The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017

The Immigration Law Practitioners' Association (ILPA) is a registered charity and a professional membership association. The majority of members are barristers, solicitors and advocates practising in all areas of immigration, asylum and nationality law. Academics, non-governmental organisations and individuals with an interest in the law are also members. Founded in 1984, ILPA exists to promote and improve advice and representation in immigration, asylum and nationality law through an extensive programme of training and disseminating information and by providing evidence-based research and opinion. ILPA is represented on advisory and consultative groups convened by Government departments, public bodies and non-governmental organisations.

These regulations amend the National Health Service (Charges to Overseas Visitors) Regulations 2015 (SI 2015/238). They can be found at http://www.legislation.gov.uk/uksi/2017/756/contents/made ILPA has worked closely with Doctors of the World and the National Aids Trust to analyse the regulations.

The regulations make a number of changes. They:

- **Extend, from 21 August 2017. the secondary care settings in which charges can be levied;**
- **Make provision for up-front payment from 23 October 2017;**
- **Require immigration status checks to be made and eligibility to be recorded on health care records from 23 October 2017**.

Because the regulations were laid just before recess and also because parliament does not sit during the party conference season, the 40 days to pray against them runs beyond 23 October 2017. ILPA urges MPs and Peers to pray against the regulations before the October 2017 changes take effect.

Charging in a wider range of settings

The regulations provide, with effect from 21 August 2017t, for charging for secondary care provided outside hospital settings except in GP surgeries and extend the obligation to charge to all who are providing NHS services, such as community health organisations. Any organisation receiving NHS funding will be legally required to check every patient before they receive a service to see whether they should pay for their care. While government argues that the definition of a 'hospital' in the 2015 regulations is wide enough to encompass other secondary care services, that is not how it has been generally interpreted so a change in practice is anticipated. A wide range of health services will be affected, such as health visiting, school nursing, community midwifery, community mental health services, termination of pregnancy services, district nursing, support groups, advocacy services, and specialist services for homeless people and asylum seekers. Providers will include NHS organisations and, as of October, community interest companies and charities. These services are often specifically commissioned to reach marginalised communities and individuals unlikely to seek out NHS care. The new provisions are sufficiently widely drafted to encompass, for example, charities providing drug

and alcohol services under contract to local authorities: 'any other person providing relevant services'.[1] An exception is made for those providing services in connection with female genital cutting.

The anticipated financial saving for the NHS is small (£200,000 a year[2]), based on little evidence and may be overestimated. The cost to community services is estimated to be £13.64 per provider per year[3], but this fails adequately to take into consideration additional administrative time to check paperwork. The Government has made multiple commitments to carry out an assessment of the unintended consequences of extending NHS charges to those at particular risk, including pregnant women and children[4], but this has not happened.

Up-front payment

The regulations make provision for up-front payment of the estimated costs of treatment to be required.[5] This change will affect people who are entitled to free care but who may not have easy access to paperwork and passports, such as homeless people, elderly people, those living with mental health conditions and asylum seekers. The inevitable increase in bureaucracy could lead to increased patient waiting times. And there is a risk that, rather than check all patients' paperwork, trusts rely on 'racial profiling' as a means of identifying chargeable patients, therefore increasing health inequalities.

Checks and recording of status

Every hospital department in England will be legally required to check every patient's paperwork before treating them, to see whether they are an overseas visitor or an undocumented migrant and should pay for their care. Every patient, British citizen or person under immigration control, will be asked about their residency status, providing identity documents and proof of address and will need to prove they are entitled to free NHS care.

Pilots requesting all patients to provide two forms of identity prior to appointments are being carrying out in 20 hospital trusts across England.

The regulations require[6] (new regulation 3A) trusts to record that a patient is not entitled to free NHS secondary care against that patient's NHS number. This measure, and up-front charging, were not included in Department of Health's 2016 consultation on NHS cost recovery and as such have not received public scrutiny.

