Department of Health

Questionnaire: Consultation on making a fair contribution

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

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

Or alternatively, please write to:

Cost Recovery Programme

Department of Health

506 Richmond House

79 Whitehall

London SW1A 2NS

What is your name? Adrian Berry, Chair

What is your email address? info@ilpa.org.uk

What is your organisation? Immigration Law Practitioners' Association (ILPA)

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
- vulnerable groups?

Yes

If yes, please explain.

The Health and Social Care Act 2012 places duties on the Secretary of State[1], the NHS Commissioning Board [2] and on Clinical Commissioning Groups [3] to reduce health inequalities and inequalities of access to the health service. The question as to how to avoid impacts on health inequalities, persons with protected characteristics or vulnerable groups is therefore incorrectly posed. The duty on health bodies is to reduce health inequalities and not simply to avoid exacerbating them. However, the extension of charging into primary care will exacerbate health inequalities rather than reduce them and the proposals cannot be implemented in a way that would avoid negative impacts on these groups.

In so far as these forms of care are to be brought within the charging regime at all, ILPA agrees that the existing secondary care charging exemptions for secondary care should be applied to primary medical care and emergency care, however the consultation document provides an incomplete list of these exemptions, the exemptions are not currently wide enough to cover all relevant categories of vulnerability and the use of exemptions would be insufficient to mitigate the specific impact of extending charging into primary and emergency care.

The proposal to extend charging into primary care settings does not take into account the necessary role of providers in primary health care and emergency medicine in actively identifying health needs and vulnerable persons who should be supported to access free health care. Some examples are provided below.

ROLE OF UNIVERSAL SERVICES IN IDENTIFYING HEALTH NEED AND VULNERABLE PERSONS

- Victims of human trafficking and modern slavery

The National Health Service (Charges to Overseas Visitors) Regulations 2015 create an exemption from charging for secondary care where a competent authority has identified the overseas visitor as a victim of human trafficking or considers that there are reasonable grounds to believe that they are a victim of human trafficking [4]. Victims of trafficking therefore only currently qualify for secondary health care as such following a formal status determination by the Home Office. The exemption does not adequately take into account the role of health care providers in identifying victims of trafficking and this role would be further undermined by the extension of charging into primary care and emergency medicine.

The Department of Health has issued guidance highlighting the role of staff in every health care setting in identifying victims of human trafficking and modern slavery [5]. The guidance advises health care providers that trafficked people may not self-identify as victims of modern slavery and that they may be prevented from revealing their experience to health care staff from fear, shame or other barriers such that it can take time for a person to feel safe enough to open up [6]. The document therefore provides examples of indicators of trafficking to support health care providers in identifying victims of trafficking and slavery [7].

Research examining contact of NHS secondary healthcare services with victims of trafficking (undertaken before the more restrictive charging regime for secondary care was implemented in April 2015) indicated that many victims of human trafficking come into contact with NHS services during the time they are trafficked, or after their escape and that up to one in eight NHS professionals reported coming into contact with a patient they suspected may have been trafficked [8]. Reported contact with victims of trafficking was highest among professionals working in maternity services, mental health, paediatrics and emergency medicine [9]. An identified limitation of the research was that professionals working in dentistry, sexual health and termination of pregnancy services were under-represented in the study [10] and these are also likely to be important settings for the identification of victims of trafficking. A quarter of those who reported contact with victims identified that their knowledge or suspicions arose because of disclosure by another professional involved in their care [11], highlighting the potential role of clinical staff in primary healthcare settings in identifying victims of trafficking that fell outside the scope of the research. The research concludes that healthcare providers can play a critical role in identifying and referring potential victims of human trafficking and by providing clinical care [12].

E-learning training for healthcare providers on identifying and supporting victims of modern slavery issued in partnership with the Department of Health states that healthcare settings may often offer

victims of modern slavery their only opportunity to come into contact with people who can identify the signs of trafficking [13].

Research into young people trafficked for sexual exploitation makes similar findings and highlights the importance of a range of healthcare settings accessible to victims [14]:

"One of the ways perpetrators exert control over young people is to prevent them from accessing or using any service, including school and healthcare services. The child will be prevented from registering with or visiting a GP for fear that the abuse will be identified. There was evidence of young people 'escaping' to access a 'walk in' centre or 'accident and emergency' to treat severe health problems."

Trafficked young people may also present without health care needs that reach the threshold of requiring immediate and necessary care with the risk that they may be turned away from services where charging is introduced. The research identified that young people may present to health services as a means of attracting attention to the abuse they were experiencing, exaggerating physical health symptoms which, without careful attention to identifying the undisclosed underlying experience of trafficking, might lead to the young person being discharged without follow up intervention [15]. The research highlights the importance of universal and accessible health services. The risk of being charged for accessing primary settings or A&E may prevent trafficked persons from presenting at these services altogether.

The creation of barriers to accessing healthcare in primary or secondary healthcare settings through the extension of charging would prevent the identification of victims of trafficking and lead to the UK being unable to comply with its positive obligations to identify victims of trafficking under Article 10 of the Council of Europe Convention on Action Against Trafficking in Human Beings [16] and Article 4 of the European Convention on Human Rights [17].

- Victims of domestic violence

Under the current NHS charging regulations, treatment for a physical or mental condition caused by domestic violence is exempt from charging in secondary care settings, however the extension of charging into primary care settings and emergency medicine may prevent domestic violence being identified by clinicians.

NICE Guidelines on domestic violence cite research indicating that a high proportion of women attending accident and emergency departments, primary care, family planning, reproductive and sexual health settings are likely to have experienced domestic violence and abuse at some point [18]. Research also indicates that prevalence of domestic violence in women attending an accident and emergency department is high and this means that this is an important site for intervention through asking women about experiences of domestic violence which may not otherwise be disclosed [19]. The NICE Guidelines on domestic violence recommends that health and social care providers should ensure frontline staff in all services are trained to recognise the indicators of domestic violence and abuse and can ask relevant questions to help people disclose their past or current experiences of such violence or abuse [20].

The restriction of access to primary health care and emergency health care settings risks limiting the identification of victims of domestic violence and reducing their access to healthcare treatment, increasing the disease burden and exacerbating health inequalities.

IMPACT ON PEOPLE WITH PROTECTED CHARACTERISTICS UNDER THE EQUALITY ACT 2010

We identify below examples of the disproportionate impact the proposals are likely to have on people with protected characteristics under the Equality Act 2010. Many of the protected characteristics are relevant to a person's ability to speak up for themselves and negotiate complex bureaucracies. Those least able to negotiate officialdom will be hit hardest by the bureaucracy involved in both evidencing and advocating for their entitlements to healthcare [21].

- Race

The proposals to extend charging into primary health care and emergency medicine will be applied to non-EEA nationals who are not covered by the Immigration Health Surcharge and EEA nationals unable to demonstrate their entitlement to healthcare. These groups are by definition not British citizens and the proposals will reduce the likelihood that they obtain the healthcare that they need, including health care to which they are entitled.

In our response to questions 3-6 below, we highlight the difficulties that NHS providers are likely to experience in correctly identifying the immigration status and entitlements of persons within these groups, leading the likelihood that people from Black and Minority Ethnic groups and EEA nationals are unable to access healthcare to which they are entitled.

People from Black and Minority Ethnic groups are also more likely than people not from such groups to have their eligibility questioned and lead to disproportionate impacts on British Citizens from these groups, particularly those who may have difficulty evidencing entitlement such as homeless persons, people from Roma or traveller communities, or those with mental health difficulties.

The Committee on the Elimination of Racial Discrimination, interpreting the duties on States under the UN Convention on the Elimination of Racial Discrimination has held that States should ensure they respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services [22]. The Committee has indicated its concern about the poor health outcomes experienced by Gypsy and Traveller communities. It also recommended that impact assessments are undertaken to ensure economic measures are not discriminatory to those at risk of racial discrimination [23].

