Department of Health

Equality Analysis

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

November 2017

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1. Introduction

Public Sector Equality Duty

The Public Sector Equality Duty is set out in section 149 of the Equality Act 2010 (available at http://www.legislation.gov.uk/ukpga/2010/15/section/149). The Public Sector Equality Duty states that a public authority must, in the exercise of its functions, have due regard to the need to—

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and,
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.[1]

The relevant protected characteristics are—

- age;
- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- marriage and civil partnership (only in respect of the need to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010);
- sex; and,
- sexual orientation.

We have considered our policy proposals in light of this duty and of the Act more widely, considering the impact on these protected groups.

This document builds on the analysis the Department of Health carried out in response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England, which set out policy proposals that are now reflected in the National Health Services (Charges to Overseas Visitors) Regulations 2015. The Department of Health consultation response was published in February 2017.

This equality analysis assesses the impact of the changes introduced by the National Health Services (Charges to Overseas Visitors) (Amendment) Regulations 2017 on overseas visitors

[1] http://www.legislation.gov.uk/ukpga/2010/15/section/149

with any of the protected characteristics, in comparison with the rest of the overseas visitor and ordinarily resident population.

2. Equality Analysis

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

What are the intended outcomes of this work? *Include outline of objectives and function aims*

The National Health Service (Charges to Overseas Visitors) Regulations 2015 (the Principal Regulations) were an outcome of the Visitor and Migrant Cost Recovery Programme (the Programme), part of a cross-government programme on Migrant Access to Benefits and Public Services, and the culmination of the 2012 review of overseas visitor charging policy, consultation by the Home Office and the Department of Health and on-going engagement with stakeholders. The overarching aim of the Programme is to improve identification and cost recovery from overseas visitors and migrants not eligible for free NHS funded care, and to ensure that the NHS in England receives fair contribution for the cost of healthcare it provides to visitors who require treatment by the NHS.

The new regulations will enable a number of measures to be taken to improve cost recovery in the NHS and help ensure its long term sustainablility. The changes to the principal regulations are designed to ensure that those who are required to pay for NHS healthcare are identified and charged correctly.

Policy implemented by the regulations include:

- enshrining in legislation upfront charging for any care not deemed by a clinician to be “immediately necessary” or “urgent”;
- requiring charging for non-exempt overseas visitors for NHS secondary care services provided outside hospitals;
- introducing charging for NHS-funded secondary and community services provided by non-NHS providers;
- removing NHS assisted conception services from the scope of services available free to persons who are otherwise exempt from charge for NHS services under the immigration health surcharge arrangements;
- excluding reciprocal health care agreements from the scope of the “easement clause” which prevents charging for on-going treatment if the individual’s exemption status changes;
- better reflecting the policy that dependants of refugees, asylum seekers and failed asylum seekers are also exempt from charges;
- requiring relevant NHS bodies to identify and flag an overseas visitor's chargeable status;
- removing the exemption for employees on UK-registered ships and making their employer become liable for their NHS costs; and.
- The termination of the reciprocal healthcare agreement with Barbados, after mutual

agreement between both countries, from 1 October 2016.

This equality analysis builds on the equality analysis undertaken in 2013 and published with the Department of Health response to the consultation in December 2013 and the equality analysis undertaken in February 2017 to support the consultation on the extension of charging overseas visitors and migrants using the NHS in England.

The changes to the orincipal regulations are designed to further improve NHS cost recovery in England, with improved measures to identify and charge overseas visitors and migrants who are eligible to pay for the NHS-funded healthcare they receive.

Scope

The regulations apply in England only.

Who will be affected? *e.g. staff, patients, service users etc*

The regulations will affect:

NHS staff (clinical and administrative)
NHS administrative staff in secondary care and community care will be involved in the identification of patients who are either eligible for free NHS care or subject to charging. They will also be involved in ensuring the recovery of charges from appropriate patients. In certain areas they may be responsible for communicating to some patients that they may not be eligible for free NHS treatment and that they may need to pay for that treatment upfront. NHS clinical staff may have a role in working with administrative staff on when to require charges to be paid (eg prior to clinical staff providing non-urgent treatment) or whether the service being provided is one for which no charge is to be made.

