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

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

Do you agree?

Strongly disagree

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.

These proposals will impact disproportionately on several protected characteristic groups: age, race and gender.

1) Age:

From our direct practice experience of supporting young refugees and migrants, many of whom already have significant difficulties accessing vital services like healthcare, we are very concerned about the proposals to limit access to primary care for children and young people falling within the non-exempt categories. Children have a range of age-specific health needs which are met by primary care and we would strongly recommend an exemption for all children up to 18 years of age regardless of their immigration status or that of their parents or guardians. We would also strongly urge the Department of Health to introduce an exemption for care-leavers who arrived in the UK as unaccompanied children.

These proposed exemptions can be explained by a number of reasons:

- International and national legal obligations

The government has made a commitment to "give due consideration to the UNCRC Articles when making new policy and legislation". However, the consultation documents do not demonstrate that such consideration has been given to the government's obligations to all children under international and domestic legislation. Under the UNCRC every child has a right to the enjoyment of the highest attainable standard of health (Article 24) regardless of their status (Article 2) and the government must ensure to the maximum extent possible the survival and development of the child (Article 6). More recently, in considering the rights of children within the context of international migration, the UN Committee urged governments to "make clear in their legislation, policy, and

practice that the principle of the child's best interests takes priority over migration and policy or other administrative considerations" .

General Comment No. 15 on health reiterates that States Parties have an obligation under Article 2 to ensure that children's health is not undermined as a result of discrimination including on the basis of the child's or parent's status. This point was specifically stressed in the Committee's General Comment No. 6 in relation to migrant children: "The enjoyment of rights stipulated in the Convention are not limited to children who are citizens of a State Party and must therefore, if not explicitly stated otherwise in the Convention, also be available to all children – including asylum-seeking, refugee and migrant children – irrespective of their nationality, immigration status or statelessness."

The NHS has a specific duty to safeguard and promote the welfare of children, as outlined in UK law in Section 11(4) of the Children Act 2004, carrying on from the duties first enshrined in the Children Act 1989. The Home Office is under the same duty by virtue of section 55 of the Borders, Citizenship and Immigration Act 2009 set out in the 'Every Child Matters' guidance .

- Age-specific health needs

Children have age-specific health needs, and charging for primary care would create a barrier to promoting the health and well-being of children. Health protection is normally afforded to children, via surveillance, screening and immunisation in the primary care setting, in the form of the Healthy Child Programme . Barriers to screening and surveillance can result in delays in diagnosis and cause a lack of intervention for other conditions. GPs are one of the key providers/facilitators of early intervention programmes and the evidence of the benefits of this are well documented Any barriers to access to primary care, such as charging, impacts on child morbidity and well-being.

Case study: Baby Adeela diagnosed with life-threatening genetic disorder

Five-month-old Adeela was screened for five serious conditions. Results of the screening showed that she had Maple Syrup Urine disease (MSUD), a genetic disorder which stops the body breaking down proteins. Adeela was rushed to hospital where they discovered she was close to death. The test identified high levels of the amino acid leucine in her blood, a condition which can lead to coma, brain damage and death if not treated. The symptoms of this disease are so broad it is difficult to detect and diagnose. Adeela and her mother had 24 hour access to the hospital and the doctor.

Adeela's mother is from Pakistan and had no recourse to public funds due to her immigration status. Adeela's father was a French national but had very little contact with her and did not help. Adeela and her mother were living above a shop in poor conditions. The hospital was unsure what could be done about this due to her immigration status but they were desperate to get her appropriate accommodation especially as she was being chased by the landlord due to rent arrears. The hospital referred her to The Children's Society. We helped her to access appropriate accommodation through social services, regular financial support and access to a legal aid solicitor.

IMPACT: Adeela was an undocumented child and without being registered with the NHS and receiving free screening and emergency treatment Adeela most likely would have died.

- Trafficked children

We note the consultation proposes to exempt 'those identified, or suspected as being, victims of human trafficking'. Whilst we welcome the exemption for trafficking victims we wish to highlight that this category is very limited and will mean many victims of trafficking will remain outside the scope of these proposals. These proposals therefore risk the UK's position in continuing to play an important part in the effort to tackle modern slavery and support victims as is its stated claim through the Modern Slavery Act 2015.