- Sex

Women and girls are more likely to be victims of sexual or domestic violence than men [24] and therefore likely to suffer disproportionate impacts of being unable to access healthcare services and have their needs for protection and treatment identified as above. Women subject to immigration control whose status is dependent on their spouse or partner and whose relationship has broken down due to domestic violence may also face difficulties evidencing their entitlement if, for example, they are unable to access their documents after leaving the family home.

Women are also more likely to be overseas domestic workers, for whom there would be no provision for access to healthcare if charging was extended (see further below).

- Pregnancy and maternity

Whilst pregnancy and maternity engage the protected characteristic of sex, they are also identified as protected characteristics in their own right.

NICE Guidelines on pregnancy and maternity care identify recent arrival in the UK as a migrant, asylum seeker or refugee as a complex social factor in pregnancy requiring efforts to promote uptake of ante-natal care [25]. The evidence reviewed for the guidance identified that women are deterred from attending antenatal appointments, including booking appointments because of the perceived negative attitude of healthcare staff, including non-clinical staff such as receptionists [26].

Late booking of pregnancy appointments is also known to be associated with poor obstetric and neonatal outcomes [27].

Extending charging to antenatal services within primary care settings would deter women from accessing services where their immigration situation was irregular or where they feared or experienced difficulty evidencing their entitlement to healthcare on account of their immigration status.

Maternity services are a key setting where victims of trafficking may present [28] making these settings particularly important for the identification of victims of trafficking. It is also evidenced that domestic violence often starts or escalates during pregnancy, the NHS indicating that 30% domestic violence begins in pregnancy [29], increasing the importance of access to antenatal and other maternity services for interventions preventing harm caused by domestic violence. Preventative antenatal health care and screening also brings the costs benefit that it may eliminate the need for more costly treatment at a later stage [30].

The UN Convention on the Elimination of Discrimination Against Women requires States Parties to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period , making explicit the duty to grant 'free services where necessary' [32]. The UN Convention on the Rights of the Child requires States to recognise the right of all children to the highest attainable standard of health and to work to ensure no child is deprived of access to health care services [33]. In its General Comment No.15, the Committee on the Rights of the Child confirms that health services must be accessible to all children, pregnant women and mothers within the State and that lack of ability to pay for services, supplies or medicines should not result in denial of access [34]. The extension of charging into primary care would prevent the UK from complying with these international obligations. In 2007, the Joint Committee on Human Rights indicated that deterrence or denial of antenatal services was inconsistent with the principles of common humanity and with the UK's obligations under articles 2, 3 and 8 of the European Convention on Human Rights and recommended that charges were suspended for antenatal, maternity and perinatal care [35].

- Disability

The proposals are likely to have a disproportionate impact on persons with physical or mental disabilities as they are likely to have a greater need for healthcare services as compared with the general population.

Like the previous consultation, Sustaining Services, Ensuring Fairness in 2013 [36], the current consultation on extending charging for NHS services has failed to consider or address issues of access to community mental health services in either the consultation document or its impact assessment. This may well reflect the real ethical and practical difficulties inherent in extending charging to these services.

Mental health care is delivered across diverse services along a continuum of stepped and co-ordinated care including GP provision, primary mental health care services providing psychological treatments, specialist community-based interventions, acute services working with people in crisis in community or hospital settings, and compulsory treatment provided to individuals detained in hospital under the Mental Health Act 1983.

There are likely to be particular ethical concerns about imposing charges for services on mentally disordered patients who may not be in a position to make rational treatment choices in this context. Patients suffering from the effects of a mental health disorder may also need support and encouragement to engage with mental health services and the imposition of charges for such treatment may prevent them from accessing services altogether. Where GPs are unable to refer patients to appropriate and co-ordinated primary mental health care services on account of cost barriers, the responsibility for managing patients with mental health difficulties will fall to the GP practice in isolation. In this context, it may be difficult for GPs to assess whether treatment is 'immediately necessary' for the purpose of referral for care provided free of charge in the context of managing mental health difficulty and the risk of self-harm or suicide.

Early identification and intervention and the costs savings in treating mental health disorders at the earliest opportunity are an important theme of the cross-governmental strategy on mental health outcomes [37]. Research published by the Department of Health shows that for each £1 spent in early intervention in psychosis, £10 is saved in NHS treatment costs, of which £6 is saved in the first year alone [38].

The cross-governmental suicide prevention strategy states that accessible mental health services are "fundamental" to reducing the suicide risk in people of all ages with mental health problems [39]. Under the strategy, primary care and emergency departments are considered to have important roles in the care and follow-up of people who self-harm [40]. Early identification and prompt treatment of depression as one of the most important risk factors also play a major role in preventing suicide [41].

Where migrants are unable to access appropriate mental health care services at an earlier stage, there is a danger of their mental health deteriorating to the extent that detention under the Mental

Health Act 1983 for compulsory treatment becomes necessary to mitigate the risks to their life or safety. Such deterioration in an individual's health and ability to maintain their own insight and capacity with respect to their health is likely to engage articles 3 and 8 of the European Convention on Human Rights and undermine objectives within the National Health Service of ensuring that mental health care is provided in the least restrictive form in terms of personal freedom [42].

- Age

NHS organisations, including the NHS Commissioning Board, Clinical Commissioning Groups, NHS Trusts and NHS Foundation Trusts, are legally required to have regard to the need to safeguard and promote the welfare of the child and to ensure their functions promote and safeguard the welfare of children [43]. This is not possible where children are unable to be referred for healthcare services on account of the immigration status of their parents and their inability to pay for care.

Statutory guidance on safeguarding children identifies the role of health professionals in identifying children in young people at risk of harm across a range of health care settings, including primary health care services, emergency care, maternity services, mental health services and secondary care [44]. The inability of health professionals to identify young people at risk of harm or attend to the health needs of children and young people through their carers being deterred or turned away from healthcare settings on account of their immigration status is likely to have a detrimental impact on the welfare of children.

Sexual orientation

Primary healthcare settings play an important role in supporting lesbian, gay and bisexual migrants to disclose their sexual orientation in a safe environment and access appropriate healthcare.

Guidelines from the United Nations High Commissioner for Refugees recognise that discrimination, hatred and violence in all its forms can impact detrimentally on lesbian, gay and bisexuals' capacity to present their claim. Some may be deeply affected by feelings of shame, internalized homophobia and trauma, and their capacity to present their case may be greatly diminished as a consequence [45]. The guidance also indicates that applicants from highly intolerant countries may not readily identify as lesbian, gay or bisexual [46]. Though the guidelines refer to those in need of protection on the basis of their sexual orientation, and are reflected in Home Office policy for the determination of asylum claims on this basis [47], it is equally true for migrants who may also have a human rights claim to remain in the UK, for example on grounds of respect for their private or family life. In both cases, lesbian, gay and bisexual individuals may disclose to medical professionals

information that they have previously been unable to disclose to their lawyers, and this may play an important role in supporting and evidencing a person's application to remain in the UK that may otherwise have failed for lack of disclosure of this important element of their claim.

Studies have shown that lesbian, gay and bisexual people can feel reluctant to talk openly to their GP and may avoid appointments because of fear of prejudice [48]. For lesbian, gay and bisexual individuals, it is therefore particularly important that a range of accessible services are available, including access to sexual health provision, 'walk in' clinics and targeted care. The imposition of a charging regime is likely to prevent such persons from seeking the medical advice they need in these settings, with harmful consequences both to their health and well-being and their ability to present their immigration case.

EXEMPTIONS FROM CHARGING FOR NHS SERVICES

- Current exemptions

The consultation document provides a list of exemptions from charging for secondary NHS care, however this is incomplete. The National Health Service (Charges to Overseas Visitors) Regulations 2015 makes provision for those granted temporary protection, asylum or humanitarian protection to access free NHS healthcare and these exemptions should also continue [49].