Providers of NHS-funded care delivered by non-NHS bodies
Staff delivering NHS-funded care outside the NHS (such as private hospitals) will also be involved in the identification of patients who are either eligible for free NHS-funded care or subject to charging, and in the recovery of charges from appropriate patients.

General public
There will be an impact on the general public as they are more likely, especially at the outset of treatment, to be asked questions about their residency, which will be necessary to identify those patients who are not eligible for free NHS-fundeed care.

EEA Visitors
For EEA residents, the cost of care can be covered by the European Health Insurance Card (EHIC) or other arrangements if they are insured by another EEA member state's healthcare system. This means that the individual will receive medically necessary NHS-funded healthcare, although they will increasingly be asked to show their EHIC, S1 or other documentation to demonstrate eligibility.

Non-EEA Visitors
Charging is currently in place in secondary care (in NHS hospitals) for non-EEA visitors. However, as charging is extended further, visitors may find that they now may no longer be eligible for free NHS-funded services or exemptions. and may be subject to further charges.

The changes across the NHS will bring greater consistency across secondary care and community care, and will make access to free NHS-funded care easier to understand by visitors.

Non-EEA temporary migrants (including students) who are subject to immigration controls

Students and temporary migrants from outside the EEA who are in the UK for six months or more are currently usually required to pay the Immigration Health Surcharge, although they may benefit from an exemption or the charge may be waived, reduced or part-refunded. A person who has paid the Immigration Health Surcharge, is exempt from paying it (with limited exceptions), or has had the charge waived or part refunded is currently entitled to an exemption from charges for the duration of their visit but will no longer be exempt from charge for assisted conception services.

Students and visitors from outside the EEA who are in the UK for less than six months, so who are not subject to the Immigration Health Surcharge, are chargeable for their NHS treatment unless they are otherwise exempt. Charges will cover secondary care and community care. Immediately necessary or urgent care will still be provided without upfront payment, although this will be charged (unless it is an accident and emergence service) unless an exemption applies.

UK Expatriates
Most UK expatriates are already chargeable for their secondary care NHS treatment in NHS hospitals if they live outside the EEA. The further secondary and community care that will become chargeable will equally apply to this group.

This is because the NHS is a residence-based healthcare system: if expatriates move abroad so that they are no longer ordinarily resident here, they are no longer entitled to free medical treatment under normal NHS rules when visiting the UK unless an exemption applies.

Undocumented migrants
With more questions being asked to identify patients across secondary care and community care, it will be more likely that undocumented migrants are identified as chargeable for NHS treatment that they receive. If they then do not pay their bill (and it exceeds £500 for two months or more), non-medical information will be passed onto the Home Office which could inform future decisions regarding their entitlement to stay in, or return to, the UK.

Evidence

The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current DH Transparency Plan.

What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*

Equality Analysis

We have considered equalities issues throughout the course of the Department of Health's Cost Recovery Programme, including analysis conducted in 2013 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268632/Sustaining_services__ensuring_fairness_-_Government_response_to_consultation_-_Equality_Analysis.pdf), research and reviews by external organisations Prederi and Ipsos Mori, and ongoing discussions with stakeholders. We have also taken into consideration evidence submitted in response to the 2015 consultation on extending and improving charges.

In spring 2016, the Department commissioned Prederi to specifically consider the potential impact of proposals on protected groups as defined by the Equality Act 2010. Prederi has an established working relationship with Cost Recovery Programme, having authored the independent, peer-reviewed *Quantitative Assessment of Visitor and Migrant Use of the NHS in England* and provided key additional evidence (*Department of Health: proposed policies for visitors to make a fair contribution to use the NHS - Evidence to support an Equality Impact Assessment*) that was used within the Programme's previous Equality Analysis, both in 2013. Prederi was therefore able to build on its previous knowledge and findings to provide an external view on the Government's current proposals.