Children who are suspected of having been trafficked can be referred by agencies to competent authorities through the National Referral Mechanism (NRM) . However, research has shown that there are significant obstacles to get a referral to the NRM process. The UKHTC reports over half (55%) of all potential victims of trafficking have not been recorded in the NRM in 2014. This shortcoming was even acknowledged recently in new guidance issued to NHS staff in an attempt to increase identification of trafficked victims and subsequent referrals to the NRM. The Public Health Minster here acknowledged that: "In many cases, victims need treatment for health problems so NHS staff are uniquely placed to spot, treat and support victims of trafficking". The Department of Health recently stated that 'research highlights how important it is that the health system has an understanding of modern slavery and the need for training tools to support health professionals in identifying and providing support for victims'.

Comparisons with Europe - children exempt

Comparisons with Europe provide a compelling case to indicate that these proposals for the UK are far too restrictive for undocumented migrant children and that an exemption for all children should be introduced.

The level of care available to undocumented migrant children in many parts of Europe is varied. However, in almost all cases where research has been undertaken, it is much more comprehensive than that available in the UK now for this group, even without the restrictive proposals being put forward in this consultation.

Spain , Romania and France for example offer the same access to healthcare for undocumented children up to 18 as national children. This same rule applies to children up to 14 in Greece . In Belgium and Italy , all children under the age of 6 can access a wide range of essential and preventative treatments free of charge. In the Netherlands , if children cannot afford to pay their healthcare costs, there is a system in place to reimburse health care providers for 80-100% of their costs. In Estonia , children attending school under 19 years of age and students of up to 24 years of age are treated in the same way as insured persons, regardless of their legal status.

There is a precedent in a few countries for providing health care at a different level for children than for adults. In Spain for example, access for foreign adults is restricted but foreigners under the age of eighteen receive health care under the same conditions as Spanish nationals. France has the same level of care but reduces the requirements/ and administrative burden for children (i.e. the requirement for minimum 3 months of residence and an annual fee). If this approach is considered by the UK we must state again that restricting access for adults but not for children will still have a significantly detrimental impact on children's access and health.

- Separated children and young people

In addition to trafficking, there are many other reasons why a young person can find themselves without a legal status in the UK. For example, our research on separated children at risk highlights many cases of children who did not have documents to prove their identity. This may be because they were smuggled into the country, came here on false documents, or came here on a visa but overstayed without knowing there was anything wrong. These children will be considered undocumented or irregular (or 'illegal' as referred to in the government's documents), falling outside the scope of entitlement proposed in this consultation.

For example, Victoria Climbié who died in 2000 was brought into the UK from the Ivory Coast by her aunt on false documents to live in private fostering arrangements. Under these proposals she may have been denied access to primary care. This exemption as it stands therefore undermines attempts by the Department of Health to make progress in facilitating support to trafficked and abused children. This example gives even greater emphasis for the need to ensure that all children and young people are able to access free healthcare.

The lack of free access to primary care services would also affect the ability of services to assess for factors relating to child protection in order to make an early intervention relating to their safety. Primary health care professionals such as GPs, midwives and health visitors are in an advantageous position to notice early signs of parental abuse or neglect . By removing primary care access for irregular migrant children the government will be reducing the number of professionals who could potentially identify and intervene in a case such as that of Victoria Climbié.

Furthermore, the long-term needs of separated children in the UK is often forgotten about or avoided altogether. Our research has shown that for a sizeable number of these children who arrive, no clear resolution to their situation is considered and they are given a temporary immigration status until 17.5 years old. Upon turning 18 years old, these young people are likely to be left without status even if they have strong legal arguments for remaining in the UK and often face destitution and homelessness. The Home Office is eager to return these young people to their countries of origin as part of its function to control migration but in many cases this is not possible for these young people who have no lasting links to their countries of origin and have developed a life and social networks in the UK. Schedule 3 of the Immigration, Nationality and Asylum Act 2002 Act allows local authorities to withdraw support from care leavers who are 'appeal rights exhausted' and classed as 'unlawfully in the UK' on the basis of their immigration status, in conflict with care leaver legislation. The current Immigration Bill in parliament will further impact on this policy by completely prohibiting local authorities from providing support to this group of young people. These young people are incredibly vulnerable and the impact of secondary care charging is already apparent to us (see case of R below), restricting their access to primary care will make their situation even harder and they are a group who is unable to pay for their care. This is why this group must be exempt from primary care charging.