The current exemptions from charging for secondary NHS care make provision for individuals whose application for temporary protection, asylum or humanitarian protection has been rejected but are being supported by the Home Office under section 4(2) of the Immigration and Asylum Act 1999 or are being supported under section 21 of the National Assistance Act 1948. These categories will require amendment in light of the Immigration Bill currently proceeding through parliament which makes changes to the structure of support provision at the end of the asylum process, including the repeal of section 4 of the Immigration and Asylum Act 1999.

These exemptions for people who may have pending applications in the UK or otherwise cannot be removed from the UK are incomplete however. They would not include people who have submitted a fresh asylum claim which is awaiting consideration by the Home Office and who are housed by a member of their family or community rather than under section 4 of the Immigration and Asylum Act 1999. They would also not include people who face a genuine obstacle to removal because documents cannot be obtained on which they could be removed, because they are stateless, because it is not safe to travel to their country or because they are unable to travel, for example

because they are in the advanced stages of pregnancy, or are very ill. People in these circumstances are not permitted to work and would therefore have no means of paying for healthcare.

ILPA therefore proposes that an exemption from charging be made for persons subject to immigration bail, as defined by the current Immigration Bill. This is a new provision identifying those temporarily admitted to the UK by the authorities. It includes those who would be currently identified as being on temporary admission, temporary release or immigration bail and in contact with the UK authorities.

Without specific provision exempting this group, there is a risk that immigration detainees may not be released from detention because they will not receive treatment when released. There could be concerns that, for example, a person with poor mental health will fail to keep in touch with the Home Office because they will not in practice have the medication or other support they require to manage their condition. In these circumstances, there is a risk that Article 5 of the European Convention on Human Rights protecting the right to liberty would be breached.

ILPA also supports the conclusion of the Joint Committee on Human Rights which recommended that primary healthcare be provided free to those who have claimed asylum, including those whose claim has been refused, pending their voluntary return or removal [50].

- Proposed exemptions

ILPA considers that the provision of free primary health care and emergency care services are essential to ensuring to identifying vulnerable persons in need of services and ensuring that health professional are able to assess individuals as to their need for ‘immediate and necessary’ treatment in order to ensure compliance with the UK’s human rights obligations.

The exemption of services from charging is the most effective means of ensuring that individuals falling with the identified categories of vulnerability and health inequality are able to access healthcare. In addition to GP and nursing provision, the following services should also be exempt from charges: accident and emergency provision, ‘walk-in’ clinics, mental health services, antenatal and maternity services, sexual health clinics, family planning and abortion services and sexual assault referral centres.

The following categories of people are not included within the current exemptions for secondary healthcare charges and should be encompassed within exemptions for primary care and emergency care.

- - People subject to immigration bail

See above for discussion of this category of persons, as defined under the proposed provisions of the current Immigration Bill.

- - Children and care leavers

All children, not only those in local authority care, should be exempt from charges. Care leavers / former relevant children aged 18-25 years old, as defined under leaving care legislation should also be exempt from charges [51].

- - Overseas domestic workers

Exemptions from charging should be made for domestic workers in private households [52] and for private servants in diplomatic households [53]. Under the current immigration rules, visas are only issued to overseas domestic workers entering the UK under these routes for a period of six months with no right of extension. Their sponsoring employer is required to provide and meet the costs of comprehensive sickness insurance. As a result, there is no requirement on overseas domestic workers to pay the immigration health surcharge and they are not exempt from NHS charges. In his independent review of the overseas domestic workers visa, James Ewins QC identifies the risk of abuse to which this gives rise:

"It should first be recognised that access to, and interaction with, health professionals is an important protection for overseas domestic workers. Indeed, it may be the route by which they are identified as victims of abuse, which is the first step to them escaping such abuse and the perpetrators being brought to account. Evidence has been presented to the review that the fact of an employer taking out an insurance policy in an employee's name can create a further mechanism of control over that employee which is open to abuse, and can restrict vital access to healthcare services and personnel. It is therefore recommended that the Government make changes to the relevant provisions from a requirement of comprehensive sickness insurance to the payment of the immigration health surcharge by the employer as part of the Appendix 7 terms of employment. The increased level of information, advice and support recommended below substantially meets the

concern that any such payment would in fact be reclaimed, with menaces or otherwise, from the employee." [54]

Whilst James Ewins QC has recommended that overseas domestic workers are subject to the immigration health surcharge [55] and are able to extend their visa for up to two and a half years after fleeing an abusive employer, the Government has so far not agreed to implement these recommendations and currently overseas domestic workers trapped in, or escaping from, abusive employment situations are not exempted from secondary healthcare provision and would not therefore be exempted from NHS primary care or emergency care under the current proposals. These groups are particularly vulnerable to exploitation and may not have the means to pay for health care themselves. As the visa issued to overseas domestic workers is only for six months, there is also little time in which to make an intervention and identify those who may have been trafficked.

- - Other vulnerable groups

It is important that provision is made to ensure that other vulnerable groups such as homeless persons and Roma and traveller communities are able to access primary and emergency care without risk of being charged for this care.

EVALUATION OF THE IMPACT OF CURRENT CHARGING PROVISIONS

ILPA is concerned that no formal evaluations have been undertaken of the impact on health inequalities, vulnerable groups or people with protected characteristics of the recent measures extending charging for NHS secondary healthcare services. No plans to extend charging should therefore be considered before the impact of the existing provisions charging migrants for secondary healthcare have been fully assessed.

[1] Health and Social Care Act 2012, s.4

[2] Health and Social Care Act 2012, s.23, s.13G

[3] Health and Social Care Act 2012, s.26 (14T)

[4] National Health Service (Charges to Overseas Visitors) Regulations 2015 no.38, regulation 16

[5] Department of Health, Guidance: Identifying and supporting victims of modern slavery: guidance for health staff, 27 November 2015 at: https://www.gov.uk/government/publications/identifying-

and-supporting-victims-of-human-trafficking-guidance-for-health-staff/identifying-and-supporting-victims-of-modern-slavery-guidance-for-health-staff (accessed 02 March 2015)

[6] Ibid

[7] Ibid

[8] Ross C, Dimitrova S, Howard LM, et al. Human trafficking and health: a cross-sectional survey of

NHS professionals’ contact with victims of human trafficking. BMJ Open 2015;5:e008682. doi:10.1136/bmjopen-2015-008682

[9] Ibid

[10] Ibid

[11] Ibid

[12] Ibid

[13] e-Learning for Healthcare / Department of Health, Identifying and supporting victims of modern slavery: an interactive learning resource to support all health staff in identifying and supporting victims of modern slavery, at: http://www.e-lfh.org.uk/programmes/modern-slavery/ (accessed 02 March 2016)

[14] Jenny J. Pearce et al (2013) Trafficked young people: breaking the wall of silence (London: Routledge)

[15] Ibid

[16] Council of Europe Convention on Action Against Trafficking in Human Beings and its Explanatory Report (Warsaw, 16.V.2005) at: https://www.coe.int/t/dghl/monitoring/trafficking/Docs/Convntn/CETS197_en.asp#P220_15156 (accessed 02 March 2016)

[17] European Convention on Human Rights (Rome, 4.XI.1950) at: http://www.echr.coe.int/Documents/Convention_ENG.pdf; Rantsev v Cyprus and Russia - 25965/04 [2010] ECHR 22 (10 May 2010), at: http://www.bailii.org/eu/cases/ECHR/2010/22.html (accessed 02 March 2016)

[18] National Institute for Health and Care Excellence (NICE) Public Health Guideline: Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (PH50, 26 February 2014 at: https://www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-1996411687621 (accessed 02 March 2016), para 3.25

[19] D Sethi, S Watts, A Zwi, J Watson, C McCarthy (2004) Experience of domestic violence by women attending an inner city accident and emergency department, Emerg Med J 2004;21:180-184 doi:10.1136/emj.2003.012419

[20] National Institute for Health and Care Excellence (NICE) Public Health Guideline: Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively (PH50, 26 February 2014 at: https://www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-1996411687621 (accessed 02 March 2016), recommendation 6

[21] See Stagg, H.R. et. al., Poor uptake of primary healthcare registration among recent entrants to the UK : a retrospective study, 2012;2:e001453, doi :10.1136/bmjopen-2012-001453.