We have built an evidence base to support our policy development. This has included:

- evidence submitted in responses to our consultation on the extension of charging overseas visitors and migrants using the NHS in England;
- our equalities and vulnerable groups stakeholders (including stakeholders from migrant welfare groups, charities, third sector organisations, health organisations, NHS bodies, Royal Colleges, and others);
- cross-Government engagement regarding outcomes and the decisions to be made regarding policy changes and legislative changes;
- articles and sources of evidence including the Equality and Human Rights Commission's Triennial Review[2], the National Inclusion Health Board in England report - *'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*'. (Aspinall, 2014)[3]; and,
- Written comments, evidence, reports and insight from stakeholders as part of advice for a planned vulnerable group review, which included Doctors of the World, Royal College of Midwives, Imperial College London, Kingston NHS, Waltham Forest CCG, Maternity Action, GPs Homeless and Inclusion Health and Race Equality Foundation.

Further background and detail of our equalities work and evidence collected is set out in the equalities assessment supporting our response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England. The consultation response was published in February 2017.

[2] https://www.equalityhumanrights.com/sites/default/files/ief_migrants_refugees_and_asylum_seekers.pdf

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/305912/Inclusive_Practice.pdf

Upfront charging of non-urgent treatment Our analysis to support the consultation response (the response was published in February 2017), on upfront charging concluded that there would not be a significant impact on the protected groups as this is already the policy as set out in published guidance (since 1989), and charges are already made at some point in the treatment process and therefore making these charges at an earlier stage in the process would not have a significant effect. In addition, immediately necessary and urgent treatment will never be delayed pending the identification and charge of overseas visitors. We have carried out further analysis in relation to any impact that the process under which upfront charging will be carried out, such as securing payment for an estimate of charges (which was not considered in detail in our previous analysis) may have on these groups, which is set out below.	
Potential impact on protected groups	
Age (including carers)	Older people who are retirees are often more likely to have lower incomes than people who are not retired. If an estimated charge was higher than the actual charge, there is a potentially greater impact on those retirees on lower incomes as it would represent a higher proportion of their monthly living allowance. However, estimated charges should be, as far as possible, accurate as they are based on the treatment the clinician considers will be provided. This part of the regulations will not come into force until 23 October 2017 and the Department and system partners will use the lead-in period to ensure that NHS Trusts and other relevant non-NHS providers clearly understand how to best estimate costs, and ensure they avoid overcharging. In addition, any treatment which is immediately necessary or urgent under the principal regulations will not be delayed or refused pending payment thus mitigating the potential impact. The regulations will have a positive impact in that patients will know upfront what the cost of the treatment will be and therefore allows them to choose if they want to proceed based on that cost. However, there is also a risk that someone with low income who is charged upfront may refuse treatment due to cost, which may previously not have been so obvious without the clarity upfront charging provides. The impacts considered in relation to age may also be relevant in respect of other protected characteristics where a person with that protected characteristic is more likely to have a low income. For example, anecdotal reports suggest that people with a disability may be more likely to have a lower income and therefore over-estimates of costs may have a greater impact on their monthly income/allowance. Where estimated costs are made that are higher than actual cost there may be a time period before any excess charges will be refunded. If this period covers a number of weeks, there may be further impact on a lower income group as they will not have access to money that they may need for other purposes. To mitigate these risks we will, as far as we can, ensure that, prior to the regulations coming into force, processes are

