Equality Analysis

Sustaining services, ensuring fairness:
Government response to the consultation on migrant access and financial contribution to NHS provision in England

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Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty. It is up to each organisation to choose the most effective approach for them.

Equality analysis

Title: *Sustaining services, ensuring fairness:* Government response to the consultation on migrant access and financial contribution to NHS provision in England
Relevant line in DH Business Plan 2011-2015**:** Better Value – providing better quality care by improving productivity and ensuring value for money for the taxpayer

What are the intended outcomes of this work?

Policy aims and objectives

With increased demands on the NHS budgets, the rise in mobility of migrants and number of visitors to the UK, there is an expectation that greater pressure will be placed on services, impacting negatively on the resident population. The combination of the responses to the consultation[1] and the results of the independent research[2] make it clear that there are very real issues at the frontline in managing NHS services for visitors and temporary migrants in England. The Government believes the current system is neither fair to the taxpayer, nor effective in recovering costs. The proposals set out in the Government response to the consultation (*Sustaining services, ensuring fairness*[3]*)* seek to address this.

The National Health Service (Charges to Overseas Visitors) Regulations 2011, as amended, (the Charging Regulations) apply to everyone who is not an ordinary resident of the UK, i.e. overseas visitors (or non-residents), irrespective of age, disability, ethnicity, sex, gender identity, religion or belief, sexual orientation or socio-economic status. There are a number of exemptions in the current regulations; we are reconsidering some of these. However we will continue to exempt, some specific groups such as refugees, victims or suspected victims of human trafficking, asylum seekers and Home Office supported failed asylum seekers as before on humanitarian grounds.

We are not seeking to restrict access to healthcare, the NHS will continue to have a responsibility to provide healthcare to anybody who needs it while they are in England. However, the British taxpayer cannot be expected to cover these costs where people are not entitled to free care. At its heart the NHS has a social contract between taxpayers and the resident population; with taxpayers paying for a comprehensive health service that is free at the point of delivery to all those who live here long-term on a lawful and settled basis. In principle, others should pay for most, if not all, services they receive. We want to ensure everyone makes a fair contribution to the NHS.

Ultimately the NHS must be sustainable; it cannot provide free healthcare to the world. We need to get better at identifying those who are chargeable and recovering the costs which are due; in part through improved systems and also through the immigration health surcharge.

[1] Government response to the consultation on migrant access and financial contribution to NHS provision in England; Chapter 4 & Annex A, at: https://www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs
[2] www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs
[3] https://www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs

Applying a new system will be challenging and will require modification and refining of the proposals over the coming months. In particular, the need to balance the Secretary of State for Health's responsibilities with regard to NHS finances and recovering costs, with the duty to reduce health inequalities. In developing this equality analysis (EA) we have taken into account the concerns raised in the consultation around public health, issues with discrimination against certain groups and the need to reduce inequalities.

During the consultation process we have met organisations representing vulnerable groups and are currently working with individuals from these organisations, such as the clinical lead for the homeless in Croydon Health Services NHS Trust as well as the head of equality, diversity and human rights at NHS Employers. We will continue to do so throughout the process to develop the new system and will seek to increase the scope of this engagement as the programme develops.

The three key areas of change set out in the Government response are summarised below:

1. Who should pay for their NHS treatment?

Visitors and illegal migrants

Visitors to the UK and illegal migrants (including failed asylum seekers liable to removal, illegal entrants and people who have overstayed their visas) will continue to be expected to pay for their treatment whilst in the UK.

Non-EEA temporary migrants - new qualifying criteria for free NHS care and the immigration health surcharge

The immigration health surcharge for non-EEA temporary migrants (i.e those residing in England for between 6 months and 5 years), including workers, students and family members reflects the Government's belief that legal migrants should make a proper contribution to key public services. The intention is to align the rules (via the Home Office immigration Bill) with wider government policy by:

- Setting new qualifying criteria for free NHS care for non-EEA migrants subject to immigration control, meaning current residence with indefinite leave to remain is required for non-EEA migrants to be eligible for free NHS care.
- As a consequence of these new criteria, non-EEA temporary migrants will be required to pay an immigration health surcharge as part of a visa application, subject to limited exemptions. This will then give them access to the NHS on a similar basis to a permanent resident (possibly paying for certain treatments, though these would need to be determined).
- Visitors (those here for less than six months) will continue to be charged directly at the point of use for hospital treatment. This remains unchanged from the current rules.

Expatriates (irrespective of nationality)

Expatriates visiting the UK will be immediately entitled to free NHS services if they have previously made the required contribution to the UK (yet to be determined). The specific qualifying criteria will need to be developed but the intention is to make legislative changes in 2014 to this effect.

New exemptions

The Government consultation response sets out the intention to consider new exemptions for:

vulnerable groups, including victims of domestic and other violence as well as victims of human trafficking, of whom only those who have been given formal recognition as a victim, or suspected victim, are currently exempt. The details of these are subject to further work with the NHS, relevant agencies and advisors and an impact assessment to explore practical implications and how they should be framed. While we do not intend to establish an exemption for children we will listen to arguments about how best to cover other vulnerable children who might otherwise be denied treatment.

2. What services should we charge for?

Currently, for those who are not eligible for free NHS care, only hospital-based secondary and tertiary NHS treatment is charged for. The 2013 consultation asked the question whether charges should be introduced for primary care services, including GP services, and/or for Accident & Emergency services for chargeable patients.

Following the consultation process it has been decided that no charges will be introduced for GP consultations. Consequently consideration of this is outside the scope of this analysis. In the immediate short term Accident & Emergency services will also remain free although the response signals that A&E care will become chargeable when the new systems are in place and the Government is confident that the processes introduced will not compromise rapid access to emergency care. Charging for other services provided by GP practices (such as minor elective surgery) is also under consideration.

The consultation also raised the possibility of introducing further charges for overseas visitors in respect of other primary care services (dentistry, ophthalmology, and prescription charges in community pharmacy). These charges would be in addition to those charges that already apply to the resident population for other primary care services. As this policy is at an early stage in development a more detailed equality analysis will be undertaken once the options for implementation have been further developed.

The policies set out in the Government consultation response are consistent with our commitment to maintain a comprehensive and robust population-wide strategy on protecting and managing public health. To ensure this, it will continue to be the case that no charges (other than some prescription charges) will be made in respect of specified infectious diseases, including all STIs. No charge will be made for those detained for treatment under the Mental Health Act 1983, or treatment imposed by a Court Order. Exemptions from charging will not, however, extend to any other conditions that a patient may have. Overseas visitors who are detained in immigration removal centres or prisons will continue to be exempt from charging, as they are now.

3. Improving the system

Getting better at collecting money

The consultation responses supported the Government view that there is much to be done with regard to improving the current system for charging visitors in secondary care. In particular on improving cost recovery from other EEA Member States and from non-EEA visitors, building on existing good practice.

Introduction of a comprehensive patient registration system

Identifying chargeable patients at first contact with the NHS has been identified as a means to significantly improve cost recovery. Building on existing registration systems, the Department

of Health will be working with the NHS to develop a new NHS registration process to manage access to the NHS (free or chargeable) through better use of information and identification of individual status throughout the NHS. The intention is that this will link with the issuing of an NHS number, and be integrated into existing NHS IT systems. It is anticipated that any such registration system will require the checking, storage and sharing of personal data.

Equality analysis aims and objectives

The policy changes set out in the Government response to the consultation will ensure that those coming to the country for a limited period either as visitors or temporary residents contribute to the cost of their healthcare and that the effectiveness of the identification and charging of those non-residents will be improved. These changes will apply to all visitors and temporary migrants, irrespective of disability, ethnicity, sex, gender identity, religion or belief, sexual orientation or socio-economic[4].

This equality analysis is intended to assess if the policy proposals set out in the Government's consultation[5] ("the 2013 consultation") and in the Government's response to the consultation (accompanying this document) would have an adverse and unjustifiable impact on any group of people with particular protected characteristics[6] in comparison with the rest of the overseas visitor and migrant population. In particular:

1. if the proposed change to the test for ordinary residence would have an adverse and unjustifiable impact on any protected characteristic group in comparison with the rest of the overseas visitor population;
2. if the introduction of the immigration health surcharge, on entry to the UK, rather than charging for NHS services at the point of delivery, would have an adverse and unjustifiable impact on any protected characteristic group in comparison with the rest of the overseas visitor population;
3. if the introduction of a more robust registration scheme for new NHS patients would have an adverse and unjustifiable impact on any protected characteristic group in comparison with the rest of the overseas visitor population;
4. if proposals to improve the way we recover charges under the current system would have an adverse and unjustifiable impact on any protected characteristic group in comparison with the rest of the overseas visitor population;
5. if any of the policy proposals, if implemented, would have an adverse and unjustifiable impact on any protected characteristic group in the ordinarily resident population in comparison with the rest of the ordinarily resident population.

The analysis focuses on the policy proposals as set out in the 2013 consultation document and the Government response. It is noted that the policy proposals are still at an early stage in development and at this point it is not yet possible to undertake an in-depth equality analysis against detailed policies. The analysis will feed into further policy development and strategies to resolve equality issues and more detailed analyses will be undertaken in due course as the

[4] Protected characteristics, as defined in the Equality Act 2010: age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity

[5] Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England, https://www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs

[6] As defined in the Equality Act 2010.

policies proposed are further refined and implemented. Consideration has been given to the responses received for the 2013 consultation and where relevant equality issues have been raised in the responses they have been addressed in the analysis.

With regard to age, we do not intend to establish an exemption for children as we believe this poses a significant risk of abuse by visitors seeking treatment for children with existing serious illness, and may act as a draw to illegal migrant families. Vulnerable children, such as victims of trafficking, those seeking asylum, and migrant children in local authority care currently receive free healthcare and will continue to do so. We will listen to arguments about how best to cover other vulnerable children who might otherwise be denied treatment.

There are issues raised in responses to the consultation which are out of scope. This Equality Analysis is not intended to explore:

1. whether there should be no difference between residents of the UK and overseas visitors and migrants when it comes to charges, since Parliament has already decided that the NHS is only automatically free to people who are 'ordinarily resident' here.
2. the issues faced by the protected characteristic groups in relation to how they access treatment, their health needs or their health outcomes, either in the overseas population or the ordinarily resident population, when those issues are not to do with charging.
3. the impact of the immigration health surcharge on populations outside the UK.

The equality analysis will also not consider whether the policy in respect of charging for illegal migrants should be changed, as this policy remains unchanged.

Who will be affected?

NHS staff (clinical and administrative) – implementing the new processes for identification of patients eligible for free NHS care, determine whether treatment is immediate and necessary and ensuring recovery of charges from appropriate patients.

Visitors – an improved system for identification of patients who are potentially chargeable will mean that many who might have avoided or evaded payment in the past will be identified and charged or decline treatment when they know the cost of any potential intervention. As charging is extended to A&E and community services they will be subject to charges for the majority of services they may need to access during their temporary stay in England.