[22] UN Committee on the Elimination of Racial Discrimination, General Comment No.30, Discrimination against non-citizens, U.N. Doc. CERD/C/64/Misc.11/rev.3 (2004), https://www1.umn.edu/humanrts/gencomm/genrec30.html (accessed 02 March 2016), para 36

[23] UN Committee on the Elimination of Racial Discrimination, Concluding Comments: United Kingdom, CERD/C/GBR/CO/18-20, 14 September 2011 at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD/C/GBR/CO/18-20&Lang=En (accessed 02 March 2016), para 27

[24] See the Office for National Statistics Statistical Bulletin: Focus on violent crime and sexual offences, 2013/14, England and Wales, 07 February 2015, available at http://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/2015-02-12 (accessed 02 March 2016)

[25] National Institute for Health and Care Excellent (NICE), Clinical Guideline 110: Pregnancy and Complex Social Factors: a model for service provision for pregnant women with complex social factors, 22 September 2010, at: https://www.nice.org.uk/guidance/cg110/resources/pregnancy-and-complex-social-factors-a-model-for-service-provision-for-pregnant-women-with-complex-social-factors-35109382718149 (accessed 02 March 2016)

[26] Ibid, para 4.1

[27] Ibid

[28] Ross C, Dimitrova S, Howard LM, et al. Human trafficking and health: a cross-sectional survey of

NHS professionals' contact with victims of human trafficking. BMJ Open 2015;5:e008682

[29] See, for example, http://www.nhs.uk/conditions/pregnancy-and-baby/pages/domestic-abuse-pregnant.aspx (accessed 02 March 2016)

[30] Lu, MC et al. Elimination of public funding of prenatal care for undocumented immigrants in

California: a cost/benefit analysis. Am J Obstet Gynecol 2000; 182: 233-39

[31] Article 12, UN Convention on the Elimination of Discrimination Against Women, 1979 at: http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm (accessed 02 March 2016)

[32] Article 12(2), UN Convention on the Elimination of Discrimination Against Women, 1979 at: http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm (accessed 02 March 2016)

[33] Article 24, UN Convention on the Rights of the Child

[34] Committee on the Rights of the Child (2013) General Comment No.15 on the right of the child to have the highest attainable standard of health, 17 April 2013, CRC/GC/2013/15 at: http://www2.ohchr.org/english/bodies/crc/docs/GC/CRC-C-GC-15_en.doc (accessed 02 March 2016)

[35] Joint Committee on Human Rights (2007) The Treatment of Asylum Seekers, at: http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf (accessed 02 March 2016), para 143

[36] Department of Health (2013) Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210438/Sustaining_services__ensuring_fairness_consultation_document.pdf (accessed 02 March 2016)

[37] Department of Health (2011) No health without mental health: a cross-governmental mental health outcomes strategy for people of all ages (London: Department of Health)

[38] M. Knapp et al (2011) Mental health promotion and prevention: the economic case (London: Department of Health), p.39

[39] HM Government (2012) Preventing suicide in England: A cross-governmental outcomes strategy to save lives (London: HM Government), p.5

[40] Ibid, p.6

[41] Ibid, p.6

[42] Department of Health (2011) No health without mental health, op cit., p.6

[43] Children Act 2004, section 11(4)

[44] Department for Education (2015) Working Together to Safeguard Children at: https://www.gov.uk/government/publications/working-together-to-safeguard-children--2 (accessed 02 March 2016)

[45] UN High Commissioner for Refugees (UNHCR), Guidelines on International Protection No. 9: Claims to Refugee Status based on Sexual Orientation and/or Gender Identity within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees, 23 October 2012, HCR/GIP/12/01, available at: http://www.refworld.org/docid/50348afc2.html (accessed 02 March 2016), para 59

[46] Ibid, para 63

[47] Home Office, Asylum Policy Instruction: Sexual identity issues in the asylum claim, 22 February 2015 at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/404372/EXT_Asylum_Instruction_Sexual_Identity_Issues_in_the_Asylum_claim_v5_20150211.pdf, (accessed 02 March 2016), para 5.2

[48] National Health Service, Gay health: access to healthcare, at: http://www.nhs.uk/Livewell/LGBhealth/Pages/Access.aspx (accessed 02 March 2016)

[49] National Health Service (Charges to Overseas Visitors) Regulations 2015, regulation 15

[50] Joint Committee on Human Rights (2007) The Treatment of Asylum Seekers, at: http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf (accessed 02 March 2016), para 158

[51] The Children Act 1989 as amended by the Children (Leaving Care) Act 2000

[52] Immigration Rules HC 395 paragraphs 159~A to 159H

[53] Immigration Rules HC 395, paragraphs 152 to 159

[54] James Ewin, Independent Review of the Overseas Domestic Workers Visa, 16 December 2015 at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/486532/ODWV_Review_-_Final_Report__6_11_15_.pdf, (accessed 02 March 2016), para 115

[55] Ibid, para 121

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?

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

Yes

If yes, please explain.

ILPA recalls the words of Aneurin Bevan who founded the National Health Service:

"…no society can legitimately call itself civilized if a sick person is denied medical aid because of lack of means." [56]

The same principle is reflected in international human rights instruments protecting the right to health:

• The International Covenant on Economic, Social and Cultural Rights (ICESCR) requires States Parties to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [57], take steps to achieve the full realisation of this right [58] and guarantee this right without discrimination, including discrimination on the ground of national or social origin [59].

This duty is interpreted by the UN Committee on Economic, Social and Cultural Rights as requiring States to refrain from denying or limiting equal access to preventative, curative and palliative health services for all persons, including asylum seekers and 'illegal migrants' [60].

The Committee's most recent General Comment No.20 (2013) [61] on non-discrimination in economic, social and cultural rights reflects this position. The UN Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health has criticised Sweden on the basis that failure to make health care available to undocumented migrants including rejected asylum seekers constitutes discrimination under international human rights law [62].

• Denial of access to fundamental health care will also engage Articles 2, 3 and 8 of the European Convention on Human Rights.

The UK has legal obligations under international and domestic human rights law to ensure that all persons, regardless of immigration status, are able to access basic healthcare.

The National Health Service was not founded upon a model based on an established permanently resident population. Aneurin Bevan made this explicit:

"One of the consequences of universality of the British National Health Service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill-informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues? So the argument goes. No doubt a little of this objection is still based on confusion about contributions … The fact is, of course, that visitors in Britain subscribe to the national revenues as soon as they start consuming certain commodities…" [63]

The proposals to extend charging to NHS primary care and emergency services will have the effect of restricting access to healthcare services for migrants whose status in the UK is irregular and therefore migrants who are the most vulnerable of all. They do not take into account the fact that a person's immigration status may change over time or that an irregular immigration status may be the result of a lack of access to immigration advice or other support and that being unable to access healthcare may marginalise them further by preventing them from regularising their stay:

Case Example

A young woman was refused registration as a British Citizen as a minor on the grounds that she was not of good character because of outstanding NHS charges. She had an unpaid bill of some £46,000 which was as a result of hospital care for herself and her very premature son. She was 17 years old at the time her son was born and was living at home with her mother who had indefinite leave to remain. Her son, to whom the bulk of the charges related, was a British citizen by birth. After obtaining further evidence, her representative identified that the NHS had in fact written off the charges before the Home Office made its decision to refuse her application. The Home Office decision was challenged and the young woman subsequently registered as a British Citizen.

