



## Project 17

Unit 1.3 Resource for London  
356 Holloway Road, N7 6PA

07963 509 044

abi.brunswick@project17.org.uk

[www.project17.org.uk](http://www.project17.org.uk)

### Response to the Department of Health consultation on extending NHS charging: 'Making a Fair Contribution'

#### About Project 17:

Project 17 is an organisation working to end destitution among migrant children. It works with families experiencing exceptional poverty to improve their access to statutory support.

#### Our response:

We strongly disagree with the proposals outlined in the consultation. We believe that the proposed changes are both unworkable and dangerous. They create serious safeguarding and public health risks for people living in the UK, and present short-term savings that will be eclipsed by additional administrative expenditure and increased need for emergency care for those denied primary intervention.

We note the core principles of the NHS are:

- that it meet the needs of everyone
- that it be free at the point of delivery
- that it be based on clinical need, not ability to pay<sup>1</sup>

These proposals fundamentally change these core principles. The proposals increase the extent to which access to health care is a two-tier system, in which some people have free access while others are left without medical intervention.

Implementation of these proposals will lead to people excluded from primary care being forced into emergency situations which are both dangerous and expensive. We are aware from our extensive work with migrant families that many people currently charged for secondary healthcare are unable to pay. There is no evidence to suggest that people would be able to pay for extended charges. The cost of recouping the payment would far outweigh any benefit from the money received.

Overall, the proposals fail to recognise that many thousands of people who will be affected by the new charging regime are resident in the UK, have lived here for years and will continue to live here. Referring to 'visitors and migrants' masks the reality that many people living long-term will be chargeable for NHS care under the proposals. Many of our service-users become irregular migrants by overstaying visitor or student visas following a change in circumstances such as pregnancy, relationship breakdown or

---

<sup>1</sup> <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx>

domestic violence. People in this situation may be trying to regularise their immigration status, may be the parents of children who are British, and may have a long-term future in this country. Denying access to healthcare for people who are resident creates both short-term problems for individuals, and long-term problems for us all. More expensive secondary intervention is required, bills will not be paid, infectious diseases will not be treated and public health risks will emerge.

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

We fundamentally disagree with extending charging to primary and emergency care. If the Department goes ahead with these proposals, we would support the exemptions.

**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?**

These proposals will increase health inequalities. There will be a disproportionate impact on people with protected characteristics. People with disabilities will be disproportionately affected, simply because they are likely to have greater need for medical care, attention and intervention. People from racial minorities will be disproportionately affected as this policy is specifically designed to prevent short-term and irregular migrants from accessing healthcare. Pregnant women will be disproportionately affected due to their increased need for access to healthcare.

The Department's stated commitment to protect 'vulnerable groups' is not borne out in the proposals. The exceptions for treatment for vulnerable migrants are limited to specific types of healthcare that are directly related with an act or abuse or a criminal offence (rape, FGM etc.) Wider health needs are not exempt. We are also extremely concerned that the Department does not recognise other 'vulnerabilities', such as poverty, homelessness, exploitation.

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

Strongly disagree

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

Strongly disagree

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

Strongly agree

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

We are extremely concerned about the impact of the proposals. Whilst we welcome the proposal that primary care consultations remain free, we do not think that consultation without the option of treatment will be at all useful. Indeed, we are unclear what is meant by 'consultation', if no tests or treatment can be offered. Particularly we note the following:

- These proposals will impact people who are living long-term in the UK, who may be in the process of regularising their immigration status and may have human rights grounds for remaining in the UK.
- Once someone submits an application for leave to remain, it over a year for the Home Office to process that application. Moreover, large numbers of refusals are overturned on appeal<sup>2</sup>. As such, a person may be charged for NHS care for a period several years due to bureaucratic delays and poor initial decision-making, even though their immigration application demonstrated their right to remain several months or years previously.
- The existing rules are complicated and open to misinterpretation. In our experience they are often misapplied. For example, many of clients have been incorrectly denied GP registration. We believe that this confusion will increase if the new proposals are implemented.
- Whether or not someone has an underlying right to access free healthcare under the new rules will be a complex immigration decision. For example, primary carers of European nationals will have underlying European rights as 'Zambrano carers'. They therefore should not be charged for using NHS services, even if they do not have Home Office recognition of their right to reside. These proposals expect healthcare professionals and administrative staff at local GP surgeries to identify immigration status and effectively act as immigration control. This is unrealistic and dangerous, as mistakes will be made and people who should be able access free healthcare will be denied help.
- Preventing people from accessing primary care has significant public health consequences. TB and HIV, for example, are often diagnosed in a primary care setting. Charging for tests and treatment will deter people from accessing care. This is particularly true of migrants facing poverty. Clearly a failure to test, intervene and treat infectious diseases raises serious public health concerns for us all.
- Many of the people effected by the proposals will be children. It is unclear to us how the government's commitment to act in the best interests of children and treat the welfare of children as a primary consideration can be in line with denying children free access to primary healthcare