Case Study: R

When R arrived in the UK he was placed in foster care. He got a place at college and was receiving support from a trauma care service. However when he became appeal rights exhausted aged 21 the local authority proactively sought to terminate his support under Schedule 3. They stopped his

trauma counselling and contacted the NHS to cancel an operation on his jaw which was scheduled. They also contacted his college, who refused to withdraw his place.

R stayed in his accommodation but was in arrears and had had no access to any income for two months. He was helped by an advocate at the Red Cross who found him a community care solicitor who helped to get his support from the local authority reinstated. He is still technically appeal rights exhausted and subject to Schedule 3 although he has a fresh claim pending. He has ongoing mental and physical health problems.

2) Race:

- Impact on vulnerable families who are entitled

We are concerned that these proposals will disproportionately impact on asylum-seeking, refugee and migrant children and families as well as those from black and minority ethnic backgrounds, because the process of checking entitlement might lead to a greater propensity for discrimination. Refugees and asylum seekers already experience barriers in accessing healthcare . This includes language barriers, concerns about confidentiality, discrimination by members of staff, concerns about authority and their lack of knowledge about the UK health system, and what they are entitled to, have all been cited as pre-existing barriers . The proposed policies will only exacerbate this trend among vulnerable groups and healthcare professionals for those who will still be entitled to access free healthcare.

Case study: Young carer, Riyya refused by GP and children's services

Riyya was 11 when she and her disabled mother claimed asylum in the UK. Her mother could not walk, so it fell to Riyya to take care of her as well as do all the shopping and cleaning. She often had to take days off school to take her mother to appointments and was asked to interpret for her mother, including by solicitors and doctors. 'My mum couldn't go [sign in] every single week because of her disability, and if we don't go we can't get the money which meant a lot of the times we didn't have any money…it took around three or four months for them to realise.' Her support worker made a number of referrals to children's services and adult social care but they were consistently refused. Despite being on Section 95 asylum support during this time and entitled to primary care, they tried to register with a number of different GPs but were wrongly turned away for being asylum seekers. Riyya said: 'I felt as if we were wrong, or as if we were not equal.'

- Poor health and inability to pay for those no longer entitled

While the government has noted that asylum seekers on Home Office support will be exempt, some asylum seeking children and families will not be protected because they will not be receiving support from the Home Office. This includes families who are unable to return, are destitute and have no means to pay for health care. The current Immigration Bill being debated in the House of Lords removes support from families with failed claims who were previously supported under Section 95 and who will now being supported under Section 95A only for a proposed 90 day grace period after which they will have support removed. This policy change is going to affect 2,900 families and their children (Home Office estimate). Research has consistently highlighted that many of those applying for asylum support from the Home Office are wrongly refused because Home Office decision-makers

are not applying the correct legal test in relation to destitution: out of the cases surveyed by the Asylum Support Appeals Project, 80% were overturned on appeal .

Research available on the health needs of refused asylum seekers suggests that they are a particularly vulnerable group which could impact on their health status both on arrival and in the future . Many will have come from countries in which there is a poor infrastructure, including disrupted/minimal healthcare systems, they may have passed through refugee camps, or made long and difficult journeys to the UK. In addition, refused asylum seekers who cannot register or are de-registered from their GP surgery will not be able to obtain the appropriate medical verification that they are too sick to travel or that they are in poor health and should have their reporting requirements to the Home Office reduced or temporarily suspended. Charging will therefore create a further barrier to their access of section 4 support.