ILPA strongly agrees that GP and nurse consultations should remain free of charge in all cases and considers that this is a necessary measure towards ensuring that the UK is able to meet its human rights obligations to safeguard life and protect the right to health.

We concur with "all major NHS stakeholders and professionals from health and public health" on record as having "expressed concern that deterring people from accessing care through GPs would have a significant and negative impact on individual and public health and costs to the service of delayed treatment" following the 2013 consultation [64].

We therefore strongly support the conclusion drawn by the Department of Health that GP and nurse consultations should be retained on account of the "critical importance of unrestricted access to early prompt diagnosis and intervention in the health

interests of both public and patient health, as well as the likely cost benefits of treating the patient early to avoid emergency treatment at a later stage." [65]

However, the provision of free access to GP and nurse consultations would be insufficient in isolation to meet the UK's human rights or equality duties. At Questions 1-2, ILPA sets out the important role of Accident & Emergency services and healthcare professionals across primary and secondary health care settings in identifying victims of trafficking and other vulnerable persons who should be able to access healthcare without fear of charges.

Primary care and emergency services have an equally important role in identifying those in need of immediate and necessary treatment so that early medical intervention may be facilitated. This is particularly important in the case of vulnerable migrants who may face difficulties registering with a GP practice and present at alternative primary healthcare settings such as 'walk in services' instead or approach A& E departments as their health worsens. The Health Protection Agency has identified that only a third of immigrants register with GPs and that targeted action is required to improve registration rates and promote access to care [66].

ILPA is already aware of migrants who do not obtain healthcare for fear of the cost of treatment and being unable to pay for prescriptions:

Case example

A woman with poorly controlled type II diabetes was admitted to hospital. She was charged over £800 for treatment but could not afford to pay as she and her four children were being supported by social services under The Children Act 1989.

She would not visit her GP because she was afraid that he would send her to hospital for tests and treatment she could not afford and because she could not afford her medication. She was barely able to feed her children and was not eating regular meals herself to give the children more, which was exacerbating her diabetes.

The woman has since been granted limited leave to remain in the UK and may now access free NHS healthcare.

The extension of charging to primary care and emergency healthcare settings may increase the risk that migrants avoid accessing healthcare services as a result of fears of charging being imposed. As in the above example, where migrants are unable to pay for prescribed treatment or diagnostic testing, this will deter them from accessing from GP services that are free, with consequences both for the individual and for public health in general.

ILPA is aware that charges deter migrants from accessing healthcare services even if these charges may never be recovered in practice:

Case example

A refused asylum seeker was charged for secondary care and received numerous threatening letters demanding payment. He is destitute and prohibited from working and earning the money to pay the charge. He became frightened when he receive a latter saying that the Home Office would be informed and any future applications would be affected by outstanding charges as he wants to make an application to regularise his stay.

Fear of the NHS sharing information with the Home Office may in itself deter individuals from accessing health services:

Case example

A refused asylum-seeker with type 1 diabetes was afraid of registering with a doctor in case they contacted the Home Office so she received no formal treatment or monitoring. A friend bought her insulin. She has now been able to access advice and has a pending application to regularise her stay.

Public Health England has stated that controlling communicable diseases relies not only on screening asymptomatic people at risk as well as diagnosing and treating those who present with symptoms [67]. Restricted and delayed access to health care (and particularly primary care) can also lead to delayed diagnosis and risk of further transmission of chronic or infectious diseases [68].

Recovering costs from non-EEA migrants and from relevant EEA migrants will be unworkable and the Department of Health has not adequately taken account of the difficulty that healthcare providers will encounter in correctly assessing immigration status and the costs of supporting and training providers to do so.

In practice, it will require a system of identity checks for all, since it is necessary for British citizens or persons with permanent residence to prove that they are lawfully present in the UK. Aneurin Bevan made this point in the context of access to the National Health Service:

"However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats both must be classified…" [69]

- Non-EEA migrants resident in the UK

In 2012, the Department of Health identified confusion among General Practitioners and primary care trusts as to entitlements to health care under a more straightforward system of access to healthcare. It described:

"…a prevailing incorrect belief that a person must be ordinarily resident in the UK in order to qualify for free primary medical services. Some practices have deregistered or failed to register people they believe to be 'ineligible' in some way due to their immigration status. This has resulted in legal challenges from those denied access" [70]

As primary healthcare is free for all patients, it is difficult to understand how confusion over entitlements in this area might have arisen and this is illustrative of the difficulties in training people on a more complex system.

It remains common for individuals to be refused registration with a GP for not having a passport or document confirming leave to remain in the UK, despite being eligible for registration regardless of immigration status and despite definitive NHS England guidance confirming that inability by a patient to provide identification or proof of address are not reasonable grounds to register a patient with a GP [71].

Case example

A family was not permitted to register with a GP on the basis that they could not provide evidence of their leave to remain in the UK even though this is not a requirement in order to register with a GP. The family's documents were still with the Home Office, having been submitted to the Home Office six months previously in relation to another application that was still pending consideration.

We anticipate that it will prove extremely difficult for healthcare professionals to assess immigration status for the purpose of assessing entitlement for services, with the result that individuals who are eligible for free healthcare will be unable to access it in practice.

A significant proportion of temporary migrants in the UK do not have biometric residence documents. A significant proportion of temporary migrants entitled to access NHS healthcare are not liable under the Immigration Health Surcharge scheme. Others may have submitted their papers to the Home Office and may not be able to evidence their status with formal documents at all. The diversity of documents evidencing status among temporary migrants, and therefore entitlement to NHS healthcare, adds to the difficulty of administering the system. Immigration status is a matter of consider complexity and it cannot be assumed that a health professional or member of their support staff would be able to determine a person's immigration status from the range of documents that might evidence entitlement.

ILPA members regularly see clients who have received invoices for NHS treatment when they are eligible for NHS secondary care and clients who have incorrectly received penalty charge notices for prescription charges. This problem is likely to increase where the assessment of immigration status and entitlement to healthcare on this basis is extended across a wider range of services.

It is suggested that an individual's chargeability status will be recorded at the point of their registration with a GP practice and that this status will be flagged by IT systems

upon any subsequent interaction with the NHS [72]. A person's immigration status, if they are a 'temporary' migrant, is also likely to change over time. Those changes will be extremely difficult to capture in a system that relies on a person's immigration status being recorded at this first registration. The impact assessment has also not taken into account the costs that would be involved in training staff across the approximately 8000 GP practices in England [73] and the wide range of other primary healthcare settings to correctly identify immigration status and to ensure that this knowledge is regularly updated with the frequent changes in immigration law.

Home Office checking services cannot be relied upon to provide accurate advice to providers on an individual's immigration status. ILPA has numerous examples of incorrect advice given by the Home Office to employers using its Employers' Checking Service to verify immigration status in order to legally employ an individual, including with the effect that the individuals involved have lost their jobs as a result.

Case example

The employer of a woman who had an appeal against a Home Office decision to refuse her further leave to remain was informed, when he checked her status with the Employer Checking Service, that 'this person does not have the right to work in the UK' because 'an application for leave in the UK has been submitted by this person but it has been subsequently been rejected.' The woman's attempts to contact the Home Office were met with no response until her solicitors sent a pre-action protocol letter threatening judicial review proceedings. The Home Office finally confirmed that her in-time appeal meant that she had continuing leave under section 3C of the Immigration Act 1971 and so retained her entitlement to work. However this came too late for her to be able to retain her job.

The problems of inaccurate records held by the Home Office and its incorrect advice on immigration status are likely to be replicated, where these are used to determine an individual's access to NHS healthcare, with even more serious consequences.

- EEA nationals

The consultation document has not adequately engaged with the complexity of determining the status of EEA nationals and their entitlements to healthcare.