Temporary migrants (including students) who are subject to immigration controls (requiring visas of between 6 months and 5 years) – will be subject to the immigration health levy when applying to come to the UK to work, study or join their families. Once the surcharge is paid however, aside from identifying themselves as having paid it they should have access to the NHS on a similar basis to the resident population.

Permanent resident population of England – those families seeking to bring relatives from outside the EEA to the UK will need to take account of the costs of the surcharge for the duration of the visa.

Expatriates – who have made the required contribution to the UK (yet to be determined) will have immediate free access to services where they may be currently subject to charges in secondary care.

Illegal migrants (including failed asylum seekers liable to removal, illegal entrants and people

who have overstayed their visas) – will be more readily identified as chargeable patients in the new system and as charging is extended to A&E and community services they will be subject to charges for the majority of services.

Evidence

What evidence have you considered?
The Department has considered equality issues in its previous, recent work on charging visitors and migrants for NHS care. This equality analysis builds on these previous pieces of work, and the research and evidence which has been developed since 2012.

Literature review
Recognising that in drafting previous equality analyses (EAs) we had found little data on the impact on the individual protected characteristic groups the Department commissioned an external organisation to undertake a literature review of research to identify and collate evidence regarding the impact of the proposed policy developments on specified population groups to support this EA.

The paper is attached as an Annex to this EA, and the information in the sections below draws extensively on this evidence. The Annex includes a research reference list, a summary table of evidence as well as much more detail on the available evidence.

Background
In 2011, EA statements were compiled for work on consolidating regulations[7] and guidance and immigration sanctions for those with unpaid debts to the NHS[8]. The Department of Health also undertook in 2012 a review of rules and procedures on charging visitors and migrants to the UK for NHS care in England. The evidence from this review informed the proposals for change put forward in 2013 consultation[9]. The review identified the generosity that England affords to those people who are living in the UK on a temporary basis, who have not, yet, made a significant contribution to our society or economy, in providing them with free NHS care immediately upon moving here. It also concluded that the NHS is not currently set up structurally, operationally or culturally to identify a small subset of patients and charge them for their treatment and recover such charges from them.

2013 Consultation
Question 2 of the consultation specifically offered the opportunity for respondents to identify evidence that the proposals might disproportionately impact on any of the protected characteristic groups. Though there were many well-argued responses the majority did not provide any evidence. Instead there were many assertions made based on respondents' individual or organisational priorities. Those who did provide information largely cited evidence and data from their own clinics and projects, some of which concerned groups who will remain

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127064/EqIA-2.pdf.pdf
[8] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127063/EqIA.pdf.pdf
[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210440/Sustaining_services__ensuring_fairness_-_evidence_and_equality_analysis.pdf

exempt from charging under the government proposals (eg refugees and asylum seekers). Summaries of the responses to the questions are available in the Government response[10].

Independent research

In developing the proposals for consultation we recognised that there was a need to understand the impact and scale of the use and corresponding cost of the NHS by visitors and temporary migrants in more detail. However, while there is a great deal of speculation about the numbers of visitors and short-term migrants using the NHS, robust data are very limited. To address the absence of primary data we commissioned two strands of work[11]. The first stage was a qualitative market research study (undertaken by Creative Research) and the second phase a quantitative analysis based on population level data to model the estimated order of magnitude of NHS costs for visitors and migrants (undertaken by Prederi Ltd). This second piece of research included a literature review to look at migrant use of the NHS which has also fed into this analysis.[12] Together they will help the Government and the NHS understand the issues with and gaps in the existing processes and support the development of proposals for the new system. The research was published on 22nd October 2013.

Disability

People with disabilities are subject to the same rules about residency status and entitlement to free NHS care in the UK as other overseas visitors

People with disabilities who are visiting the UK (for less than 6 months) will be required to pay for NHS services at the point of delivery. There is evidence set out in the literature review (user charges) that people with disabilities are more likely to be adversely affected by both the extension of charging to a wider variety of services and also more efficient identification and recovery of charges. This is because people with disabilities may, due to the nature of their disability, be more likely to require healthcare than other overseas visitors. We consider that any adverse impact on people with disabilities is justified because of the need to ensure that visitors who are not lawfully or permanently resident in the UK make a fair contribution to the NHS services they access. In respect of EEA nationals in the majority of cases the cost of care will be covered by the European Health Insurance Card (EHIC) programme or other arrangements.

People with disabilities who are non-EEA nationals who come to the UK to live temporarily (eg to study or work) would, under these proposals, be eligible for access to free NHS care as a temporary resident upon payment of the immigration health surcharge, or benefit from the exemption from charge categories (where applicable). The cost of the surcharge will be the same for all within groups of applicants (ie all students will pay the same and all workers will pay the same, though the intention is that students will pay less both because their income is lower and also in recognition of the fees they are paying to study in the UK). Consequently people with disabilities will pay the same surcharge as other non-EEA temporary migrants who do not have a disability regardless of the fact they may be more likely to access care while in the UK. Setting the surcharge at the same price for overseas visitors with disabilities as for other overseas visitors advances equality of opportunity for overseas visitors with disabilities,

[10] https://www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs

[11] https://www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs

[12] Annex B: Migrant use of Healthcare Services: Findings from the literature; *Quantitative Assessment of Visitor and Migrant Use of the NHS in England Exploring the Data*,page 111 https://www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs

as they will be able to access NHS services at the same cost as other overseas visitors despite the potentially higher costs associated with their healthcare arising from their disability.

Sex

Men and women visiting for less than 6 months will be subject to the same charges as each other. They are able to be residents of the UK entitled to free NHS care, or have access to free NHS care as temporary residents upon payment of the immigration health surcharge, or benefit from the exemption from charge categories in the same ways.

The research suggests that the surcharge would have more of an impact on low-income resident families wishing to sponsor family visas as this would represent an additional barrier. It would impact on both sexes, but more significantly on women, especially single parents and older women, who are likely to have lower incomes but be in need of family support to help in their caring roles. This is recognised as an issue, but we believe that the need for migrants to make a fair contribution to the NHS and their future healthcare needs is justified.

There is additional evidence that improving registration systems and revenue collection will also impact on women more. The reasons given are that women are often lower paid, have more gaps in employment, more often responsible for children, are greater users of healthcare and live longer. This means that those women who are chargeable will face a greater burden in terms of payment for services if they are visiting or in England unlawfully. This may also impact on their children's access to care if they are less inclined to seek healthcare for anyone in the family. The increased gaps in employment may also mean women are adversely impacted by the proposal to exempt expatriates from paying for NHS care only if they have built up sufficient levels of National Insurance (NI) contributions. If they have left or leave the UK (eg to care for a family member or for employment) before they have had an opportunity to work and pay NI they will be liable to pay charges on returning home to the UK to visit. We will consider this as part of the work on prior contributions by expatriates, and will align eligibility with criteria for UK pensions and other state benefits. Existing rules to support families through NI credits will be considered in this process and could mitigate this impact.

As is the case now, overseas visitors will be charged for maternity services. Current guidance provides that maternity services are always to be considered immediately necessary[13] and should be provided to any woman regardless of if she has paid in advance or not. This position will not change and women will continue to be provided with maternity services regardless of whether they have paid in advance. Charges will be recovered after the services have been provided and services will not be withheld in cases where women are unable to pay.

Chargeable women in need of other services and men will not enjoy this blanket health safeguard and will be assessed by clinicians as to the urgency of their need, in the same manner as other patients to determine if treatment is immediately necessary regardless of advance payment. The blanket health safeguard in respect of maternity services is justified by the significant risks to both mother and baby if health goes unchecked, and the fact that, at least for delivery, it inevitably cannot be delayed.

[13] Treatment which a patient needs, to save their life or that of their unborn child; to prevent a condition from becoming immediately life threatening; or promptly to prevent permanent serious damage from occurring. Guidance on implementing the overseas visitors hospital charging regulations (Chapter 4, Para 4.7) at https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations ,

Race
Overseas visitors and migrants of any race will all be subject to the same rules in respect of charging, including requirements to pay the immigration health surcharge on entering the UK, register with the NHS and pay for NHS services. However, there is evidence (anecdotal and published – see Annex) that non-white people or people for whom English is not their first language are, on some occasions, targeted in the application of the current Charging Regulations due to speculation or assumption that they are not resident here. An improved registration system would mean that staff would have a more systematic means by which to determine chargeable status and therefore wouldn't have to rely on assumption..

Similar issues were identified in the qualitative research commissioned by the Department of Health in terms of access to interpreters and information in other languages. This applies to people who are lawfully resident on a permanent basis as well as visitors and temporary migrants.

An improved registration system, and associated guidance to NHS staff, should reduce discrimination and harassment, and advance equality of opportunity for non-white people (both overseas visitors and those who are ordinarily resident) when presenting themselves to NHS staff for care. All patients, regardless of their race, will be subject to the same processes when presenting themselves for care to determine if they should be charged.

The introduction of a more robust registration system for NHS patients may adversely affect individuals who are ordinarily resident in the UK (and will remain so under the new meaning of this term) but may have difficulty proving their status. Affected groups may include Irish travellers, homeless and transient people and other individuals who may not have proof of their residency in the UK. On the other hand a more effective system could also reduce discrimination as individuals would not be reliant on asking baseline questions, which at the moment may only be asked of certain people. The Department recognises these concerns and will ensure that any new guidance for the NHS will include advice to address these issues, including steps to assist people to prove their status.

The introduction of new systems and processes may also impact disproportionately on people for whom English is not their first language. Communications and publicity around which services are free (including GP consultations and public health-related services) will be key in ensuring all recipients of healthcare understand the new system. The Department will be working with the NHS to raise awareness of the changes amongst staff and patients.

Age
Older people who are visiting the UK for less than 6 months and subject to charging are more likely to access healthcare than younger people because they generally tend to be higher users of health services. Consequently they may be affected by a more rigorous registration process and efficient recovery of charges for a wider range of services. For older expatriates this will be countered by the proposal to allow free access to the NHS for all those who meet the fair contribution requirements through prior National Insurance contributions.

Older people, who are retirees on low incomes, would also be impacted by the immigration health surcharge as this would provide another financial barrier to coming to stay for an extended period or live with family in the UK. However, this provides the best way to ensure non-EEA migrants make a fair contribution to the costs of their healthcare at the same time as

pooling the risks across the groups. It enables costs to be lower for everyone, ensuring those with disabilities, poor health or long-term conditions are not discriminated against either in terms of cover or affordability. It also meets the duty to ensure that those who live here legally, even on a temporary basis, have access to a comprehensive healthcare system as payment of this surcharge will allow access to NHS services in much the same way as a British citizen or permanent resident (possibly subject to paying for certain treatments).

Currently, those in receipt of UK state retirement pensions can benefit from certain exemptions that younger people cannot. This is no different from other welfare benefits (eg pension payments themselves and tax rules). However, we propose to remove the exemption from charge categories for UK state pensioners and replace them with one based on the former payment of UK National Insurance contributions, thereby removing that possible indirect discrimination.

