we believe more women will also present late for pre-natal care, leading to a higher chance of complications. We predict more women will be forced to give birth at home and that if complications develop they will be too afraid to seek emergency medical attention, thus putting the safety of mother and child at risk.

2.37 **For these reasons, we strongly recommend that pregnant women should be exempt from charging.**

2.38 **In conclusion, we do not believe it is possible to implement the proposals in the consultation without having a negative impact on health inequalities or further discriminating against people with 'protected characteristics'. We therefore strongly urge the Department of Health not to introduce charging for primary care.**

## Primary Medical Care

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

Strongly disagree

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

Strongly disagree

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

Strongly agree

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

6.1 We would strongly caution against introducing any charging for primary medical care because this is such an important gateway to the NHS and any additional barriers could dramatically increase health inequalities. For the reasons outlined in our answers to question 2, such charging procedures will lead to more confusion over entitlements, more gatekeeping and greater failure to address the health needs of vulnerable people. This, in turn, will ultimately create more pressure on emergency services and potentially lead to higher costs for the NHS (in cases where costs cannot be recovered).

6.2 We know that even in the current climate (when there are, in theory, no issues with entitlement to primary care), refugee and asylum seeker communities in Liverpool already face many barriers to registering with a GP or getting an appointment. They are often not offered interpreters, which compromises the care they receive and their ability to give informed consent. Receptionists are not adequately trained and act as gatekeepers preventing asylum seekers from registering or getting an

appointment. Receptionists regularly challenge clients who are perfectly entitled to register. This can be a distressing and humiliating experience for vulnerable people, and many simply give up. Unless they have an advocate to help them, they simply avoid health services or access them further down the line when their condition is more difficult and costly to treat.

6.3 We believe the situation will become worse if the new charging regime is introduced. Reception staff and practice managers will be afraid they will be penalised if they wrongfully give access to somebody who should be charged and so will refuse care to both those who are entitled and those who are not. We already see a similar effect in housing, banking etc following the passing of the 2014 Immigration Act.

6.4 We are concerned that the decision to charge for any services apart from GP and nurse consultations may affect clinical judgement. For example, if a GP knows their patient may be charged and could end up in court for failure to pay, this could make them hesitate in making important referrals or ordering diagnostic tests. If a refused asylum seeker – who would be chargeable under the proposed new regime – has mental health issues, it is conceivable that their GP will decide not to put them at risk of further distress from being pursued for payment.

6.5 We have already outlined the importance of medical evidence and medical reports in our answer to question 2. If an asylum seeker is prevented from accessing primary care through fear of being charged, they may not be able to take further steps to evidence their case. **Again, we recommend that all asylum seekers - regardless of status - are exempt from charging.**

6.6 We welcome the idea of GP and nurse consultations being free, for the reasons outlined in our answer to question 2. However, we believe *all* primary care services should remain free. We strongly believe that people will be deterred from seeing a GP or nurse if they know any diagnostic tests or referrals for follow up care will be charged for.

6.7 **We recommend that all primary care services should remain free. However, if this is not guaranteed, we particularly recommend that diagnostic tests or referrals for specialist care be exempt from charging.**

6.8 We would also caution against linking to the Home Office database to establish whether somebody is chargeable firstly because in our experience, Home Office data is often unreliable and out of date, and secondly because this would destroy trust and could prevent vulnerable people – both with and without status – from accessing primary medical care.

6.9 Patients will soon become aware that their GP practice has a link to the Home Office database. This destroys trust and could prevent vulnerable people – both with and without status – from accessing primary medical care. Again, health issues may become far more complex if patients do not receive treatment early on, which results in patients needing more complicated procedures with higher costs. This also increases pressure on already over-loaded Ambulance and A&E services.

6.10 **We strongly recommend that the Department of Health does not enable data sharing between the Home Office and NHS and we caution against relying on Home Office data to assess eligibility for free healthcare.**

6.11 We are unclear whether Sexual Health Services will be charged for under these proposals. Primary care services are a very important route for diagnosing sexually transmitted infections. There is already a great deal of stigma associated with accessing Sexual Health Services. If access to primary care is also limited by the charging proposals this could potentially impact on the number/proportion of people diagnosed by screening. This inevitably carries a public health risk.

6.12 According to a February 2014 Health Policy article 'Sexual and reproductive health of migrants: Does the EU care?', the right of migrants originating from outside the EU "to health and in particular sexual and reproductive health (SRH) is currently not ensured throughout the EU" despite the European Union referring to health as a human right in many internal and external communications, policies and agreements, defending its universality. [3]

6.13 The article highlights the discrepancy between a proclaimed rights-based approach to health and actual obstacles to migrants' attainment of good SRH. Uncertainties on entitlements of diverse migrant groups are fuelled by unclear legal provisions, creating significant barriers to access health systems in general and SRH services in particular. Furthermore, the article points out that the rare strategies addressing migrants' health fail to address sexual health and are generally limited to perinatal care and HIV screening, rather than taking a holistic and inclusive approach in SRH policies, prevention and care.