It is not the case that EEA nationals who do not hold a European Health Insurance Card (EHIC) or who do not apply for a Provisional Replacement Certificate (PRC) in place of a EHIC to which they are entitled would, by implication, be chargeable for NHS healthcare.

For example, under EU treaty law, EEA nationals working in the UK are entitled to access NHS healthcare on the same basis as British citizens and will therefore not hold, or be entitled to, the EHIC to access healthcare. The same right of residence and access to services is extended to their spouse, civil partner, children and step-children aged under 21 years, older dependent children/step-children and dependent relatives in the ascending line. The rights of EEA nationals and their family members may also be retained in certain circumstances where their employment ceases or the where the employed EEA national dies.

None of these individuals may hold a document evidencing their entitlements. The right to reside derives from the EEA national's activity in the UK rather than through the issue of any document granting entitlement. An EEA registration certificate or residence card is not mandatory and EEA nationals may face significant delays in the issue of such documents by the Home Office evidencing their status.

ILPA members have reported cases of families living in the UK where the parent is a non-EEA national exercising EU treaty rights as the primary carer of a EEA national child ('Zambrano' cases) who have been denied access to healthcare, including registration with a GP, on the basis that they cannot evidence their eligibility for healthcare. This is often because their passports have been submitted to the Home Office with other applications.

A Home Office checking service may be unable to confirm an individual's status as EEA nationals are not required to register with or apply to the Home Office to exercise Treaty rights in the UK so the Home Office may hold no records for them. Even if the individual was known to the Home Office, this is no guarantee that the Home Office will provide correct information as to their status and entitlements. As above, ILPA is aware of numerous examples of mistakes made the Home Office Employers' Checking Service when confirming the status of EEA nationals when contacted regarding their right to work in the UK.

Case example

The Parliamentary and Health Service Ombudsman upheld a complaint by an EEA national who was unable to prove his right to work whilst UK Visas and Immigration dealt with his application for a permanent residence card after exercising EU treaty rights in the UK as a worker for five years. After submitting his application in May 2012, the individual was sacked from his job in July 2012 when the Employer Checking Service told his employer that it could not confirm his right to work. It did so on the basis that neither a letter confirming a decision to grant the residence card nor a certificate of acknowledging the application had been issued even though the issue of certificates of acknowledgment had been discontinued by UK Visas and Immigration. He was unable to work until early 2013 when he finally received his residence card [74].

The task of determining eligibility for health care would become even more complicated for healthcare professionals and support staff in the light of proposals in the consultation to remove EEA nationals residing in the UK from the definition of 'ordinary residence' for the purpose of access to healthcare. Healthcare professionals would be required to determine whether the EEA national was a 'qualifying person' exercising EU treaty rights as a worker or the relative of a worker and correctly apply the case law as to work that amounted to 'genuine and effective activity' for this purpose. An EEA national who is a student or self-employed might hold a EHIC, might have comprehensive sickness insurance or might qualify for healthcare on the same basis as a worker if they were undertaking some employed work. They may qualify as worker even though they might define and describe themselves as a student. Determining entitlements accurately would therefore require a significant level of investigation by healthcare providers or registration staff where a EHIC is not presented.

There is an issue concerning non-economically active EU citizens and their family members who are 'staying' in the UK and who may receive free NHS care in the UK (with the cost being charged to their home EU member state). In such a situation, the principal EU citizen needs to be insured for public health care but so long as he or she has 'comprehensive sickness insurance' and ought not be charged as Regulation (EU) 883/2004 entitles them to draw on public health insurance in the home state to receive free NHS care in the UK. It is not a requirement of EU law in relying on such provision that an EHIC need be held.

The costs involved in determining status for the purpose of recovering charges from EEA nationals who do not hold a EHIC have not been adequately considered in the impact assessment of the proposals. The consultation document describes a pilot conducted to test the collection and processing of EHIC data in which it was found

that collecting data to identify whether a person was an EEA national and held an EHIC card only took an additional 1-2 minutes of registration time [75]. Whilst this pilot demonstrates that the identification of EEA nationals holding EHICs may be achieved with little additional registration time for the purpose of maximising recovery of healthcare costs from EEA States, it may not reflect the time that would be involved to determine whether the person may be charged for healthcare. This is particularly the case in light of the parallel proposals to remove EEA nationals from the definition of ordinary residence for the purpose of accessing healthcare, as this would necessarily require the healthcare provider to consider and assess whether the individual did not hold a EHIC card because they qualified for healthcare on another basis as above.

Where EEA nationals are prevented from accessing NHS healthcare, for example as a result of difficulties understanding their entitlements or how these might be evidenced, this will amount to unlawful discrimination under European Union law.

For both non-EEA nationals and EEA nationals, we identify a risk of litigation, actions for damages against General Practitioners and/or others who get the decision as to whether a person is eligible for treatment wrong and against practitioners who get the decision as to whether a person is in need of immediate necessary or urgent treatment wrong. These actions could be brought by the person wrongly denied care or by others infected by a disease they have transmitted.

[56] Aneurin Bevan, In Place of Fear, 1952, chapter 5

[57] Article 12(1)

[58] Article 2(1)

[59] Article 2(2)

[60] Committee on Economic, Social and Cultural Rights (2000) General Comment No.4 (2000): The right to the highest attainable standard of health, E/C.12/2000/4, para 34 at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G00/439/34/PDF/G0043934.pdf?OpenElement; this position is also reflected in the Committee's General Comment No. 20 (2009): Non-discrimination in economic, social and cultural rights, E/C.12/GC/20 at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f20&Lang=en (accessed 02 March 2016)

[61] Ibid.

[62] See for example A/HRC/4/28/Add.2 28 February 2007 (Implementation of General Assembly Resolution 60/251 of 15 March 2006 entitled ‘Human Rights Council’, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standards of physical and mental health, Paul Hunt, Addendum, Mission to Sweden), at: http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx (accessed 02 March 2016)

[63] Aneurin Bevan (1952) In Place of Fear, chapter 5

[64] Department of Health (2013) Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268630/Sustaining_services__ensuring_fairness_-_Government_response_to_consultation.pdf, (accessed 02 March 2016), para 106

[65] Ibid

[66] Helen R Stagg, Jane Jones, Graham Bickler, Ibrahim Abubakar (2012) Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study, BMJ Open 2012;2:e001453 doi:10.1136/bmjopen-2012-001453 at: http://bmjopen.bmj.com/content/2/4/e001453.full (accessed 02 March 2016)

[67] Public Health England (2013) Government Consultation: Migrants’ access to the NHS: PHE response, Response to FOI request, 14 May 2014

[68] Ibid

[69] Aneurin Bevan (1952) In Place of Fear, chapter 5

[70] Department of Health (2012) Review of overseas visitors charging policy, Summary report, April 2012, para.2

[71] NHS England, Patient Registration: Standard Operating Principles for Primary Care (General Practice), November 2015 at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/11/pat-reg-sop-pmc-gp.pdf (accessed 02 March 2016)

[72] Department of Health (2015) Impact Assessment: Visitor and Migrant Cost Recovery- Extending Charging, at: p.13 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482648/Impact_Assessment.pdf (accessed 02 March 2016)

[73] British Medical Association, General Practice in the UK, July 2014 at: http://www.bma.org.uk/-

/media/files/pdfs/news%20views%20analysis/press%20briefings/pressbriefinggeneralpracticeintheuk_july2014_v2.pdf (accessed 02 March 2016)

[74] http://www.ombudsman.org.uk/make-a-complaint/case-summaries/volume-1/parliamentary/man-compensated-for-loss-of-his-job (accessed 02 March 2016)

[75] Department of Health (2015) Making a fair contribution: a consultation on the extension of charging overseas visitors and migrants using the NHS in England, p.15

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

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

Do you agree?

Strongly disagree

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

Yes

If yes, please explain.