Younger working age adults may be adversely impacted by the proposal to exempt expatriates from paying for NHS care only if they have built up sufficient levels of National Insurance contributions. If they have left or leave the UK (eg to study or for employment) before they have had an opportunity to work and pay NI they will be liable to pay charges on returning home to the UK to visit. We will consider this as part of the work on prior NI contributions by expatriates.

Some children who are subject to charging may have increased healthcare needs comparative to other children. In particular, children whose parents are here unlawfully may have poorer health and reduced access to healthcare than other children of overseas visitors or migrants. There is evidence that there would be a particular concern for children with respect to any new more effective registration process given they are often not in a position to manage their own documentation. In addition, if their parents are discouraged from accessing healthcare due to their immigration status or the need to pay this may adversely impact on the health of any children for whom they are responsible.

We do not intend to establish an exemption for children as we believe this poses a significant risk of abuse by visitors seeking treatment for children with existing serious illness, and may act as a draw to illegal migrant families. Vulnerable children, such as victims of trafficking, those seeking asylum, and migrant children in local authority care currently receive free healthcare and will continue to do so. We will listen to arguments about how best to cover other vulnerable children who might otherwise be denied treatment.

Gender reassignment (including transgender)
Individuals who are transgender or transsexual will be subject to the same rules about charging for NHS services as other overseas visitors and it is not anticipated that there will be any specific adverse impact on this group.

Sexual orientation
All overseas visitors, regardless of sexual orientation will be subject to the same rules about charging for NHS services as other overseas visitors and it is not anticipated that there will be any specific adverse impact on this group.

Religion or belief
As for race, it is important that people whose religion can be assumed by their appearance are not targeted in demonstrating entitlement due to speculation or assumption that they are not

resident here (see race).

Currently, missionaries are exempt from charge, which is not an exemption category that can be enjoyed by a person of no belief. We propose to remove this exemption and replace it with one based on the prior payment of a sufficient level of UK National Insurance contributions, thereby removing that possible discrimination.

Pregnancy and maternity

Treatment of pregnant women and provision of maternity services, which are only available to women, are always considered to be immediately necessary and will be provided whether the woman has paid in advance or not. The differential treatment here is justified on the basis that men do not require those services and in recognition that there are significant risks to both mother and child if their health goes unchecked.

The impact of a more rigorous registration process may delay access to antenatal care. There is evidence that any delay contributes to poor outcomes for mother and baby. Ensuring free access to GP services will ensure all pregnant women have access to healthcare and signposting to antenatal services. Similarly a more effective revenue collection system means pregnant overseas visitors may be more likely to be identified and charged for the services they are provided than is currently the case. This effect will be increased with the extension of charging to other services in primary care and the community.

The policy position in respect of providing maternity services to overseas visitors will not be changing. This is a complex and sensitive area where the risks to the health of both the mother and baby if refused or deterred by the need to pay are significant. However, our independent research confirms that deliberate maternity health tourism through the short-term visit entry is a problem, and this could only increase, potentially significantly, if services were provided free of charge. We need to ensure that the principle of fair contribution to NHS services is maintained whilst ensuring that women continue to be provided with immediately necessary care regardless of whether they have paid in advance.

Carers

Carers will be subject to the same rules about charging for NHS services as other overseas visitors and it is not anticipated that there will be any specific adverse impact on this group whilst they are in the UK. However, if a resident were to have been a carer for an extended period and in doing so not built up their NI contributions they would not be eligible for free NHS care on visits to the UK if they were to leave the country to live elsewhere. We will consider this as part of the work on prior contributions by expatriates. Existing rules to support families through NI credits will be considered in this process and could mitigate this impact.

Other identified groups

Residential status (people who are subject to immigration controls)

The proposed policy narrows the definition of persons who are ordinarily resident. Consequently there will be many people who would be ordinarily resident under the current system (for example non-EEA workers and students who are here for a limited period with a visa) but who would not be ordinarily resident under the proposed new meaning and consequently be subject either to payment of the immigration health surcharge on entry to the UK or charged at the point of use for NHS services. Becoming subject to charging and/or required to pay the surcharge will not have a differential impact on those people who are in the

UK lawfully. They will be treated the same on the basis of their length of stay in the UK.

Homeless people/ those of no fixed abode

Homeless people face difficulties in registering for healthcare under current administrative processes. Imposing an additional administrative requirement in order to prove eligibility to use services is likely to increase barriers to access. This group may include people who are ordinarily resident and entitled to free NHS care.

The Department recognises these concerns and will ensure that guidance for the NHS on the new system will include advice to address these issues, including steps to assist people to prove their status. We will work with organisations representing the homeless and other vulnerable groups to develop these steps.

Gypsy traveller communities

Traveller communities experience similar difficulties as homeless people and those of no fixed abode in accessing healthcare, particularly in relation to registering as they can struggle to provide proof of residence. We will work with organisations representing the traveller communities and other vulnerable groups to develop approaches to mitigate any impacts of the new system. This group may include people who are ordinarily resident and entitled to free NHS care.

The Department recognises these concerns and will ensure that guidance for the NHS on the new system will include advice to address these issues, including steps to assist people to prove their status. We will work with organisations representing the traveller communities to develop these steps.

Those with low or no income

A group who may be adversely affected by charging are people who must pay at the point of delivery and who are on low incomes or have no income at all (eg some illegal migrants or failed asylum seekers). The proposed policy is not introducing charging for this group; they are already chargeable and will remain so under the proposed policy, but intends to ensure that more people who are required to pay, do pay. This group, will, with improved registration be more likely to be identified and charged in a greater range of services.

The NHS, like all other public healthcare providers, has a legal, ethical and moral duty to provide emergency healthcare to anybody, even if costs are not recoverable. Immediately necessary and urgent treatment will not be delayed or denied, but may be limited to what is clinically necessary and payment sought after treatment. This obligation will not change and arrangements for payments in instalments can often be arranged at hospitals. Otherwise treatment will be provided only after payment has been received, as is already the case in the NHS in England.

Illegal migrants (including failed asylum seekers liable to removal, illegal entrants and people who have overstayed their visas)

There is no change in policy with regard to those who are here unlawfully as they will continue to be liable for full treatment charges when accessing the NHS (subject to existing exceptions) though the extension of charging to additional services will mean they are liable for more costs.

The proposals may nevertheless have an adverse impact on illegal migrants who will not have the option of paying the immigration health surcharge which means they will not be able to ‘cap’ their healthcare costs in the same way as a lawful temporary migrant. The ineligibility of illegal migrants to pay the surcharge prevents the promotion of equal opportunity for those

individuals with those overseas visitors who are eligible to pay the surcharge. Some illegal migrants may be in a position to pay the equivalent of the cost of the immigration health surcharge for their care but not to pay more than that – these individuals are potentially disadvantaged compared to those overseas visitors who can pay the surcharge. There is evidence that illegal migrants already experience barriers (eg through lack of understanding of how the NHS system operates, culture and language) to registration with the NHS /primary care, these proposals mean these barriers may increase as the identification/registration and cost recovery system becomes more efficient.

As noted above the changes are intended to ensure that more people who are required to pay do pay. We believe this is justifiable on the basis that people should make a fair contribution and also that the NHS is, in all but emergencies, for the benefit of those who are lawfully in the country. Policy has been developed with regard to ensuring that differences in treatment between overseas visitors who pay the surcharge and those that don't does not compromise public health outcomes or access of overseas visitors to healthcare that is immediately necessary or urgent. Emergency treatment will not be delayed or denied, but may be limited to what is clinically necessary and payment sought after treatment and this will not change. However, access to elective care or care that is not immediately necessary or urgent care will continue to be provided only after payment has been received. GP consultations will continue to be free of charge to encourage people to access care early and to ensure that conditions affecting public health are identified and treated free of charge.

As noted above (in section on age) some children of illegal migrants (who are subject to charging) may have poorer health and reduced access to healthcare than other children of overseas visitors or migrants. There are two particular concerns in regard to the proposals; the first is that with any new more effective registration process they may not be in a position to manage their own documentation and secondly if their parents are discouraged from accessing healthcare due to their immigration status or the need to pay this may adversely impact on the health of any children for whom they are responsible (eg reduced access to routine vaccinations).

We do not intend to establish an exemption for children as we believe this poses a significant risk of abuse by visitors seeking treatment for children with existing serious illness, and may act as a draw to illegal migrant families. Vulnerable children, such as victims of trafficking, those seeking asylum, and migrant children in local authority care currently receive free healthcare and will continue to do so. We will listen to arguments about how best to cover other vulnerable children who might otherwise be denied treatment.

Engagement and involvement

Was this work subject to the requirements of the cross-government Code of Practice on Consultation? (Y)

How have you engaged stakeholders in gathering evidence or testing the evidence available?

As part of the 2012 review the Department engaged with stakeholders on the frontline of the NHS, the BMA and migrant support groups. Subsequently we have had discussions with key delivery partners on the intentions of the policy proposals in this consultation. In advance of the launch of the consultation we engaged with key stakeholders as set out in the Evidence document supporting the consultation. During the consultation process this engagement continued, including through the Department's established partnership arrangements such as:

- the National Stakeholder Forum [partners across health and social care],
- the Strategic Partners Forum [voluntary and third sector organisations] and
- the Department of Health Social Partnership Forum [NHS employers and employees/unions].

We are also working closely with frontline NHS staff and managers, NHS England and other NHS bodies to discuss the detail of the proposals and to ensure that the new system is practical and workable for the NHS in particular.

As part of this we have appointed Sir Keith Pearson as an independent NHS advisor, to lead the next stages of the work. He has established a senior NHS Reference Group to support design and delivery, including work on equalities. Sir Keith has been engaging with stakeholders across the sector since his appointment in September 2013.

How have you engaged stakeholders in testing the policy or programme proposals?
We have met or spoken to key stakeholders and outlined the content of the proposals for the new system.

Through the NHS reference group we are working through programme proposals. This will help shape development of a proportionate and realistic implementation plan.

A Process Mapping workshop was held on 23 September 2013 to look at access to NHS services by overseas visitors, migrants and students. A number of frontline NHS staff such as GPs, overseas visitor managers, secondary care representatives and Government policy makers were present to advise on how the current system works, to identify differences in operation across different scenarios and discuss potential changes to visitor and migrant access arrangements and what are the barriers and how to overcome them.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:
We have had a number of face-to-face meetings with various stakeholders during the consultation to discuss the proposed policy developments. These stakeholders included:

British Medical Association
City Hearts
College of Emergency Medicine
Freedom from Torture
National Association of Primary Care
National Union of Students
National Voices
Overseas Visitors Managers from a range of NHS Trusts
Poppy Project (Eaves)
Refugee Council
Royal College of General Practitioners
Royal College of Obstetricians and Gynaecologists
Salvation Army
Social Partnership Forum (NHS Employers and representatives of a range of trade unions)
Still Human Still Here (Amnesty International led coalition)
Strategic Partners (DH partnership forum with voluntary and third sector organisations)
Universities UK
Conversations and email correspondence also took place during the consultation with other

stakeholders.