6.14 **We strongly recommend that Sexual Health Services are exempt from charging.**

6.15 **We also strongly recommend that health professionals should have the power to waive a charge if they consider it cost effective to do so. Similarly, health professionals should always have the ability to waive charges where it would jeopardise public health not to treat the patient.**

## NHS Prescriptions

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

Strongly disagree

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

Strongly disagree

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

9.1 Yes. We strongly disagree with the proposal to remove prescription exemptions for non-EEA residents to whom the surcharge does not apply. Over the last few months we have seen many people receiving letters demanding payment for NHS prescriptions and informing them they do not have a valid HC2 Certificate. These were often dispatched in error when the individual or family *did* have a valid HC2 Certificate. Again, reliance on Home Office data should be avoided for this purpose. In addition, refused asylum seekers (who would not be exempt from charging under these proposals) are usually entirely destitute, having no permission to work and with Home Office support and housing withdrawn. They would have no means of paying and making them chargeable would certainly increase health inequalities.

9.2 There are significant costs associated with training NHS staff to assess entitlement. The prescribing clinician would need to check this for every patient. As most prescriptions will be for low cost medications

[3] 'Sexual and reproductive health of migrants: Does the EU care?', Health Policy, February 2014Volume 114, Issues 2-3, Pages 215–225 http://www.sciencedirect.com/science/article/pii/S0168851013002881

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.

9.3 **We strongly recommend that prescription exemptions should not be removed from children; pregnant women and women who have had a child in the previous month who hold a valid exemption certificate; people with a specified medical condition who hold a valid exemption certificate; those prescribed contraceptives and other listed medication; and those in receipt of certain benefits.**

## Primary NHS Dental Care

**QUESTION 10: 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

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

Strongly disagree

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

12.1 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.

## Primary NHS Ophthalmic Services (Eye Care)

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

Strongly disagree

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

14.1 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. **We recommend that on costs grounds alone the ophthalmic proposals should not be taken forward.**

## Accident and Emergency (A&E)

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

Strongly disagree

**QUESTION 16: If you disagree or strongly disagree with the proposals in 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

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

Unsure what services are included within an A&E setting. Need more information.

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

18.1 Currently, free access to A&E, Walk-In Centres, Urgent Care Centres and Minor Injuries Units is a vital safety net for vulnerable people who have been unable to register with a GP due to the barriers outlined in our answer to question 2. These are also an important access point for transient populations who may not have been resident locally long enough to register with a GP practice. Charging people for A&E care would prevent them from getting life-saving treatment and we thoroughly disagree with this proposal. We do not feel the Department of Health's commitment to make urgent and immediately necessary care available is enough of a safety net if people know they will subsequently be charged and are also concerned it will be impractical to administer.

18.2 **We strongly recommend that all treatment within NHS A&E settings, including Walk-In Centres, Urgent Care Centres and Minor Injuries Units should remain free.**

18.3 We do not 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. Indeed, we believe the current system of charging for secondary care is wrong and recommend that it should be reviewed. For the reasons outlined in our response to question 2, asylum seekers - regardless of status - should not be charged for any healthcare, whether primary, emergency or secondary care.

18.4 A person who is admitted to hospital is inevitably very unwell. The first priority for them and their family should be getting better, but instead, fear of the bill that will follow treatment causes emotional distress not to mention putting a strain on family relationships. This undermines recovery, and again, contributes to increased health inequalities.

18.5 We believe all NHS-funded services provided within an NHS A&E setting should be exempt from a requirement to apply the Charging Regulations on the grounds of protecting public health. Ensuring people can get access to the services they need will also aid the identification and treatment of infectious diseases that could be injurious to the health of the general population. This includes active TB, HIV and Cholera. Indeed, the Department of Health has already recognised the need to ensure infectious diseases are exempt from charging, yet without access to free A&E services (and most primary care services), we cannot see how these conditions would be identified.

18.6 We also believe anybody who presents at NHS A&E services who is experiencing extreme psychological distress should be exempt from charging on public protection grounds. The Department of Health already recognises the need for this under the list of exemptions from charging within the consultation document: "Anyone receiving compulsory treatment under a court order or who is detained in an NHS hospital or deprived of their liberty (e.g. under the Mental Health Act 1983 or the Mental Capacity Act 2005), who is exempt from charge for all treatment provided, in accordance with the court

order, or for the duration of the detention." However, we fail to see how such individuals will be identified if they are deterred from using A&E services because they are afraid of being charged.

18.7 We believe that the proposed introduction of charges for primary care will deter asylum seekers from seeking timely treatment, resulting in them making greater use of A&E services. This will impose a considerable additional burden on A&E departments. Moreover, we anticipate a negative impact on waiting times caused by clinicians and Overseas Visitors Officers needing to liaise before proceeding with treatment.