The United Nations Human Rights Council, in passing its resolution on access to medicine in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health recognised that access to medicine is one of the fundamental elements in achieving rights to enjoyment of the highest standard of physical and mental health. It stressed the responsibility of States to ensure access to all, without discrimination, of medicines that are affordable, safe, effective and of good quality [76].

People prevented from accessing health treatments through being unable to pay prescription charges through lack of means risk deterioration in their health. As identifying the impact of treatment prescribed may form part of a GP's diagnosis of a condition, there is a risk that dangerous, chronic or infectious conditions are not diagnosed or are subject to delayed diagnosis. As discussed at questions 3-6 above, there is also a risk that individuals do not engage with GP care due to being unable to follow any course of treatment prescribed, with well-documented risks to public health and the increased costs of treating illnesses after these have reached a more critical stage, that would be otherwise mitigated through early intervention at the primary care level.

Self- medication and its link with over medication can be observed in proximity to emergency aid responses and refugee camps all over the world, where medicines from aid agencies make their way into the local markets. People may purchase drugs on the look of the drug alone or in the belief a drug will do things it cannot do – for example an antibiotic treat a virus. When it fails to help, they may take more. People who cannot or dare not access the National Health Service will be passed medicines by family and friends. They may take a maximum dose, or more. This may not do them any good, and it may also increase the risk of drug resistant strains developing.

[76] United Nations Human Rights Council, Resolution 12/24: Access to medicine in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/RES/12/24, 12 October 2009, at: http://daccess-ods.un.org/access.nsf/Get?Open&DS=A/HRC/RES/12/24&Lang=E (accessed 02 March 2016), preamble

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

Do you agree?

Strongly disagree

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

Do you agree?

Strongly disagree

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

Yes

If yes, please explain.

Please refer to comments above.

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

Do you agree?

Strongly disagree

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

Yes

If yes, please explain.

Please refer to comments above.

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

Do you agree?

Strongly disagree

QUESTION 16: If you disagree or strongly disagree with the proposals in question 15, do you agree that charging should cover care given within an NHS A&E setting if an individual is subsequently admitted to hospital, or referred to an outpatient appointment?

Strongly disagree

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

Yes

If yes, please explain.

NHS-funded services provided within an NHS A&E setting should generally be exempt.

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

Yes

If yes, please explain.

ILPA is strongly opposed to extending charging to attendance at Accident & Emergency departments. Emergency procedures may be provided to a person who is not conscious, or who is in great pain or great distress. Family members with them may be distraught. Such a person is in no position to consent to receiving treatment for which they will be charged and might afterwards dispute the necessity of the treatment or say that they had consented under duress. The implications for professional ethics of charging are particularly complicated in emergency settings.

Treatment in an emergency should not be denied or delayed due to the determination of a person's immigration status. The working assumption in an accident or emergency department must be that the person needs such treatment. A person's presenting at an Accident and Emergency department is an indication that they think that they need such treatment. It may be difficult to communicate with people but given the working assumptions in an Accident and Emergency department, if it is not possible to get a clear idea of what a person's concerns are, they will be treated as needing emergency treatment.

Accident & Emergency departments are important settings for the identification of individuals at risk, such as victims of human trafficking, victims of domestic violence and those in mental health crisis. 'Walk-in' services play a similarly important outreach function for vulnerable individuals who may face difficulties registering with a GP and accessing healthcare through this formal route. The introduction of charging would deter individuals from these services and from accessing help. Fear of NHS charges and the potential immigration consequences of these may lead people to make dangerous decisions as to whether to attend Accident & Emergency when they are suffering severe ill-health. ILPA is already aware, as described above, of individuals who do not access health services for fear of charges or immigration consequences.

Please also refer to our comments at questions 1-9 above.

QUESTION 19: Our proposal for ambulance services is to introduce charging for all treatment delivered by NHS Ambulance Trusts. This would include any cost incurred

for treatment delivered by NHS paramedics, including at the site of an accident, any use of ambulance services, and any treatment carried out outside an A&E department or equivalent.

Do you agree?

Strongly disagree

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

Strongly disagree

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

Yes

If yes, please explain.

The National Health Service has a duty to ensure that immediate and necessary treatment is provided to those in need of this in order to be compliant with its duties under human rights legislation. The consultation document states that it is not the intention to restrict access to emergency care or to cause a delay in urgent and immediately necessary care to patients, however this is the obvious effect of proposals to charge for treatment delivered by paramedics, “including at the site of an accident”, and ambulance services.

The very action of calling the ambulance services or the attendance of paramedics at the scene of an accident will be indicative of the fact that the individual is in need of immediate and necessary treatment. The sending of an air ambulance will be clear evidence of a major emergency involving an individual in a critical condition. It would be unethical to seek to recoup charges in these circumstances.

As with Accident & Emergency settings, there would be real concerns as to whether an individual could consent to charging for attendance at the site of an emergency or for calling an ambulance. An ambulance may be called for a person who is unconscious or acutely ill. The individual, their family members or the person arriving first on the scene and calling the ambulance may be terrified and distraught.

Those taking 999 calls would be unable to consider a person’s immigration status or discuss charges with them before sending an ambulance without increasing the levels of distress of a distraught individual in an emergency or taking time that would have a negative impact on the rest of the service. As before, migrants may take the risk of not calling for help where they fear the charges and immigration consequences that may be imposed on them as a result. The development of a culture where people are obliged to hesitate before calling an ambulance for others

for fear of imposing unnecessary charges on them may harm the wider population as much as migrants targeted by these proposals.

We note that these extreme proposals have been put forward without any analysis within the impact assessment, due to insufficient information being available to scope the policy at this time [77]. This alone should provide a sound reason for not proceeding with proposals to extend charges to the use of the ambulance service.

[77] Department of Health (2015) Impact Assessment: Visitor and Migrant Cost Recovery- Extending Charging, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482648/Impact_Assessment.pdf (accessed 02 March 2016), p.8

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

Do you agree?

Strongly disagree

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

Do you agree?

Strongly disagree

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

No

If yes, please explain.

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

Yes

If yes, please explain.

The Minister in the House of Lords stated in the course of the progress of the Immigration Bill introducing the Immigration Health Surcharge through parliament that:

“[W] have made it clear that we intend no such additional charges will apply when the surcharge is introduced. The Department of Health has also made it clear that it would consider such changes in the future only in the event of any exceptional and compelling specific justification for health purposes.” [78]

No ‘exceptional and compelling specific justification for health purposes’ has been put forward in support of the removal of fertility treatment from the scope of services covered by the Immigration Health Surcharge. Health services should not be removed from the Immigration Health Surcharge scheme in the absence of exceptional and justification as this would permits health services to be restricted on an arbitrary basis. The National Health Service already operates a rationalised system of care properly based on NICE guidelines and other clinical evidence to inform decision-making about healthcare choices.

The level at which the Immigration Health Surcharge was set is a significant expense for temporary migrants living in the UK. The level of the Surcharge was not informed by a strong evidence base and is likely to high in comparison with the actual use of the health service by temporary migrants. Average costs of healthcare for the resident population do adequately serve as comparators for benchmarking the level of the Immigration Health Surcharge. The justification for treating migrants differently from the resident population by imposing the Surcharge was stated to be the latter’s long term connection with the UK. But if that is correct then over the course of a lifetime the British citizen or settled person will make the greater demands on the National Health Service associated with increasing age. Those migrants who remain in the UK long enough to make these demands will remain in the UK long enough to make contributions akin to those made by a British citizen or settled

person. The figures for each age bracket are averages and include persons making very heavy demands on the National Health Service because of disability or chronic conditions. We suggest that such persons are under-represented among ‘temporary’ migrants and that a consideration of the demographic evidence as to the health of migrants is required. Many migrants faced with, for example, a serious illness or an underlying health problem will chose to return to the country of origin to have it treated (as the consultation paper identifies in Part Six is the case for British citizens). Against the spectre of health tourism, unquantified and ill-defined in the original 2013 consultation and challenged by other careful studies, is the question of the circumstances in which migrants draw less heavily on the National Health Service than they are entitled to do.