NHS Reference Group member organisations:
Independent NHS Chair
NHS England
Public Health England
King's College Hospital NHS Foundation Trust
NHS Employees
Central and North West London NHS FT (MH & Community
Commissioning Support Unit Network
BMA and GP Partner, Endeavour Practice
Kingston Hospital NHS Trust
Temple Fortune Health Centre
Foundation Trust Network
St. George's Healthcare NHS Trust
Croydon Health Services NHS Trust
Health and Social Care Information Centre
Lewisham and Greenwich NHS Trust

The NHS Reference Group have met twice since their formation and will continue to meet on a monthly basis into the New Year.

Since his appointment Sir Keith has met:
University College London Hospital
Council of the Royal College of General Practitioners
Croydon Health, Clinical lead for homeless health services
Overseas Visitor Manager (OVM), Brighton & Sussex University Hospital
St George's Healthcare NHS Trust Overseas Visitors Manager
Health and Social Care Information Centre
Council of the Royal College of General Practitioners
Care Quality Commission
National Voices
Federation of Ophthalmic and Dispensing Opticians
Company Chemists' Association
Pharmaceutical Services Negotiating Committee
British Dentistry Association

Summary of Analysis

The Department of Health does not believe that our proposals would directly discriminate against any of the groups with protected characteristics amongst visitors and migrants to the UK. The proposed strengthening of the requirement to be a permanently settled resident of the UK along with strengthened systems to identify those who are not, does not prevent anyone from being entitled to free NHS treatment based on their ability or disability, sex, race, age, gender reassignment, sexual orientation or religion or belief.

There may be indirect discrimination (from the application of provisions for charging when people access treatment) in some areas but where this exists we believe it is a proportionate means of achieving a legitimate aim and therefore justifiable. These groups are set out below, with any appropriate mitigating actions:

- Maternity services – justifiable as only women can be pregnant and in recognition of health risks associated with delayed treatment. A more rigorous process for identification and collection of charges will impact more on visitors and illegal migrants this will be mitigated to some extent by the continued commitment to consider maternity services to be immediately necessary and provided whether the woman has paid in advance or not.
- Other groups (homeless, gypsy travellers, Irish travellers) who are ordinarily resident but will have difficulty demonstrating residency – justifiable because it is necessary to introduce a more robust registration system to identify and recover charges from those people who are chargeable and in recognition of the need for people to make a fair contribution to the cost of their healthcare. The Department of Health plans to introduce guidance and work with organisations supporting these groups to assist people to prove their status.
- Illegal migrants who cannot pay the surcharge and are at a disadvantage compared to other migrants who can 'cap' their healthcare costs at the cost of the surcharge - justifiable because of the need to ensure that people make a fair contribution to the costs of the NHS. The proposals to continue to provide GP consultations free to all will ensure that this group can continue to access medical advice and any public health need can be addressed. They will also be able to make an informed decision regarding the costs of the next steps of their care.

Many impacts on certain groups arise if they are more likely than others to need to access healthcare and consequently the fact they will be more likely to be identified as chargeable under the new system than the current system. For some, visitors and illegal migrants, the position is not changing. They remain chargeable; they are just more likely to be asked to pay.

Temporary migrants from outside the EEA, who are visiting the UK for six months or longer will now be required to pay the surcharge but all the protected characteristic groups will be treated in the same way as other overseas visitors in respect of the surcharge; irrespective of any potentially greater need, and some may potentially benefit as the cost of their care during their stay may exceed the cost of the surcharge.

Consistent with the principle that everyone should make a fair contribution; the proposals seek to ensure that those who are not permanently settled in the UK should contribute to the funding of the NHS. We recognise that in any system that restricts a particular benefit to certain cohorts of people there will be differences in treatment, but we consider that any differences in treatment contained in these proposals are justifiable.

Since the UK has a residence based healthcare system, differences in entitlement to free NHS healthcare in England, are based on residency status. Given resources for healthcare are finite, they cannot be spent on those from outside the UK without diminishing, perhaps significantly, the resources that are available for UK residents. It is already the case that free NHS hospital treatment is reserved only for lawful, settled residents in the UK, and certain clearly defined groups of people who are not UK residents. The changes being made will reserve free NHS care for:

1. UK/EEA nationals who are properly settled in the UK,
2. Non-EEA nationals with indefinite leave to remain in the UK who are properly settled here,
3. Non-EEA nationals who are subject to immigration controls but have paid the immigration health surcharge (subject to possible payments for certain treatments),
4. Expatriates who have made the required contribution to the UK (yet to be determined), and

5. Those others who must, or who we consider should, be exempt from charge due to humanitarian or international obligations or ties to the UK (eg asylum seekers or the armed forces).

Currently, only hospital-based secondary and tertiary NHS treatment is charged for, but the intention is to extend charging to all but GP consultations, for those visitors or migrants that are chargeable.

Eliminate discrimination, harassment and victimisation

We believe that creating a system whereby a person's entitlement to free treatment is recorded on their health record and tracks them around the healthcare system will lead to less direct questioning of individuals at each stage of their care, which may reduce any current unacceptable targeting of people for questioning based on their race or appearance.

The Department of Health will be providing guidance for the NHS in March 2014 which will set out immediate ways to help address these issues in the current system, including non-discriminatory and systematic approaches to identifying chargeable patients. Further, updated, guidance is anticipated in March 2015 to reflect the new system changes.

Advance equality of opportunity.

The Department of Health believes that these proposals are likely to promote equality of opportunity through:

- Limiting healthcare costs for all non-EEA temporary migrants - people who are more likely to use healthcare services (eg older people and people with disabilities) will be able to cap their healthcare costs by paying the immigration health surcharge. The surcharge allows risk to be pooled across all temporary non-EEA migrants and consequently those with higher healthcare needs will be able to travel to the UK and access NHS services at the same cost as those with much lower or minimal healthcare costs.
- A new registration process - the introduction of a more efficient registration process should reduce instances of people being targeted by NHS staff as being potentially chargeable on the basis of their race. Clear tracking of patients through the system, including their chargeable status, should reduce the need for regular questioning by staff based on inappropriate assumptions about a person's eligibility for free NHS care.

The introduction of this policy may prevent the promotion of equal opportunity for people who are not eligible to pay the surcharge, either as a consequence of their legal status or because they are here for a short-term visit. They will continue to be required to pay for their healthcare directly, which may be expensive. Steps are being taken to mitigate these issues, specifically:

- GP consultations will continue to be free of charge which will enable people to access primary care without a cost deterrent and also allow identification and management of public health issues.
- Immediately necessary treatment will not be withheld because of person's inability to pay, although that treatment may be limited and costs recovered after the medical intervention has taken place.

Promote good relations between groups

We believe that the fact that everyone will make a fair contribution to the costs of their healthcare in the future will promote better relations between residents and visitors/migrants, as it will make the system fairer, more transparent and simpler to explain. It may reduce any current hostility or misconception about what visitors and migrants receive at the expense of the taxpayer.

What is the overall impact?

Very little empirical evidence was found that directly assessed the impact that imposing a immigration health surcharge or requiring people to register for healthcare would have on the selected population groups, though homeless people and Gypsy Travellers are likely to be disproportionately impacted by registration requirements.

Evidence relating to charging for healthcare (user charges) is more robust. Although some groups may be disproportionately affected by the proposed policy options often this is through an association with low-income. Effects will not be felt uniformly across all members of a particular group as income will vary across groups.

Addressing the impact on equalities

As noted earlier in this document the specific proposals for changes to the system for identifying, registering and charging visitors and migrants for services provided by the NHS in England are still at an early stage of development. During the development of the new system account will be taken of the likely impacts on equalities during this process. There are a number of initial actions the Government proposes to take in order to mitigate the impacts on protected groups:

Immigration health surcharge – the surcharge is the best way to ensure non-EEA temporary migrants make a fair contribution to the costs of their healthcare at the same time as pooling the risks across the groups. It enables us to keep the costs lower for everyone, ensuring those with disabilities or long-term conditions are not discriminated against either in terms of cover or affordability. It also meets the duty to ensure that those who live here legally, even on a temporary basis, have access to a comprehensive healthcare system as payment of this surcharge will allow access to NHS services in much the same way as a British citizen or permanent resident.

GP consultations – We recognise the critical importance of unrestricted access to early diagnosis and intervention is in the health interests of both public and patient health, as well as the likely cost benefits of treating the patient early to avoid emergency treatment at a later stage. Consequently we propose to retain free access to GP consultations for all people requiring care.

Guidance for the NHS – We will be issuing guidance to the NHS in March 2014 and again in March 2015 which will allow us to clarify the new system and ensure that staff are reminded of their responsibilities with regard to equalities (for example with regard to how they approach identification of potentially chargeable patients).

Registration – We shall be working through the NHS Reference Group and with other

stakeholders representing vulnerable groups, particularly those who are legally resident, but may be adversely affected by changes to implement a more rigorous registration system to ensure safeguards are in place.

Action planning for improvement

The Department has been working on a variety of engagement sessions to inform and help shape this work including:

- A process mapping workshop attended by a variety of frontline and government officials
- An NHS reference group has been set up who's membership includes those specifically looking at equalities
- A number of subgroups which have patient, public and migrant group representatives
- A detailed stakeholder engagement strategy designed for the independent advisor to the programme Sir Keith Pearson.

We will continue to work with colleagues around vulnerable groups to ensure that their voice is heard and adequately reflected over the course of the programme. Throughout development and implementation we will continue to be mindful of how changes could affect inequalities.

We will work with analyst colleagues to consider as the programme develops

- Cost-effectiveness
- Outcome measurement
- User experience

EEA citizens

Some EEA citizens who should be covered under the European Health Insurance Card (EHIC) scheme or other schemes like the S1 form (which provides healthcare cover for EEA state pensioners) are currently not being identified, and so the costs of their care are not being recovered from their home countries.

Improving frontline systems to identify these groups and collecting the details needed to claim the cost of their healthcare from their home countries is one of our priorities in the short term. We do not believe that this raises any equality issues as this would apply equally to all EEA citizens irrespective of their gender, race, ethnicity or any of the other protected characteristics.

Please give an outline of your next steps based on the challenges and opportunities you have identified:

The high-level direction of travel for implementation is set out in the Government response to the consultation that this EA supports. More information will be available in January and a detailed, co-produced and costed implementation plan will be published in March 2014. This will include further consideration of equalities and the Secretary of State's duties with respect to inequalities in more detail as well as any revised guidance to the system.

For the record

Name of person who carried out this assessment: Helen Tomkys

Date assessment completed: 19 November 2013

Name of responsible Director/Director General: Kathryn Tyson, Director International Health and Public Health Policy

Date assessment was signed: 20 November 2013

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Department of Health: proposed policies for visitors to make a fair contribution to use the NHS

Evidence to support an Equality Impact Assessment

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The Department of Health has consulted on a series of policy options which aim to increase the revenue that it receives from visitors/short-term migrants who either use, or are eligible to use, NHS care. This report examines the evidence that these policy options will have on specified UK population groups. These include protected groups specified under the 2010 Equality Act and the homeless, gypsy travellers and irregular migrants. The proposed policy options fall under 3 categories: 1) a health surcharge for non-EEA migrants, 2) improved process to detect chargeable patients and recover costs, and 3) user charges, including mandatory insurance.

Evidence was found to suggest that the first two policy options could impact on the specified UK population groups, although effects varied by policy area. A health surcharge payable by UK sponsors (British citizens/permanent residents) of family migration visas will impose a disproportionate burden on low-income individuals. This will affect both men and women (**gender**), although the UK gender pay gap suggests more women will fall into this group. Other low-income sponsors, such as retirees, will also be affected (**age**). Revising recovery processes including more effective registration has a disproportionate impact on children (**age**) whose parents are unable to provide the correct registration documents. If registration delays access to care this will have a disproportionate effect in terms of outcomes for individuals where there is established evidence that access to early care is beneficial (**pregnancy and maternity**). Indirect evidence of impact comes from research into equity in access and barriers to healthcare amongst specified population groups in the UK. For example BME and migrant groups experience difficulties in accessing healthcare due to language barriers and a lack of translation services. Homeless people, Gypsy Travellers and irregular migrants[14] face difficulties in registering for healthcare under current administrative processes. Imposing an additional administrative requirement in order to prove eligibility to use services is likely to increase barriers to access.

There is strong evidence to show that those on lower income, those at extremes of age (young and old), women and those with more illness who use more healthcare are disproportionately affected by user charges, particularly out-of-pocket payments. The likely impact of this policy option will be higher in particular groups related to **age, gender, and disability**. The effect that user charges for short-term migrants will have on the UK population is not clear.

This review covered several topic areas and very little empirical research was found that related specifically to policy options 1 and 2 and equity issues. Secondary sources of evidence were used and were useful to provide context against which informed judgements regarding the impact of policies can be made.

[14] The term 'irregular migrant' is used in this review when referring to a group of residents (including failed asylum seekers, illegal entrants and those who have overstayed their visas. Although this terminology is frequently used in research literature, 'illegal migrant' is a more commonly used Government term so is the one used in the Equality Analysis that this document supports.

Policy Options Equality Matrix

Population Group	Health surcharge with visa	Compulsory registration	User fees (all sectors of healthcare economy)
Age – older people and children	Burden of costs will be higher for low-income UK sponsors of family visas eg retirees	Will disproportionately impact on children whose parents cannot provide appropriate documentation	Will impact on older people as they have higher healthcare needs. Will impact on children as they are less likely to receive preventative care
Disability	No evidence found	No evidence found	Will impact on individuals with high healthcare needs
Gender	Burden of costs will be higher for male and female low-income UK sponsors of family visas. May disproportionately effect females as result of pay gender gap.	No evidence found	Will impact on women who on average have lower pay
Ethnicity	No evidence found	May impose a barrier to healthcare for BME individuals who do not speak English as a first language	No direct evidence found.[15]
Religion or belief	No evidence found	No evidence found	No evidence found
Marriage/civil partnership	May impact on family unification	No evidence found	No evidence found
Sexual Orientation	No evidence found	No evidence found	No evidence found
Pregnancy and Maternity	No evidence found	Could delay access to antenatal care with a resulting impact on pregnancy outcomes	No direct evidence found
Carers	No evidence found	No evidence found	No direct evidence found

[15] Policy will impact on people of limited means across all groups.

Irregular Migrants	This policy is not applicable to this group	Will impose an additional barrier to care	May act as an additional deterrent
Homeless	No evidence found	Will impose an additional barrier to care if registration requires proof of address	Not applicable to this group
Travellers	No evidence found	Will impose an additional barrier to care if registration requires proof of address	Not applicable to this group

Following an extensive consultation and data gathering exercise the Department of Health (DH) is considering policy options that aim to ensure that visitors to the UK make a fair contribution to the cost of any healthcare needs that may arise during their stay. In order to comply with Public Sector Equality Duties DH has proposed to undertake an Equalities Impact Assessment (EqIA) of the proposed policy options. This will identify and assess both the positive and negative impacts that the implementation of a new policy may have on specified groups. This is necessary to ensure that the new policy is lawful and to propose any mitigating actions deemed necessary to reduce any negative impacts of the policy.

Under the provisions of the Public Sector Equality Duty (PSED) contained in Section 149 of the Equality Act 2010 all public bodies, including Ministers of the Crown, are required in the exercise of their functions to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected[16] characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The DH is considering several policy options that can be broadly grouped into 3 categories:

1. A Health Surcharge.

   This would be payable by all non-EEA visa applicants wishing to come to the UK on a points based visa (Tier1, 2, 4 and 5) for between 6 months and 5 years and all non-EEA people who apply to come to the UK as a family dependent of either a PBS applicant or a British citizen/permanent resident. It does not apply to settled migrants who have been granted leave to remain or British citizenship.
2. Improving recovery processes under the current rules

   Implement revised processes that ensure visitors who should be charged for NHS care under the current rules are identified and billed. This could include a system that requires all people who are eligible for free NHS care to register and be issued with proof of eligibility that could be presented to healthcare services if required.
3. User charges or Mandatory Insurance

   Introduce user charges at the point of delivery for all non-EEA short-term migrants (staying between 6 months to 5 years) for all types of healthcare (primary, secondary and community) with the exception of treatment for specified infectious diseases. An alternative to point of care user charges would be to require all non-EEA short-term migrants to take out mandatory health insurance.

[16] Protected characteristics are identified as age, gender, sexual orientation, gender reassignment, disability, pregnancy and maternity, race, religion or belief, marriage and civil partnership.

Prederi were asked to support the EqIA by carrying out desktop research to identify and collate evidence regarding the impact of the proposed policy options on specified population groups.
This document presents evidence from the research literature and wider sources which will help to inform the Equality Impact Assessment by providing information on some likely impacts that each of the proposed policy categories may have on both protected and other vulnerable groups[17] in the UK.

Exceptions to the Public Sector Equality Duty:
Section 149(9) of the Act Schedule 18 identifies exceptions to the PSED which includes immigration. In general the exceptions concern areas in which applications of the PSED may interfere with the exercise of an authority's functions (Pryper, 2013). Short-term migrants (here for 6 months to 5 years) may not be subject to equality duties. It should be borne in mind that some of the proposed policies apply to migrants only – health surcharge and user charges – and although they may have equity impacts within the short-term migrant population, these impacts may not extend to the UK population.

[17] Vulnerable groups for the purposes of the EqIA identified as homeless people, Gypsy Travellers and Irregular Migrants.

Approach

This is a pragmatic search for evidence using a combination of database, internet searching for grey literature, expert recommendations and reviewing relevant documents including consultation responses. As this review was completed over a short time period (2 weeks) it does not aim to be exhaustive. This is not a systematic literature review but rather a summary of key evidence with a focus on compiling the main themes specific to equity issues identified from readily available research, other evidence sources and consultation documents. Therefore the search for evidence is not exhaustive and to mitigate against potential risk of failing to include key evidence, DH information scientists also carried out a database search to identify relevant literature.

This work attempts to present evidence to inform analysis of the potential impact that three proposed types of policy intervention may have on both protected and vulnerable groups in the UK. The proposed categories of policy interventions are**: Health Surcharge**, **Tightening up recovery processes with or without compulsory registration, and introduction of user charges/insurance**. The impact groups are protected population groups that the Secretary of State has a Public Sector Equality Duty towards as well as additional vulnerable groups that DH felt were relevant. These impact areas were **age (older people and children), disability, gender, ethnicity, religion or belief, sexual orientation, pregnancy and maternity, carers, irregular migrants, homeless and travellers.**

There are many combinations of the proposed policy changes and population groups to consider and timescales do not allow for deep search of evidence on each of the many topics in scope of the EqIA.

Consultation responses were initially reviewed in order to inform the literature search. Given the timescales a search was undertaken using one bibliographic database (Medline) using broad search terms to be inclusive in the initial identification of evidence. The evidence included was selected using inclusion criteria. This provides an initial summary of the evidence identified and further searches may wish to be undertaken

Where no empirical research was identified for combinations of population groups and policy intervention, attempts were made to source other sources of information. Snowballing of references from reviews was undertaken to ensure a breath of coverage of evidence. Where possible systematic reviews of literature were prioritised for inclusion, but where this was not possible, primary research was included. This will not guarantee that we have captured all the literature and there may be some we have not identified that gives an opposing view. Therefore primary research is included to give a sense of what might happen and is no way definitive of what would happen.

Consultation Responses

The DH public consultation exercise canvassed views from a wide range of individuals and organisations on the proposals to charge short-term migrants for healthcare. Respondents were specifically asked:

> Do you have any evidence of how our proposals may impact disproportionately on any of the protected characteristic groups?

Many respondents replied to this question and a selection of responses were made available for the purposes of this report. These were helpful in providing information on potential inequity issues which could be further investigated. Potential equity issues highlighted by consultation responses are given below.

Health Surcharge

- If set too high may deter all but the most affluent
- Will disproportionately affect migrants on a low income currently in the country if they have to pay retrospectively
- Prospectively it will have a greater impact on low-income migrants who have to reapply for their visa whilst in the country. Likely to have a disproportionate effect on women as they tend to be in manual and low-paid work.
- Will affect British citizens/permanent residents sponsoring family members and this may disproportionately affect women if they are more likely to be sponsoring family members (children) than men.

Registration

- Act as another barrier to accessing healthcare amongst those who already experience barriers to care – irregular migrants, homeless, elderly who may not have the required documentation to register and travellers. This will then adversely impact on the children of these people.
- The policy will impact disproportionately on ethnic minorities and certain races already in the country as they will be discriminated against if they are asked to proof eligibility for healthcare based solely on their ethnic origin.

User fees

- Charging for primary healthcare will deter people who can't afford it from attending and will have a knock on effect for public health and emergency services.
- A variable rate, mandatory insurance scheme will require those who have pre-existing conditions eg pregnant and the elderly to pay higher premiums and these groups are more likely to be economically inactive.
- Women are higher users of healthcare than men therefore they would be disproportionately affected by a fee for service funding mechanism.

General

- Anything that limits access to primary care will have a disproportionate effect on children as they are heavily reliant on primary care services for both prevention services (surveillance, screening and immunization) and treatment.
- Pregnant women would be disproportionately affected because antenatal care would not be covered by the levy. They are also disadvantaged because of poor pregnancy outcomes in women who cannot access antenatal care early, especially if they come from vulnerable groups.

Sources of Evidence

The following information was sourced according to the 3 proposed policy categories:

1. ***Health surcharge***

   Evidence to assess the impact of this policy proposal was predominantly sourced through Home Office and UK Border Agency data and reports. The rationale for this was that a visa levy could be considered to have similar impacts as an increase in visa charges. The Home Office previously increased visa charges for non-EEA migrants in 2007 and then 2010. It has carried out research anticipating the impact this would have on migrant groups as well as analysing post implementation visa application numbers in order to asses whether these impacts were realised. This research provides an applicable, proxy indication of likely health surcharge impacts on UK visa applications within selected applicant groups.