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

Strongly disagree

---

<sup>2</sup> <https://www.gov.uk/government/publications/immigration-statistics-july-to-september-2014/immigration-statistics-july-to-september-2014>

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

Strongly disagree

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

Removing prescription exemptions from non-EEA residents is dangerous to individuals; costly to the NHS; and raises public health concerns.

The existing exemptions reflect medical need and public health priorities. Forcing people on low incomes who can currently benefit from HC2 certificates to pay for prescriptions will simply mean that people in poverty will not access medication. Treatable and preventable conditions will escalate and individuals will require more costly emergency intervention later.

This system will be administratively complex. It will be almost impossible for GP surgeries to determine whether, for example, an EEA national has acquired permanent residence. Inevitably, people who should be entitled to free NHS care will be asked to produce EHIC cards. We strongly resist the Department's plans to turn medical professionals into immigration officials.

#### **Questions - Primary NHS Dental Care**

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

Strongly disagree

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

Strongly disagree

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

We raise similar concerns here as expressed in response to question 9. As with prescription charges, removing exemptions for dental care will mean that people in serious need of medical intervention are unable to access it. Failure to provide dental care to children, to pregnant women and to people with pre-existing health concerns will mean that early warning signs are not detected and more serious health problems will develop.

We echo the response from the National Aids Trust, which states that dentists are often able to identify undiagnosed HIV and propose testing. Charging that effectively prohibits people in poverty from accessing dental care will reduce HIV diagnosis.

We also endorse Maternity Action's response to this question, which states that dental care for pregnant women should be considered 'immediate and necessary' rather than 'routine' because links have been established between adverse pregnancy outcomes and poor dental health.

#### Questions - 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?**

We object to the imposition of charging for ophthalmic care on the same basis as our objections for prescription and dental charges. We further note that the Department's own impact assessment estimates that these measures would in fact cost the NHS an additional £32.7m over 5 years to implement.

#### Questions - 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 question 15, do you agree that charging should cover care given within an NHS A&E setting if an individual is subsequently admitted to hospital, or referred to an outpatient appointment?**

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)?**

All NHS funded services provided within an A&E setting should be exempt from charging. These services exist to meet identified public health and individual health needs.

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

We believe these proposals are both ineffectual and dangerous. Implementation would require A&E departments to put in place additional bureaucracy, provide extra training for staff and expend financial resources on employing those tasked with assessing eligibility. This would put more pressure on services that are already struggling to meet the needs of the community.

People attending A&E may be unable to consent to treatment because of illness or other lack of capacity. Those who cannot afford treatment may incur charges because they are unable to refuse

treatment. Moreover, charging for urgent services will put people off seeking medical attention if they do not have enough money to do so. Ultimately, this will result in higher rates of mortality.

### Questions - 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.

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?

This proposal will act as a disincentive to accessing emergency healthcare. Many people will avoid seeking help for fear of accruing debt that they will be unable to pay. We find this morally objectionable. Moreover, it is fundamentally contrary to the core values of the NHS, which are built of universal access to medical services that are free at the point of delivery.

As with A&E services, implementing charging for ambulance services raises complex practical and ethical issues surrounding consent. Would a person be charged if, for example, an ambulance was called by a well-meaning third party but then turned away by the patient for fear of accruing charges?

The implication that paramedics are expected to ask patients about their immigration status before administering treatment is unworkable and fundamentally alters the work of the paramedic. The paramedic would be responsible for identifying whether the need for treatment was immediate and necessary before taking a decision as to whether to provide services before requiring payment. This is a decision that must be made by a clinician (not a paramedic).

These provisions will prevent vulnerable groups, including pregnant women, those with disabilities, those experiences domestic abuse, and those living in poverty, from accessing emergency services. Inevitably this will result in increased morbidity.

### Questions - Assisted reproduction

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

Strongly disagree

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

Strongly disagree

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

No. We strongly object to removing access from any health services to those who have paid the health surcharge. It is noted that those who pay the surcharge have effectively already paid twice: through the surcharge and through taxation.

