Response to the Department of Health's Consultation *'Making a fair contribution'* from the Race Equality Foundation supported by the Coalition for Race Equality (CORE) and other partners

Submission date: 4th March 2016

CORE Members:

Black Training and Enterprise Group (BTEG), the Black South West Network (BSWN), BME National, Croydon BME Forum, Friends, Families and Travellers, JUST West Yorkshire, OLMEC, Operation Black Vote (OBV), Race on the Agenda (ROTA), the Race Equality Foundation, the Runnymede Trust and Voice4Change England.

Other partners supporting this response:

Enfield Racial Equality Council; Haringey Race and Equality Council; the Institute of Equality and Diversity Practitioners (IEDP); Race Equality Matters (REM) and Training and Support 4 Services and Exiles Cooperative Ltd (TS4SE).

About the Race Equality Foundation

The Foundation promotes race equality in social support and public services. We do this by: a) exploring what is known about discrimination and disadvantage; b) developing evidenced-based better practice to promote equality; c) disseminating better practice through educational activities, training and development programmes, conferences, written materials and websites, and; d) working with a range of national and local partners from the community, voluntary, statutory and social enterprise sectors delivering health, housing, social care and parenting support. Established in 1987, as part of the National Institute for Social Work (NISW), the Foundation was originally known as the Race Equality Unit. We became an independent charitable organisation in 1995, and in 2006 we became the Race Equality Foundation. The Foundation is a founding member of CORE and currently CORE's host. We have offices in London, Manchester and Leeds.

About the Coalition for Race Equality (CORE)

CORE, the Coalition for Race Equality, is a race equality network that brings together national, regional and other leading race equality focused voluntary and community organisations in England (for more information on CORE visit here). Our member organisations operate nationally and/or across the English regions, are recognised as leaders and experts in race equality and work to challenge racism, particularly systemic racism. CORE's purpose is to improve the collective capacity of our members to advance race equality and challenge racism. CORE facilitates collaborative working between our members and with others at national, local and regional levels; CORE also promotes effective and positive strategic approaches which genuinely advance race equality. Our members include the Black Training and Enterprise Group (BTEG), the Black South West Network (BSWN), BME National, Croydon BME Forum, Friends, Families and Travellers, JUST West Yorkshire, OLMEC, Operation Black Vote (OBV), Race on the Agenda (ROTA), the Race Equality Foundation, the Runnymede Trust and Voice4Change England.

About this joint submission/response to the consultation

The Foundation has been liaising with the Department of Health's Recovery Team since late 2013. We, and partners, have raised fundamental concerns about the extended hospital charging regime introduced in 2015; following the 2013 consultation (Sustaining services, ensuring fairness). We are profoundly concerned about 'Making a fair contribution' (MAFC), its overall impact and serious flaws in its assumptions, evidence base, principles and a wide range of legal compliance issues. The consultation document states that the Department welcomes *'responses to all of the questions above as well as any additional comments'* (part 19, page 58). Unfortunately, the questionnaire does not provide a framework for addressing our detailed and substantive concerns. We have therefore taken the decision to divide our submission into two parts, part A of this joint submission makes clear the nature and extent of our broader concerns. Part B responds to the specific consultation questions.

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PART A: THE BROADER CONCERNS OF THE FOUNDATION AND PARTNERS

1. This response

1.1 About this response

This part of our submission explains the nature and extent of our broader concerns about the consultation 'Making a Fair contribution' (MAFC). We focus on MAFC's overall impact and serious flaws in its assumptions, evidence base, principles as well as MAFC's failure to address a wide range of legal compliance issues.[1] We are concerned about how Black, Minority Ethnic and Refugee (BMER) communities and individuals will be affected by the proposals given the Foundation's and CORE's race equality remits. Given the extreme nature of health exclusion which they experience, we have highlighted specific concerns about the health inequalities/exclusion experienced by certain BMER groups, for example Gypsies and Travellers and vulnerable migrants.[2] We are also concerned about a range of wider equalities, children's rights and human rights issues; we have commented on MAFC's failure to adequately address adverse and/or discriminatory impacts of the proposals on children, disabled people, women and homeless people, many of whom will also be members of BMER communities.

Important national work on health inclusion and exclusion, initiated by the National Inclusion Health Board (NIHB), sets the context for, and provides key evidence in relation to, this submission.[3] Given the detail provided in this part of our submission, we have sought to make comparatively short and focused responses to each of the 37 consultation questions in part B of this submission. These responses draw on the structured analysis provided in this part of our submission. We have identified nine broad overarching, cross-cutting themes and concerns. Where relevant, we have also identified actions that the Department of Health should take to address these issues and concerns.

1.2 Three reference documents provided

We have provided three reference documents to assist the Department of Health and others reading this submission. Appendix 1 provides extracts from an important national report on health exclusion 'Inclusive Practice'. Appendix 2 identifies outstanding evaluations and reviews that the Department of Health committed to produce. Appendix 3 draws on the NHS Constitution and sets out the NHS principles and values.

[1] MAFC is used in this submission as the acronym for *'Making a fair contribution'*.
[2] See part A: 2.2 for a definition of this term.
[3] Although the NIHB ceased to operate at the end of 2013, key reports and associated work initiated by the NIHB was published by the Department of Health between 2013 and 2016.

1.3 This part of our report

Our assessment is that the proposals contained in 'Making a Fair Contribution' (MAFC) are irreparably flawed. This part of our submission explores why we regard MAFC's proposals as irreparably flawed and injurious to the health of individuals, communities and the wider public under the nine cutting themes set out below.

a) Section 2 draws on, and explains the importance of, the National Inclusion Health Board's work on health inclusion and vulnerability.
b) Section 3 overviews the proposed overall MAFC regime and identifies groups that are likely to be adversely affected by this regime.[4]
c) Section 4 comments on why the MAFC regime would be likely to undermine the achievement of public health priorities and worsen health inequalities. We also identify a series of unintended deterrent effects and other unintended consequences.
d) Section 5 identifies and comments on the significance of key reviews, equalities and cost benefit analyses and research that the Department of Health committed to publish, and consider, **prior** to MAFC's publication. We also explain that this work should have been explored with stakeholders and informed the proposals.
e) Section 6 assesses MAFC's four overarching principles against the principles and values set out in the NHS Constitution. It also assesses MAFC's proposals against MAFC's four overarching principles and the NHS Constitution. We conclude that MAFC's principles and consultation proposals inadequately address the NHS Constitution's principles and values as well as wider legal obligations.
f) Section 7 explains why MAFC's proposals fail to properly address the Health and Social Care Act 2012 Act's duties to reduce health inequalities and inequalities in access to healthcare.
g) Section 8 draws on the Equality Act 2010, it explains why the MAFC charging regime will encourage discrimination and argues that due regard has not been paid to the Public Sector Equality Duty.
h) Section 9 explains why MAFC's proposals are inconsistent with provisions in the Human Rights Act 1998 and the UN Convention on the Rights of the Child. It also questions whether the proposed regime is compliant with the European Race Directive and other international obligations.
i) Section 10 proposes a range of remedial actions that should be taken by the Department of Health to address the issues raised in this part of our consultation response.

1.4 This submission and supporting other submissions

The Foundation and partners also wish to endorse the submissions made by other members of the Entitlement Working Group and in particular the submissions made by Doctors of the World, Maternity Action and Still Human Still Here.

[4] Given the nature of the MAFC regime, this is not intended to be an exhaustive assessment of all the vulnerable groups or groups protected under the Equality Act 2010 who are likely to be affected.

2. The relevance, and importance, of the work of the National Inclusion Health Board (NIHB) and the relevance of the NIHB's approach to vulnerability

2.1 The National Inclusion Health Board (NIHB)

The National Inclusion Health Board (NIHB) championed *'the needs of those most vulnerable to poor health outcomes'* and advised government.[5] Its role was to*: 'provide cross-sector and interdisciplinary leadership and ownership of the Inclusion Health agenda nationally; champion the needs of vulnerable groups and promote the principles of the Inclusion Health approach; provide direction, oversight and decision making for the delivery of the Inclusion Health programme; provide evidence-based challenge across health and social care; work in partnership with Government to develop and drive innovative solutions.'* The NIHB met from 2012 to the end of 2013. The NIHB initiated and funded a number of important reports/resources, published between 2013 and 2016, that are relevant to this submission.

The Board's eminent members included representatives from the Care Quality Commission (CQC), the Faculty of Public Health (FPE), Public Health England (PHE), the Association of Directors of Adult Social Services (ADASS), University College London, leading academics in the field, and St Mungo's, a leading homelessness charity. [6] The Department of Health played a key role in the NIHB's work serving on the NIHB's Data and Research Working Group.[7] Given the NIHB's national remit and role in relation to reducing health inequalities, the relevance of this work to the matters addressed in MAFC, the fact that the Department of Health is an NIHB partner MAFC's proposals should be revised in the light of 'Inclusive Practice' and the NIHB's associated work and recommendations.

2.2 Defining vulnerability

The NIHB adopted a definition of vulnerability which, like the concept of institutional racism and discrimination, recognised the institutional nature of the concept of vulnerability. The NIHB accepted that: *'It is more important to focus on the systems which trigger and cause vulnerability and aim to correct those rather than the people who were adversely affected. Vulnerability isn't a characteristic of disadvantaged people but of the "social spaces" they have to occupy in unequal societies.'*[8] We agree with the NIHB's definition of vulnerability;

[5] Visit: https://www.gov.uk/government/groups/national-inclusion-health-board

[6] NIHB members were: Professor Steve Field, Chair, (Care Quality Commission); Professor Sir Michael Marmot (University College London); Charles Fraser (St Mungo's); Professor John Ashton (Faculty of Public Health); Sandie Keene (Association of Directors of Adult Social Services); Duncan Selbie (Public Health England). The Department of Health serviced the NIHB.

[7] The Data and Research Working Group of the National Inclusion Health Board included a representative from the Department of Health's Health Inequalities Unit.

[8] Source: Understanding vulnerability. Workshop of the Data and Research Working Group, Inclusion Health Programme, May 2012

we suggest that consideration be given to this approach informing the Vulnerable Groups Review currently being scoped by the Department of Health (see part 2 & appendix 2, 3,).

2.3 Inclusive Practice

The NIHB's report 'Inclusive Practice', published in January 2014 is one of a series of reports, from the Inclusion Health programme published between 2013 and January 2016.[9] Whilst this submission specifically draws on 'Inclusive Practice', the other reports/resources are also relevant.[10] 'Inclusive Practice' provides particularly helpful evidence on health inequalities, adverse health impacts and organisational arrangements to reduce such inequalities and impacts. 'Inclusive Practice', and the other reports/resources, should be considered in revised MAFC proposals.[11] 'Inclusive Practice' focuses on four key groups – vulnerable migrants, Gypsies and Irish Travellers, homeless people and sex workers.[12] However, the report's analysis is also relevant to other groups who face health inequalities/exclusion from healthcare provision.

Box a: Inclusive Practice

Inclusive Practice provides *'a detailed synthesis of the scientific literature within the UK and elsewhere, of the impact of efforts to provide good access to primary care and to prevent avoidable hospitalisation for the four vulnerable groups identified in the Department of Health Inclusion Health programme: vulnerable migrants, Gypsies and Irish Travellers, people who are homeless, and sex workers.'* Inclusive Practice, page 6

2.4 Reaching groups vulnerable to health exclusion

Unsurprisingly there were differences in terms of access and the issues faced by the four different groups, and differences within these groups (see appendix 1).[13] Nevertheless, it is possible to identify some cross cutting themes directly relevant to MAFC's assumptions and proposals. These cross-cutting issues and themes are: a) GP registration rates; b) the importance of good practice, outreach, engagement, trust and interdisciplinary, multi-

[9] Inclusive Practice: Vulnerable Migrants, Gypsies and Travellers, People Who Are Homeless, and Sex Workers: A Review and Synthesis of Interventions/Service Models that Improve Access to Primary Care & Reduce Risk of Avoidable Admission to Hospital, Peter J Aspinall, Reader in Population Health, University of Kent, 2014. Visit: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305912/Inclusive_Practice.pdf

[10] The other independent reports, published by the Department of Health under the auspices of the National Inclusion Health Board's work, were: Commissioning inclusive health services: practical steps, published 19 August 2013; Effective health care for vulnerable groups prevented by data gaps, published 7 March 2014;.Gypsy and Traveller health: accommodation and living environment, published 8 January 2016; and Educating health professionals to support vulnerable groups, published 8 January 2016.

[11] It was commissioned and overseen by the Data and Research Working Group of the Inclusion Health Programme and approved for publication by the National Inclusion Health Board in 2014.

[12] The term vulnerable migrants is defined as '*Asylum seekers (including failed asylum seekers), refugees, and undocumented or irregular migrants (including those who have entered the country illegally and migrants with irregular documentation, such as visa overstayers) are included in the definition of vulnerable migrants. Other groups may be vulnerable with respect to health care access (e.g. students from overseas).'* Inclusive Practice, page 7.

[13] Appendix 1 provides extracts from 'Inclusive Practice's Executive Summary and Recommendations.

disciplinary and innovative service provision; and c) the need for more research and data. With respect to GP registration rates, all four groups experienced some very low GP registration rates; as low as 19%, for some vulnerable migrants, and 30% for some Gypsies and Travellers. However, some GP registration rates for these groups could be in the range of 80% to 90%. For vulnerable migrants and Gypsies and travellers whose GP registration rates were particularly variable, higher GP registration rates tended to be associated with urban areas, good practice, effective engagement activities, outreach work, interdisciplinary provision, multi-disciplinary services and innovative provision.

'Inclusive Practice' pointed to the importance of a number of factors in reaching groups particularly vulnerable to health exclusion, health inequalities and reduced access to appropriate health provision. Recognised good practice included outreach programmes and services, community based programmes, engagement and building trust and the provision of appropriate services designed to meet community needs. Often the healthcare and other services, required by service-users, were provided by a multi-disciplinary team or a team that could work across traditional NHS boundaries associated with primary, secondary or community care. The document makes it clear that numerous models of care have been developed but no one size fits all model was advocated; however innovative service provision was a central theme (see appendix 1, 6.3). Though Inclusive Practice noted that few of the programmes had been fully evaluated, reference was made to the evaluation of the London Healthcare Pathway for homeless people; this evaluation demonstrated that it reduced the use of inpatient care and was cost effective (see appendix 1, 6.3). The NIHB identified data gaps and called for more research and evaluation.[14]

2.5 Drawing on Inclusive Practice and questioning MAFC's key assumptions and proposals

Analysis of MAFC's proposals and key themes and issues in 'Inclusive Practice' leads the Foundation and partners to question MAFC's key assumptions and proposals. Some excluded groups have low GP registration rates, especially in rural areas or where targeted programmes to reduce exclusion are not in place. If GP and nurse consultations become **the only free access point** for NHS care, this raises questions about what will happen to those groups not registered with a GP. At present, individuals from groups vulnerable to health exclusion may have a number of access points for NHS care. The access points currently available, where people are not registered with a GP, include outreach services/projects, community based services, Walk-in services, some specialist services and A&E. However, under the MAFC proposals, for those thought to be subject to the charging regime, and not otherwise exempted, all of these other access points/doors would have to operate the charging regime.

[14] Effective health care for vulnerable groups prevented by data gaps, published 7 March 2014.

Experience of working with outreach services and excluded groups suggests that the threat of being charged and the information exchange requirements associated with operating a charging regime would deter many targeted by such services. We are concerned that MAFC's charging regime would in practice result in many of the most vulnerable no longer accessing healthcare. If the MAFC regime were implemented, it would be likely to generate human rights legal challenges about the denial of medical treatment.[15]

The NIHB's work made it clear that GP registration rates varied widely for excluded groups likely to be affected by the proposals. Moreover, even in the urban areas in which these groups may be more likely to have a GP, other access points in addition to GPs are required. Limiting the service provided by a GP or nurse to just a 'consultation' is equally flawed. 'Inclusive Practice' shows that GPs and nurses operating effectively depend on their ability to: conduct or order appropriate diagnostic tests; write prescriptions; and refer to other colleagues and specialists in primary care, secondary care and/or community care including charitable and voluntary organisations. Requiring all providers to operate the charging regime, for anything apart from GP or nurse consultations, would undermine the ability of GPs and nurses to provide professional, high quality, effective and timely care and severely damage or even destroy the good practice models identified in 'Inclusive Practice'.

The evidence, provided in 'Inclusive Practice', supports the profound concerns expressed by the Foundation, partners and other colleagues about the likely adverse impacts, unintended consequences and deterrent effects of MAFC's charging regime. Making the outreach services, interdisciplinary providers, multi-disciplinary services and third party providers chargeable has the potential to destroy the accessibility and effectiveness of these important services and teams. [16] This is particularly important because it would also waste previous investments. Developing such specialist and innovative programmes, services and teams often involves many years of work as well as significant investments in finance, people and other resources. Equally concerning is the fact that typically the NHS is likely to be just one of a number organisations involved in the development and/or the ongoing operation of these initiatives. Grant-making trusts, local authorities and of course charitable and voluntary organisations are often important partners.[17] The Department of Health's Vulnerable Groups Review (VGR), currently being scoped, needs to assess how MAFC's proposals would impact on the types of multi-disciplinary, interdisciplinary and innovative services identified by the NIHB as being so crucial to reducing health inequalities for the most excluded. The VGR should explore how to ensure that such services/activities are not damaged by changes in the charging regime and/or assess whether any of the proposals should be withdrawn or amended.

[15] The importance of this impact is picked up in part A: 4 of this submission on unintended consequences and deterrents and parts A: 7, A: 8, A: 9 and in our responses to relevant consultation questions.
[16] See part A: 4.
[17] See responses to questions 26-28 for these and additional issues.

3. The regime, the exemptions and those likely to be adversely affected

3.1 The charging regime – an overview

The consultation document proposes that the charging regime should be extended into primary care, secondary care and community care. Primary care is defined, in the consultation document, as care *'provided by those who act as a first point of contact for patients, except in emergencies.*' Primary medical care is defined *as 'healthcare services provided in NHS General Practice (GP) surgeries, primary Walk-In Centres and Out of Hours services.*' Secondary care is defined as *'care provided by medical specialists who generally do not have first contact with patients, except in emergencies.'* [18] Community care is identified in MAFC, as including all NHS funded care provided by third parties and NHS funded continuing care.[19] In terms of NHS services, only GP and nurse consultations would remain free under the MAFC proposals. Apart from access to free NHS GP and nurse consultations, those not deemed to be ordinarily resident in the UK would only receive free care if eligible for an exemption.

Box b: Areas into which it is proposed to extend charging for certain overseas visitors and migrants

Primary care	**Secondary care**	**Community care**
Primary Medical Care (section 4)	Accident and Emergency (section 8)	Non-NHS providers and Out-of Hospital care (section 11)
NHS Prescriptions (section 5)	Ambulance Services (section 9)	NHS Continuing Care (section 12)
Primary NHS Dental Care (section 6)	Assisted Reproduction (section 10)	
Primary NHS Ophthalmic Services (eye care) (section 7)		

3.2 Overviewing the exemption regime, key concerns and issues

MAFC's proposals, for extending the charging regime to primary, secondary and community care, build on a complex range of existing statutory exemptions. [20] There are exemptions for certain groups, many infectious diseases, sexually transmitted diseases as well as treatment required because of domestic violence, torture, Female Genital Mutilation (FGM) or sexual violence. The exempted groups are defined in the relevant statutory regulations which came into force on 6th April 2015 and in the amendments to these regulations. Key amendments came into force on 1st February 2016 that exempted, or clarified the exemptions on, victims of FGM, human trafficking and modern slavery. Whilst we welcome

[18] Source: MAFC NHS definitions, part 1, page 10.
[19] Continuing care includes a range of NHS funded end of life care including NHS funded hospice care and other complex packages of care for those with complex healthcare needs.
[20] The National Health Service (Charges to Overseas Visitors) Regulations 2015 (SI. 238)as amended by the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2015 (SI. 2025)

and support these exemptions, we have a number of concerns about important gaps in the existing charging regime and associated exemptions, on which MAFC builds, have been operationalised. Key concerns include issues around identifying exempt individuals, ensuring that exempt people are not charged, whether people are informed that they are exempt, the potential for errors and delays, whether errors are being rectified promptly, discrimination, racial profiling and adverse impacts and gaps in the exemption regime.

The MAFC regime would require staff across the NHS to take on additional roles with respect to checking/rechecking the immigration status of patients and operating a complex charging and exemption regime; this is a high risk strategy especially as the NHS is already under significant financial, staffing and other pressures.[21] Getting to grips with the new charging and exemptions regime will require significant investments in guidance and training especially for administrators, clinicians and others who have to operate the new regime. It will also require new administrative systems, new reporting arrangements, new monitoring, appropriate complaints procedures, financial and debt collection systems and associated software and technology. [22] We are concerned about Department of Health's failure to evaluate the operation of the current hospital charging regime and whether: a) the exemptions are properly understood by hospitals; b) hospitals have properly operationalised the exemption regime; and c) individuals, who are exempt, know that they are exempt so that they can challenge any mistakes made.[23] We are also concerned that Department of Health has not undertaken or published comprehensive and credible cost benefit analyses of the existing or the proposed regime. In the absence of proper costs benefit analyses, we believe that it is impossible to identify those parts of the proposed regime that will cost more, in the medium to long-term, in both financial and health terms than the short term financial benefits that may be achieved; these issues are explored further in parts A: 4.3, A: 5.3, A: 10.2 and the responses to questions 2, 27 and 28 of this submission. The Foundation and partners contend that these deficiencies must be addressed **before** the regime is extended.

3.3 Why the proposed system is so challenging

Any system that depends on assessing an individual's immigration status to check whether that person is, or is not, exempt from charging is inherently complicated. Complications arise because immigration law is notoriously complicated, the law is subject to change,

[21] Financial pressures *'are growing, with large numbers of hospitals now in deficit. Looking further ahead, pressure to spend more will grow as the costs of treatment rise, public expectations increase and the population continues to age.'* The Kings Fund, July 2015. Visit: http://www.kingsfund.org.uk/projects/funding-and-finances. In terms of staff, in September 2015, UNISON reported that 65% of NHS workers were considering leaving the NHS, Undervalued Overwhelmed, UNISON, 2015. Visit: https://www.unison.org.uk/news/press-release/2015/09/unison-warns-of-staff-exodus-as-two-thirds-plan-to-leave-the-nhs/

[22] Even though hospitals have had some exposure to various charging regimes for some years they have struggled to recover charges.

[23] See part A: 5 and appendix 2 for what the Department of Health promised with respect to evaluations.

someone's immigration status may change as they move through the immigration system and decisions are made and individuals may not know their immigration status.

Box c: Factors that make the exemption regime challenging

a) Immigration status may be affected by changes in the law. For example there may be changes in primary legislation.[24] There may also be changes in statutory regulations and/or changes as a result of legal judgments/case law. Where changes result, the any guidance to staff must be updated otherwise there will be the possibility of a legal breach
b) Immigration status my change because of immigration decisions made. [25]
c) The Home Office may provide incorrect or no information to individuals or the NHS. Or conflicting information may be provided.[26]
d) An individual may be undocumented and it may be entirely unclear whether any exemption might be applicable.
e) A parent who brings in their child for medical assistance may or may not know their child's immigration status and/or a child may present who is unlikely to know their status.
f) Whilst some undocumented minors may be looked after by the State others may be homeless and/or on their own.[27]
g) Someone may have been in the UK for many years but their immigration status may not have been regularised.

The Foundation and partners contend that the Department of Health needs to introduce a simpler but more comprehensive exemption regime. We also contend that the charging regime must not incorporate the deterrents or generate the unintended consequences identified in part A: 4 of this submission. Some of the fundamental changes required are set out in part A: 10 of this submission.

3.4. Errors and delays in identifying exemptions and providing treatment

If the MAFC regime were to be introduced across the NHS, errors will occur especially if key provisions are not properly tested and piloted **before** any national rollout. Delays in accessing treatment, not deemed to be immediately necessary or urgent, are also inevitable if the **pay first, treatment second** policy, currently in place and proposed by MAFC, is

[24] The Immigration Act 2014 came into force from 2014 onwards. Currently another major Immigration Bill is going through parliament; this Bill will become the Immigration Act 2016, almost certainly before June 2016. In addition to the 2016 Act, there will be new and amended statutory regulations and possibly one or more statutory code of practice The guidance on the charging regulations, last updated in February 2016, will have to be updated again to take account of these changes in primary or secondary legislation.

[25] For example, someone's immigration status may change because: a) they successfully challenge an immigration decision and become eligible for an exemption; b) they lose what may or may not prove to be their final immigration appeal and do not qualify for any other exemption.

[26] In November 2015, the Home Affairs Select Committee noted that *'the current backlog of cases stood at 318,159 and there had been an increase between Q1 and Q2, with the Migration Refusal Pool being the biggest contributor to the backlog.'* Visit: https://www.ein.org.uk/news/home-affairs-select-committee-publishes-latest-quarterly-report-work-immigration-directorates

[27] The Children's Society has published a range of reports documenting how at risk undocumented minors are. Visit: http://www.childrenssociety.org.uk/what-we-do/policy-and-lobbying/young-refugees-and-migrants-0

retained.[28] This pay first policy clearly runs the risk of harming individuals denied treatment until they pay (see part A: 3.7). If the identification of an exemption entitlement is delayed, this may result in delays in treatment not deemed to be immediately necessary or urgent. As it is not always possible to assess whether a condition is life-threatening or serious; there is a real possibility that sending a patient away by mistake could cause serious harm or even death. There are attendant risks of complaints and possibly legal challenges. [29]

3.5 Who may be adversely affected by the charging regime

The submissions made by respondents to the 2013 consultation on charging 'Sustaining services, ensuring fairness' and the associated Equalities Analysis, identified a number of groups that might be adversely affected by the charging regime proposed at that time. Specific concerns were raised about the impact on Gypsies and Travellers, undocumented or irregular migrants, pregnant women, children, others subject to immigration controls and those whose second language is English. [30] Other groups identified as being particularly vulnerable included detainees, homeless people and people on no or low incomes.

If people have to self-identify and demonstrate eligibility for an exemption, this presents a range of formidable challenges. For example, as there is no blanket mental health exemption, those living with mental health issues, who need appropriate interventions especially at times of crisis, are likely to find it particularly stressful to negotiate the exemption regime when in crisis and may be unable to do so. There are also some perversities about the system, for example someone detained under the Mental Health Act would be entitled to free healthcare whilst detained. However, once discharged the same person would need to fall within one of the exempted groups to receive care; those requiring mental health services are not automatically exempted. Similarly, the exemption system would also be likely to defeat many learning disabled people, those with poor verbal communication skills and/or those with a fear of dealing with authorities; such fears are not unusual for victims of war, torture, trafficking and violence. These difficulties will be greater for anyone whose first language is not English, those who have a limited grasp of the system and/or anyone who is fearful of being referred to the Home Office. Women, people with long-term health issues, those with poor literacy/communication skills and other vulnerable people within our communities will be adversely affected by changes. There are particular

[28] The guidance advises that *'providers are strongly encouraged to obtain a deposit ahead of treatment deemed urgent if circumstances allow. However, if that proves unsuccessful, the treatment should not be delayed or withheld for the purposes of securing payment*.' MAFC, para. 2.3, page 11. The current guidance on the charging regulations, updated in February 2016, states *'that Non-urgent, or elective treatment should not begin until full payment has been received.' Guidance on implementing the overseas visitor hospital charging regulations 2015, Department of Health, Feb. 2016,* page 4

[29] If MAFC's proposals are implemented any legal challenges would be faced by relevant providers in the statutory, private, voluntary, community, charitable and social enterprise sectors; although the Department of Health might be joined to the case.

[30] The concerns with respect to pregnant women also extended to antenatal care. Sustaining services, ensuring fairness: Equality Analysis, December 2013, pages 13, 15 & 16. Visit: https://www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs

challenges for girls and women, because although family planning is exempt, this *'does not include termination of pregnancy'.* However, the fact remains that family planning services will be underused/accessed because girls and women are likely to be unclear about what is chargeable and what is not. Moreover, the fear of being charged or reported to the authorities will not be countered by an 'exemption' label. So, although family planning is exempt, low use of its provision together with the vulnerable situation of undocumented women, particularly those who are destitute, means that they will be put at increased risk of having an unwanted pregnancy; this may leave such women with few alternatives. As well as raising the risk of backstreet abortions, more girls and women may opt for inherently dangerous self-help.

Errors made by the NHS staff, seeking to navigate this complex charging and exemption regime, and/or racial profiling could also result in individuals from BMER communities being mistakenly being told that they are chargeable and/or denied access to healthcare unless they challenge the decision. Extending the requirement to prove eligibility for healthcare, across the majority of NHS services, raises the risks of racial profiling and adverse disproportionate impacts on BMER communities. It would mean that members of BMER communities could be affected by the implementation of MAFC whether or not they are recent migrants, undocumented migrants or members of settled communities; the legal implications are considered later in this submission. The MAFC proposals would also delay or deny access to health-care to anyone unable to pay and not deemed to be in need of immediately necessary or urgent treatment living with a long-term medical condition. We advocate an exemption for people with long-term medical conditions (see part A: 10 of this submission). We continue to argue that these serious adverse consequences for public health and health inequalities – for BMER communities, particularly vulnerable migrants, and wider communities – must first be evaluated in comprehensive cost benefit and equality analyses and then addressed in revised proposals **before** the charging regime is extended further (see parts A: 4.3, A: 5.3 & A: 10.2).

3.6 The importance of third party providers, specialists and outreach work

Experience of working with migrant and refugee groups, outreach services and with victims suggests that it may be hard to identify victims of violence, modern day slavery and human trafficking.[31] It may be just as hard to identify if the treatment is required because of the violence experienced. There are many factors that prevent people from disclosing that have suffered these forms of violence and exploitation. Where disclosures are made, often this is where relationships have been established with trusted people in voluntary, charitable or community organisations, social enterprises or other specialist community-based and/or outreach services. Often providers that work with these client groups are central to

[31] Victims of violence exempted under the regulations include victims of domestic violence, sexual violence, FGM and torture if the treatment is required because of said violence.

facilitating disclosure, assisting the individual to access services, providing advocacy and supporting individuals. NHS funded third party providers, specialist community-based and outreach services, working with the most vulnerable, play critical roles in identifying exempt people and helping to operationalise such exemptions. The roles played justify exempting such third party providers and services from being brought into the charging regime; this issue is picked up in the recommendations provided in part A: 10 of this submission.

3.7 The dangers of payment in advance and addressing gaps and deficiencies

At first glance payment in advance seems a perfectly logical requirement. In fact in most marketplaces unless one requires payment in advance payment would never be received. However, the NHS is not just a marketplace, it is intended to be a comprehensive health service built on the principles and values set out in appendix 3. Introducing the charging regime proposed under MAFC runs the risk of doing fundamental damage to the NHS. The current and proposed payment in advance regime – for all but GP and nurse consultations and urgent or immediately necessary treatment – runs a series of key risks.

Box d: Key risks associated with pay first, treatment second policy

a) If patients who require immediately necessary or urgent treatment are not properly identified, their well-being and lives may be jeopardized. If treatment is withheld until it is deemed to be immediately necessary or urgent treatment, patients will eventually have to be treated but at much greater personal and financial cost. This regime may particularly impact on children where diagnosis may be challenging.[32]

b) If people fear that they may be chargeable, they may be dissuaded from accessing health care until they are very ill. The pay first, treat second is likely to operate in direct opposition to the good practice principles underpinning effective health prevention programmes.

c) Contrary to the NHS principles and values, pay first, treat second is also likely to make cost rather than clinical need the determining factor in relation to whether healthcare is provided to some of the most vulnerable in society.

d) Counterintuitively, the policy is likely to result in the requirement to provide much more costly but later health interventions compared to the financially cheaper interventions that might have been required if early diagnoses and treatment had been initiated.

Apart from the extended hospital healthcare charging regime rolled out since 2014, which has not been properly evaluated, there is no direct UK equivalent to the proposed MAFC regime. However, the proposed MAFC regime does encourage parallels with the US regime in which those uninsured and unable to pay for healthcare languish. In the USA, those patients who are uninsured, who are unable to pay: are less likely than those with coverage

[32] It can be particularly difficult to diagnose children with certain conditions. For example, a young boy who was left with brain damage and severe hearing impairment as a result of a hospital's delay in diagnosis of meningitis and the Defendant NHS Trust eventually had to agree to pay a sum equivalent to approximately £1.5 million to settle the case. Visit: https://www.leighday.co.uk/News/2010/July-2010/Deafness-and-brain-damage-after-boy-s-misdiagnosed

to receive timely preventive care and many uninsured people do not obtain the treatments recommended by their health care providers. Furthermore, they are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalised for avoidable health problems and to experience declines in their overall health. When hospitalised, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance. In addition uninsured children also face problems getting needed care. [33]

With respect to gaps in MAFC's exemption regime, we know that the regime is not comprehensive and some vulnerable groups are not exempted (see A: 3.5). These deficiencies would become even more problematic if MAFC's proposals resulted in most, if not all, NHS service provision being subject to the charging regime. The Department of Health needs to develop a simpler exemption regime with greater coverage for the most vulnerable, the destitute and poor; the regime must also have a much reduced potential for encouraging racial profiling. The component parts of the regime must also stand up to relevant cost benefit analyses and equality analyses or be amended or even scrapped to address identified issues. The Foundation and partners believe that exempting the most vulnerable would not reduce income generation because the most vulnerable are most likely to be destitute or without funds so realistically will never be able to pay (see A: 10).

4. The regime, unintended consequences and deterrents

4.1 The proposed regime and immediately necessary or urgent care

If MAFC's proposals are introduced, patients not deemed to be ordinarily resident in the UK, and not otherwise exempted, would only have access to free GP and nurse consultations and immediately necessary or urgent NHS treatment. Though immediately necessary or urgent NHS treatment would chargeable in due course, it is supposed to be accessible without upfront payment. [34] The Department of Health's guidance is clear that clinicians must make the decision about whether treatment is immediately necessary or urgent. [35] But

[33] The Uninsured: A Primer - Key Facts about Health Insurance and the Uninsured in the Era of Health Reform, Melissa Majerol, Vann Newkirk, and Rachel Garfield. Kaiser Family Foundation, November 2015. Visit: http://kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-the-era-of-health-reform-how-does-lack-of-insurance-affect-access-to-health-care/

[34] *'Immediately necessary treatment is that which a patient needs: to save their life; or to prevent a condition from becoming immediately life-threatening; or promptly, to prevent permanent serious damage from occurring'.* Guidance on implementing the overseas visitor hospital charging regulations 2015, para. 8.4, page 70, Department of Health, February 2016. Visit: https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations

[35] '*Urgent treatment is that which clinicians do not consider immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to return home. Clinicians may base their decision on a range of factors, including the pain or disability a particular condition is causing, the risk that delay might mean a more involved or expensive medical intervention being required, or the likelihood of a substantial and potentially life- threatening deterioration occurring in the patient's condition if treatment is delayed until they return to their own country.'* Guidance on implementing the overseas visitor hospital charging regulations

whilst the Guidance advises trusts that payment for immediately necessary treatment will be due after treatment, it also states that payment may be requested in advance in the case of urgent treatment. [36] Other tests, diagnoses and treatment would be subject to payment in advance. For those who are unable to pay, and those who do not know that they would be exempt, this charging regime and lack of clarity about the associated exemptions would be likely to delay or prevent access to healthcare.

4.2 Increasing health exclusion and the MAFC regime

There is clear evidence that a higher proportion of people from migrant communities, Gypsies and Travellers, sex workers, refugees and undocumented migrants, compared to other groups, are not be registered with GPs (see A: 2.4). The evidence also suggests that these groups/individuals may rely disproportionately on NHS funded outreach services, walk-in services and accessing A&E in an emergency. Reaching these groups, and ensuring that their health needs are met, often depends on a multidisciplinary or interdisciplinary approach, in which trust, outreach work, community engagement and work across primary and secondary care play vital roles. Our assessment is that the MAFC proposals could destroy vital work in this area (see part A: 2.4 & 2.5). Under the MFAC proposals, those not deemed to be ordinarily resident in the UK, and not otherwise exempted, would be subject to the charging regime. This charging regime would reduce or even exclude these patients from access to the majority of NHS primary, secondary and community care services provided by the statutory sector and NHS funded services provided by third parties.[37]

Whilst we accept, and welcome the fact, that immediately necessary or urgent treatment must be provided, we share the concerns expressed by other stakeholders that charging for such treatment will inevitably act as a barrier to accessing treatment for those unable to pay (see A: 4 & A: 10). Although the Department of Health's revised guidance, published in February 2016, is clear and helpful with respect to the definitions of immediately necessary or urgent treatment, we remain concerned about how immediately necessary or urgent treatment is being interpreted by hospital trusts and the fact that the vulnerable, destitute and poor will still have to pay unless otherwise exempted.[38] The Impact Assessment published on 7th December 2015 contained no risk assessment of the likely impact on public

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2015, para. 8.7, page 71, DH, February 2016. Visit: https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations

[36] *'In circumstances where it is possible and appropriate to assess charges and request payment before or during a course of immediately necessary treatment, relevant NHS bodies should make clear to the patient that treatment will not be withheld or delayed if they do not pay in advance or provide an appropriate EEA healthcare form.'* Guidance on implementing the overseas visitor hospital charging regulations 2015, para. 8.21, page 73, Department of Health, February 2016. Visit: https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations

[37] Third parties would include private sector, charitable and voluntary sector organisations as well as social enterprises and other non-statutory providers that provide NHS funded services.

[38] The updated Guidance published in February 2016 reflects the advice from Doctors of the World however it is now critical to ensure that hospital trusts understand and comply with this guidance..

health priorities and the associated costs to the overall system; such a risk assessment is essential **prior** to any decision to extend the charging regime further.

4.3 Public health priorities and MAFC

Public Health England's 2015/16 annual plan identifies a series of outcomes that for 2016.[39] These outcomes/priorities include: reducing TB; improving global health security; reducing smoking and harmful drinking; tackling childhood obesity; reducing dementia risk; ensuring every child has the best start in life; and improving workplace health and wellbeing. Desired public health outcomes also include establishing prevention programmes that reduce growth in NHS activity and improve outcomes in the following areas: atrial fibrillation; hypertension; falls in the frail elderly; smoking in pregnancy; diabetes; and alcohol harm. Public health priorities include: improving the quality and coverage as well as reducing inequalities in the uptake of national screening programmes; and extending and improving the UK's world-class immunisation programmes. The MAFC regime would harm individuals, families, local communities and wider public health objectives by increasing barriers to NHS healthcare and delaying and/or deterring BMER communities, and other vulnerable groups, from accessing timely and appropriate health care. Whilst MAFC may appear to offer short term savings, proper cost benefit analyses must examine the likely short, medium and long term health and financial costs. A proper evaluation would be likely to show that any short term financial savings would be far exceeded by the short, medium and long-term health consequences for individuals, families and local communities and associated costs. Examining the case of Tuberculosis (TB) is illustrative (see A: 4.4). If these wider public health impacts are properly factored in, the policy simply fails to hold water.

4.4 Examining the case of TB

Public Health England has identified that early diagnosis, [40] ongoing treatment, drug resistance and social factors[41] play important roles in relation to TB and its spread. TB is a greater problem in areas with high BMER populations and in the homeless. For example, in 2015, the London Assembly reported that parts of London had higher rates of TB than Rwanda, Eritrea and Iraq. There were more than 2,500 new cases of TB in London – about 40% of the UK's total and a third of London boroughs exceeded the World Health

[39] Who we are and what we do: Annual Plan 2015/16, Public Health England, July 2015. Visit: https://www.gov.uk/government/publications/public-health-england-annual-plan

[40] With respect to TB '*the average delay from symptom onset to treatment start is unacceptably long and increasing; nearly one-third of pulmonary TB cases had a delay of more than four months in 2014'* According to Public Health England *'to reduce this delay, improved awareness in affected communities and among health professionals, and improved access to high quality services are required.'* Tuberculosis in the UK 2015 report, Public Health England, October 2015, page 7. Visit:

[41] According to PHE, *'nearly one in ten TB cases in 2014 had at least one social risk factor, and there has been no reduction in the number of cases with social risk factors over the past five years.' Furthermore, a higher proportion of those with social risk factors have drug resistant TB and worse TB outcomes, which highlights the added importance of tackling TB in this group, including through targeted outreach services.'* Tuberculosis in the UK 2015 report, Public Health England, October 2015, page 7. Visit: https://www.gov.uk/government/publications/tuberculosis-in-england-annual-report

Organisation's (WHO) "high incidence" threshold and *'prisoners, refugees, migrants, people with substance abuse issues and homeless people'* were most at risk. In response, Dr Onkar Sahota, chair of the London assembly's health committee said: *"If we don't get a grip on London's TB situation now, the harder and more expensive it will be to tackle in the years to come. With pressures on health budgets, we can't afford to take our eye off the ball."* [42] These facts, and the case example below, show why free doctor and nurse consultations and free treatment for TB will be insufficient to tackle/reduce TB and why the MAFC regime would undermine tackling this important public health priority.

Box e: Examining the case of TB

Some people have latent TB; this means that they have been in contact with the disease at some time in their past, but they do not have active TB and are not currently ill or infectious. If the individual is healthy, well nourished, has warm shelter and is not significantly stressed, the disease is very unlikely to activate. However, the poverty, homelessness, a shortage of nourishing food and extreme stress that vulnerable migrants often experience, may lead the TB to become active. Such individuals may become ill and infectious creating an obvious risk for their families, local communities and possibly a wider public health risk. [43]

The Charging guidelines are extremely complex, and it is very unlikely vulnerable undocumented migrants, who could be chargeable but for the TB exemption, will know that TB treatment is free. Even if everyone knows that TB treatment is free, neither they nor medics would be sure of a TB diagnosis before undertaking the relevant diagnostic test or tests. Such individuals fearing the costs of diagnostic tests if it turns out not to be TB are therefore are unlikely to access health care until they are extremely ill; in these circumstances they may become so ill that they are more likely to go to A&E. Some undocumented people, fearing the consequences of their data being shared with the Home Office or Police, will be unwilling to engage with any NHS provider operating MAFC's charging and data sharing regime. Fears about charging and/or data-sharing may encourage some people to resort to self-help through Internet or community sourced drugs. Those who do not seek treatment from the NHS or seek late medical treatment may also have an increased risk of antibiotic drug resistance. The immigration data sharing aspects of the MAFC regime may also undermine contact tracing within these communities, increasing these costs and the likelihood of delays in treatment for others.

[42] TB rates in parts of London 'worse than Iraq, Eritrea and Rwanda', the Guardian, 27/10/15. Visit: http://www.theguardian.com/society/2015/oct/27/tb-rates-in-parts-of-london-worse-than-iraq-eritrea-and-rwanda

[43] *'The TB bacteria in your body might stay 'asleep' permanently. However they could, at some point, wake up and turn into active TB, making you develop symptoms and become ill. This is more likely to happen if your immune system becomes weakened, as the result of another illness or stress caused by personal circumstances (such as bereavement, loss of work or poor housing).'* The Truth about TB, TB Alert, the UK's national tuberculosis charity. Visit: http://www.thetruthabouttb.org/what-is-tb/latent-tb/

4.5. Lessons from abroad

In 2012 Spain introduced a law restricting access to the National Health System for undocumented migrants.[44] Undocumented adults were entitled to free emergency care only. Health insurance (€60 per month) could be obtained after a year of residence in Spain. However, children under 18 years and pregnant women continued to receive free healthcare under the same conditions as Spanish citizens, including antenatal, delivery and postnatal care and vaccination. In 2014, the European Committee of Social Rights expressed concern over this restrictive policy that excluded undocumented migrants from the healthcare system stating that *'the economic crisis cannot serve as a pretext for a restriction or denial of access to healthcare that affects the very substance of the* ***right of access to healthcare'.***[45] A coalition of NGOs gathered over 1,500 cases of individuals whose human right to health had been violated as a result of the exclusion of undocumented immigrants from the public healthcare system between January 2014 to July 2015. They include 31 cases of cancer, 38 cases of cardiovascular disease, 62 cases of diabetes, 14 cases of degenerative muscle disease, 28 potentially-mortal cases if not treated properly and 27 cases involving individuals with serious mental health problems. A number of regions created their own regulatory framework permitting illegal immigrants to access free health care, while other regions largely ignored the ban.[46] In 2015, Spain reversed the policy because of the pressure it put on accident and emergency wards which described as 'saturated'. The health ministry has not produced any data to show whether public money was saved by the ban. Announcing the U-turn the Prime Minister explained *"it seems more sensible and reasonable that basic health care should be offered [to immigrants] at local centres so that, among other things, A&E wards are not collapsed".*[47]

4.6 Likely unintended consequences and deterrent effects

If implemented MAFC's extended charging regime would create a complex system with few non-chargeable entry points for those denied access to healthcare. As a consequence, we

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[44] *'Under the reform pushed through three years ago … illegal immigrants were banned from the public health service unless they paid into a special insurance scheme. The only exceptions were pregnant mothers, children and access to A&E in emergency cases. It is estimated that over 800,000 migrants had their health cards removed while the government reported that only 500 people had signed up to the special insurance policy.'* Spain to allow illegal immigrants to access free public healthcare, James Badcock, The Telegraph, 1st April 2015. Visit: http://www.telegraph.co.uk/news/worldnews/europe/spain/11509227/Spain-to-allow-illegal-immigrants-to-access-free-public-healthcare.html

[45] [1] 3 J. A. Pérez-Molina and F. Pulidob,"¿Cómo está afectando la aplicación del nuevo marco legal sanitario a la asistencia de los inmigrantes infectados por el VIH en situación irregular en Espana?", Elsevier, 2014, http://apps.elsevier.es/watermark/ctl_servlet?_f=10&pident_articulo=0&pident_usuario=0&pcontactid=&pident_revista=28&ty=0&accion=L&origen=zonadelectura&web=www.elsevier.es&lan=es&fichero=S0213-005X(14)00362-0.pdf&eop=1&early=si

[46] *'Catalonia and the Basque Country … created their own regulatory framework permitting illegal immigrants to access free health care, while other regions largely ignored the ban.'* Spain to allow illegal immigrants to access free public healthcare, James Badcock, The Telegraph, 1st April 2015. Visit: http://www.telegraph.co.uk/news/worldnews/europe/spain/11509227/Spain-to-allow-illegal-immigrants-to-access-free-public-healthcare.html

[47] Spain to allow illegal immigrants to access free public healthcare, J. Badcock, The Telegraph, 1st April 2015.

would anticipate significant pressures on the few remaining points of free access. We would anticipate the MAFC's implementation would generate increased pressures on free GP and nurse consultations and free non-NHS funded healthcare provided by charities, social enterprises and religious groups. With respect to GPs surgeries, this is likely to be particularly problematic given the unprecedented pressures on this service and the fact that nationally the number of GPs is substantially below that needed.[48] Migrants are more likely to live in areas of high deprivation and GP, and other health, services tend to be chronically overstretched and Inclusive Practice suggests that some of the most vulnerable experience practical barriers to registering with GPs (appendix 1, 8.1). GP surgeries may be overwhelmed and new bottlenecks created, if: significant numbers of new patients seek to register who cannot pay for prescriptions, diagnostic tests or treatment; and/or registered patients increase their demand for free consultations but effectively cannot be referred on because they cannot pay. The shared concerns, of the Foundation, partners and other members of the Entitlement Working Group, are that the overall impact of implementing MAFC's proposals would have a series of unintended deterrent effects and consequences. These unintended deterrents and consequences, summarised below, present serious dangers to individuals, local communities, public health priorities and our wider society.

a) Individuals may not receive immediately necessary or urgent treatment thereby jeopardising their health, well-being and possibly their lives.
b) Screening, early, diagnosis, intervention, referrals and treatment are critical components of public health programmes and strategies such as the TB strategy. If immunisation levels fall, 'herd immunity', '*which occurs when the vaccination of a significant portion of a population (or herd) provides a measure of protection for individuals who have not developed immunity'*, may be undermined. [49] The communicable disease exemptions are important but many people from vulnerable and BMER groups access immunisation programmes through GPs and the types of services described in Inclusive Practice. MAFC's unintended deterrent effects, see part A: 4.4, are likely to reduce levels of participation in immunisation and other public health programmes. Such reduced participation levels would impact adversely on individuals, their local communities and would be likely to lead to greater medium and longer term costs for the NHS.

[48] *'GPs and practices are under unprecedented pressure. There are about 340 million consultations annually in general practice in England, an increase of 40 million per year from five years ago. This represents the single greatest rise in volume of care within any sector of the NHS. The increase has not been matched by an increase in GP numbers and staff, nor by an expansion in infrastructure, against a background of falling resource. There is now a large and increasing gulf between the workload demands on practices and their capacity to deliver essential services to their registered patients.'* Quality first: Managing workload to deliver safe patient care, BMA, January 2015. Visit: http://www.bma.org.uk/support-at-work/gp-practices/quality-first

[49] Herd immunity *'arises when a high percentage of the population is protected through vaccination against a virus or bacteria, making it difficult for a disease to spread because there are so few susceptible people left to infect. This can effectively stop the spread of disease in the community. It is particularly crucial for protecting people who cannot be vaccinated. These include children who are too young to be vaccinated, people with immune system problems, and those who are too ill to receive vaccines (such as some cancer patients).'* Vaccines today, 9/2/15. Visit: http://www.vaccinestoday.eu/vaccines/what-is-herd-immunity/

c) The threat of charging may deter chargeable individuals from seeking prompt medical attention. Even if patients do seek prompt medical attention, the costs – of diagnostic tests, prescriptions or medication, specialist assessments or treatment – may deter them from continuing or necessary follow up medical interventions.
d) For those denied access to healthcare or deterred from accessing medical attention because they cannot pay, dangers include accessing unregulated, potentially ineffective dangerous medications, herbal remedies or other products under the counter, over the Internet or from countries of origin. Medication of such uncertain origins may be counterfeit, have deteriorated and/or may be unfit for human consumption. Antibiotics sourced in this way, may increase antibiotic resistance in individuals and communities.
e) Individuals may be deterred from accessing healthcare because they would have to disclose sensitive, personal and painful information about domestic violence, FGM, human trafficking, sexual violence or torture etc. With the co-operation and support of relevant specialist agencies, outreach services, some of these hurdles may be overcome. However, if such provision is caught up in the charging regime, it is likely that many fewer exempt individuals will be identified and supported.
f) Without early diagnosis, prompt and effective medical intervention and treatment, patients will often deteriorate; some conditions may become more complex, and expensive, to treat. Where delays also result in stress, that stress may exacerbate the underlying health conditions and undermine the mental health of patients.
g) If timely and effective mental health interventions are not made, those with poor mental health are likely to be at greater risk of: being detained/sectioned; the revolving door of detention, breakdown in the community and detention; self-harm; and even harming someone else. Mental health services must remain outside of the extended charging regime together with associated diagnostic services, prescriptions and support.
h) GP surgeries may face increased demands for their services but be unable to address these demands or provide patients with a high level, quality and professional service because patients are unable to pay and GPs and nurses cannot undertake free diagnostic tests or make appropriate referrals.
i) Important outreach and community based services may be destroyed, if these services provided by charitable and voluntary organisations, social enterprises and others are required to operate the charging regime. This would deny access to healthcare for failed asylum seekers, undocumented migrants and members of settled BMER communities mistakenly denied access to statutory NHS services.

The Foundation and partners have drawn on our experience, relevant literature and evidence available to us. We contend that the Department of Health must undertake the evaluative work promised (see part A: 5 and appendix 2) and the additional work documented in this submission before implementing any extension of the charging regime.

5. The significance of the missing DH evaluations and reviews

5.1 The need for evidence based policy development

Successful policy development and implementation should be informed by the effective evaluation of a project; this is especially true for a project designed to be implemented in phases.

5.2 Missing evaluations, research and assessments and MAFC

Six key evaluations or reviews should have been undertaken before the publication of proposals to extend or not extend charging into primary and secondary care (see appendix 2). Of these evaluations, as far as we are aware, only the Major Projects Authority Review (MPAR) has been produced. However, the MPAR has not been published nor has it been the subject of open discussion with stakeholders; the MPAR's ability to contribute to effective scrutiny of this programme has therefore been limited.

Of the other five reviews or evaluations, as far as we are aware, only the Vulnerable Groups Review (VGR) has commenced (see appendix 2). Unfortunately, the timing of the VGR is problematic because, as at the end of February 2016, only the initial scoping work had been commenced and no terms of reference had been provided to stakeholders. Unfortunately, fundamental questions about whether the review will be an Equalities and Vulnerable Groups Review are as yet unanswered. Although we accept that the Department is committed to considering the results of the review, nevertheless it is unclear: a) whether and if so how equalities issues and concerns about racial profiling will be addressed; b) how the review will inform the 'Making a fair contribution' consultation process or proposals; c) when stakeholders will have an opportunity to see, explore the outcome of the full review; and discuss the implications for the MAFC consultation proposals or revised proposals with the Department.

5.3 The importance of clear terms of reference

Furthermore, without the terms of reference for the reviews or the publication of the evaluation reports/reviews and cost benefit analyses, it is impossible to tell whether concerns about equalities or other adverse impacts on vulnerable groups will be addressed. The absence of the promised cost benefit analyses is particularly problematic because we cannot tell how different groups – for example the most financially and socially vulnerable including failed asylum seekers, undocumented migrants, disabled people and different black and minority ethnic (BME) communities – have been, or may be, affected. Whilst we accept that some of the reviews may have been delayed for good reasons, the evidence from these analyses, reviews and reports should have been properly evaluated and scrutinized **prior** to MAFC's launch. Crucially, this work should have informed the consultation launched in December 2015 rather than serving as a rear-guard justification for decisions already taken.

6. MAFC's four overarching principles, the proposals and Inconsistencies with the NHS Constitution and wider legal obligations

6.1 MAFC's four overarching principles do not properly address the NHS principles

The 2013 consultation asked respondents to comment on the four overarching principles; no similar invitation was made in relation to the same four principles cited in MAFC.[50] However, it is important for stakeholders to again make it clear that MAFC's four principles do not adequately address the NHS's guiding principles or values or important legal obligations. It is a matter of equal concern that similar flaws run through the consultation proposals. [51]

Box f: MAFC's four overarching principles

- A system that ensures access for all in need – everybody needs access to immediately necessary treatment irrespective of their means or status. In particular, no person should be denied timely treatment necessary to prevent risks to their life or permanent health
- A system where everybody makes a fair contribution to the NHS – the NHS is under increasing pressure and it is right that in the future everyone who benefits from its services makes a fair contribution to ensure it is sustainable.
- A system that is workable and efficient – any new rules and systems must enable the NHS to recover charges and to use its public funds appropriately. In doing so, it must not compromise the efficient, cost-effective and safe delivery of quality healthcare or place undue burdens on staff. The role of NHS staff should not extend to immigration control, and clinicians should not be diverted from treating patients.
- A system that does not increase inequalities – the Secretary of State has a duty to have due regard to the need to reduce inequalities relating to the health service. In developing these proposals we shall ensure the needs and interests of vulnerable or disadvantaged patients are protected.

Source: Making a Fair Contribution, para 2.1, page 11.

6.2 MAFC, reducing accessibly and likely harm

MAFC's four principles and the consultation proposals inadequately address NHS principle 1, the commitment to provide a comprehensive service, available to all and NHS principle 2, access to NHS services based on clinical need, not an individual's ability to pay. If MAFC's charging regime is implemented, NHS services will not be available to all and the charging regime may have the unintended consequence of encouraging indirect discrimination and racial profiling. Furthermore, services deemed to be non-urgent will be denied to very

[50] Making a fair contribution, para. 2.1, page 11

[51] We note that a number of stakeholders raised this issue in 2013 when commenting on the same four principles in 'Sustaining services, ensuring fairness'. Both the Discrimination Law Association (DLA) and the Immigration Law Practitioners Associations (IPLA) identified that the four principles did not properly reflect the NHS Constitution's principles or values or relevant legal obligations.

vulnerable people who are unable to pay. Clinicians have said that it is not always easy to diagnose whether immediately necessary or urgent treatment is required. In the *'normal system'* if the need for urgent or immediately necessary treatment is misdiagnosed, then an ill person could reasonably be expected to seek medical assistance again in time to prevent serious harm or death. However, under MAFC many people would effectively be locked out of the services that could act as a safety net. If Walk-in services, third party providers, outreach and A&E were all chargeable, as proposed under MAFC, it is entire foreseeable that the new regime will result in serious harm, death and associated ligation.

6.3 Complexity, inefficiencies and MAFC

Contrary to MAFC principles 3 and 4, the system – especially for undocumented migrants, those whose immigration status is subject to change and others from BMER communities wrongly asked to prove their entitlement to health services – is likely to be unworkable and inefficient. The regime is also likely to result in failures to collect debts from those who are destitute or simply too poor to pay. If MAFC were to be implemented, people are likely to be excluded from accessing NHS Services by: a) the complex exemption regime; b) the deterrent effects associated with the charging regime; c) the complex nature of the immigration regime and uncertainties about who is exempt; d) errors made about exemptions; and e) charging mistakes. Whilst MAFC's core principle sets out clear commitments to a system that is efficient and does not increase complexity, health inequalities or discrimination, the Foundation and our partners are clear that MAFC's proposals will be inefficient and will increase health inequalities and discrimination whilst also undermining the protection currently afforded to vulnerable and disadvantaged patients (see A: 4, A: 5, A: 7, A: 8 & A: 9).

6.4 Undermining a patient centred approach, NHS values, quality provision and standards

MAFC's four principles and the consultation proposals inadequately address NHS principle 4, a patient centred approach. The proposed regime is likely to result in treatment that is the opposite of patient centred and patients caught up in the charging regime who cannot pay are likely to be experience services which inadequately address the core NHS values in relation to working together for patients, respect and dignity, quality of care, compassion, improving lives and everyone counts. MAFC's four principles and the consultation proposals inadequately address NHS principles 3 and 5, namely securing the highest standards of excellence and professionalism and working across organisational boundaries with partners to *'provide and deliver improvements in health and wellbeing'*. If the consultation proposals are implemented, instead of focusing on standards and improvements in wellbeing, significant organisational and administrative efforts, time and costs will instead have to be devoted to making the complex charging regime work.

7. The Health and Social Care Act 2012

7.1 The relevance of duties to reduce health inequalities and inequalities in access

The Health and Social Care Act 2012 places a range of legal obligations on NHS partners; key obligations, in relation to reducing health inequalities and inequalities of access to the health service, set out below

a. Duty as to reducing inequalities*: 'In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.*' H&SCA 2012, s. 4.
b. The Secretary of State, the NHS Commissioning Board and Clinical Commissioning Groups (CCGs) must include in their annual reports an assessment of how effectively they have discharged their duties as to reducing inequalities.
c. The NHS Commissioning Board *'must, in the exercise of its functions, have regard to the need to'*: a) *'reduce inequalities with respect to their ability to access health services;* and *b) 'reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services'* (H&SC Act 2012, s.23, 13G).
d. *'Each clinical commissioning group must, in the exercise of its functions, have regard to the need to— (a) reduce inequalities between patients with respect to their ability to access health services, and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.'* H&SCA 2012, s. 26 (14T)
e. Relevant inequalities, '*means inequalities between the persons for whose benefit relevant services are at any time provided with respect to— (a) their ability to access the services, or (b) the outcomes achieved for them by their provision.'* H&SCA 2012, s.27 (8)
f. Health inequalities *'means the inequalities between persons with respect to the outcomes achieved for them by the provision of services that are provided as part of the health service.'* H&SCA 2012, s. 175 (9)

7.2 A failure to address the consequences of MAFC for these duties

Implementing the MAFC proposals will damage programmes to improve health inequalities and address the needs of the most excluded. The Department of Health has not given serious consideration to how to alleviate the adverse impacts – on health inequalities and inequalities in access to healthcare – documented throughout this submission and by the Department of Health's wider work on health exclusion. The Foundation and partners contend that these deficiencies must be rectified **before** any further extension of the charging regime. The promised reviews, evaluative work and analyses must be undertaken, the exemption regime must be extended and a number of key areas must also be exempted from any extended charging regime (see A: 5, A: 10 & appendix 2).

8: The Equality Act 2010, the Public Sector Equality Duty and adverse impacts

8.1 Protected characteristics and MAFC

The Equality Act 2010 identifies eight protected characteristics for the purposes of service-delivery – age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Foundation and partners have identified a range of adverse impacts in relation to disability, pregnancy and maternity, race and sex. The Department of Health's Guidance states that if individuals are not already known to be ordinarily resident in the UK, they should be asked a standard set of questions. Chapters 3, 4 and 5, of the updated guidance on the charging regulations, outline who is ordinarily resident and who should be exempt.[52] As we have made clear in this submission, we are concerned about whether this guidance is sufficient and whether individuals are being racially profiled when hospital records do not show that they are ordinarily resident in the UK. Experience suggests that busy hospitals and NHS providers dealing with long queues of people, often the norm in the NHS, are unlikely to ask everyone a standard set of questions when their residence status is unclear. Instead, we are concerned that it is more likely that those who are from visible minorities, identified by their ethnicity, colour, accent or inability to speak English, will be targeted. We accept that the guidance is clear that this racial profiling should not happen and would amount to discrimination. Unfortunately, 50 years after the first Race Relations Act, it should be obvious that whilst telling people not to discriminate is important, it is insufficient to prevent racial discrimination. We are equally concerned that particular groups of disabled people – those living with mental health issues, the learning disabled and others with cognitive issues – may face particular challenges negotiating this complex system. If suitable remedial actions are not taken, then not only may the rights of individuals under the Equality Act 2010 be breached but the regime created may be non- compliant with, and or breach, the Public Sector Equality Duty.

We remain concerned that these new requirements to prove eligibility for healthcare will lead to racial profiling and impact disproportionately on BMER communities, whether or not individuals are: a) recent migrants; b) undocumented migrants; or c) members of long established communities. Women, people with long-term health issues, those with poor literacy and communication skills and vulnerable people within our communities may also be adversely affected by changes. The Foundation and partners contend that the numerous adverse equalities impacts, identified throughout this submission, show that that the Department of Health has paid insufficient regard to the elimination of unlawful discrimination and the need to advance equality of opportunity. Furthermore, there has been a failure to give proper consideration to whether the charging policy will result in indirect discrimination.

[52] Not already known, means that the hospital records, in particular the Spine on the records, available to those dealing with the patient do not show that the individual is ordinarily resident.

8.2 The Department of Health believes that it is compliant

The consultation document suggests that equalities concerns have been addressed by: the decision to retain free access to GP (and nurse) consultations for all; by its overarching principles; the Guidance on the revised Charging Regulations; and the statutory exemptions (MAFC, page 6). However, the Department of Health's assessment is deficient because:

a) free access to GP and nurse consultations will still leave many patients without the healthcare that they need (see parts A: 2 and A:3);
b) MAFC's overarching principles fail to incorporate key equalities and other domestic and international legal obligations, in that they inadequately address:
    a. the anti-discrimination requirements of the Equality Act 2010;
    b. the requirements of the Public Sector Equality Duty;
    c. the Health and Social Care Act's requirements in relation to reducing health inequalities and inequalities in access to healthcare;
    d. human rights obligations and wider obligations;
c) the Guidance on the regime is welcome but it is not a substitute for the various reviews and evaluations, including equalities and costs benefit analyses that are needed to provide evidence on how the regime is working in practice.

8.3 The Equality Act and the Public Sector Equality Duty

Section 149 of the Equality 2010, the Public Sector Equality Duty, requires public bodies to give due regard to the need to eliminate unlawful racial discrimination, advance equality of opportunity and foster good relations.[53] MAFC only make one reference to the Public Sector Equality Duty which asserts that the Duty has been taken into account. We argue that this submission presents significant evidence that due regard has not been given to this Duty. Our submission explains why the regime is likely to encourage indirect discrimination and adversely impact on BMER communities. The MAFC regime presents serious challenges in terms of compliance with the general Public Sector Equality Duty. The actions proposed thus far by the Department of Health are insufficient and will not prevent racial profiling. Given the extent of the adverse impacts identified, the Foundation and partners call on the Department of Health to publish comprehensive analyses, the reviews promised and consider the actions set out in part A: 10 of this submission (see appendix 2). We also call on the Department of Health, pursuant to its statutory duties and obligations – under the Public Sector Equality Duty, the Human Rights Act 1998 and the Health and Social Care Act 2012 – to amend the proposals in MAFC and change the proposed charging regime itself.

[53] Section 149 (1), the Public sector equality duty 1) A public authority must, in the exercise of its functions, have due regard to the need to— (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

9. The Human Rights Act 1998, the UN Convention on the Rights of the Child and other international obligations

9.1 The Human Rights Act 1998

The Human Rights Act 1998 (HRA) gives further effect to rights and freedoms guaranteed under the European Convention on Human Rights (ECHR). It does so in a number of ways. First, the HRA requires the Government to issue a statement for all new Bills introduced in parliament setting out whether its proposals are compatible with the human rights protected by the HRA (section 19, HRA). We note with concern the lack of reference to human rights throughout MAFC, and would encourage the Government to make clear its assessment of the human rights implications of the plans and proposals related to MAFC as soon as possible.

Second, the HRA requires all public authorities to act compatibly with the human rights protected by the HRA (section 6, HRA). This duty very clearly falls on those providing NHS services. Given the wide range of issues raised in this submission, we would argue that a number of human rights are engaged. These include:

a. the right to life (Article 2), which would be engaged by a failure to provide life-saving treatment; [54]
b. the right to be free from inhuman and degrading treatment (Article 3) which could be engaged for example by the denial of treatment which leaves someone experiencing extreme physical or mental harm or suffering (irrespective of whether that was the intention); [55]
c. the right to respect for private and family life (Article 8) could be engaged where there issues of physical and psychological well-being. [56]

Each of these rights places a positive obligation on public authorities, such as NHS services, to take reasonable steps when a known person is at immediate risk of having this right breached. Any proposals around charging for NHS services would need to make clear that,

[54] Article 2: Right to life, (1) Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. (2) Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection. Article 14, Prohibition of discrimination

[55] Article 3, Prohibition of torture. No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

[56] Article 8 (1) Everyone has the right to respect for his private and family life, his home and his correspondence. Article (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

where a risk to human rights exists, professionals are able to take action to prevent a breach. In particular, the proposals should make clear that in healthcare settings both Articles 2 and 3 are absolute rights, and there can be no justification for breaching these rights. Whilst Article 8 is a right which can be restricted, including for immigration and economic reasons, such restrictions must be proportionate. The Government must therefore demonstrate that the proposals are the least restrictive in the circumstances. Finally, the HRA also includes protection for the right not to be discriminated against in relation to the other human rights it protects (Article 14), unless the discrimination can be reasonably and objectively justified.[57] This includes protection against discrimination based on nationality, age, gender and "any other status". As such, it can include discrimination which may be for more than one reason. Given the issues raised by MAFC, in particular the impact on children with various immigration statuses, we believe the Government must demonstrate that any proposals will not breach Article 14, in conjunction with Articles, 2, 3 and/or 8.

9.2 Children and the UN Convention on the Rights of the Child

We share the concerns expressed by the Children's Society in their response to the 2013 consultation on charging.[58] The concerns then expressed are equally applicable to MAFC's proposals. The Foundation and partners agree with the Children's Society that '*all children, young people and families should be able to access free primary and secondary health care regardless of their immigration status.'* We believe that MAFC's proposals would breach of the UN Convention on the Rights of the Child (UNCRC) which state that every child, without discrimination, has a right to the highest standard of health and medical care attainable. We also agree with the Children's Society that:

a) irregular migrant children and young people should be recognised as a particularly vulnerable group, already at risk of destitution, exploitation and social exclusion, and their rights should not be breached for the purpose of immigration control;
b) charging for primary healthcare for parents and children will create a barrier to promoting the health and well-being of children and also presents a public health risk;
c) obstacles to accessing primary care can have knock on effects on emergency services in terms of increased attendance and could also reduce the use of preventative treatments such as immunisations which would create increased costs for the NHS;
d) the lack of free access to primary care services will affect the ability of healthcare professionals to identify factors which raise child protection concerns.

[57] Article 14, Prohibition of discrimination. The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.
[58] Response from the Children's Society to the 2013 consultation, Sustaining services, ensuring fairness.

9.3 Compliance with other international obligations

In terms of the UK's international obligations, we believe that the proposed regime would undermine compliance with key provisions set out in the European Race Directive and the UN Convention on the Elimination of All Forms of Racial Discrimination (CERD). [59]

We note that the European Race Directive applies to social protection, including social security and healthcare and access to and the supply of goods and services available to the public. Whilst Article 3 provides for different treatment based on nationality and residence, it does not allow the type of racial profiling or indirect race discrimination about which the Foundation and Partners have raised concerns.[60] We also note the UN Convention on the Elimination of All Forms of Racial Discrimination requires States Parties to *'undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law'* and that these rights extend to the *'right to public health, medical care, social security and social services'* (Article 5, e (iv).[61] The Foundation and Partners have been unable to identify that the Department of Health has given due consideration to these wider legal obligation.

9.4 Action to comply with human rights and international obligations

Given the adverse impacts identified in this submission, including the possibility of denial of treatment resulting in serious harm or death, the Foundation and partners contend that the Department of Health has given insufficient consideration to whether the MAFC proposals should be amended to comply with the Human Rights Act, and in particular:

a) the impact of proposals on the ability of public authorities, within the NHS, to comply with their duty under section 6(1) of the Human Rights Act 1998);
b) consideration of the compatibility of proposals with the right to life, the right to be free from inhuman and degrading treatment and the right to respect for private and family life, and the associated non-discrimination provision; and
c) the impact of proposals on the ability of health practitioners within the NHS to fulfil the operational positive obligation to protect human rights, particularly the right to life and to be free from inhuman and degrading treatment.

The Foundation and partners also contend that action is needed to comply with the UN Convention on the Rights of Child, exempting children from the charging regime is crucial. Consideration must also be given to whether changes can be made to the regime to address the European Race Directive, CERD and other international obligations.

[59] Directive 2000/43/EC – or the Race Equality Directive – prohibits discrimination on grounds of race and ethnic origin.
[60] Council Directive 2000/43/EC
[61] Visit: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx

10. Action that should be taken by the Department of Health

10.1 The need for the Department of Health to address these concerns

We contend that the Department must address the concerns and issues in relation to the existing charging regime **before** extending said regime in the manner proposed in MAFC. Key activities include undertaking the promised research and evaluations (see appendix 2) and taking steps to ensure that the existing charging regime works effectively, efficiently and in accordance with relevant NHS principles and values.[62] The existing regime must also work in accordance with relevant equalities, human rights and other legal obligations, ethical principles and good practice in relation to public health and reducing health inequalities.

Given the fundamental issues raised in this response, other responses to MAFC, the previous responses to 'Sustaining services, ensuring effectiveness', the Foundation and partners contend that there is a compelling case for not extending charging regime at all given the current available evidence. Should the Department of Health decide to implement any of the MAFC proposals, despite compelling evidence to the contrary, the Foundation and partners argue that:

a) any revised proposals must properly address key principles, explored in part A: 6 of this submission and the legal issues and obligations explored in parts A: 7 to A: 9 of this submission;
b) before any national roll-out of an extended charging regime, a comprehensive cost benefit analysis, and/or a series of linked cost benefit analysis must be undertaken and relevant feasibility studies must be undertaken;
c) certain areas/activities should be excluded from the charging regime;
d) the exemption regime must be augmented to better protect those most vulnerable to, and of risk of, health exclusion and health inequalities;
e) if the decision is taken to implement any changes, the implementation programme must include actions to ensure that the charging regime genuinely operates consistently with the MAFC's principles, the NHS's principles and values and relevant legal obligations.[63]

10.2 The need for cost benefit analyses and feasibility assessments

We are concerned that the Department of Health appears to approaching the introduction of the charging regime with little understanding of the issues involved or likely consequences. Furthermore, even though financial targets dominate the agenda, little hard evidence has been provided in the consultation document, the Impact Assessment or elsewhere to demonstrate that it even makes financial sense to develop a national charging regime which will require every organisation managing access to healthcare to: a) extend

[62] See D2 and appendix 1.
[63] See part A: 6 of this submission.

and/or develop new or administrative systems to operate charging and debt recovery; b) train all relevant clinicians, operational and administrative staff; c) make patients aware of the regime and establish complaints procedures; d) monitor the operation of the system; deal with any litigation occasioned by the new regime. The submissions made in 2013, in response to 'Sustaining services, ensuring fairness', by a range of organisations questioned the financial cost effectiveness of the regime proposed at that time; the viability of the proposals and whether the financial costs would exceed the financial gains. Similar questions arise in relation to MAFC's proposals.[64]

In 2014, a House of Commons' briefing paper noted that a detailed government review, published in 2013, had questioned the costs effectiveness of extending the charging regime across the NHS. [65]

Box g: Questions about cost effectiveness identified by government research

Although there may be good policy reasons, and potentially significant income opportunities in extending the scope of charging, the NHS is not currently set up structurally, operationally or culturally to identifying a small subset of patients and charging them for their NHS treatment. Only a fundamentally different system and supporting processes would enable significant new revenue to be realized.

Source: House of Commons Standard Note: SN/SP/3051, Version updated:28 October 2014[66]

In light of this research, and previous questions posed, about the cost effectiveness of the proposals, the Department of Health must be able to answer a number of key questions, including those set out below, **before** giving the green light to an extended charging regime.

a) Is it possible to identify parts of the NHS regime where the returns from charging significantly exceed the administrative costs?
b) For example, now that changes have been made to the EHIC regime and the health surcharge has been introduced, how effectively are these systems working? How much is being collected, what percentage of what should be collected is being collected? Are the administrative arrangements in relation to these parts of the charging regime working as efficiently as they can?
c) Would changes or investment in administrative systems, resources relation to EHIC or the health surcharge offer significant financial returns? If so what could be done?

[64] Department of Health consultation Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England, July 2013. Response from the Immigration Law Practitioners Association, pages 7, 19. The Discrimination Law Association's submission, page 3, page 13, extra costs of proposals Visit: https://www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs Visit: http://www.ilpa.org.uk/resources.php/20831/ilpa-response-to-the-department-of-health-consultation-sustaining-services-ensuring-fairness-a-consu Visit:

[65] DH, 2012 Review of overseas visitors charging policy: Summary report, April 2012 (published July 2013),

[66] Original paper cited. DH, Sustaining services, ensuring fairness: Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment, July 2013

d) What data is available on the groups targeted for charging? Is it possible to identify the appropriate classes for disaggregation? Does the Department of Health and the data on the financial costs and the financial returns from groups targeted for charging? For example, is the data on the finances generated from EHIC users and the costs associated with administering that part of the system available? Is equivalent data available in relation to those subject to the health surcharge? Is the equivalent data available in relation to those groups vulnerable groups identified in parts 2, 3 and 4 of this report? We note commitment were made to produce a range of data (see appendix 2: 4, 2: 5 and 2: 6).
e) Is it possible to disaggregate the data to say what is happening to groups with protections under the Equality Act 2010 and the Human Rights Act 1998?
f) What have been the costs of any litigation where treatment has subsequently been deemed to have been withheld in error and/or other successful legal challenges have been made? Are there any estimates for likely future legal challenges should charging be extended across the NHS with the attendant risks identified in this submission and others?
g) Moving into the territory of health economics, drawing on the work of leading academics and bodies in the fields of Epidemiology, Public Health and health economics,[67] for example Professor Sir Michael Marmot, the National Inclusion Health Board, what can be said about the short-term, medium term and long-term costs for individuals, particular groups, communities, society and the NHS?

10.3 Services/activities that should definitely not be chargeable

Should the Department of Health decide to implement any of the proposals contained in MAFC, we would argue that the proposed charging regime should not be extended to Accident and Emergency Services, Ambulance Services, diagnostic tests, prescriptions, NHS funded community care provided by third party agencies or NHS funded continuing care. The rationale for excluding each of the areas is covered in our responses to the relevant consultation questions and in our comments on the Impact Assessment published alongside MAFC.[68]

10.4 Our proposed amended exemptions

We advocate the amendments to the wording of, and/or coverage provided by, a number of existing exemptions, these are set out below.

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[67] '*Health Economics is an applied field of study that allows for the systematic and rigorous examination of the problems faced in promoting health for all. By applying economic theories of consumer, producer and social choice, health economics aims to understand the behavior of individuals, health care providers, public and private organizations, and governments in decision-making.'* John Hopkins University

[68] See: Accident and Emergency Services (MAFC questions 15-18); Ambulance Services (MAFC questions 19 – 21); diagnostic tests (MAFC questions 7/8); prescriptions (see MAFC questions 13/14); NHS funded community care provided by third party agencies (MAFC questions 26 –29) or NHS funded continuing care (MAFC questions 30/31)

a) Refused asylum seekers not otherwise exempted should be exempted. Regulation 15 a – d would need to be amended. We believe that relevant regulations applicable in Scotland, Northern Ireland and Wales may provide suitable models.
b) All children should be exempted, in addition to children looked after by an LA and those children exempted by virtue of other exemptions [Regulation 15 e).
c) Regulation 9(f) should be amended. This regulation provides for the exemption of services *'provided for the treatment of a condition caused by— (i) torture; (ii) female genital mutilation; (iii) domestic violence; or (iv) sexual violence, provided that the overseas visitor has not travelled to the United Kingdom for the purpose of seeking that treatment.'* We would argue for the removal of the need for a causal link between the treatment required and the causal link condition. We believe that those who experience such violence are vulnerable and in line with the NHS principles and values should be able to secure medical treatment without charge. The amended exemption would be for individuals who need treatment who have suffered (i) torture; (ii) female genital mutilation; (iii) domestic violence; or (iv) sexual violence, provided that the overseas visitor has not travelled to the United Kingdom for the purpose of seeking that treatment.
d) Victims of hate and or violent crime should be added to the amended exemption above or a new exemption should be created.

10.5 Our proposals for new exemptions

The Foundation, and, partners, would also advocate the creation of a number of additional exemptions set out below.

a) Diagnosis, prescriptions and treatment of long term medical conditions should be exempted where there is a clear public health argument for early intervention and where treatment would eventually have to be provided as urgent or immediately necessary. This recognises that in many cases by the time treatment would have to be provided, as urgent or immediately necessary, the damage to the individual would or could be extensive, the treatment costs would be also extensive and the individual would be unlikely to be able to pay. In such circumstance, both the individual and State would lose out. Long-term health conditions would include Diabetes, Glaucoma, Sickle Cell, Stoke and Stroke prevention and Thalassemia.
b) Pregnant women should be exempted.
c) Drug and Alcohol services and service-users.
d) Mental health services and mental health service-users should be exempted.
e) Families supported by LAs under section 17 should be exempted.

Appendix 1:Extracts from Inclusive Practice's Executive Summary and Recommendations

4. Findings for Vulnerable Migrants[69]

4.1 Policy on access to primary and secondary care

- There is no required minimum period of stay in the UK before a person - including asylum seekers, refugees, and failed asylum seekers - can be registered with a GP. GPs can only decline such people if their list is closed or on non-discriminatory grounds.
- GPs have a duty to provide emergency treatment free of charge regardless of migrants' residential or registration status.
- Charging regulations in secondary care have frequently changed. Since May 2012 a person granted asylum, temporary or humanitarian protection under immigration rules is exempt from NHS charges and should be recognised as a refugee.
- Those seeking asylum, where the outcome is not known, are also exempt from secondary care charges.
- Failed asylum seekers are generally liable for NHS hospital treatment charges, although there are exemptions for those continuing to be supported by the Border Agency.
- Since October 2012 diagnosis and treatment for HIV/AIDS is now free to all overseas visitors.
- On 3 July 2013 a further open consultation was launched on migrant access to the NHS, which includes plans to end free access to primary care for all visitors and tourists.

4.2 Access to Primary Care

- Studies of registration levels for refugees and asylum seekers are variable in quality and often specific to particular parts of the country only. The most robust estimates suggest that only about a third of all generic new entrants to the UK. Within this group asylum seekers were least likely to become registered (around 19%) compared with other migrants. It should be noted this evidence is based on those entering the UK from countries with a high risk of TB who underwent port health tuberculosis screening.
- Surveys focused on major urban centres such as London show much higher registration rates have been achieved, including rates in excess of 90%.
- Significant and continuing barriers to registration continue to be reported including: the unwillingness of practices to register asylum seekers; a shortfall in translation services; lack of knowledge of eligibility by practice staff; and burden of documentation required to show proof of residence.

[69] Inclusive Practice: Vulnerable Migrants, Gypsies and Travellers, People Who Are Homeless, and Sex Workers: A Review and Synthesis of Interventions/Service Models that Improve Access to Primary Care & Reduce Risk of Avoidable Admission to Hospital, Peter J Aspinall, Reader in Population Health, University of Kent, 2014. Visit: https://www.gov.uk/government/publications?keywords=NIHB&publication_filter_option=all&topics%5B%5D=all&departments%5B%5D=department-of-health&official_document_status=all&world_locations%5B%5D=all&from_date=&to_date=

Appendix 1:Extracts from Inclusive Practice's Executive Summary and Recommendations

4.3 Elements of Promising Practice in Primary care

- A number of promising, but largely unevaluated models of service have developed, mostly based within urban centres with large concentrations of refugees/asylum seekers, including
- London, Sheffield, Nottingham, Sandwell and Glasgow.
- Elements of good practice that have been identified include:
    - The incorporation of health advocates to help navigate barriers to registration can significantly increase registrations
    - The development of specialist GP practices for refugees and asylum seekers
    - In the absence of specialist practices, using contractual arrangements such as Locally Enhanced Schemes to incentivise general practice.
    - New entrant schemes to facilitate registration and assessment, including bussing of new arrivals from Induction Centres to specialist and other practices

4.4 Prevention of Avoidable Hospital Admission

- Few interventions have been identified; it is likely that avoidable attendance at A&E can be prevented by effective registration in primary care, but there are no robust evaluations to demonstrate this.
- For asylum seekers, one of the main issues for concern is whether practitioners can be trusted to interpret eligibility rules for free care correctly.
- Maternity care is a major health issue; some parts of the country have developed maternity care pathways for non-English speaking migrants but barriers to GP registration inhibit cost effective maternity care.

5. Findings: Gypsies and Travellers

5.1 Policies

The government has established a Ministerial Working Group to facilitate improving the life chances of Gypsies and Travellers. This has yet to endorse specific policies to improve access to primary care and has been criticised for not adequately engaging Gypsy / Traveller organisations in its work. Amongst other policy initiatives, the Equality and Human Rights Commission has highlighted, in the context of the Dale Farm evictions, that the right to a home is protected in Article 8 of the European Convention on Human Rights (the right to respect for private and family life, home, and correspondence).

5.2 Access to primary care

- Numerous largely geographically specific studies have reported wide variation in GP registration rates for Gypsies and Travellers, ranging from 80-100% but as low as 40%. The lowest levels were recorded in one study for those living in trailers (38%) and those who travel all year (37%).
- By contrast, in Northern Ireland, registration rates of over 90% have been reported.
- Barriers to registration include: a reluctance to fill in forms, mobile lifestyles, temporary registration status often given, and poor response to written materials due to literacy problems.

Appendix 1:Extracts from Inclusive Practice's Executive Summary and Recommendations

5.3 Elements of good practice in primary care

A number of promising services have been identified, in both rural and urban areas. Many initiatives have focused on meeting a range of key health needs of Gypsies / Travellers, including maternity and child healthcare, dental health and health promotion, and generic health awareness projects. Improving GP registration is often seen as one element of these programmes. Examples of models of promising practice include Leeds, Sheffield, Barnsley, Cambridgeshire, South East coast, and Bristol. The Pacesetters Programme, funded by the previous Government, has helped ensure that a number of initiatives have been independently evaluated. The recurring elements of good practice include:

- Gypsy / Traveller engagement in the design and delivery of the service is central to the success of any model
- Building confidence and trust through a "trusted person" and core services is essential
- Time and costs of community input should be built into budgets
- The development of hand-held records is seen as good practice, but not all the evidence supports its implementation
- A GP enhanced service model has been drawn up with detailed specifications

5.4 Elements of Good Practice in Secondary Care

There were few studies identifiable for this group. The lack of adoption of the 2011 Census ethnic category for Gypsies and Travellers in hospital episode statistics (HES) makes this task harder.

6. Findings: People who are Homeless

6.1 Policy

The Cross-government Ministerial group on Preventing and Tackling Homelessness has focused on reducing the risks of homelessness in groups such as single men and women who are outside the legislation on homelessness. It has also focused on reducing street homelessness by supporting efforts to prevent people from being discharged from hospital on to the street and to ensure that housing benefit changes do not have an adverse impact. A number of coordinated, resourced voluntary sector initiatives have reduced rough sleeping. The Localism Act has allowed local authorities more flexibility in offering rented private sector accommodation if it meets a "suitability" threshold.

6.2 Access to Primary Care and Prevention of Avoidable Hospital Admissions

As there is still no common agreed definition of homelessness across government, studies of GP registration rates may not be comparable. The most reliable audits by Homeless Link have found a registration rate of 82-85%, most with permanent registration. Registration rates with dentists are much lower at around 40%. For most single homeless people barriers to registration and receipt of effective primary care relate to their chaotic lifestyles, often worsened by drug and alcohol misuse. In addition the mobility of homeless people makes it difficult to engage with the rigid opening hours of core services. This often results in a pattern of deferring consultation until health issues become acute and can lead to frequent attendance in hospital, the so-called "revolving door" phenomenon.

Appendix 1:Extracts from Inclusive Practice's Executive Summary and Recommendations

6.3 Elements of Good Practice: Primary and Secondary Care

Numerous models of care have been developed, ranging from: no specialist/mainstream provision through to nurse-led outreach to a fully dedicated, specialist homeless service integrating both primary and secondary care. The fully integrated model includes an intermediate "step-down" facility that is currently being piloted in London and will be evaluated. There are also a number of mobile clinics that provide services to homeless people and others such as sex workers. Surveys indicate that about one third of former Primary Care Trusts do not provide any specialist homeless services, a quarter provide outreach, and 10% provide temporary registration. This finding does not in itself define good practice as cost-effective practice models will be related to the size of population served. Most of the models across the range have not been evaluated. Notable exceptions are the city- wide Integrated Services for Homeless People in Boston, USA and the London Healthcare Pathway for Homeless People in London. The Boston service is a mix of primary, outreach, intermediate and hospital care: its notable achievements include medical respite care that bridges the widening gap between hospitals and shelters, an electronic medical record system that coordinates care and monitors quality measures across two hospitals and 80-plus shelter and street clinics, multidisciplinary teams that integrate medical and behavioural care and ensure continuity of care, the inclusion of the homeless in the programme's governance and design of services, and consistent provision of preventive services.

The London Healthcare Pathway involves a fully funded discharge planning team with primary care leadership, hostel involvement, and a health care navigator with experience of homelessness. This is one of the very few evaluations identified in the review that has demonstrated both a reduction in use of in-patient care and an increase in cost-effectiveness. It is now being adopted by several other trusts serving urban populations. There are a number of intermediate care services based within or separately from homeless hostels. The need is based on the assumption that many homeless people have chronic conditions that require continuing care and rehabilitation that does not require the full services of an acute hospital. The largest, led by St Mungo's in London, has shown promising results in relation to improved health of its clients, better engagement with services, and significantly reduced use of hospital care.

Key emerging elements of good practice include:

- Multidisciplinary care across sectors
- Person-centred care
- Service user engagement and influence
- Inclusion of linked primary, hospital and respite services
- Coordinated care and effective discharge planning in hospital
- Specialist services/facilities in areas serving high concentrations of homeless people

7. Findings: Sex workers

Appendix 1:Extracts from Inclusive Practice's Executive Summary and Recommendations

7.1 National Policy

The Department of Health's sexual health framework acknowledges the need to provide specialist services to meet the significantly poorer health experience of sex workers and to address the sensitivities of sex workers to disclosure in statutory services. Both the Department of Health and the Home Office have supported initiatives to protect sex workers from violence, to prevent and arrest sex traffickers, and to facilitate the better reporting of violence to the police. Some of these initiatives have had a positive effect although a recent policy change before the Olympics that resulted in the closure of a number of brothels in the Olympic boroughs resulted in a serious fall-off in attendance of sex workers at well-established specialist sexual health clinics.

7.2 Access to primary Care

GP registration rates, mainly in major urban areas, have been reported at about 80% with GPs being the most common source of healthcare. However, there is evidence that sex workers do not often disclose their occupation to their GP and also have low uptake rates of key preventive services such as cervical screening and hepatitis B vaccination. About 80% report difficulties attending an appointment, especially those sex workers who work at night. Street sex workers, whose health is often poorest and who may have drug misuse problems, find it particularly difficult to keep appointments.

7.3 Elements of Good Practice

Some specialist services aim to improve primary care registration as part of the specialist service they offer. There are alternative models in place, such as the Transitional Primary Care Team in East London, that provide registration for those refused registration in mainstream primary care. This service is accessible to a number of vulnerable groups including sex workers. The favoured models in major urban areas are dedicated services or outreach models. There are a number of innovative but mostly unevaluated examples of these services in Edinburgh and London. One outreach service in London, Sexual Health On Call (SHOC), has been independently evaluated and has shown that with the additional use of bilingual workers and a dedicated clinic, it has been able to engage large numbers of both migrant street and off street workers, such that over half of its clientele are migrants. A further approach is the use of mobile clinics that are accessible out of hours, especially at night, though there has been little robust evaluation of such models. The use of cultural mediators and peer educators who are drawn from amongst off-street migrant sex workers has been general practice elsewhere in Europe and has shown promising results in engaging a largely invisible majority with health care.

Broader multiagency partnerships of sex workers, local authorities and health services aiming to reduce crime and violence and promote exit from sex work have also been established in some cities. One such service working with a group of sex workers in Nottingham has shown promising reductions in local crime, increased use of drug misuse services by sex workers, increased access to health screening, and an apparent fall in sexually transmitted infections.

Appendix 1:Extracts from Inclusive Practice's Executive Summary and Recommendations

Key elements of good practice have been identified as:

- Sustainable, joined up multiagency services rather than fragmented single agency approaches
- A broad range and balance of services should be offered that address both sex worker health needs and those of community safety and crime prevention.
- The UK Network of Sex Work Projects has stated that services should be non-judgemental and accept that some sex workers do not wish to exit.
- Access to specialist medical and other staff.
- Active engagement with sex workers and their networks.

7.4 Secondary Care

No specific interventions have been identified for this group that have had as their objective the reduction of avoidable hospital admissions.

8. Recommendations and Next Steps

8.1 Key National Issues

The National Inclusion Health Board endorsed the following national issues recommendations below:

- Frequent changes to eligibility for access to free secondary care for overseas visitors (including asylum seekers and failed asylum seekers) present barriers to good access for these groups and training for primary and secondary staff on eligibility issues is needed (Department of Health).
- The strong evidence that some GP practices refuse to register vulnerable populations needs to be addressed through the primary care commissioning process, and the NHS Constitution (NHS England).
- Responsibility for spreading good practice and training staff in a new, localised health system needs to be clarified (NHS England & Public Health England)
- Given the almost absent information for health surveillance for the four groups, a
- surveillance strategy and supporting data needs to be drawn up/implemented
- (Public Health England)
- The lack of consistent, routine information on health service use and outcomes in the four groups reviewed hampers the development of evidence-based JSNAs, prevents effective local performance monitoring/improvement, and makes research more costly. This is reflected in the almost complete lack of secondary care studies amongst Gypsies and Travellers, asylum seekers and refugees, and sex workers (work is to be taken forward between DH, PHE and NHS England based on the earlier review "Hidden Needs"- https://www.gov.uk/government/publications/effective-health-care-for-vulnerablegroups-prevented-by-data-gaps

Appendix 2: Outstanding Department of Health evaluations and reviews	
1	**The next Major Projects Authority review of the NHS Cost Recovery Programme:** A document has been published for internal consumption by NHS partners but as far as we are aware this document been subject to public scrutiny by stakeholders.
2	**Evaluation of stages 1 -3:** An interim evaluation of stages 1-3 should have been published in April 2015 but has not been published as far as we are aware.
3	**Vulnerable groups review: I**n March/April 2014, stakeholders were informed that the *'Programme recently underwent a Major Projects Authority (MPA) review which resulted in a clear recommendation for a piece of research into the impact of the programme on vulnerable groups.'* [70]
4	**Monitoring and Evaluation commitments made in the Visitor and Migrants NHS Cost Recovery Programme IA No: DH 3130: Impact Assessment published on 14/7/14:** Currently, *'the NHS cannot provide an accurate assessment of its performance in recovering payments due from those overseas visitor patients who are chargeable for their treatment. In order to be able to monitor progress in maximising the recovery of costs incurred through the treatment of chargeable visitors and migrants who use the NHS, it will be necessary to measure, by Trust, the following metrics (for visitors and migrants): a) Invoiced income; b) Actual cash recovered; c) Bad debt – provision; & d) Written-off debt'* (para. 127, page 40). The document also stated that a full evaluation of the Cost Recovery Programme would be undertaken *'both during implementation and after the Programme are complete'* … *'the formative evaluation will take place during the next two years, while the different phases are being implemented, to learn lessons about what works in cost recovery as the evidence emerges'* (para. 128, page 40). Post implementation assessment expectations were set out.[71]
5	**Equality Analysis -Overseas Visitors Charging Regulations and Guidance:** *'The Department of Health will now conduct an equality analysis on the charging regime, including the collection of data as part of its review of charges for overseas visitors for healthcare in England.* [Source 2015 Equality analysis. Gateway reference: 16473]
6	**Equality Analysis – Immigration Sanctions for those with unpaid debts arising from the NHS (Charges to Overseas Visitors) Regulations 2011:** The Government will monitor the impact of the immigration sanctions and the sharing of information on NHS debtors by working with the NHS to understand how it may affect different groups differently. [Source: Equality Analysis – Immigration Sanctions for those with unpaid debts arising from the NHS (Charges to Overseas Visitors) Regulations 2011. Gateway reference: 17038]

[70] *'We will be looking for input and ideas from vulnerable group representatives to ensure the review is robust and representative. The Home Affairs Committee has also made it a condition of our new charging regulations that we undertake a review specifically on the impact of the programme on vulnerable children. We are now looking into whether this will form part of the MPA review (noted above) or whether it will be a standalone piece of research. Again, we will be looking for input and ideas from representatives of vulnerable groups, especially those representing children.'*[Source: Health Inequalities Workshop: 10/7/14

[71] *'The post-implementation evaluation will be undertaken to understand the extent to which the Programme's objectives have been achieved, and whether the costs and benefits are in line with expectations. Staff attitudes and stakeholder opinions about the Programme will be monitored, providing a baseline and regular updates which will feed into the evaluation.'* Source: Visitor and Migrants NHS Cost Recovery Programme IA No: DH 3130: Impact Assessment published 14/7/14, para. 128, page 40

Appendix 3: The NHS principles and values

The NHS principles [72]

1. The NHS provides a comprehensive service, available to all

It is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose and treat both physical and mental health problems with equal regard. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. Access to NHS services is based on clinical need, not an individual's ability to pay

NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. The NHS aspires to the highest standards of excellence and professionalism

It provides high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

4. The patient will be at the heart of everything the NHS does

It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. As part of this, the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces, reservists, their families and veterans are not disadvantaged in accessing health services in the area they reside. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

5. The NHS works across organisational boundaries

It works in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values reflected in the Constitution. The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing.

[72] https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Appendix 3: The NHS principles and values

6. The NHS is committed to providing best value for taxpayers' money

It is committed to providing the most effective, fair and sustainable use of finite resources. Public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. The NHS is accountable to the public, communities and patients that it serves

The NHS is a national service funded through national taxation, and it is the government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

NHS values

Working together for patients: Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.

Respect and dignity: We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest and open about our point of view and what we can and cannot do.

Commitment to quality of care: We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes.

Compassion: We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for patients, their families and carers, as well as those we work alongside. We do not wait to be asked, because we care.

Improving lives: We strive to improve health and wellbeing and people's experiences of the NHS. We cherish excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation. We recognise that all have a part to play in making ourselves, patients and our communities healthier.

Everyone counts: We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste opportunities for others.

PART B: OUR RESPONSES TO THE MAFC CONSULTATION QUESTIONS

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

Do you agree?

Strongly agree.

However whilst we agree with the proposal to extend existing exemptions across into any new chargeable areas, the Foundation believes that there should be a pause during which a proper evaluation of the current hospital charging regime should be undertaken. The rationale for this recommendation is provided by part A of this submission. The Foundation and our partners contend that the charging regime proposed in 'Making a Fair Contribution' (MAFC) and the current regime are fundamentally flawed. We have a number of recommendations about how the exemption regime could be strengthened; these are located in part A: 10 of the submission.

QUESTION 2: Do you have any views on how the proposals in this consultation should be implemented so as to avoid impact on: • people with protected characteristics as defined under the Equality Act 2010; • health inequalities; or • vulnerable groups?

Yes

- One of MAFC's central flaws is that the use of the terms overseas visitors and migrants. Use of these terms gives the impression that the charging regime applies to a homogeneous group of people. The language distances one from the reality made clear in parts A: 3, A: 4 & A: 10). In the Department of Health's earlier consultation, direct reference was made to illegal migrants. Whilst we might argue that undocumented or irregular migrants would be more acceptable to us as a term, at least the 2013 was clear about some of the different groups being referred to. We urge the Department to consider part A of our submission in full. The approach adopted by the Department to date, in addition to being fundamentally flawed, is also wrongheaded. The equalities, human rights and associated legal obligations examined in parts A: 7, A: 8 & A: 9 of this submission require the Department's substantive consideration.
- The general Impact Assessment (IA) published on 7/12/15, alongside the consultation document 'Making a Fair Contribution', correctly identifies the need to '*identify any potential for worsening access to healthcare, which may affect some groups of individuals disproportionately.'* However, no equalities analysis has yet been published

that addresses the requirements of the Public Sector Equality Duty or other provisions within the Equality Act 2010 (see part A: 8).

- It is absolutely critical that the Department of Health to produces disaggregated data and meaningful cost benefit analyses (see parts A: 3, A: 4, A: 5 & A: 10)
- We note that the IA published on 7/12/15 states that an *'Equalities Analysis will be published alongside the Government response to this consultation.'* The Department of Health also undertook to produce a series of evaluations, reviews and cost benefit and equalities analyses (see parts A: 5, A: 10 & appendix 2). These analyses must be produced and inform fundamental revisions to the charging regime proposed in MAFC.
- The proposals to extend charging should be placed on hold pending the completion and assessment of outstanding reviews, equalities analyses and cost benefit analyses have been undertaken (part A: 5, A: 10 & appendix 2).
- The four principles, set out on page 11 of MAFC, should be amended to fully address the principles and values set out in the NHS constitution and relevant legal obligations (see parts A: 6, A: 7, A: 8, A: 9 & A: 10).
- The terms of reference for the Vulnerable Groups Review (VGR), and the associated scoping work currently in hand, should take account of the work of the National Inclusion Health Board (part A: 2 & appendix 1).
- A number of area and activities should be excluded from the extended charging regime (see part A: 10).
- The exemptions should be amended and increased in order to bring all vulnerable groups within the scope of the exemption regime whilst simplifying the operation of this regime (see part A: 10).
- A proactive information and guidance programme for existing hospital trusts should be developed to ensure that they understand the current exemption regime and are able to identify exempt groups and properly operationalise the charging regime (see A:3).
- Detailed consideration should be given to the unintended consequence and unintended deterrent effects identified (see A: 4).
- Outreach services, specialist and community based services, voluntary, community, charitable organisations and social enterprises play crucial roles in relation to reducing health inequalities and helping to support and advocate on behalf vulnerable groups and individuals (see parts A: 2, A: 3 & A: 10). These crucial roles must be understood by the Department of Health Team (s) responsible for MAFC (see parts A: 2.4, A: 3.6 & A: 10).
- The proposals to bring outreach services, specialist and community based services, voluntary, community, charitable organisations and social enterprises within the scope of the charging regime must be dropped (see A: 2.4, A: 3.6 & A: 10)
- Any additional areas added to the MAFC regime should first be piloted before being rolled out nationally. The aim should be to ensure that the principles, set out on page 11 of MAFC, the wider NHS principles and values and relevant legal obligations are properly addressed.