We also support families who are destitute and have no recourse to public funds. These are families who currently have no legal right to remain in the country. There are an estimated 120,000 undocumented children in the UK – the reasons for becoming undocumented are complicated and diverse (Source: No Way In No Way Out, University of Oxford). However many undocumented children were born here, and the majority of those born abroad entered the UK legally, either with their parents who then held a valid visa, or unaccompanied. In many families, some members are British citizens while others are undocumented. These families often need support from the local authority under Section 17 of the Children Act 1989. We find that current charging for secondary care results in children not getting the treatment they need and sometimes means families are forced into significant debt. We have worked with a family for example who has received retrospective bills for NHS antenatal care, dating from 2006, and are now facing debts totalling up to £18,500, due to the NHS (Charges to Overseas Visitors) Regulations 2011. Furthermore, these families have applications to regularise their status, and such debts will adversely affect their application.

Refused asylum seekers and many families with no recourse to public funds are not allowed to work and earn money and do not have access to the mainstream welfare system, therefore denial of access to free health care will arguably encourage informal and exploitative working to pay for their healthcare. There is evidence that NHS trusts have pursued asylum seekers for debt, often in an aggressive manner, even when they have no means of paying substantial hospital bills . This has resulted in a great deal of distress to the children and parents, despite this approach being time consuming and expensive.

3) Gender

- Pregnancy and maternity

We are concerned about the impact these proposals will have on pregnant women and newborns who may experience follow-on effects from any restriction on maternity services, which are vital to their healthy start in life. Charging for primary care services in particular will impact on pregnant women as 83% of women first seek maternity care through their GP (Source: Maternity Action) . There is clear evidence that current charging policy has negatively impacted on pregnant women's health and well-being. The outlined proposals are only going to make this situation worse. One factor in poor maternal health outcomes for vulnerable migrants is poor general health. Women

may arrive in the UK with undiagnosed conditions such as congenital heart disease, HIV/AIDS or tuberculosis, or have undergone female genital mutilation (FGM) in their country of origin. Some women may have psychological and physical problems secondary to their experiences in their country of origin and en route to the UK, such as physical injuries and rape.

However, as highlighted in the parliamentary inquiry supported by The Children's Society on asylum support for children and young people in 2012, the lack of consistent and adequate support and access to vital services for women in the asylum system also has implications for their health needs . For example, the inquiry highlighted that refugee and asylum seeking women make up 12% of all maternal deaths, but only 0.3% of the population in the UK. Pregnant asylum seeking women are also seven times more likely to develop complications and three times more likely to die during childbirth than the general population. In the UK, 46% of stillbirths and deaths in the first year of a child's life are due to low birth weight; there are clear links to malnourishment, poor accommodation and a lack of cash-support, all of which are far more likely to be experienced by an asylum seeker.

Research has found that the current charging system results in pregnant women being denied access to care because they are not able to pay for their treatment upfront, because staff are unaware of entitlements, or because they have been deterred from accessing treatment due to a fear of incurring large debts . In some cases women experienced rude and aggressive treatment by Overseas Visitor Managers, and threats to bring in debt collectors prior to giving birth .

Similarly charging for GP services may then result in vulnerable pregnant women delaying the commencement of maternity care or not seeking it at all. If access to free healthcare is further curtailed, both through changing the definition of ordinary resident and through charging for primary care, this will most likely result in more mothers not engaging with services putting both them and their children at risk.

- Public Health and health inequalities

Charging for primary care would undermine the government's commitment to an effective childhood immunisation programme with an aim to reduce the incidence of childhood infections. NICE recommends how to reduce differences in uptake and highlights several groups as being at particular risk of not being immunised including "those from some minority ethnic groups, those from non-English speaking families, and vulnerable children, such as those whose families are travellers, asylum seekers or are homeless" . Charging could have an impact on immunisation up-take within these groups. NICE has stressed that reduced immunisation up-take could also have an impact on herd immunity . From a public health perspective, it is important that the proportion of people vaccinated reaches a certain percentage. For example, measles target vaccine coverage is over 95%. In Northern Ireland there is a considerable lack of legal clarity about entitlement to primary care. In 2012-2013, 15 cases of measles affected a migrant community, many of whom had no access to a GP and therefore had not been vaccinated . Several required hospital admittance for several days at significant cost to the NHS. Proposals to limit access to primary care for some children are detrimental to the health of both individual children and the population as a whole.