**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?**

We oppose restricting funding fertility treatment based on immigration status. This is a clinical treatment and it is not clear to us why it should be given particular consideration under these proposals. Further, removing the right to NHS funded fertility treatment may interfere with the right to a family and private life (Art 8 ECHR) by preventing some people from establishing families based on immigration status.

#### **Questions - 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?**

We object to the proposal to impose charging for non-exempt visitors to non-NHS providers of out of hospital care. We believe that all providers should be exempt. Many of these services provide crucial preventative care and help manage chronic conditions. If these provisions are effectively rendered inaccessible for migrants with limited resources, chronic conditions will become emergencies and serious health conditions will develop. Emergency medical intervention will be required, and this more expensive treatment will be provided because the care will be immediate and necessary. But patients will still be unable to pay and the NHS will lose money.

This proposal calls for the establishment of complex bureaucracy that will be difficult to regulate and expensive to implement. Further, it would force organisations such as charities and voluntary organisations to understand and apply complex immigration rules. It is simply not workable.

**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)?**

Whilst we object to all charging for NHS-funded services, we particularly recommend exempting the following from the charging regulations:

1. Drug and alcohol services

2. Sexual and reproductive services (including sexual health and pregnancy termination)
3. Mental health services
4. Hospices
5. Maternity services
6. Children's services
7. Health visitors

These services make significant contributions to public health and to the health of our communities. As with other charging proposals, we do not accept the argument that charging will be cost-effective. Administrative difficulties coupled with later complications and the need for emergency intervention will outweigh any potential income from charging.

**QUESTION 29: Are you aware of any data on the number of overseas visitors that access NHS funded care provided by non-NHS bodies, or outside the hospital setting (and when the providers of that care are not hospital employed or directed staff)?**

No

#### Question - NHS Continuing Healthcare

**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 and NHS-funded Nursing Care should be covered by the NHS Charging Regulations?**

No. Those accessing continuing health care are doing so because their needs have been assessed and medical professionals have concluded that care is required. Given that the Department does not know of any examples of people who are not ordinarily resident accessing continuing healthcare, it cannot be argued that the availability of care is having any real impact on the NHS' financial stability.

#### Question - Defining Residency for EEA Nationals

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

Strongly disagree

#### Questions - 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?**

This proposal will make third parties liable for NHS debt accrued by people to whom they have provided limited financial support. This is an unduly harsh mechanism through which people who are ordinarily resident will become indebted to the NHS, with no control over the amount of debt that they accrue.

**Question - Overseas visitors working on UK-registered ships**

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

Strongly disagree

**Questions - Further areas for consideration**

**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

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

The impact assessment proceeds upon the basis that these regulations will only apply to short-term visitors. This is not correct. Last year we worked with 300 families who are, or were previously, living permanently in the UK without regular immigration status. The use of the term 'visitor' denies the reality that there are people - including children born in the UK - who will be effected by these proposals. This group is exceptionally vulnerable. Unable to work and excluded from mainstream welfare benefits, families with children in this situation often face extreme poverty and will be simply unable to afford the charges for NHS care. As such, children born in this country, who in all probability will become British citizens and live their lives in the UK, will be unable to access care from the NHS.

When people trying to regularise their immigration status accrue NHS debt and cannot pay it, the impact of this debt goes beyond the cost to the NHS. It can also impact immigration status by indicating to the Home Office that an individual is not of 'good character'. These proposals will make avoiding accruing charges much more difficult. Consequently, people living in the UK while trying to regularise their immigration status will face a compounded penalty: the initial NHS charge alongside the negative impact on immigration applications.

The impact assessment does not identify the true scope of administrative costs required to implement the charging regime. It does not take into account, for example, the cost of bad debt that will be accrued when people in poverty inevitably fail to pay. We also doubt whether the costs of new computer systems have been adequately accounted for, and whether the true cost of training has been factored

in. Further, mistakes will be made and litigation is likely to follow. The cost of additional legal advice and representation should also be considered.

We do not consider that a realistic analysis of how providers of primary care are expected to implement the charging regime and assess immigration status has been conducted. The current system relies on Overseas Visitors Teams within hospitals to identify who should be subject to charging. These resources will not be available to GPs, dentists, opticians, health visitors, walk-in centres etc. Additional staffing costs and administrative resources have not been properly assessed.

We are further concerned about data sharing between the Home Office and the NHS. It is not clear how the provider is expected to determine a patient's immigration status. We are concerned that personal information may be passed between the Home Office and the NHS without proper safeguards or consideration.