QUESTION 3: We propose recovering costs from EEA residents visiting the UK who do not have an EHIC (or PRC).

Do you agree?

Strongly disagree

QUESTION 4: We propose recovering costs from non-EEA nationals and residents to whom health surcharge arrangements do not apply.

Do you agree?

Strongly disagree.

QUESTION 5: We have proposed that GP and nurse consultations should remain free to all on public protection grounds.

Do you agree? Yes, we welcome this provision. However, by itself the provision is limited (see parts A: 2, A: 3 & A: 4). GP and nurse consultations must be free but this is insufficient to address the requirements of the Equality Act 2010, the Human Rights Act 1998, wider international obligations or to prevent irreparable harm (see A: 3, A: 4 & A: 10)

Strongly agree

QUESTION 6: Do you have any comments on implementation of the primary medical care proposals?

Yes

We believe that the proposals would prove to be unworkable, increase health inequalities and prove to be inconsistent with relevant legal obligations. We have presented a detailed analysis of the proposals in MAFC's underpinning principles in parts A: 3, A: 4 & A: 6 of this submission.

QUESTION 7: We propose reclaiming the balance of cost of drugs and appliances provided to EEA residents who hold an EHIC (or PRC) (over and above the prescription charge paid by the patient) from the EEA country that issued the EHIC/PRC.

Do you agree?

Strongly disagree.

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

Do you agree?

Strongly disagree.

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

Yes
In addition to those matters addressed in part A of this submission, we concur with the submission made by Still Human, Still Hear in this regard. There are significant costs associated with training NHS staff to properly assess entitlement and the prescribing clinician would need to check this for every patient. This proposal would also necessitate the use of two prescription pads. As most prescriptions will be for low cost medications for managing long-term conditions or preventing a deterioration in illness, it is likely to be cost ineffective to charge for them, particularly if by doing so the individual is deterred from visiting a GP, fails to access the medication they need and then later needs urgent or immediately necessary care. Consequently, charges for NHS prescriptions should only be applied if it can be demonstrated that the proposals are cost effective and can be implemented in a non-discriminatory way. In addition, vulnerable people should be able to access prescription medication, in particular the prescription exemptions should not be removed from children; pregnant women and women who have had a child in the previous month who hold a valid exemption certificate; people with a specified medical condition who hold a valid exemption certificate; prescribed contraceptives and other listed medication; or any of the groups listed in A: 10 of this submission; or those in receipt of certain benefits (listed in Annex D).

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

Do you agree?

Strongly disagree.

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

Strongly disagree.

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

Yes

We note the response from Maternity Action in relation to the importance of oral health for pregnant women. Again our concern is the impact on the vulnerable groups who fall through the current exemption net. We are also concerned about people from BMER communities being wrongly denied dental treatment (see parts A: 2, A: 3 & A: 4). We also make the simple points that the logic of this would be that destitute individuals, the poor and others excluded from the exemption regime, would be unable to secure dental treatment. The logical consequence would be for BMER children, young people, the elderly, and the disabled to be in pain until treatment has to be provided as urgent or immediately necessary. This cannot be the way that a modern civilised society conducts business nor is it consistent with the principles and values set out in the NHS Constitution or the UK's legal obligations (see parts A: 7, A: 8 , A: 9 & appendix 3).

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

Do you agree?

Strongly disagree.

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

Yes

There is clear evidence that the incidence of Glaucoma and diabetes are higher in some UK BME communities.[73] The proposal to remove eye tests could therefore impact disproportionately on failed asylum seekers from BMER communities suffering from Glaucoma or Diabetes. Placing such individuals at risk of losing their eyesight, if they cannot afford to pay for sight tests, seems disproportionate. Diabetes is a serious disease, which if not addressed by proper medication, proper diagnoses and ongoing medical supervision /treatment can lead to serious complications including the loss of limbs, loss of eyesight and other life threatening complications. Diabetes is a classic example of a disease, which

[73] See Scholarly Articles on the incidence of Glaucoma and Diabetes

disproportionately impacts on BMER communities, where a failure to properly diagnose, manage and medicate can have long-term and adverse life changing consequences. Withholding checks that are currently free would simply be a disaster for some individuals. The proposal is short sighted and ill considered. We agree with Still Human, Still Here and note that the impact assessment, published on 7th December 2015, makes it clear that this proposal is not cost effective and would cost the NHS an estimated £32.7 million over 5 years. There are additional associated costs in relation to training NHS opticians to properly assess entitlement to these services. On costs grounds alone the ophthalmic proposals should not be taken forward. In addition, it should be noted that most free optical care is preventative and, in some cases, if not provided will have serious implications for the individuals eye and general health (e.g. failure to pick up diabetes). The fact that the Impact Assessment suggests that the policy would cost money, would also raise serious legal questions about its proportionality and raise the likelihood of legal challenge.

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

Do you agree?

Strongly disagree.

Part A of our submission provides detailed evidence that explains why we argue that the proposals presented in MAFC are fundamentally flawed and wrongheaded. We have summarised our concerns in our response to question 2 of this submission.

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

No

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

No A&E services should be chargeable (see parts A: 3, A: 4, A: 7, A: 8, A: 9 & A: 10)
QUESTION 18: Do you have any comments on implementation of the A&E proposals?

Yes

We are profoundly concerned that the MAFC proposals would prove unworkable. The concept that in an overworked A&E department that busy nurses, doctors and administrators should be focusing on anything other than clinical need is simply unacceptable. We also note that, if errors are made, there could be serious consequences for patients, staff and NHS providers (see what if example below).

Example
For example if a patient were misdiagnosed and actually had a condition that subsequently was proven to have required immediately necessary treatment but immediately necessary or urgent treatment was not in fact provided. If the patient was subsequently to be identified as having been ordinarily resident in the UK but they had been denied treatment because of a name mix up. If that patient suffered serious harm or even patient died, apart from the disastrous outcome for the patient, there would be additional consequences, including legal consequences for the hospital of NHS provider. We draw your attention to parts A: 3, A: 4 and A: 5 of this submission.

QUESTION 19: Our proposal for ambulance services is to introduce charging for all treatment delivered by NHS Ambulance Trusts. This would include any cost incurred for treatment delivered by NHS paramedics, including at the site of an accident, any use of ambulance services, and any treatment carried out outside an A&E department or equivalent.

Do you agree?

Strongly disagree.

We draw your attention to our response to question 37. We note that ambulances were deemed to be outside of the scope of the Impact Assessment published on 7th December 2015 alongside the MAFC consultation document. We therefore question their (ambulances) inclusion in this consultation.

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

Strongly disagree

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

No comment

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

Do you agree?

Strongly disagree

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

Strongly disagree

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

No

If yes, please explain.

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

Yes

If yes, please explain.

We share the views and concerns expressed by Maternity Action on this point.

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

Do you agree?

Strongly disagree.

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

Yes.

If yes, please explain.

There should be a blanket exemption for voluntary, charitable and community organisations and social enterprises (see A: 3.6 & A: 10).

The consultation document suggests fundamental changes to the current regime in proposing that NHS care should be *'chargeable to non-exempt overseas visitors wherever, and by whomever, it is provided.'* [74] These proposals, to extend charging to non NHS providers of service, present particular issues and challenges for voluntary and community organisations (VCOs), charities, social enterprises and other third party providers. Parts A: 3 & 4 of this submission demonstrate the critical roles played by these third party providers from the voluntary, charitable and community sectors and social enterprises in reaching and supporting hard to reach groups. Those who work in other parts of the NHS will know that it is unusual for the parts of the third sector, referenced in part A of the submission, to be solely funded by the NHS. Often these third party providers are not only bringing specific expertise, skills, knowledge and the ability to reach into communities but they also bring in funds. Often these funds are secured from grant making charitable trusts that either would not or could not fund the NHS directly. The proposals to make all NHS funded organisations operate the proposed charging regime:

- demonstrates a lack of understanding of the roles placed by these agencies and a lack of understanding of the services, outreach work and initiatives that would be damaged by this approach (see parts A: 2, A: 3, A: 4 & A: 10);
- impinge on the independence of these organisations, could undermine their charitable objectives and might force some organisations to withdraw from partnerships with the NHS;
- ignores the principle of partnership working set out as principle 5 of the NHS Constitution (see Appendix 3: 5);
- ignores the principles agreed between Government and the sector in the Compact. [75]

[74] MAFC consultation document, para. 11.5, page 35

[75] *'Working with government: The way the voluntary sector organisations work with government is changing. Contracting with government is increasing, consortia and partnership arrangements are on the up. As relationships develop it is increasingly important to make sure that it does so on a fair and equitable basis. This includes: a) proper notice being given for funding decisions; b) reasonable contract terms being agreed and entered into; c) the independence of voluntary sector organisations being respected and upheld. Source: NCVO.'* Visit: https://www.ncvo.org.uk/practical-support/cross-sector-working/compact-agreement

If the Department of Health wants to negotiate a different relationship with the third sector – including charitable, voluntary and community organisations and social enterprises – this consultation/MAFC is not an appropriate vehicle. The Foundation also notes that the Impact Assessment published by the Department of Health in July 2014 said*: 'This impact assessment will cover only the changes which will be implemented for Phases 1, 2 and 3 in secondary care as part of the visitor and migrant cost recovery programme.* ***The cost benefit analysis of the options around extending charging to primary and community care will be analysed in a separate impact assessment which will be published by the end of the FY14/15.'*** [76] As far as the Foundation is aware, this promised cost benefit analysis has neither been published nor has it been discussed with stakeholders. We also note that the Impact Assessment (IA) published on 7/12/15 specifically stated that: community care was outside of the scope of the Impact Assessment because there was *'insufficient data to scope policy at this time';* and that *'no data'* is available was available re NHS Continuing Healthcare and it was likely to *'have a very small effect overall.'* [77] In the circumstances, it is reasonable to conclude that the DH has not met its commitment to produce an Impact Assessment examining the possible consequences of extending charging to community care and /or third party non-statutory providers.

The Foundation believes that it is wrong in principle to impose charging obligations on non-statutory organisations when no financial case or evidence has been presented to justify such a fundamental policy change; and there has been no negotiation. For many providers, including charitable bodies and other VCOs, these proposals would present unacceptable operational challenges, serious administrative costs and barriers to service-users.

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

Yes

If, yes, please explain.

See the response to question 27. There should be a blanket exemption for third party voluntary and community sector providers and social enterprises. Perhaps more importantly, pursuing such a policy would appear ill-advised given: the absence of evidence to support this proposal; evidence of harm that the proposal would cause; the likelihood

[76] Title: Visitor and Migrants NHS Cost Recovery Programme IA No: DH 3130: July 2014 visit https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331623/Impact_assessment.pdf

[77] Impact Assessment [7/12/15]: Areas out of scope of this Impact Assessment, page 8

that significant barriers to accessing NHS services by some of the most vulnerable would be created; associated breaches of the Compact; and the possibility of legal challenges.

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

No

If yes, please explain (anonymised information only).

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

No

If yes, please explain.

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

No

If yes, please explain.

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

Do you agree?

No

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

Do you agree?

Strongly disagree.

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

Yes

If yes, please explain.

Please see part A: 10.2 of this submission.

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

Disagree.

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

No

If yes, please explain.

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

Yes

If yes, please explain.

The absence of evidence supporting the inclusion of six areas in the consultation proposals
The Impact Assessment said that six areas fell outside of its scope: a) Community Care; b) NHS Continuing Healthcare; c) Ambulance and paramedics; d) changing sponsorship rules; e) overseas visitors working on UK registered ships; f) assisted reproduction. In each case, the Impact Assessment, published alongside MAFC identified that either '*there is insufficient evidence on which to base an estimate currently'* or the area is *'likely to have a very small effect.'* In all six of these cases, MAFC includes proposals for extending charging into these areas. Confusingly, the Impact Assessment, suggested that the *'consultation process is intended to address the lack of data/or policy details so estimates of costs and benefits of these options can be developed for the final IA.'* This appears to suggest that a consultation process can be used to gather data and evidence required. However robust research should

be undertaken by the Department of Health and said research must be properly evaluated to provide required evidence. If the six areas were deemed to be outside of the IA's scope, proposals to extend charging in each of the six areas should not have been included in MAFC. The Department of Health also needs to recognise that there are real differences between a consultation process and research and evaluation activities.

The absence of equalities analyses

The Impact Assessment (IA), published on 7/12/15, states that an '*Equalities Analysis will be published alongside the Government response to this consultation'* but does not contain a proper equality analysis.[78] This IA correctly identifies the need to *'identify any potential for worsening access to healthcare, which may affect some groups of individuals disproportionately.'*[12] However the failures to produce the promised evaluations and reviews (see A: 5 & appendix 2) mean that the evidence required to assess compliance is unavailable.

Failure to properly address compliance with key principles or legal obligations

The failure of the Impact Assessment to identify or provide disaggregated equalities data on the different classes or groups, of people affected by the proposed policy changes, is exceptionally problematic. The Impact Assessment fails to identify who would be affected by the proposals and whether the proposed policy proposals are consistent with the overarching principles adopted or relevant legal obligations (see parts A: 7 – 9).

Failure to adopt an evidence-based policy approach

The approach adopted by the Department of Health is a classic example of placing the cart before the horse. Despite the Department having little or no evidence to justify the implementation of its policy proposals and despite its failure to undertake key research and evaluations, MAFC proposes the introduction of major policy changes that have significant adverse equalities, human rights and wider legislative implications (see part A of this submission). Fundamental policy changes, especially policy proposals with such far reaching implications, simply should not be introduced on the basis of little to no evidence. The Department of Health should design the robust evaluation and research programmes promised, then gather and evaluate the evidence before making proposals for fundamental change. Wanting to do something is not a justification for doing it!

[78] Impact Assessment [7/12/15]: D, Equalities and health inequalities, page 6