The system proposed is likely to further increase inequalities by charging the vulnerable, excluding them from certain treatments and by increasing barriers to accessing care. The Marmot Report, Fair

Society, Healthy Lives , stressed that “tackling health inequalities was a matter of social justice, with real economic benefits and savings”. Yet research shows that child health inequalities are increasing. Over the last ten years, the difference between rich and poor children’s health has grown almost seven times greater . The Secretary of State for Education, NHS England and Clinical Commissioning Groups all have a legal duty, under the Health and Social Care Act 2012, to reduce inequalities by improving the health outcomes of groups including the marginalised and vulnerable .

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.

We oppose the proposals within this consultation in their entirety and have particular concerns about how these proposals, if implemented, would impact on children, young people and families who fall outside of the exempt groups as described in our answer to question 2.

We strongly believe that immigration status should never be a barrier to good health for anyone and particularly for children given the government's obligations to promote every child's right to the enjoyment of the highest attainable standard of health. We believe that this principle is undermined by the current proposals since access to health care would be restricted according to immigration status and contribution rather than need. The proposals do not take into account the government's obligations to address the health needs of all children or its obligations not to discriminate based on a child's nationality, ethnicity, social group or other

status or their parents' status. This is outlined in Article 2 of the UNCRC as well as in the Home Office guidance 'Every Child Matters' . We also notice that this first principle only covers 'immediately necessary treatment' but should in our view at least include 'urgent treatment' as well .

The consultation says that "it is fair that people who are in the country for a short time and are not ordinarily resient should meet the costs of all NHS treatment they receive'. We think that this principle is problematic and would argue that the NHS was born out of the notion that "good healthcare should be available to all, regardless of wealth" Suggesting that everybody makes a fair contribution fails to take into account the particular circumstances and capacities of some members of society, such as children, who cannot be expected to make a contribution to the running of the NHS, whatever their nationality or immigration status.

We feel that the proposals outlined are not workable and efficient. The proposals are unworkable and will place heavy burdens on the NHS. They also present contradictions with current guidelines and strategies relating to healthcare. They are also inefficient because they seek to discourage access to primary care and preventative services, the first point of call for most people seeking help or advice. This will inevitably lead to an increased burden on A&E and more expensive treatment if children, young people or parents develop serious illnesses which could have been prevented with early intervention or diagnosis via a GP or health clinic. An example of this is the need to vaccinate all children to provide herd immunity against a number of infectious diseases.

We therefore propose that several fundamental principles need to be taken into consideration in the implementation of primary care proposals.

- A child's right to health:

The right of the child to receive the highest attainable standard of health is outlined in Article 24 of the UNCRC: "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services".

In addition, General Comment No. 15 (2013) adopts a comprehensive approach to guide States Parties in understanding and implementing their obligations under article 24. It also reiterates that States Parties have an obligation under Article 2 to ensure that children's health is not undermined as a result of discrimination because of the child's, parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status .

- Child first, migrant second - The importance of not allowing immigration status to take precedence over any child's well-being is addressed by the Children

Act 1989 which incorporates elements of best interests in domestic legislation stating that in the upbringing of a child the child's welfare shall be the court's paramount consideration. This is the starting point for any discussion about undocumented migrant children.

- A system which promotes Public Health and does not negatively impact on it - Public Health being defined as: "The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society."

- A system where existing services standards and guidelines are not being undermined - This includes NICE guidance, obligations under the Children Act 1989, Health and Social Care Act and Equalities legislation among others

It must be noted that charging for healthcare and the fear of detection will have an impact on parents and children, even if children were exempt. Research has shown that the cost of a service impacts on how accessible it is perceived to be by parents and paying for services often acts as a disincentive for parents and consequently affects their children . Doctors of the World found that in their London clinic, one in five (20%) feared arrest if they sought help for illness and more than 40% did not even try accessing mainstream healthcare services before asking for help . Research in the Netherlands found that parents who were undocumented were afraid that hospitals had the duty to report them to the police and that they would not be able to pay hospital bills. These concerns caused parents to delay going to hospital when their child was unwell . It must therefore be acknowledged by the government that any policy of charging for adults would also have a detrimental impact on their children.