The Immigration Health Surcharge was intended to be a health insurance scheme that pooled risk and allowed those making contributions to the scheme to access healthcare in accordance with need. Any changes should be undertaken based on a comprehensive evaluation of the use of the scheme and its costs. The impact assessment identifies that there is insufficient information and limited data to scope the impact of removing fertility services from the Immigration Health Surcharge scheme [79]. No changes should therefore be made given the importance of evidence-based policy-making in healthcare.

It is not the case that treatment is likely to need to continue after a person’s visa has ended. A student may be issued a visa for the duration of their university course of three years or longer. A person migrating to the UK for work may be granted a visa for five years. Many ‘temporary migrants’ will be on a route to settlement in the UK.

The proposals that would require both partners to be ordinarily resident or hold Indefinite Leave to Remain are disproportionate and discriminatory. It is not uncommon for family migrants to be expected to accrue 10 years of lawful leave before qualifying for settlement [80]. Persons with limited leave, including refugees and those granted humanitarian protection, cannot settle in less than five years and many take much longer than this to achieve settlement. British citizens would be unable to access fertility treatment where their partner was a national from another country. During this time, fertility problems will exacerbate with age making them more difficult and costly to treat and potentially leaving individuals without the opportunity to have a family at all.

[78] Lord Taylor of Holbeach CBE to Baroness Smith of Basildon, Immigration Bill – Response to the House on Landlords and Health, 24 March, 2014

[79] Department of Health (2015) Impact Assessment: Visitor and Migrant Cost Recovery- Extending Charging, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482648/Impact_Assessment.pdf (accessed 02 March 2016), p.8

[80] As described in the Immigration Directorate Instructions, Chapter 8, Annex, Guidance on application of EX.1 – consideration of a child's best interests under the family rules and in article 8 claims where the criminality thresholds in paragraph 399 of the rules do NOT apply, Home Office, at https://www.gov.uk/government/collections/chapter-8-family-members-transitional-arrangements-immigration-directorate-instructions (accessed 02 March 2016)

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

Do you agree?

Strongly disagree

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

Yes

If yes, please explain.

Charging should not be extended to non-NHS providers of health care. Many of these providers will be specialist organisations targeting the needs of particular groups who suffer health inequalities, such as outreach services for hard-to-reach groups, services for sex workers and others at risk of violence and abuse, culturally appropriate services targeted at communities with reduced access to services etc.

The extension of charging would create administrative and additional cost burdens for charities and others providing these services. Charging service users may conflict with an organisation's charitable objects. It would also create ethical dilemmas such that those best placed to provide these services would be likely to opt out of providing them at all, thus having an adverse effect not only on migrants but on all who had previously received those services.

Primary health care service should be exempt from charging, including Sexual Assault Referral Centres, sexual health services, family planning and abortion providers. Services provided by not-for-profit or charitable organisations should also be exempt from the charging regime.

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

Yes

If yes, please explain.

See question 27 above.

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

No

If yes, please explain (anonymised information only).

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

Please choose No or Yes

If yes, please explain (anonymised information only).

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

Please choose No or Yes

If yes, please explain.

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

Do you agree?

Strongly disagree

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

Do you agree?

Disagree

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

Yes

If yes, please explain.

- Residency for EEA nationals (question 32 above)

The definition of ordinary residence should not be amended to exclude EEA nationals for the purpose of accessing free NHS healthcare.

The concept of ordinary residence provides an approximation for healthcare entitlements of EEA nationals exercising treaty rights and is both well-established and familiar to clinical and administrative staff within the NHS. Considerable investment would be required to train large numbers of healthcare and support staff in understanding and correctly applying the entitlements of EEA nationals across the varying qualifying categories under EU Community law. This is compounded by the difficulties involved in determining entitlement where EEA nationals may not hold standard documents confirming their right of residence.

In this context, EEA nationals are likely to experience barriers to accessing the healthcare to which they are entitled, in breach of Community law and with the risk of being unable to receive the treatment or early treatment that they need because of a lack of means to pay for this.

In 2013, the Department of Health stated that it was one of its priorities to better identify EEA visitors from whom costs could be recovered from their home country and other groups of EEA nationals who may not be ordinarily resident under the

current definition [81]. However, the impact assessment for the current consultation contains no further data or research on the numbers of EEA seeking treatment in NHS healthcare settings, aside from the small pilot study reported in which 272 EEA national patients were considered and only in terms of whether they were a visitor or whether they were ordinarily resident.

It is inappropriate to implement a legislative change of this significance in the absence of adequate data to inform an evidence-based assessment of a change in policy. This concern is heightened where the risks of healthcare providers failing to correctly identify categories of entitlement for EEA nationals are likely to be high.

There is no impediment to NHS recouping the costs of healthcare from EEA countries of residence whilst providing free healthcare at the point of delivery to EEA nationals who are defined as ordinarily resident for domestic purposes. This should be attempted and efforts to correctly identify qualifying status fully evaluated prior to considering the significant legislative change proposed, so that this may be informed by an evidence-based approach.

- Recovering NHS debt of visitors (question 33)

Individuals who support applications of family members or others visiting them in the UK may undertake to support and accommodate them for the period of their stay. Any stay would be a finite period of time of less than six months. It would be a disproportionate and unfair burden to require those sponsoring family members or others to additional accept liability for the unknown, unpredictable and indefinite amount that might be incurred by a visitor suffering an accident or medical emergency whilst in the UK as proposed in this consultation. Corporate sponsors such as universities or employers are not included within the scope of the proposals which are targeted uniquely at private individuals seeking family or friends to join them for a visit and have the least means.

In practical terms, it would be impossible for a sponsor to demonstrate to the Home Office that they had sufficient funds to cover every medical eventuality or emergency that might arise. Many private healthcare insurers provide cover of £1million or more to cover emergencies but it could not seriously be suggested that private sponsors offer a similar level of 'insurance cover' for their visitor. There is no means by which

a fair sum could be determined and the stipulation of a high sum of money will discriminate against nationals from countries with weaker economies.

- Overseas visitors working on UK-registered ships (question 35 below)

Weird and wonderful exemptions tend to have been put in place for a reason, often in response to a specific problem that has arisen or an international obligation.

We question whether removal of these categories will result in significant savings for the National Health Service as it is estimated that expansion of charging is likely to have a very small effect overall [82].

There is a risk, therefore, of reinventing the wheel when the problem this exemption addresses arises. No impact assessment has been conducted for this proposal as

'no data is available' [83]. This is despite the fact that removing the exemption in this area was first mooted as part of the consultation on NHS charging launched in 2013. A full evaluation of the impact of this proposal should be conducted so that any policy change may be informed by the best evidence.

[81] Department of Health (2013) Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England, para 104

[82] Department of Health (2015) Impact Assessment: Visitor and Migrant Cost Recovery- Extending Charging, at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482648/Impact_Assessment.pdf (accessed 02 March 2016), p.8

[83] Ibid

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

Do you agree?

Strongly disagree

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

No

If yes, please explain.

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

Yes

If yes, please explain.

The impact assessment relies heavily on the data submitted with the 2013 consultation proposing charges for NHS healthcare. This data was widely recognised to be insufficiently robust to make evidence-based policy choices.

There has been no evaluation of the introduction of charging for secondary NHS healthcare services that consider the impact of these changes on access to urgent and necessary treatment, on health inequalities, on vulnerable groups and on individuals with a protected characteristic under the Equality Act 2010. This is an essential prerequisite for considering extending charging to primary care and emergency care settings so that any policy change in this area can be informed by evidence of impact.

If you have any comments or want to raise broader questions or issues, associated with or raised by the consultation please tell us: