Asylum Matters' Response to Formal Review of Overseas Visitors Charging Amendment Regulations

Asylum Matters works in partnership locally and nationally to improve the lives of refugees and people seeking asylum through social and political change. This submission reflects input from partner organisations in four regions of England (North East, North West, West Midlands and Yorkshire and Humber). However, it must be noted that many of our local partners were unable to input into the evidence-gathering process as the timeframe was too short. Review questions were released just prior to the Christmas holidays, leaving stakeholders returning to work in January less than a month to gather, collate and submit evidence. The first concern of staff and volunteers in busy frontline organisations is with serving vulnerable refugees and asylum seekers, and a much more generous timeframe would have been needed to elicit their input. The Department of Health should acknowledge that this time-frame inevitably limits the quality and quantity of evidence available about the impact of the Amendment Regulations.

This review comes not long after the amendments to the regulations have been made, and the accompanying guidance released. As such, it is our belief that these changes have not yet been 'bedded in' to many services and that some 'relevant services' – particularly community services delivered by non-NHS providers – are not yet aware of their duties under the regulations. It is therefore difficult to accurately assess the full impact of these changes on vulnerable groups at this stage. The availability of relevant testimonies, case studies and quantitative data is thus limited. In light of this, in some instances we have drawn on evidence from *before* the regulations came into force (or after the regulations came into force but before the new rules were fully implemented by services) and used this to forecast the likely impacts on vulnerable groups. We call on Department of Health (DH) to give due regard to this evidence and recognise its value, within the constraints set by the review.

In addition, it is extremely difficult to quantify a 'deterrent effect' of these regulations, and stakeholders responding to this review do not have the resource to do so adequately. We believe DH should invest in rigorous independent research to capture this impact in light of their duties under the Equality Act 2010 and their commitment to reducing health inequalities.

We regret that the review is not a formal consultation and has not been widely advertised or posted online. As such, we believe it has not reached the widest possible range of interested parties. This will inevitably undermine the diversity and range of the submissions provided. We feel strongly that a formal consultation, in addition to a rigorous independent evaluation of the impact of the regulations on vulnerable groups is required.

Any perceived limitations in the conclusiveness of evidence submitted by the review deadline does not necessarily indicate an absence of impact on vulnerable individuals, nor does it indicate that more conclusive evidence would not be available at a later date.

We also regret that the review only refers to the impact of the Amended Regulations, even though the original Regulations, implemented in April 2015, have never been rigorously evaluated, particularly in relation to their impact on vulnerable groups. The Amendment Regulations are also being implemented within a wider context of other changes to health services – including the Memorandum of Understanding between NHS Digital and the Home Office that enables the sharing of patient data for immigration enforcement purposes, and new questions added to GMS1 forms about residency status – which in combination are likely to exacerbate the negative effect on vulnerable groups. The Amendment Regulations cannot be considered in isolation from these other initiatives, and Department of Health should reflect this in their analysis.

The narrow focus of the review questions also precludes stakeholders from including evidence about more indirect effects of the Amendment Regulations on vulnerable groups. For example, these changes bring with them an administrative burden and additional costs to the NHS, they take up the time of clinical and non-clinical staff, and increase patient waiting times, all of which affect the service received by vulnerable groups and the wider population.

Extending charging into community services

1. Do you have any evidence of how the extension of charging into relevant services provided in the community, or to non-NHS providers of relevant services, has had a particular impact on persons sharing a protected characteristic?

As any NHS funded organisation – including charities – that provides community-based services are now legally required to check the eligibility of patients and, in some circumstances, charge them for the care they need, we are concerned that particular services designed to address health inequalities faced by certain parts of the population will be unable to meet the needs of their particular target group.

Relevant community services identified by DH include: community midwifery, community mental health services, termination of pregnancy, drug and alcohol treatment services, district nursing, outreach services – services targeted at difficult to reach groups, advocacy services provided under the Care Act 2014, and routine screening for non-infectious diseases.

However, to date, DH has not been able to provide a full list of community healthcare services that will be chargeable. DH acknowledge that "producing such a list would not be possible given that community services are not defined or delivered in a standard way across localities."[1] Consequently, many Community Healthcare and non-NHS providers of relevant services will not yet have implemented the new charging regime, either because they do not think their services are relevant, or because they have not yet received any official guidance from DH or Public Health England as to how they are meant to operationalise the charging regime.

While it is a challenge to provide robust evidence for something that has largely not yet happened, we can safely predict some unintended outcomes of these proposals based on previous experience of working with particular protected groups.

DH has a duty under the Equality Act 2010 to ensure persons with 'protected characteristics' - which are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex or sexual orientation – do not face discrimination. However, the nature of many community services which are small in scale and operate with limited staff capacity, mean that there is a strong risk that racial profiling is being relied upon to determine chargeable status. Unlike hospital-based services, they do not have dedicated OVM teams, potentially leading to untrained individuals making these assessments.

Additionally, the fact that DH cannot produce a full list of affected services demonstrates the lack of clarity that persists in relation to the implementation of the regulations. This lack of clarity about who is entitled to free care carries the risk that certain groups are being erroneously denied free care or are delayed in accessing the care they need as a result.

Age: Children who are born to non-exempt patients will now be chargeable for community healthcare services. Children, who are not in a position to regularise their own status, are reliant on the actions of their parents. This extension of charging threatens to damage the health of young children resident in the UK, with risks to public health and personal development.

The following case study from a counselling project in Liverpool (Family Refugee Support Project) demonstrates that a child could be left without mental health support.

> *A single father and son of secondary school age, are living in Liverpool. The father is living with PTSD and receives medication for anxiety and depression. He also has a heart condition and receives medication for this. The family now have refugee status but were initially refused asylum and did not have any ongoing representations under consideration by the Home Office for several months pending finding a lawyer and making a fresh claim. It was at this point the father was referred to Family Refugee Support Project (FRSP)*

[1] Email from Cost Recovery Team to 'Vulnerable Groups' mailing list on 8 December 2017

from an NHS counselling service, as it was recognised that longer term support was required. In addition, the son was receiving counselling from the Child and Adolescent Mental Health Service. FRSP are still providing long-term therapeutic support.

This case shows that an individuals' eligibility for free care can change swiftly as their immigration status changes over time. When the father was referred to FRSP from the NHS counselling service, and the son was receiving counselling from the Child and Adolescent Mental Health Service, the family had no representations under consideration by the Home Office. During that period, they were therefore receiving a service to which they would not be entitled under the Amendment Regulations, although they would eventually become eligible for free treatment upon gaining refugee status. A break in their mental health support would have been both pointless given their eventual eligibility and harmful for their long-term wellbeing.

Pregnancy and Maternity: Pregnant women are affected by high rates of charges in maternity care. Women shoulder the costs of peri-natal, post-natal care, and delivery, as well as costs associated with the newborn child (see answer to question 6).

With the expansion of charging to include non-NHS providers of services, and the lack of a treatment-based exemption for terminations, we are also concerned that chargeable pregnant women will be unable to access an abortion. In the North East, one woman who was seeking an abortion was told she would have to pay £1,000 up front, or if she carried her baby to full term, she would be charged £5,000 for maternity care. She has no means to pay £1,000 up front for an abortion, so has been forced to continue with the pregnancy.

In a separate case from the North East, a woman had been to the local hospital and asked for a pregnancy termination. They told her that it would cost £1,000 because of the new regulations. In fact, this woman was entitled to free secondary care. She was understandably very distressed by this news but had the confidence to query the information she had been given. Eventually the issue was sorted out and a "training need" was identified by the hospital. However, it is easy to see how other women facing this situation may be erroneously denied access to this service and forced to seek another route to a termination.

Race: In the whole charging regime, there is a threat of discrimination by perception – the belief that people of a particular colour, nationality, or ethnic background might be more likely to be chargeable. (See more below in Question 6)

Sexual Orientation: Some people who seek refugee protection are LGBTQ and are fleeing persecution based on their sexual orientation. Research by UKLGIG highlights the difficulties LGBT asylum applicants have in getting their case for protection from persecution on the basis of sexual orientation recognised. Up until 2010, it was estimated that 98% of sexual identity claims were routinely refused by the Home Office.[2] Substantial improvements have been made since this time, but the process of assessing sexual identity claims remains flawed. As such, LGBT applicants are more likely to be refused, rendering them chargeable for healthcare.

2. Do you have any evidence of how the extension of charging into relevant services provided in the community, or to non-NHS providers of relevant services, has had a particular impact on any other vulnerable group?

Community services and non-NHS providers are often commissioned to address the health inequalities faced by particularly vulnerable groups. Introducing charges in these settings undermines the vital role they play in safeguarding children and vulnerable adults, resulting in increased health inequalities.

In our opinion, it is too early for the full impact of these regulations to be fully known. However, our experience of the current charging regime in secondary care is that there are already significant legislative and practical barriers faced by vulnerable people when they try to access the healthcare that they need.

One of the most protracted barriers is around providing identity documents to clarify eligibility for free NHS care. Many vulnerable patients will struggle to provide the relevant documentation to prove their eligibility for free care,

[2] "Failing the Grade" 2010, UKLGIG and "Missing the Mark", 2013, UKLGIG: https://uklgig.org.uk/?page_id=1225

particularly new migrants, people who have no fixed address, the elderly, and those living with mental health difficulties. Although this should not impact on their ability to access primary care services, the extension of charging into relevant services provided in the community or to non-NHS providers of relevant services will narrow referral pathways for vulnerable groups who cannot provide their eligibility for free care.

This case study from Manchester illustrates the barriers already faced by one patient in getting access to primary care services:

> *A vulnerable migrant from the Middle East living in Levenshulme, Manchester was prevented from accessing a GP for his chronic asthma due to not being able to prove his immigration status. The man tried to register with two Greater Manchester GP practices, but was unsuccessful, meaning he was without access to medication for some months. His mental health has been affected as he experiences anxiety and insomnia brought on by the worry of not being able to get the medication he needs.*

There should be no question about this patient's eligibility for free primary care, as there is currently very clear guidance to NHS staff regarding entitlement to primary care which has frequently been restated, and yet he is experiencing significant barriers to registering with a GP. We can surmise that the same sorts of barriers will prevent vulnerable patients accessing community care services.

A primary care provider in Yorkshire reported that when they attempted to refer a vulnerable patient on to community mental health care, they were asked by the secondary healthcare provider to confirm the patient's eligibility for free care. This primary care provider had not been trained in the new regulations, nor should it be their responsibility to police access to secondary care services. Eventually it was determined that the patient in question was fully exempt from charging, but it is concerning that primary care providers are being asked to gate-keep access to secondary care services on behalf of those services.

In addition to the changes brought in by the Amendment Regulations, new 'supplementary questions' on the GMS1 patient registration form designed to identify chargeable patients, are leading to further confusion at GP practices as refugees and asylum seekers are asked to produce paperwork proving their eligibility, despite clear guidance from NHS England that the inability to provide identification or proof of address should not be considered grounds to refuse to register a patient.

In those community services that are already applying eligibility checks, NHS staff time is being taken up checking eligibility, which has significant knock on effects on the time available to support vulnerable patients. Community healthcare and non-NHS providers do not have the same charging infrastructure as hospitals. Without the presence of an Overseas Visitors Manager Team, it is evident that untrained admin/ reception staff, and in some cases clinicians are being asked to determine patient's eligibility for care. Community midwives, district nurses and mental health providers should not be distracted from providing healthcare to patients by being tasked with checking eligibility for care.

Third sector organisations have also seen an increase in their own staff time being used to mitigate the impact of extending charging to community services: for example, by advising and assisting vulnerable patients such as refugees and people seeking asylum on their eligibility for free healthcare and advocating for erroneous charges to be dropped at secondary healthcare level. We can reasonably expect this workload to increase with the expansion of the charging regime.

Importantly, third sector organisations working with vulnerable patients including refugees and people seeking asylum are not experts in the NHS charging regulations. However, these organisations have been expected to field questions about a service user's eligibility for free care from the healthcare provider.

3. Do you have any evidence that the extension of charging into relevant services provided in the community, or to non-NHS providers of relevant services, may have deterred individuals from seeking treatment?

As outlined above, the lack of clarity and misinformation about who is eligible for free care threatens to make vulnerable patients reluctant to present to services and deter them from accessing the care that they need. Again, it

is not possible to fully assess the impact of these new regulations for the following reasons: we do not believe that all relevant services have started to enact the charging regulations; and for those that have it is difficult to quantify the impact of deterrence so soon after the regulations have been put into force.

However, we are concerned that the mechanics of the new charging regulations will facilitate further disengagement from healthcare services by vulnerable patients. Tasking healthcare professionals (e.g. midwives, drug and alcohol teams) with checking eligibility for free care in community settings risks undermining trust between patients and healthcare professionals. This is particularly worrying for healthcare services commissioned by either the Clinical Commissioning Group or the Local Authority to address the needs of a particular vulnerable group, as fears of charging (whether well-founded or not) will impact on that provider's ability to mitigate health inequalities.

On a more general note, expanding charging into more areas of NHS care provision may have wider impacts on the quality of life of vulnerable patients. In one case, due to fears of being charged for healthcare, one vulnerable asylum seeker living with mental health difficulties was forced to disengage from sporting activities that were helping his mental wellbeing as he feared sustaining an injury and being charged for treatment:

> *Adam from Sudan was one of the founding members of our football team in 2015 and has been playing with them ever since and representing the Centre at matches across West Yorkshire. His asylum case was refused and he was made homeless in 2016. He has been living with a volunteer host family for over a year, while his new legal representatives help him present his case to the Home Office with stronger evidence.*
> *During this difficult period, football has been a sanctuary for Adam. Every Saturday he eagerly meets the team, helps the coordinator sort out the kit and motivates the other players. Football has played an important role in maintaining his mental health and wellbeing, providing a sense of dignity and building his confidence and self-esteem.*
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> *He recently hurt his ankle during football practice and had a couple of weeks off. We have since found out that he wants to quit the football team altogether because he is scared of further injuries and that if he hurts himself and requires medical treatment, he would be charged for receiving that treatment.*

4. Do you have any evidence that the extension of charging into relevant services provided in the community, or to non-NHS providers of relevant services, may have had an impact on public health?

Any system that deters people from seeking healthcare at the earliest opportunity creates risks to public health. People seeking asylum already experience problems registering with a GP as they are commonly asked to provide proof of address and identity documents they cannot easily access. The extension of charging/ eligibility checks to community services means yet more preventative care services are out of reach for asylum seekers.

In Liverpool, a local support project reported cases of two women who had been forced into prostitution in order to survive after their access to accommodation and support was withdrawn. Both had contracted STIs as a result of this sexual activity, but were too afraid to get tested as they feared they would be charged. An exemption exists for testing and treatment of STIs, but this is not widely known about.

5. Do you know of any examples of good practice or steps that could be taken which might mitigate the issues that you have raised in your responses to questions 1, 2, 3 and 4?

The requirement for all relevant bodies to charge upfront for treatment that is not immediately necessary or urgent

6. Do you have any evidence of how the requirement to charge upfront for treatment that is not immediately necessary or urgent, has had a particular impact on persons sharing a protected characteristic?

With a highly complex immigration system, it is a challenge even for trained Overseas Visitors Managers (OVMs) to understand and keep track of immigration statuses and how this correlates to a patients' eligibility for free healthcare. For example, for people claiming asylum in the UK, their eligibility for free healthcare is linked to the

statutory support they might be receiving from either the Home Office and Local Authorities. So, while an asylum-seeker awaiting an initial decision or any appeal is not chargeable, one that is refused is chargeable. However, even once refused they would be eligible for free healthcare if they make a successful Section 4 support application or a successful fresh asylum application.

The complexity of this system is reflected in a recent survey by Medact of 198 healthcare professionals working in the North West of England, which demonstrated an alarming lack of knowledge about who is entitled to free care, with the risk that certain groups will be erroneously denied free care. The survey found only 21% of responders felt confident defining the terms "asylum seeker", "failed asylum seeker", "economic migrant" and "refugee", with only a quarter correctly identifying which groups were eligible for free primary care. 32% failed to identify "failed asylum seekers" as eligible for free emergency care. 88% felt that they would benefit from further training on issues surrounding asylum seeker and refugee health.[3]

To identify who is chargeable, many people will require in-depth consultations with a professional interpreter and a practitioner who understands the asylum process, but an interpreter is not routinely provided for 'administrative purposes'. Asylum seekers' circumstances change over time and these consultations will need to be frequently revisited to remain up to date, which is a drain on NHS resources. In addition, the NHS will inevitably rely on the Home Office to verify eligibility of certain patients. The Home Office currently has a backlog of more than 10,000 asylum applications which have been waiting for more than the target six months for an initial decision on their claim. In this context, it is extremely unlikely that the Home Office will have the resources required to ensure that asylums seekers' eligibility for free healthcare is updated with sufficient speed and regularity to ensure their records are up to date and correct.

One of our partners reported that a local hospital insisted that two asylum seeker patients – both pregnant - provide an ARC card as proof of their eligibility for free care. However, ARC cards are often not issued for weeks/months and sometimes are never issued by the Home Office so they are not in themselves proof of being an asylum seeker. Demanding to see an ARC card appears to be a mis-application of the guidance, which states: "Asylum seekers and those applying for leave to remain as victims of domestic violence are not issued with a BRP. These groups should have an NHS record visible on the Spine, but if one is not available you should continue to use good judgement and other available documentation such as the Application Registration Card (ARC) or evidence of exemption from paying the health surcharge from the Home Office to ascertain eligibility for free NHS services. You will need to continue to exercise good judgement and make enquiries of the Evidence and Enquiry team at the Home Office, where individuals are not recorded on the Spine and where you cannot verify that the health surcharge has been paid."

In addition, the classification of urgent care is a clinical decision, not an administrative one, and making it without clinical involvement would be grossly negligent. However, our conversations with medics suggest some trusts appear to routinely not involve medical staff in these decisions. While we are concerned that the charging rules are an extra burden on staff, it is even more concerning that OVMs are choosing not to involve clinicians in important decisions about urgent care needs.

The new requirement to charge up front and withhold treatment until an individual can pay means the regulations carry the strong risk that lifesaving care could be withheld from vulnerable patients. We have seen multiple cases where patients' outstanding unpaid bills are being used by hospital trusts as a reason to withhold further treatment, where it is not clear that the necessity or urgency of this new course of treatment is being assessed in each instance.

Charging up front for treatment that is not immediately necessary or urgent has, in our experience, had a negative impact on a number of groups of persons with a protected characteristic. The 'intersectionality' of people seeking asylum must be recognised, meaning some asylum applicants share more than one protected characteristic and can be open to multiple forms of discrimination and health inequality. The timeframe of this review has prevented many of our local partner organisations from submitting evidence which would have helped demonstrate the impact of the regulations on a wide range of persons with a protected characteristic. However, we do have recent evidence about

[3] Healthcare professionals' views and experiences of dealing with refugees and asylum seekers: a survey of NorthWest practitioners, Oct 2017, Medact https://medactmanchester.files.wordpress.com/2017/10/medact_report_2017.pdf

three protected characteristic groups that have been affected by charging: Age (children) and Pregnancy/ Maternity and Race.

Age: Children who are born to non-exempt parents are now subject to up front charging for NHS care. Children, who are not in a position to regularise their own status, are reliant on the actions of their parents. Up front charging threatens to damage the health of young children resident in the UK, with risks to public health and personal development.

Two cases from the West Midlands concern children supported by the Local Authority under Section 17 of the Children's Act (which is not included in the list of exemptions from charging).

> *Joseph and his family, (wife and 3 children) are refused asylum seekers. They have been in the UK for 15 years and are supported by Social Services under Section 17 of the Children Act. They have made an Article 8 application for Leave to Remain which is outstanding, with an appeal listed in a couple of months.*
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> *One of his children has been diagnosed with Autism and therefore has speech and language problems, dental problems and hearing problems. At the moment he needs some dental treatment which requires a general anaesthetic and a stay in hospital, due to his diagnosis of Autism. The son did have some treatment previously and the family were sent a bill for over £1,000 as a result. This has not been settled as they are unable to pay it due to the low level of support they receive. Therefore, because the family cannot pay for further treatment, the local surgery is attempting to arrange to carry out the dental treatment in a primary setting, ie without general anaesthetic, however this is very distressing for the child. If the family were eligible for free healthcare the recommended treatment would be for this procedure to be in a secondary setting.*

This case demonstrates that a vulnerable child faces having treatment either withheld or a less suitable form of treatment given due to the immigration status of his parents. The child is disabled, so falls into two protected characteristic categories.

In another circumstance, the treatment of a very unwell child was withheld due to a previous bill for care being unpaid.

> *John and May accessed a volunteer support organisation in Birmingham at the end of November 2017. They have two children and the whole family is supported by Social Services under Section 17 of the Children Act. One of the children suffers with sickle cell anaemia. They had an outstanding application for Discretionary Leave to Remain on compassionate/health grounds with the Home Office because the child was so unwell. Treatment of the condition was discussed with the family and it was decided the best course of treatment was a stem cell transplant. May stated that at no time was there a discussion with the family about whether they would be charged for this treatment; they were asked to provide ID to show whether they were entitled to healthcare but she was unsure what this meant.*
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> *Unfortunately, the stem cell transplant was unsuccessful and a second transplant was clinically recommended as the best cause of treatment for the child as he was now in a life-threatening situation. However, the family then received a bill for £101,000 (for payment of the first transplant and care). As they were unable to pay this invoice, the second transplant, was delayed. May and John contacted a solicitor to find out if they could help their situation. Their solicitor has been able to secure their Discretionary Leave to Remain and negotiated with the hospital for the second stem cell transplant to proceed. They are still in negotiation about the payment of the invoice.*

This case clearly shows how a life-saving course of treatment that was clinically recommended was withheld by the hospital because the child's parents couldn't afford to pay.

Recommendation: To avoid vulnerable children seeing care withheld or delayed, we strongly recommend DH exempt all children from charging, regardless of immigration status.

Two cases from the Family Refugee Support Project in Liverpool, which offers counselling and psychotherapeutic support to families going through the asylum process, demonstrate how charging their parents for healthcare can negatively affect the mental health of children.

> *An asylum-seeking family of four, including a mother, father and two school aged daughters, are currently living in Liverpool. The family have been refused asylum by the Home Office. They were then let down badly by a lawyer, who submitted a very poor fresh claim on their behalf, which consisted of no legal arguments alongside a bundle of evidence. This evidence has now been submitted and refused by the Home Office, and the family have been unable to find a lawyer to help make their case. They are currently working on submitting a fresh claim themselves, but have struggled to make an appointment to submit this (their MP contacted the Home Office, who acknowledged lack of staff to pick up fresh claim enquiries / make appointments to submit; this has delayed them having representations under consideration).*
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> *The mother and father both have multiple health issues, with limited mobility, and are in receipt of ongoing treatment and care at local hospitals. The treatments are not classed as 'emergencies', but involve a combination of surgical treatments which may now be stopped. Were this to be the case, the parents would struggle to manage their chronic pain and health conditions even more than they do currently, and their already limiting mental health issues (depression and anxiety) would be exacerbated. This, in turn, will impact on their ability to parent their children.*

This case demonstrates that charging up front for healthcare can exacerbate existing mental health conditions, and shows how charging for healthcare could impact on vulnerable children. It also shows how external factors that are beyond the control of individuals, such as poor legal representation or lack of free legal advice, as well as delays with the Home Office processing fresh claims, can impact on their eligibility for free healthcare. A separate case also shows how charging for healthcare impacts on vulnerable children.

> *An asylum-seeking family of five, including mum, dad and three children – all 10 years old or younger, currently living in Liverpool. They have been in the UK for seven years, including some periods without legal representation. Both parents are torture survivors, but strong physical and expert evidence of this, whilst accepted in part by the Home Office, has been attributed to 'rogue officials' in their country of origin, so the Home Office has judged that they do not require protection from their government. They recently submitted a fresh claim for asylum via a lawyer. This family were questioned last year by Home Office staff prior to an ante-natal appointment at the Liverpool Women's hospital, and told that the mother did not qualify for treatment as they were here 'illegally'. At this time, they had an ongoing claim under consideration, but the Home Office system was not up to date. This created huge distress, and the family were frightened they would be deported. Anxiety symptoms escalated for both parents. Whilst they tried to hide this from the children, their oldest child became distressed with physical and mental symptoms being demonstrated. Both parents and two of their children have ongoing health issues; both children are being regularly monitored at Alder Hey Hospital for health conditions.*

This case further demonstrates that while the amendment regulations include exemptions from charging for survivors of torture, in practice it is very difficult for individuals to evidence this in order to qualify for free care. This case also demonstrates that the Home Office database - which healthcare providers rely on for intelligence about who is eligible for free care - is sometimes not up-to-date, meaning eligible patients could be wrongfully denied free care.

Pregnancy and Maternity: Pregnant women are affected by high rates of charges in maternity care. Women shoulder the costs of peri-natal, post-natal, and delivery, as well as costs associated with the newborn child. We have come across numerous examples where charging for maternity care has created considerable confusion and distress, both for women who are chargeable and those who should be exempt from charging. While maternity services should be treated as immediately necessary – and therefore provided regardless of a woman's ability to pay - the very threat of being charged further down the line means some women are going without vital maternity services.

In the following case, being charged up front made the patient reluctant to access services and caused a vulnerable pregnant woman to miss her appointments:

> *While she was pregnant, E, who is a refused asylum seeking woman and therefore chargeable for healthcare, received a call from Guys & St Thomas' immigration team stating that she is no longer eligible for free maternity care, and that she needs to start paying. She was told that if she wanted antenatal and intrapartum care she would be expected to pay £5,000. Understandably, E was scared by this as she does not have the means to pay, so therefore did not attend her next appointment with the midwife. E was then in Manchester for some months, and accessed maternity care after receiving support to re-book appointments, due to fear of charging again. E had the baby in London while visiting her partner and has since received the first hospital bill, but has no means to pay.*

This demonstrates that fear of charging can lead not only to important appointments and health checks not taking place, but also to NHS resources being wasted as vulnerable patients do not attend scheduled appointments. Being a refused asylum seeker means this lady has no permission to work in the UK and therefore no means of paying for maternity care. Billing such patients who ultimately cannot pay is damaging as it deters them from accessing care, and pursuing bad debt also wastes valuable NHS resources.

Recommendation: We recommend the Department of Health follow the example set by the devolved governments of Wales, Scotland and Northern Ireland, and ensure universal access to free healthcare for asylum seekers, by including an exemption from charging for refused asylum seekers.

The following case demonstrates what damage could be done to the unborn baby as a result of fear of charging for maternity care:

> *A refused asylum seeker from Ethiopia who was heavily pregnant and living in Liverpool had a number of health problems, including being HIV positive and having a diagnosis of epilepsy. She was supported by the Local Authority, giving her a roof over her head and limited financial support.*
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> *Her health problems had the potential to impact on her unborn child (e.g. the slight risk of her HIV being passed on, although this is minimised through medication, plus the potential effect of her epilepsy medication on the child). She also had a history of toxoplasmosis, which was a concern earlier on in her pregnancy, and required further testing.*
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> *When she went to her regular appointment at the Home Office reporting centre, she handed over a letter from the hospital as proof of her current address. This led to a Home Office enforcement officer erroneously informing her she would be charged for her NHS treatment, and would be sent a bill at some point in the future. The officer also mentioned that any outstanding debts related to this could affect any future asylum-related claim.*
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> *Due to the number of health problems the lady has, she is under the care of numerous different departments (antenatal/fetal medicine unit, neurology, GUM/HIV clinic), and has a lot of appointments to attend and medication to take. As such, the mention of having to pay for her NHS treatment made her very anxious, especially as she receives a very small amount of money to live on and has no realistic way of paying for treatment. For a period, she refused to attend appointments and was only persuaded to return after her support worker was able to demonstrate she would not be chargeable for healthcare.*

In this case, the lady was not in fact chargeable for care. However, the suggestion that she may be was enough to cause her to disengage from appointments, potentially putting her unborn child at risk. She had a support worker from a third sector organisation who was sufficiently aware of the charging rules to know she would not be chargeable and persuaded her to go to her appointments. Had she not had access to this support, the outcome may have been different.

Recommendation: We strongly recommend that all maternity care be exempt from charging, to protect vulnerable women and their unborn children.

Race: In the whole charging regime, there is a threat of discrimination by perception – the belief that people of a certain race, national origin or ethnic background are more likely to be chargeable. Our local partners have highlighted multiple cases where refugees, who are not chargeable for healthcare, have either had their entitlement to free healthcare queried or have been erroneously billed, as this case demonstrates:

> *A lives in Preston, and is a Syrian refugee brought to the UK via the government's Vulnerable Persons Resettlement Scheme. She received a bill of £2,500 for treatment at the local hospital in Dec 2016 and was informed if the debt wasn't settled within 14 days, she would be referred to a debt collection agency. The letter also said that a person with outstanding debts "may be denied a further immigration application to enter or remain in the UK." The letter noted "If you believe you are exempt from paying NHS treatment costs, evidence is required to support your claim. Please refer to the weblink below for exemption guidance." As a person with limited English, A was not able to understand the letter and became very worried about the bill.*
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> *A local support project stepped in to help. One of the main issues was that the hospital would not accept A's Biometric Resident Permit as ID, insisting instead on a passport. It took the support worker a considerable amount of time to explain to the hospital that the Biometric Resident Permit was a legitimate form of ID, and that A was not chargeable.*

This individual was not chargeable and should not have been billed by the hospital. This is not an isolated case and we have seen a greater number of erroneous charges since the Amendment Regulations came into force. In another case, a woman who had joined her husband in Stoke through the family reunion process had her entitlement to free maternity services questioned by the local hospital, despite having leave to remain in the UK. The family spoke only Arabic and so had been unable to understand the hospital's letters requesting proof of entitlement. A third sector adviser was eventually able to support them to provide the hospital with the evidence required, but the family found it a distressing experience.

We believe the Amendment Regulations are leading hospitals to rely on racial profiling as a means of identifying potentially chargeable patients. This is discriminatory and is having a damaging effect on vulnerable refugees.

Moreover, people whose first language is not English find it particularly difficult to understand when the hospital asks them to prove entitlement and it appears hospitals are making no concessions to allow for these additional language needs.

A refugee support project in Blackburn has noted that limited English is also leaving new refugees open to penalty charges for claiming for free dental work. Individuals who have been granted positive decisions by the Home Office and have found work are no longer entitled to free dental work as they are not on income based Job Seekers Allowance. If they fail to tell the Dentists about this, they will now invariably end up with a dental charge and a penalty charge. If contact is made with the NHS at this stage, and if a completed HC1 is sent quickly and the NHS agree to put the charge on hold, the penalty charge can be withdrawn. The refugee support project is trying to inform clients who start paid employment about the need to complete a HC1 as soon as possible and the implications if they don't, but limited English means new refugees often don't realise what is required of them. Healthcare providers need to make reasonable adjustments in order to ensure people with limited English are not unfairly disadvantaged by charging procedures.

7. Do you have any evidence of how the <u>requirement</u> to charge upfront for treatment that is not immediately necessary or urgent, has had a particular impact on any other vulnerable group?

Other vulnerable groups who are negatively impacted by charging and who are not included within the above list of those with a protected characteristic include men and women facing homelessness and economic exclusion, women fleeing domestic violence and stateless people.

Men and women facing homelessness and economic exclusion:
The UK asylum process is complex and difficult to navigate, with only 30% of people granted refugee protection at initial decision in the last year, and a significant number of people refused asylum by the Home Office. Following a

refusal of their case, asylum seekers lose access to housing and financial support (Section 95), except in limited circumstances when they may qualify for Home Office Section 4 support or support from the Local Authority. Refused asylum seekers are not permitted to work in the UK and struggle to meet their basic needs. They are often forced to rely on friends, charities and faith groups for shelter and food. This group is chargeable for healthcare, despite having no means of paying for it. It is important to note that refused asylum seekers may later successfully make their case for refugee protection after securing legal representation/ submitting additional evidence, or may be given another form of leave to remain in the UK. In fact, in the last year more than a third of initial decisions to refuse asylum were overturned at appeal stage. Before gaining refugee status, a person may transition in and out of the category of 'refused asylum seeker' but in the process may be excluded from free care for months or even years at a time.

There is no doubt that asylum seekers' experience of destitution adversely affects their health and wellbeing. People who are destitute have much poorer access to healthcare. A survey by Oldham Unity in 2016 of the health needs of destitute service users found 23% of respondents were not registered with a GP. All of those who were unregistered had attended A&E in the last 12 months. This demonstrates extra pressure on emergency services when people cannot access primary care.

We are aware of a number of cases where urgent treatment was delayed until Home Office support could be accessed (thus qualifying the asylum seeker for free healthcare). However, it can be very difficult and time-consuming to apply for Home Office support and it is unconscionable to delay treatment needed by vulnerable people until this support is in place.

The following case demonstrate how being a refused asylum seeker prevented a vulnerable patient getting the care he needed, with serious consequences for his health outcomes.

> *In Newcastle earlier in June – July 2017, a man was admitted into the RVI hospital for 3 days for urgent treatment for a heart condition, following a heart attack. He had been in the UK over a decade, and refused asylum. He had suffered from serious heart problems since 2015, when he had a cardiac arrest.*
>
> *At the time of the treatment, tests showed that he needed further treatment to prevent the heart condition recurring and deteriorating, including a stent procedure, however he was too ill to have this at the time so was told to delay the treatment until his health improved. While on the waiting list, in August 2017, he received a letter informing him that he would now have to pay for this and any other hospital treatment because of his immigration status.*
>
> *The patient also suffers from liver and thyroid problems, and he is taking several different prescriptions daily. These health issues require regular GP and hospital appointments. However, letters from the hospital have said that further appointments, including to check whether the thyroid treatment may make risk of heart attack more likely, would be chargeable.*
>
> *Without accessing appropriate treatment, the man's health was likely to deteriorate. As a refused asylum seeker he continued to be chargeable for secondary care, but had no right to work in the UK or access to other financial support, and therefore had no means of paying for the treatment that medical professionals deemed he needed. His treatment was delayed pending an application for Section 4 support, which would qualify him for free care.*
>
> *In October, his application for Section 4 support was approved and he is now eligible for free NHS treatment and has begun the lifesaving care he needs. However, on the 3rd November 2017 he received a letter billing him for £5,099 for the hospital treatment for his heart attack earlier in the year, as at that time he was chargeable. He contacted the hospital to flag that he had no means of paying this. They looked into this and he was offered a payment plan to aid him to pay back the amount, but living on section 4 support – which is a cash-less form of asylum support amounting to just £5 a day – he will not be able to do this. He has been advised that he will need to go to court to get the charges dropped, or they may affect his claims to stay in the UK. This situation is a cause of stress to the patient who laments his position, saying "I was ill. I need treatment. I can't pay. What can I do? How to pay? I have no idea."*

In another case, fear of being charged and having no means of paying outstanding bills stopped a refused asylum seeker from accessing potentially life-saving treatment.

> *H went to hospital about 3 months ago with heart problems – he had a scan, and was then discharged. After a month, they sent him a bill for this treatment. As a refused asylum seeker with no right to work and no access to benefits, he could not pay the bill. H received another bill, and then a letter from a debt collector. After receiving these bills, H did not access any health care in case he was charged again (including his GP). H went to the British Red Cross drop in, who have contacted the hospital to explain H can't pay but H is waiting for their response.*

Suddenly receiving a large bill can be alarming for vulnerable people and can push them into precarious situations. For example, local partner organisations report that people with Discretionary Leave to Remain have been forced to borrow money at high rates of interest in order to pay the health surcharge when they renew their DLR application. We have also heard reports of vulnerable people turning to loan-sharks in order to clear hospital debts.

Recommendation: We recommend the Department of Health follow the example set by the devolved governments of Wales, Scotland and Northern Ireland, and ensure universal access to free healthcare for asylum seekers, by including an exemption from charging for refused asylum seekers.

Women fleeing domestic violence/ sexual violence

Exemptions from charging exist for treatment required for a physical or mental condition caused by domestic abuse or sexual violence. However, these exemptions are not being correctly applied in practice, leading to extremely vulnerable women being erroneously charged for healthcare, as this shocking case from the West Midlands reveals:

> *Mrs Ahmed (this name has been changed) was a victim of domestic violence who became pregnant as a result of rape. Following the delivery of her baby, she was charged nearly £2,000 for ante natal care by Sandwell and West Birmingham Hospitals Trust. An Independent Domestic Violence Advisor made the OVM aware that the patient was a victim of domestic violence. The OVM accepted the patient didn't have to pay for 'perinatal mental health clinic and wellbeing clinic during her pregnancy as this was directly attributable to her having been a victim of domestic violence.' However, they stated she was still chargeable for 'general and standard treatment during her pregnancy and delivery, including the usual ante natal appointments, scans and inpatient stay for delivery of her child… because we have not seen any evidence that the need for this treatment (i.e. the pregnancy itself) was directly attributable to domestic or other forms of violence.'*
>
> *The OVM had formed this judgement without fully investigating the case. Had they done so, they would have found that the pregnancy was the result of sexual violence at the hands of an abusive partner (who has now been charged with three counts of rape). Following further advocacy by the Independent Domestic Violence Advisor, the charges for ante-natal care and the delivery of the baby were also dropped. This process took 3 months.*

This case demonstrates that the exemption from charging for victims of domestic abuse cannot easily be applied in practice, leaving an extremely vulnerable woman liable to pay for maternity services for a pregnancy resulting from domestic abuse. This case is very concerning as many women who are victims of domestic violence do not have a worker to advocate on their behalf. As well as not investigating the case fully, the OVM also failed to apply the new definition of domestic violence that includes coercive control and specifically references that this should be understood as a pattern of behaviour and not a single incident. As such, billing for treatment in such a compartmentalised way completely fails to treat the patient holistically and causes unnecessary distress and anxiety to an already vulnerable patient.

Stateless people

We are concerned that the Regulations and Guidance appear to exclude people who are in the process of applying for leave to remain in the UK because they are stateless from exemption from NHS charging. The Regulations and Guidance also do not provide clarity on the entitlements of people who are in the UK with limited leave to remain on

the basis of their statelessness (leave to remain under Part 14 of the Immigration Rules). These people are not included in the exemptions and would therefore appear to be liable for NHS charges.

Recommendation: We recommend that DH introduce an exemption from charging for those people who are in the statelessness determination procedure and those people who have leave to remain under Part 14 of the Immigration Rules.

8. Do you have any evidence that the requirement to charge upfront for treatment that is not immediately necessary or urgent, may have deterred individuals from seeking treatment?

It is very difficult to capture the exact number of people who may be deterred from seeking treatment as a result of up front charging. Anecdotally, partner organisations report that clients are increasingly fearful / scared / concerned about accessing healthcare, as they are unsure what they will be charged for. Many refugees and asylum seekers feel hospital staff do not know who they are supposed to charge (and this is borne out in evidence of erroneous charges), However, neither do individuals feel confident enough to challenge these decisions. This is leading to vulnerable people simply deciding not to access healthcare, or only doing so in an emergency when their symptoms have worsened and they urgently need medical attention. This damages the individual's health but also leads to poor use of precious NHS resources.

9. Do you have any evidence that the requirement to charge upfront for treatment that is not immediately necessary or urgent, may have had an impact on public health?

A refused asylum seeker who had previously been wrongly charged for an ECG, and subsequently harassed by a debt collection agency, was too fearful to go for a chest x-ray that had been recommended by his GP in order to exclude TB. He had to be convinced to attend the appointment, which took up a considerable amount of the GPs time. In addition to being a public health risk, this demonstrates a 'hidden cost' to the NHS of the amendment regulations.

10. Do you know of any examples of good practice or steps that could be taken which might mitigate the issues that you have raised in your responses to questions 6, 7, 8 and 9?

Recording when a patient is an overseas visitor

The Amendment Regulations require NHS trusts and foundation trusts to record on a patient's NHS Record (their 'consistent identifier'), when they have such a record, whether they are an overseas visitor, whether an exemption from charge category applies and on what date the assessment of their chargeable status took place.

11. Do you have any evidence of how the requirement to record a patient's overseas visitor status has had a particular impact on persons sharing a protected characteristic?

12. Do you have any evidence of how the requirement to record a patient's overseas visitor status has had a particular impact on any other vulnerable group?

13. Do you know of any examples of good practice or steps that could be taken which might mitigate the issues that you have raised in your responses to questions 11 and 12?