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?

Please choose one

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.

- This proposal will mean many vulnerable people including children would be unable to access prescription medication. Currently the most vulnerable, destitute migrants are able to get HC2 certificates to exempt them from prescription charges but many vulnerable migrants are unaware of this and so do not get their prescriptions dispensed at all, and so often go without important or essential medication. The proposal will deny all poor and vulnerable migrants access to prescription medication. Vulnerable people should be able to access prescription medication, in particularly the prescription exemptions should not be removed from children.

- The majority of prescriptions will be for standard low cost medications for routine treatment, treating conditions early, or managing long-term conditions which if not treated will deteriorate and they will require more expensive, invasive treatment which becomes 'immediately necessary' and there will be a risk to their health.

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?

Please choose one

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?

Please choose one

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

No

If yes, please explain.

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?

Please choose one

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

No

If yes, please explain.

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.

We consider that all NHS-funded services provided within an NHS A&E setting should be exempt from charging. A&E services are essential for all families, children and young people especially if they are destitute and not registered with a GP. The consequence of these families and children being unable to access A&E is likely to be increased maternal mortality and morbidity.

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

Yes

If yes, please explain.

The Department of Health itself recognised in 2012 that "there is some evidence of higher and sometimes inappropriate use of A&E by short term visitors and others who may experience barriers to registering with a GP." From our experience, the consultation's proposed intention to introduce charges for primary healthcare treatment will deter a much greater number of short term visitors and vulnerable migrants from seeking timely treatment from GPs resulting in these groups making greater use of A&E.

It is already recognised that A&E is struggling to cope with its existing commitments and this will impose a considerable additional burden on A&E departments. For example, homeless people currently attend A&E six times more often than the general population and stay in hospital three times as long as a result of the difficulties they have in accessing primary care. It will also threaten the effectiveness of A&E care both for the individuals affected and for the general population as these individuals will generally end up in A&E when their health has deteriorated and it is more difficult and costly to treat them.

Charging for emergency treatment also raises specific practical issues. Firstly, it is extremely difficult to obtain information from a patient during an emergency or when they are acutely ill. Trying to obtain detailed information on their immigration status would often be impractical even if NHS staff had the specialist knowledge required and the patient spoke adequate English to be able to explain their status.

Clinicians will often need to be involved in deciding whether a chargeable visitor who is unable to pay for care should still be treated because their condition requires immediately necessary or urgent care. Where a clinician identifies symptoms which could be life threatening, undertakes tests, but then does not treat the problem because it has not yet reached the threshold of urgent or immediately necessary, then administrative and clinical time is wasted. The migrant is likely to return to A&E when their health deteriorates, and the whole process will be repeated.

For all the above reasons, we believe that charging should not be extended to A&E care. Trying to assess entitlement at A&E and whether treatment is urgent or immediately necessary is likely to increase delays, put individuals' lives at risk, and may lead to people being wrongly charged or discriminated against as staff seek to make quick decisions because of resource pressures. Furthermore, in the context of repeated government concern about how over-stretched A&E services are, to introduce another level of bureaucracy for checking the chargeability status of a patient, seems very counterproductive.

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.

We oppose the implementation of the NHS charging proposals for similar reasons to those presented in relation to A&E services. Charging would simply add another barrier to children's access to care and adds a further deterrent to them seeking medical attention. The consequence of children and their parents being unable to access ambulance services in an emergency is likely to be increased mortality and morbidity.

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?

Please choose one

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?

Please choose one

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

Please choose No or Yes

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?

Please choose No or Yes

If yes, please explain.

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.