2. ***Tighten recovery rules/registration***

   Although the DH proposals apply to non-EEA short-term migrants only, policies which aim to improve recovery of charges could impact on the UK population especially if proof of eligibility is required from all people entitled to use free-at-the-point-of-delivery NHS care. Some population groups within the UK face barriers to accessing healthcare when compared to the general population. Evidence was sought which summarised these access barriers with the purpose of identifying any access barriers that could be exacerbated with the introduction of new recovery rules. The information is largely sourced from high quality, systematic reviews as these provide the most accurate and valid summaries of the topic areas of interest. Additionally research describing the impact that implementation of eligibility rules has had on access to healthcare in other countries was also sourced through database search and reference search.

3. ***User charges***

   Evidence to assess the impacts of user charges was mainly extracted from systematic reviews studying the effects introducing/removing user charges has on demand for healthcare and use and how this impacts this has on sections of the population.

Findings

The following section highlights the main findings from the review of evidence. This has been divided up into the categories covering the three proposed policy changes: **Health Surcharge; Registration/Tightening up the recovery process; and Introduction of user charges/insurance**. Within these sections, potential impacts on specific population groups have been highlighted where evidence was available.

Health Surcharge

The following section provides a summary on evidence found on impacts of increasing visa charges on inward migration in general, and impacts this may have on specific population groups, in particular **men and women of working age whose spouse/children** are unable to obtain visas, those with lowest financial means which is likely to affect **women, especially single parents and other non-working age groups, eg retirees on low pensions**. Some of the potential unintended consequences of this are also highlighted in this section.

Charges impacting on migration levels

Evidence of changes in visa charge may be used as a proxy for looking at potential effects of a health surcharge. In 2007 the Home Office commissioned research to understand the price sensitivity of visa fees on different types of applicants. An ergonometric study looking at the price elasticity of visas amongst participants from China, India, Pakistan, Turkey, Russia, Ghana, Nigeria and Saudi Arabia applying outside the UK demonstrated that there is a level of sensitivity in pricing across nationalities and travelling groups (Home Office 2007). However research conducted amongst visa applicants who had applied within the UK (TNS 2007) found that although the visa fees were considered to be high amongst certain migrant groups – notably highly skilled migrants, students and visitor visa applicants – the visa fee was not a deciding factor when considering coming to the UK. All participants in this study had been granted leave to remain, although they were asked about their original visa application, and this could have biased the results as they may view the UK visa fees more favourably than other applicants. The Home Office have monitored the impact of fee changes upon application volumes, for historic rounds of fee changes and found that fees have not had a statistically significant impact on application volumes in previous years. No statistically significant elasticity of demand was found for visit visas, Tier 2 work, Tier 4 student and settlement visas and the Home Office concluded they are not sensitive to changes in price (UKBA, 2010; Home Office, 2013). There has been a marked reduction in visa applications over the past few years. For example work related entry visas declined from 193,620 in 2005 to 105,194 in 2011 and student visas declined from 2009 to 2011 from 273,000 to 237,000 respectively (Blinder, 2013). The Home Office analysis suggests that these reductions are due to other non-price related factors.

Based on the findings from this work, it could be assumed that an additional visa charge in the form of a health surcharge would not negatively impact in inward migration patterns and therefore by association not have equality ramifications. However, customer research carried out (TNS, 2007) found that if visa charges were raised to a threshold of £500, a substantial minority of applicants reported that they would not consider applying to the UK for work visas; this threshold fell to £200 for student and visitor visas. The findings theoretically suggest visa price sensitivity, although the threshold at which this occurs in reality appears not to have been yet met. The addition of a health surcharge on the visa cost could reach this threshold causing patterns of inward migration to change. However no research has been done to model this and it is not possible to predict whether there would be an impact on equality for UK protected population groups and vulnerable populations.

Charges impacting on specific groups

Non-EEA family members of British citizens/permanent residents and temporary migrants (individuals who have been granted visas under the Points Based System) require visas to live in the UK. Analysis of migration statistics show that the majority of visa applications for family unification (ie dependents of British citizens/permanent residents) are for women (at least 60% every year since 1997) and the majority are for people coming from Asia (Blinder, 2013). In addition, children comprise an increasing share of family unification migration, increasing from 7% (1,890 children) in 1997 to 17% (5,560) in 2011. In 2012 the rules governing eligibility for family visas changed requiring sponsors (usually a spouse or a parent) to provide proof of a minimum income of just above £18,000 per annum (increased if the application is also for dependent children). Evidence given to the All Party Parliamentary Group on Migration (All Party Parliamentary Group on Migration, 2013) looking at the impacts this change in visa eligibility has had showed that this

requirement has impacted more on the lower-earning sections of the UK working population seeking to sponsor a non-EEA partner and child. Much of the evidence was anecdotal in nature but over 280 submissions were received, including over 175 submissions from families who had been affected by the rules. Written evidence was also received from charities, lawyers, local authorities, businesses and MPs from across the UK.

British citizen/permanent resident groups who were highlighted as being particularly affected by the Minimum Income Rules were low paid workers, some of them in full-time employment. Sectors that were specifically mentioned included health, social care, the service industry, security workers and some people living in religious communities where their accommodation and living expenses were being met by a religious order. A submission from Middlesex University anticipated that the income requirement would disadvantage women, as the full-time gender pay gap currently stands at 14.9%. Other groups that were affected were retirees on state pensions and workers outside of London where pay is lower.

It is feasible that a health surcharge would have an effect on low-income British citizens/permanent residents wishing to sponsor family visas as this would represent an additional barrier to the one that is already imposed by the change in family visa requirements. This would impact both men and women of working age whose spouse/children are unable to obtain visas with the greatest effects being felt by those with the fewest means. Women may be overrepresented in this group, especially single parents. Other non-working age groups, eg retirees on low pensions could also be affected.

Additional impacts

There may be unintended consequences if the inability to bring in dependents results in British citizens/permanent residents leaving the UK. Evidence submitted to the APPC suggested this maybe the case for some healthcare workers. This could leave a skills shortage and a reduction in the level of care given to vulnerable people – sick, elderly and disabled – within the UK, but there is no evidence to suggest that this will happen at scale.

Tighten Recovery Rules/Proof of Eligibility

This section highlights evidence of policy impacts which aim to improve recovery of charges or require registration or proof of eligibility on the existing UK population. There is evidence to show that some population groups within the UK face barriers to accessing healthcare when compared to the general population (Goddard, 2003) . This section summarises some of these access barriers for specific population groups including Black and Ethnic Minority Groups, LGBT communities, gypsy travellers, homeless people and undocumented migrants in order to highlight any barriers which could be potentially worsened with the introduction of new recovery rules. Evidence for the impact of registration is presented and finally the evidence on additional consequences of implementing such policies is given at the end of this section.

Equity in access to healthcare in the UK

Black and Minority Ethnic Groups

A systematic review looking at equality of access to healthcare services in England (Goddard, 2003) found that barriers to help-seeking amongst BME groups included a

perception of language difficulties, lack of awareness about beliefs and values amongst healthcare providers and a lack of translation facilities. Lack of interpreting services, especially when accessing out of hours care, is a particular problem. Mothers whose first language is not English report that journeys to treatment centres for their children are more difficult especially if they have larger families which made attendance more difficult. After adjusting for need, there appears to be higher rates of consultation in primary care amongst some ethnic minority groups than amongst similar white groups (South Asians, Pakistani Indian, Bangladeshi origin); and lower rates in some groups, such as the Chinese. Patterns are not always consistent between genders. Use of specialist outpatient and inpatient care appears lower amongst ethnic minority groups than equivalent white groups but this is not consistent across gender, age or specialism and many studies reviewed had poor methodologies. Research on the uptake of preventive care was equivocal. Additional evidence from the Millennium Cohort Study showed that BME women were less likely to access antenatal care, although this association disappeared after adjustment for socio-economic factors (Jayaweera, 2010).

The risk of particular chronic diseases is higher in some BME Groups (Atkinson *et al*, 2001). People of South East Asia descent have a higher incidence of cardiovascular disease and diabetes. This high diabetes risk is true for Afro- Caribbean who also have a higher incidence of stroke than the UK white population. Afro-Caribbeans are more likely to be diagnosed with a psychotic illness although this may in part be due to a cultural artefact. All cancer mortality is lower amongst first generation BME migrants in Europe than host populations. (Rechel et al, 2013).

LGBT communities

There is a paucity of high quality research carried out in the UK with respect to access to healthcare amongst LGBT communities. A systematic review carried out by the University of Birmingham (Meads *et* al, 2009) reported findings from two systematic reviews, 11 quantitative and 14 qualitative primary research papers. Most of these were focussed on the health of lesbian or gay people and there was almost no research on bisexual and transgendered individuals. Lesbian and gay people reported numerous barriers to healthcare including homophobia and heterosexism, misunderstandings and lack of knowledge, lack of appropriate protocols, poor confidentiality and the absence of LGBT-friendly resources. However utilisation rates amongst LGBT groups were not measured empirically or compared to the UK population, with the exception of cervical screening uptake which was lower for lesbian and bisexual women than the general population.

Gypsy Travellers

It is estimated that there are between 200 to 300 thousand gypsy travellers within the UK. A large mixed method study carried out in 2004 for the Department of Health showed that travelling communities experience poorer health compared to the UK population even when health status was matched to individuals of comparable socio-economic status and educational achievement (Parry *et al,* 2004). Specific health needs include high levels of anxiety and depression and an increase in certain long-term conditions. In particular Gypsy women experience worse pregnancy outcomes compared to matched control with statistically significantly more gypsy women reporting a miscarriage than non-gypsy women (29% and 16% respectively) as well as having statistically higher rates of stillbirth and neonatal death (Parry *et al*, 2007).

Gypsy Travellers report not being allowed to register with GPs as they cannot provide proof of residence and are therefore considered ineligible. High illiteracy rates and cultural incongruence between travellers and healthcare providers also contribute to reduced access to healthcare. Other contributing factors include inadequate health promotion material, competing priorities, enforced mobility, lack of transport and poor time keeping, inflexible systems, pressure to reach targets, discrimination, marginalization, lack of trust and low expectations on the part of agencies (Matthews, 2008; Attebury, 2010).

Homeless People

The evidence base regarding the healthcare needs of rough sleepers and single homeless people in emergency accommodation is relatively well developed. However, less is known about the needs of particular vulnerable groups of homeless people, such as homeless families. Findings from 2 systematic reviews (Quilgers *et al,* 2003; Centre for Social and Economic Inclusion, 2005) show that NHS bureaucracy poses a barrier to accessing healthcare. Effects include not be able to register with GPs without supplying a permanent address to being unable to receive other care – secondary and community – as appointments booking systems require an address even if the patient is registered with a GP. GP receptionists can believe that a patient is not eligible to permanently register without a permanent address. Not having a permanent address additionally makes discharge from hospital difficult.

A European-wide qualitative survey (Canavan *et al,* 2012) of 111 homeless-specific services within 14 European Capital cities, including the UK, reported that homeless people faced many barriers to accessing healthcare. A common theme identified was the difficult and chaotic life circumstances of homeless people, including alcohol and

substance abuse issues and difficulties in maintaining medication compliance. The unwillingness amongst the homeless population to engage with the services was also seen as a barrier, often due to a lack of trust in health professionals. Barriers relating to health insurance were frequently reported, mainly relating to not having insurance or not being registered with a GP. Admission and discharge procedures in the health services were also highlighted, with the main barrier being a lack of clear responsibility within the services in relation to the treatment of homeless people.
Population characteristics such as being from a BME or LGBT group may add to existing organizational barriers to accessing healthcare amongst the homeless. English research presents evidence that hostile attitudes are sometimes faced by people from these groups and there may be reluctance amongst these groups to use services in which the main user group is White and male.

Undocumented Migrants
A recent scoping review carried out by researchers from the London School of Hygiene and Tropical Medicine (Woodward, 2013) has collated evidence relating to health and healthcare for undocumented migrants in Europe. Fifty-four relevant studies were identified but they varied greatly in methodological quality and in particular sampling of the study population. However the studies demonstrated particular trends. Access to healthcare was reported in 80% of studies reviewed and documented barriers to care included lack of awareness of legal entitlements among both undocumented migrants and health-care providers. Ambiguities on what constituted an emergency and lack of guidelines on treatment options contributed to uncertainty among health professionals and denial of entitled care. Fear of being reported to the authorities was cited as an important barrier to care seeking, even in the absence of any reporting obligations. Financial obstacles limited access to secondary care, with access to primary care also affected. Costs prevented many migrants from accessing care or medicines, while reimbursement systems increased workloads among healthcare providers. Cultural and language barriers were described as reducing undocumented migrants' ability to negotiate treatment options, potentially compromising quality of care.

In particular certain groups were identified as being particularly vulnerable. These were pregnant women, children and detainees. Several studies found that pregnant women experienced delayed access to antenatal care and experienced payment barriers to obstetric and gynaelogical care. Women were much less likely to take up prevention services such as STI screening and contraception services and had high abortion rates.

With respect to children parents delayed seeking care due to a lack of understanding of entitlement. Evidence was found of challenges of registering an undocumented baby and missed newborn vaccinations. One included study reported that 50% of detained undocumented migrants had sought healthcare mainly for injuries and dental problems and there was high suicide rates amongst detainees.

Overall undocumented migrants had high healthcare needs especially psychological ones. Children were particularly vulnerable to the psychological effects of being an undocumented migrant resulting from the insecurity of parental status and dangerous and unhygienic living conditions.

Impact of compulsory registration

A study assessed whether the introduction of compulsory registration requirements increased the length of time it took from requesting Medicaid care to this care being

authorized for pregnant women in Oregon (Bauer *et al*, 2011). Participants were all pregnant women who requested antenatal Medicaid support in a nine month period before the eligibility rules came into force compared to all women requesting support in a nine month period after implementation of the new rules. It found that the mean length of time between application to authorization increased from 18 to 22.6 days and in the 9 months following implementation of the eligibility rule the number of patients waiting over 7 days increased significantly from 68% to 76%. The proportion of applicants waiting over 30 days rose from 19% to 28%. The authors concluded that additional administrative processes requiring proof of eligibility to services to be verified appears to have delayed access to care in this setting. This was seen as critical if care is needed urgently or there are benefits of receiving early care such as is the case in pregnancy.

Even when registering for a service brings benefits such as free healthcare not all eligible individuals will chose to do so, as was found to be the case in Ireland and New Zealand (Nolan *et al*, 2012; Cumming *et al*, 2011). Both of these countries have implemented healthcare funding policies which have resulted in fewer citizens paying out of pocket user charges and more being funded through a capitation system with care being free at the point of delivery. However individuals are required to provide proof of entitlement via an entitlement card. In both countries uptake of this card has been less than 100%. In the UK Stagg et al. found that approximately only one third of all new migrants (non-EEA) had registered with a GP in the nine months after entry even though they were eligible for free primary care (Stagg *et al*, 2012).

Registration impacting on specific groups

Research from the US (Oregon Department of Human Services, 2008) shows that compulsory registration requirements can lead to some individuals being denied access to healthcare. In 2005 the State of Oregon required all US citizens wishing to use Medicaid to prove eligibility by submitting documents that proved citizenship. An evaluation of this policy found that 1% of individuals applying were denied or had their benefits closed (approximately 1,000 people). Of those, 64% of applicants whose benefits were closed or denied were children. 67% were re-applicants and 96% spoke English as their first language. The race/ethnic breakdown of denied applicants (new to Medicaid) was similar to the general Medicaid population. The number of applications and proportion applying from high immigrant areas did not drop after the introduction of the rules. Qualitative research showed process factors in obtaining the relevant proof of information impacted on eligibility decision making including a lack of time to get the right information (birth certificates), lack of money and transportation to order and receive certificates from other states, complicated and confusing processes in obtaining birth certificates which were extenuated by language barriers. Missing forms in the application packs meant that adults were unable and did not know that they had to register their children. For children missing affidavits or other identity documents was the number one reason for closure/denial. The overall rules of what documents to provide and who was eligible were confusing especially to Spanish speaking families.

Additional impacts

One of the additional impacts of implementing such policies is the variability in the application of eligibility rules at a local level that may lead to variation and inequity in accessing services.

In a study looking at the views of primary care providers about charging systems, registration policies and their views of impact on overseas visitors (OV) in an ethnically

diverse London borough, Hargreaves et al. found variation amongst GP practices with respect to registering overseas visitors and charging them for primary care services. The reasons for this included variation in the interpretation of eligibility rules and whether or not the practices had systems in place to identify non-eligible migrants (66% of practices did). Some GPs expressed concern that this would have deleterious effects on those who could not afford care, in particular women and children. The authors concluded that variation in the implementation of the charging policy led to inequity in the provision of care.

There is also variation in the implementation of rules governing the charging of overseas visitors in secondary care. Research undertaken in 29 NHS Trusts (Creative Research, 2013) found that two Trusts did not identify chargeable patients at all and that of the remainder the number of people detected as being eligible to pay for care and subsequently charged varied substantially between Trusts. Aggregate data for all Trusts showed that three quarters of the total number of visitors who were charged were from non-EEA countries. The issue of a systematic bias towards identifying non-EEA nationals, especially non-White individuals, was raised as a concern in the consultation responses. It is impossible to say whether this is happening from these research findings without knowing the underlying distribution of chargeable visitors presenting to each Trust. However both the primary and secondary care studies highlight the fact that without consistent application of explicit rules, inequity may arise.

User Charges

There is a large body of research on the effects that user charges including out of pocket payments, co-payments and insurance, have on demand and use of healthcare. Compared to the other two proposed policy categories (Health surcharges or Registration) there is more evidence specifically looking at introduction of user fees in healthcare settings and impacts of this generally on the population, with some evidence on impact on specific groups. This section summarises the findings of systematic reviews that examine the impact user charges have in low, middle and high income countries and discusses the consequences for particular population groups.

Impact of user fees on demand for and use of healthcare

In general an increase in user fees leads to a reduction in demand and use of healthcare services (Creese, 1991). A Cochrane review (Lagarde *et al*, 2011) looking at the impact of user fees on access to health services in low- and middle-income countries found a decrease in utilisation with the introduction or increase in fees with reductions being in the range of 5-50%. However after an initial drop usage rates did begin to increase with time (months to years). Conversely removal of user fees causes an increase in use, in some studies usage rates almost trebled with the reduction of fees, although this was not uniform for all types of healthcare. Use of preventative care and most non-inpatient curative services tended to increase whereas inpatient rates stayed the same. Studies that examined the impact of increasing user fees at the same time as increasing service quality found that utilisation rates increased. Rates were highest for those facilities that improved quality and accepted a mixed method of payment, with some patients paying out of pocket and others through capitation via local taxation. This appeared to improve equity as the proportion of low-income patients accessing care increased.

In the UK a study that examined dental use before and after introducing a more rigorous charging regime found that patients not exempt to charges were 4 times more likely to receive emergency care only. They were 340 times more likely to receive a check-up only

and if treatment was received it would be 40% less than that received by patients who did not pay out of pocket (Creese, 1991).

Nolan et al. investigated the effects of removing user fees for GP services on GP utilization in Ireland using a cross sectional study design with a large representative sample of the Irish population. They compared GP use amongst 4 groups – those with government provided full medical cover, those with cover for GP visits only, those with private health insurance, those with no cover at all and investigated whether self reported GP use in past 2 years differed for each group. They found that self-reported GP use declined with decreasing levels of cover. The group with no cover had the lowest proportion of people reporting GP use. This remained after adjusting for socio-economic and health need variables

Impact of user fees on specific population groups

User charges disproportionately affect the poor for whom price elasticity effects are greatest. Corrieri et al. found that amongst individuals aged 65+ all studies reported that low-income individuals spent a higher proportion of their income (up to 43%) on healthcare compared to high-income individuals. The burden of prescription drugs was around 10 times higher for those on a low income compared to high-income groups. In the elderly inequalities are likely to be most apparent due to extensive use of medical services caused by age-related morbidity. Cost reducing strategies amongst the elderly included taking less medication than prescribed or not filling prescriptions and getting into debt.
A systematic review looking at medication use amongst socioeconomically deprived individuals (Lexchin *et* al, 2004) and those in poor health (including those with disabilities and long-term conditions). Studies universally showed that medication use decreased with increasing prescription charges, including co-payments. The larger the share of income spent on prescription drugs, the higher the degree of price sensitivity. Poor and sick people were the most price-sensitive groups. Prescription charging/co-payments led to patients foregoing essential medications and increases in use of emergency services, nursing home admissions and serious adverse events.

Corrieri et al. (2010) found gender related differences with respect to the burden of out-of-pocket payment for healthcare with women spending a higher proportion of their disposable income on OOP across all age groups. The reasons given were that women had lower pay, more gaps in employment therefore less exposure to employer related insurer schemes and needed more healthcare, some of which was poorly covered by insurance schemes in general eg breast cancer treatment. Additionally elderly women have longer life expectancy and are more likely to be widows with the loss of their husbands pension.

User fees for prevention services impact on children who require interventions such as immunization and screening. A high quality community randomized control trial (Lagarde *et al*, 2011) studied the impact on uptake of a prevention treatment at primary schools when fees were introduced. Descriptive data show that 19% of pupils took the drugs after fees were introduced, while the uptake rate of free drugs was 75%. In a regression analysis, the authors found that introduction of cost-sharing was responsible for the major part of this reduction in uptake. Also in the Cochrane review three studies reported the impact of fee removal on preventive services, and although only one showed a positive increase in utilisation immediately after the intervention, in all three studies the effect in preventive services was more favourable in the long run (12 months after the intervention), where increases in preventive care visits varied between 5% and 92%.

New Zealand and Ireland are two high-income countries where a substantial amount of healthcare is funded via out-of-pocket charges. In a narrative review of international evidence looking at the impact of different charging models and the implications this may have for NZ on equity of resource distribution and access Cummings and May (1999) describe the different funding mechanisms for primary care that were instigated from the 1960s onwards in NZ with emphasis on healthcare reform from the 1990s onwards. They found that user fees impacted on provider behaviour with GPs less likely to take on more complex cases as these are less cost-effective than short simple consultations (assuming a flat fee for all consultation types). There was evidence that people were unwilling to pay for preventative care e.g. low national rates of immunization uptake (63% in 1998). The system resulted in an uneven distribution of GPs, where areas of high healthcare need were underserved due to limited income factors. Out of pocket charges encourages gaming by providers eg choosing high cost services over lower ones, requiring more consultations, shorter consultations. There is evidence from NZ that high-need/morbidity groups have low utilization of primary care services than would seem appropriate given their poor health status.
Point-of-care user charges have the potential to have a very large impact on people with limited means. However, many short-term migrants do not fall into this category. An analysis of UK 2011 Census data (ONS, 2013) showed that a higher proportion of foreign-born nationals were occupied at professional level than the UK born population (20% and 18% respectively).

This document has drawn on a range of evidence from research literature and wider sources and has attempted to highlight some of the key issues that could inform the Equity Impact Assessment being undertaken by DH. We have summarised these sources and where possible have highlighted evidence on the likely impacts that each of the proposed policy categories may have on the protected and other vulnerable groups in the UK.

Limitations

When considering this evidence summary there are several limitations that need to be considered. Firstly the quality of evidence should be taken into account when making decisions incorporating evidence from this review. Where possible we have drawn on evidence from systematic reviews. In some instances data from primary research has been drawn upon. Some of the studies may be subject to issues of methodological quality which may confound or bias the results. Quality of the evidence source was assessed at the time of inclusion, although given the lack of evidence covering this particular area the inclusion criteria were kept purposefully broad. The search was restricted to evidence written in English.

In terms of generalisability of the findings, the evidence presented covers wide ranging populations from UK, other developed countries and developing countries. Findings in some of these populations and settings may not be directly generalisable to the UK but provide useful information to theorise about what could potentially happen if a similar approach was taken in the UK. The same is true for some of the studies included that were not specific to healthcare setting or to the interventions being proposed but provided information that may be illustrative and help to inform decisions.

Given the limited timescales there is a possibility that important evidence may have been missed. This review should be interpreted with these limitations in mind when using this evidence summary to inform further work and decision-making.

Discussion of findings

Despite the limitations, this evidence summary has highlighted the following groups that may potentially be impacted by the proposals.

- ***Visa Surcharge*** – may impact on existing residents who wish to support family member visa applications to enter the country. According to the evidence, the population groups likely to be most affected could be **single parents, particularly women, those in low-income groups and the older population** (retired and likely to be related to income). Therefore it would be important to consider the impacts of these proposals on **age** and **gender.**
- ***Registration/eligibility*** – may impact on particular groups more than others. According to the evidence **children** were more likely to be affected when proving eligibility or for registration compared to other population groups. Therefore it would be important to consider impact on **age.** Delays in access to healthcare eg antenatal care, may have disproportionate effect in contributing to poor outcomes **eg pregnancy and maternity**
- ***User charges*** – There is strong evidence to show that those on lower income, those at extremes of age (young and old), women and those with more illness who use more healthcare incur higher out-of-pocket user charges and therefore the likely impact of these proposals will be higher in particular groups related to **Age, Gender, and Disability**.

Impacts by inference - It appears that the homeless and Gypsy Travellers could be impacted by introducing requirements to demonstrate proof of eligibility to receive NHS care. This could also extend to some long-term migrants who face language barriers when accessing care.

Irregular migrants already face considerable challenges when accessing healthcare even if they are legally allowed to do so (such as failed asylum seekers on. Imposing registration requirements and user charges is likely to exacerbate these. However it should be noted that under current rules many irregular migrants are required to pay for their healthcare (excepting emergency care and treatment of certain infectious diseases).

The review has also highlighted some additional impacts of implementation of such policies. For example for visa surcharges, there is likely to be a risk of outward migration of those who can't afford to pay for family visa surcharges (single parents, more likely to be women, those with less economic means, retired). This may have knock on effects for the remaining population. For registration, the evidence showed that there have been varied applications of the rules for charging overseas visitors for primary care. This leads to inequity of access, although the studies identified did not examine if this affected a particular population group more significantly.

In summary very little empirical evidence was found that directly assessed the impact that imposing a migrant health surcharge or requiring citizens to register for healthcare would have on the selected population groups. Evidence relating to user charges is more robust. Although some groups may be disproportionately affected by the proposed policy options often this is through an association with low-income. Effects will not be felt uniformly

across all members of a particular group as income will vary across groups. Homeless people and Gypsy Travellers are likely to be disproportionately impacted by registration requirements.

All Party Parliamentary Group on Migration. (2013) Report of the Enquiry into New Family Migration Rules. http://www.appgmigration.org.uk/family-inquiry

Atkinson M, Clark M, Clay D, Johnson M, Owen D et al. (2001) Systematic review of ethnicity and health service access for London. Centre for Health Services Studies (CHESS), University of Warwick

Bauer, Joanna, Angus, Lisa, Fischler, Nurit, Rosenberg, Kenneth D., Gipson, Teresa F., DeVoe, Jennifer. (2011) *The Impact of Citizenship Documentation Requirements on Access to Medicaid for Pregnant Women in Oregon.* Journal of Maternal and Child Health. 15:753-758

Blinder S. (2013) Briefing. Non-European Student Migration to the UK. The Migration Observatory. The University of Oxford.
Blinder S. (2013) Briefing. Non European Migration to the UK: Family and Dependents. The Migration Observatory. The University of Oxford.
Blinder S. (2013) Briefing. Non-EU Migration to the UK. The Migration Observatory. The University of Oxford.
Canavan et al. (2012) *Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities.* BMC Health Services Research, 12:222 http://www.biomedcentral.com/1472-6963/12/222

Centre for Social and Economic Inclusion (2005) *Access to mainstream public services by homeless people: A literature review.*

Creative Research (2013) *Qualitative Assessment of Visitor and Migrant Use of the NHS in England. Observations from the Front Line – Summary.* Prepared for the Department of Health.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251906/Qualitative_Assessment_of_Visitor___Migrant_use_of_the_NHS_in_England_-_Observations_from_the_Front_Line__SUMMARY.pdf

Creese A. (1991) *User charges for health care: a review of recent experience.* Health Policy and Planning; 6(4): 309-319

Corrieri S, Heider D, Matschinger H, Lehnert T, Raum E, Konig HH. (2010) *Income-, education- and gender-related inequalities in out-of-pocket health-care payments for 65+ patients - a systematic review.* International Journal for Equity in Health; 9(20): 1475-9276

Cumming, J; Mays, N. (1999) *Shifting to capitation in primary care: what might the impact be in New Zealand?* Australian health review : a publication of the Australian Hospital Association; 22(4): 8-24.

Cumming J, Mays N (2011). *New Zealand's primary health care strategy; early effects of the new financing and payment system for general practice and future Challenges*. Health Economics, Policy and Law 6(1), 1-21.

Goddard M. (2008) *Quality in and Equality of Access to Health Services in England. CHE Research Paper 40*. Centry for Health Economics. University of York.

Home Office (2007) A New Charging Regime for Immigration and Nationality Fees. Race Equality Impact Assessment Report.

Home Office. (2013) Fees and Charges proposals in HO Immigration Bill 2013
IA No: HO 0091

Jayaweera, H. And Quigley, M. A. (2010) 'Health status, health behaviour and healthcare use among migrants in the UK: Evidence from mothers in the Millennium Cohort Study', Social Science and Medicine, Vol. 71, pp. 1002-1010.

Lagarde M, Palmer N. The impact of user fees on access to health services in low- and middle-income countries. Cochrane Database of Systematic Reviews 2011, Issue 4. Art. No.: CD009094. DOI: 10.1002/14651858.CD009094.

Lexchin J, Grootendorst P. (2004) Effects of prescription drug user fees on drug and health service use and on health status in vulnerable populations: A systematic review of the evidence. International Journal of Health Services; 34(1): 102-122

Matthews, Z. (2008). Better Health Briefing 12. The Health of Gypsies and Travellers in the UK. A Race Equality Foundation Briefing Paper. Communities and Local Government. Race Equality Foundation

Meads C, Pennant M, McManus J et al. (2009). *A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research.* Department of Public Health, Epidemiology and Biostatistics,

University of Birmingham (Birmingham),

Nolan A, Smith S. (2012) *The effect of differential eligibility for free GP services on GP utilization in Ireland.* Social Science and Medicine 74 1644-1651

Office for National Statistics (2013) *Economic and Social Characteristics of the Resident Population of England and Wales by Nationality and Country of Birth in 2011*. http://www.ons.gov.uk/ons/dcp171766_318067.pdf

Oregon Department of Human Services (2007) *Implementation of the U.S. Deficit Reduction Act of 2005 in Oregan and its impacts on Oregon Health Plan clients.* An overview of the effects of the new identity and citizenship documentation requirements during the first six months of implementation, September 1, 2006 – February 28, 2007 http://www.oregon.gov/DHS/citizenship/report0705.pdf

Parry, G. Van Cleemput, P. Peters, J. Moore, J. Walters, S. Thomas, K and Cooper, C. (2004). *The Health Status of Gypsies and Travellers in England. Sheffield*. University of Sheffield.

Parry G. et al. (2007) Health status of Gypsies and Travellers in England. Journal of Epidemiology and Community Health 61(3): 198–204.

Pryper D (2013) *The Public Sector Equality Duty and Equality Impact Assessments.* House of Commons Library; Standard Note: SN/BT/6591

Quilgers D, Pleace N. (2003) *Delivering Healthcare to Homeless People: An Effectiveness Review*.

Rechel B. Mladovsky P. Ingleby D. Mackenback J. McKee M. (2013) *Migration and health in an increasingly diverse Europe.* Lancet: 381: 1235-1245

Stagg HR, Jones J, Bickler G, et al. (2012) *Poor uptake of primary healthcare registration among recent entrants to the UK: a retrospective cohort study.* BMJ Open 2012;2:e001453.doi:10.1136/bmjopen-2012-001453

TNS (2007) Managed Migration Pricing Research Report of Findings.

UK Border Agency (2010) Impact Assessment of Fee Changes for Tier 4 visas, Tier 1 post

study visa, In UK Dependant Application, Nationality, Transfer of Condition, and Sponsor Action Plan. IA No: HO0010

Woodward A, Howard N, Wolfers I. (2013) *Health and access to care for undocumented migrants living in the European Union: a scoping review*. Health Policy and Planning;1–