18.8 Closing off avenues to free primary and emergency care also leaves refugee support organisations and advisers in an impossible position. Currently, we advise clients to register at local GP practices but inform them that if the health need is urgent or if the surgery is closed, they should use A&E services. If we know this will lead to vulnerable people with fragile mental health receiving a big bill it will be difficult to know how to signpost them and could lead to an individual's health being heavily compromised.

## Ambulance Services

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

Strongly disagree

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

Strongly disagree

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

21.1 An ambulance will normally only be called in an emergency situation. If a refused asylum seeker (who would be chargeable) is involved in an accident and someone else calls ambulance they would not be in a position to object and explain they cannot pay for treatment.

21.2 We do not believe charges for ambulance services should be implemented. See answer to Q18 above for details.

## Assisted reproduction

**QUESTION 22: 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?**

Strongly disagree

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

Strongly disagree

**QUESTION 24: Are there any other services that you think we should consider removing access to for those who have paid the health surcharge?**
No

**QUESTION 25: Are there any groups of individuals who you believe should continue to have the right to access NHS funded fertility treatment, even if they are not ordinarily resident, and (in the case of non-EEA citizens), do not have Indefinite Leave to Remain in the UK?**
25.1 We are concerned that the period refugees are forced to wait before securing Indefinite Leave to Remain may take them beyond the allowed age to be eligible for IVF.

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

## Non-NHS providers of NHS care and Out-of-Hospital care

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

Strongly disagree.

**QUESTION 27: Are there any non-NHS providers that should be exempt from a requirement to apply the Charging Regulations?**
27.1 Yes. We believe charities, voluntary and community organisations and providers who are established as social enterprises should be exempt from a requirement to apply the Charging Regulations. 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.

**QUESTION 28: Are there any NHS-funded services provided outside hospital that should be exempt from a requirement to apply the Charging Regulations (e.g. on public protection grounds)?**
28.1 Yes. We believe 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 should be exempt from a requirement to apply the Charging Regulations. A compelling case for charging for out-of-hospital care has not been made in the consultation and the cost of charging for these services is likely to greatly outweigh the net benefits of providing them for free.

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

No

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

No

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

31.1 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.

**QUESTION 32: Our proposal for defining residency for EEA nationals is to exclude EEA nationals from being considered ordinarily resident in the UK for the purposes 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

## Recovering NHS debt of visitors resident outside the EEA

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

**QUESTION 34: Do you have any evidence on the impact of this proposal on NHS cost recovery or any comments on the implementation of such a proposal?**
34.1 It is not clear from the proposal document who would be chargeable for the care received by dependent children. If parents believe they may be charged this could deter them from seeking help and put the health of children at risk. It may also put the health of the parent at risk due to the emotional distress caused by not being able to pay for their children's care. We have witnessed clients becoming extremely hopeless if they find they cannot provide for their children. One adviser was asked "If I kill myself, will this country take care of my children?" The proposals could force loving parents to such extremes.

34.2 **We recommend that children – regardless of the immigration status of their parents – should be exempt from any healthcare charging.**

34.3 Individuals who are severely isolated from their home community, and potentially the local community too (such as refused LGBTI asylum seekers) may not be able to rely on other people to pay their healthcare charges.

34.4 We are concerned these proposals may also lead individuals to presume they need someone to 'vouch' for them or sponsor them. This could potentially lead to individuals getting themselves into exploitative situations and/or relationships with others.

34.5 As the need for healthcare can be unpredictable, this could impact significantly on the individual and the third party – particularly if healthcare charges are excessive. Indeed, the proposals do not clearly set out what levels of interest or fines would be applicable to the individual and/or the third party.

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

N/A

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

No

## Impact Assessment

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

37.1 As outlined above, we are extremely sceptical about the cost effectiveness of introducing these charges. Registering asylum seekers for primary care is already a lengthy process due to confusion over entitlements. We believe any new charging regime would make this administratively burdensome, and would inevitably take more time than the 1.5 extra minutes estimated in the Impact Assessment. We also believe there will be additional staff training costs for GP practices to ensure receptionists understand the multitude of different documents denoting immigration status. The status of a person going through the asylum system changes rapidly. In order to check whether a person's chargeable status has changed, GP surgeries would need to repeat status checks regularly, which would involve extra resources and staff time.

37.2 We are concerned that there are aspects of these proposals that have not been impact assessed (noted on page 8 of the Impact Assessment). In light of this it is highly unlikely these proposals are cost effective.

37.3 In light of the potential breaches to equality law introduced by the proposed charges (outlined in our answer to Question 2), we believe these could leave GP practices, hospitals and other healthcare providers open to discrimination-based legal challenges. These costs have not been taken account of in the Impact Assessment.

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