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[1] Regulation 2, definition of a relevant body.
[2] *Impact Assessment: Visitor and Migrant Cost Recovery – Amending and Extending the Charging Regulations* from: "https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/630516/Cost_Recovery_IA.pdf
[3] The DH's £100,000 training fund would need to be split between a low estimate of 7,331 independent provider sites and a high estimate of 9607 sites, resulting in a per site funding range of £10.40 - £13.64 for staff retraining and associated administration costs of implementing cost recovery programmes. Ben Gershlick, Zoe Firth. *Briefing: Provision of community care: who, what, how much?* The Health Foundation. April 2017.
NHS Confederation. "Key statistics on the NHS". Last updated: 14 / 7 / 2017 10 am. Retrieved 07 / 08 / 2017 from: http://www.nhsconfed.org/resources/key-statistics-on-the-nhs
[4] Department of Health made these commitments following recommendations by Home Affairs Committee and Major Projects Authority (both in 2015) that such evaluations took place before cost recovery was extended to other areas of the NHS.
[5] Regulation 3 of the 2015 regulations as amended by the 2017 regulations.
[6] New regulation 3A of the 2015 regulations.

What will happen in practice

If a patient cannot prove that they are entitled to free care, they will receive an estimated bill for their treatment and will have to pay it in full before they receive any treatment other than that which is 'urgent' or 'immediately necessary'. Doctors will have to review each case to decide if care is 'immediately necessary' or 'urgent' enough to go ahead and provide treatment before requiring payment. Immediately necessary services are defined to include antenatal, intrapartum and postnatal services to mother and baby, and any other relevant service that the treating clinician determines that the recipient needs promptly to save his/her life; to prevent a condition from becoming immediately life-threatening or to prevent serious permanent damage from occurring.[7]
That the Bill will be estimated is a separate cause for concern. Whatever they are told the costs will be, patients may be fearful of having treatment because they are worried about what the final bill will be. Conversely, the initial estimate may be such as to put the patient off having treatment, or paying it up front although the actual cost may have been affordable. We do not know how quickly refunds will be issued; people may be out of pocket for some time.

Services remaining free to all

GP consultations, family planning services; compulsory mental health care; treatment for a range of communicable diseases that might pose a public health risk; and treatment provided in a sexually transmitted diseases clinic; treatment of a physical or mental condition caused by torture, female genital mutilation, domestic violence or sexual violence (where the patient has not travelled to the UK for the purpose of seeking such treatment) remain free to all. In addition an amendment is made to regulation 9 of the 2015 regulations as amended to provide that palliative care services provided by community interest companies or palliative care charities (s 33D of the Value-Added Tax Act 1994).

The obligation to check patient paperwork, however, applies to services exempt from charging on public health grounds, such as infectious disease departments and HIV clinics.

Other changes - IVF

IVF treatment etc. is henceforth excluded from the services persons who have paid the Immigration Health Surcharge can access (new regulation 9A of the 2017 regulations). There are exemptions where a 'course of treatment' has already begun; for serving members of the armed forces and for seriously injured veterans and for those who fall to be treated under regulation 9 (infertility treatment: further provision) of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibility and Standing Rules) Regulations 2012 (SI 2012/2996).

ILPA and other organisations working with patients under immigration control consider that the regulations should be withdrawn. The government should carry out and make public the results of:

- an assessment of the impact of extending charges into community services on groups at particular risk, pregnant women and children as recommended by Home Affairs Committee and Major Projects Authority (MPA) in 2015 and resulting in a commitment to do so from Department of Health. This review has not been carried out.

[7] Regulation 3(7) of the 2015 regulations as amended

- an assessment of the impact of upfront charging and checking patient paperwork on access to services, health outcomes and patient waiting times, including an evaluation of the ongoing pilots taking place in hospital trusts
- an impact assessment evidencing the proposed regulations will not breach the Secretary of State for Health's duty to reduce health inequalities under the Health and Social Care Act 2012
- a human rights impact assessment on upfront charging
- a public consultation on the parts of the regulations not included in the 2016 consultation on NHS cost recovery: upfront charging and recording information against NHS number (consistent identifier).

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On the completion of the above, any regulations to extend charging into new areas of care and / or introduce upfront charges should:

- exempt all services that protect public health, including public mental health services, drug and alcohol treatment services and community midwifery services.
- exempt all services provided by charities or community interest companies
- exempt all abortion providers
- exempt asylum seekers whose claims have been refused, as is the situation in Northern Ireland and Scotland;
- require all decisions to withhold healthcare pending payment to be 1) subject to a second clinical opinion and (2) open to challenge by a patient;
- be accompanied by Department of Health guidance for hospitals and doctors 1) outlining how to implement the regulations in a way that is not discriminatory and does not violate human rights or increase health inequalities and 2) confirming that routine identity documents checks should not be carried out in services where NHS charges do not apply, such as infectious disease services and A&E, or in maternity services.