We believe that all non-NHS providers providing NHS funded health services should be exempt from a requirement to apply the charging regulations. Many services provided by non- NHS providers target the most vulnerable sections of the community. They often provide preventative care, management of chronic conditions and community based support. Such providers include charities and other voluntary and community organisations which depend on NHS or local authority funding to provide the service. If they were unable to provide a free service to some of their clients and patients, it is likely that the services would become unviable, if they depended on charging rather than on commissioning by local authorities and NHS trusts. It would also be beyond the capacity of such providers, who have extremely specialist knowledge, to deal with the classification of clients/ patients into chargeable and not chargeable.

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.

- We believe that the following services provided by voluntary sector providers should be exempt: mental health services, hospices, drug and alcohol related services, sexual and reproductive health services including termination of pregnancy, maternity and children's services, and any services targeted at migrants regardless of their immigration status. Community services may comprise specialist services for vulnerable groups such as antenatal and parenting services for minority groups, diabetes services, HIV services or other health promotion services. These are often provided by specialist voluntary organisations who are more accessible and more flexible than standard NHS services.

- The impact of charging for such services is likely to far outweigh the cost of providing these services, and people who need them are likely to simply do without the benefit of the service if they were charged, adversely affecting their own, and public health.

- Specialist services that are accessible to non-chargeable individuals including asylum seekers and refugees might be forced to make distinctions to exclude other chargeable but equally needy individuals. This is not the role of health service providers.

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?

No

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?

No

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?

Strongly disagree

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

Yes

If yes, please explain.

This seems a particularly discriminatory proposal. We believe it is unreasonable to expect a third party to take on unlimited liability for unforeseen circumstances. An individual can commit to provide financial support for a visitor for a period of time who is unable to prove they have sufficient funds, but they should not be expected to take responsibility for an open ended amount of debt that has resulted from an unforeseen event (e.g. a car accident) and which could amount to many thousands of pounds.

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

Do you agree?

Please choose one

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 states that one of the government's priorities is to ensure that the NHS (Charges to Overseas Visitors) Regulations ("the Charging Regulations") are applied effectively. But this consultation extends charging without investigating the problems of implementation of the regulations in secondary care.

- The impact assessment states that it has legislated to ensure exclusions to charging for vulnerable groups but the range of designated vulnerable groups is woefully inadequate. We believe that the following groups should also be designated as vulnerable and excluded from charging:

  - pregnant women and women in the perinatal period
  - all children up to 18 years old
  - all care-leavers who have been supported by the local authority under Section 20 of the Children Act 1989 including those who may transition onto Section 10B (Schedule 9: Availability of local authority support) as a result of the Immigration Bill currently in parliament
  - families supported by local authorities under section 17 of the Children Act or under the new Section 10A (Schedule 9: Availability of local authority support) as per Immigration Bill currently in parliament
  - people obtaining mental health treatment in the community

Our concern is that failure to exempt these highly vulnerable groups undermines the effort to ensure that the regulations do not create barriers, particularly to children, young people and their parents or carers access to care, and will not lead to graver

health problems affecting both the health of the individuals concerned and the public health.

- We do not consider that free access to GP and nurse consultations without the services and tests that GPs and nurses provide also being free at the point of delivery is workable or significantly mitigates the risk of worsening access to healthcare.

- In our view the impact assessment does not take account of the full costs of extending charging to primary care and to the other areas in the consultation. The costs involved in implementing charging in primary care, along with the additional expenditure incurred from delayed treatment, pursuing debts and defending possible legal challenges are likely to be substantial and the measures will put the health of individual patients and the wider community at risk.

- We believe health professionals should have the power to waive a charge when they consider it cost effective to do so (e.g. the patient does not have the means to pay and not treating them would most likely lead to them presenting again either at a GP's surgery or at A&E once their illness requires urgent treatment). Similarly, health professionals should always have the ability to waive charges where it would risk public health not to treat the patient.

Key reports from The Children's Society:

Not just a temporary fix: Durable solutions for separated migrant children http://www.childrenssociety.org.uk/what-we-do/resources-and-publications/not-just-a-temporary-fix-durable-solutions-for-separated

Cut Off From Justice: The impact of excluding separated migrant children from legal aid http://www.childrenssociety.org.uk/what-we-do/resources-and-publications/cut-off-from-justice-the-impact-of-excluding-separated-migrant