	clearly set out and understood by NHS Trusts and non-NHS providers so that patients can make informed decisions about their care before incurring any debts, and any unnecessary delays in making refunds are avoided where possible. Upfront charging for non-urgent care should already be being applied in NHS hospitals and estimating costs is part of that existing process. Therefore, we do not believe over-estimating will be a significant problem. To the extent that there is an impact on any particular protected group, the impact is justified. We consider that ensuring the long-term sustainability of the NHS is a legitimate aim and that ensuring those who are required to pay for NHS healthcare are identified and charged correctly, and that those overseas visitors who are chargeable, but have needs that are non-urgent and can await their return home, be required to pay upfront, is a proportionate way of achieving this aim. We believe that upfront charging, which necessitates reliance on estimated costs, is a more effective and fair way of recovering charges than charging after the event. In addition, it should be noted that immediately necessary or urgent treatment, including maternity services and postnatal care, will never be withheld as a result of eligibility checking or payment related issues.
Disability (including carers)	See point above in relation to potential lower incomes. People with a disability may be more likely to use NHS-funded services. These groups may therefore face a disproportionately greater impact than the rest of the overseas visitors' population where there is upfront charging, although we believe such impact is justified as we consider that ensuring the long term sustainability of the NHS is a legitimate aim and ensuring that those who are required to pay for NHS healthcare are identified and charged correctly, is a proportionate way of achieving this aim.
Pregnancy and maternity	Since maternity services are always to be considered immediately necessary, those individuals receiving them will not be subject to upfront charging for their maternity care. Therefore there will be no impact.
Gender reassignment	Overseas visitors with gender dysphoria may require treatment that may be provided in stages over a period of time, and thus are more likely to use NHS-funded care than other overseas visitors who do not require such treatment. There may therefore be an impact on this group due to a requirement to pay upfront for non-urgent care. However, we are of the view that any potential impact is justified as NHS funds are limited and should not be spent on services for people who do not have a sufficiently close connection with the UK.
We do not consider there is likely to be any impact on persons with the protected characteristics of sex, race, religion or belief or sexual orientation in relation to upfront charging and the necessity to estimate charges. It should be noted that the current policy strongly recommends upfront charging and we consider reflecting this in the regulations is justified and proportionate.	

NHS secondary care services provided outside hospitals	
The regulations remove a previous exemption for services provided outside a hospital. However, given that the definition of a hospital[4] is very broad, and the exemption did not include when staff employed by, or under the direction of, a hospital provided the service, in most cases secondary care delivered by an NHS organisation outside a hospital was chargeable. The change to the regulations puts this beyond doubt, and will increase awareness of this position, but does not introduce wide-ranging change on charging for out of hospital care into the legislation. We have considered any impacts the wider implementation of the policy may have on protected groups.	
Potential impact on protected groups	
Age (including carers)	It is likely that older people require more out of hospital services, particularly care support. Older people who are retirees are also often more likely to have lower incomes than people who are not retired. Therefore, there is potentially a greater impact on this group as they may need to pay for treatment that previously they were not charged for and this may represent a higher proportion of their income/living allowance. Children are common recipients of services such as speech and language therapy which is a service often provided out of hospital. These services will be charged for in respect of children who are not exempt from charges. The adults responsible for payment of such charges will therefore be impacted by these regulations. We believe that any of the impacts stated above are justified as we consider that ensuring the long-term sustainability of the NHS is a legitimate aim and ensuring that those who are required to pay for NHS healthcare are identified and charged correctly, is a proportionate way of achieving this aim. Any impact is also mitigated as immediately necessary or urgent treatment will not be withheld due to payment. Furthermore, the change in law is considered minor, and that such services may well be chargeable already.
Disability (including carers)	People with a disability are more likely to require hospital services and may require more out of hospital services such as physiotherapy, occupational therapy, speech therapy or mental health services. There may be a potential impact if this group are charged for these services

[4] "Hospital" means:

(i) any institution for the reception and treatment of persons suffering from illness;

(ii) any maternity home; and

(iii) any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation, and includes clinics, dispensaries and outpatient departments maintained in connection with any such home or institution, and "hospital accommodation" must be construed accordingly.

	when previously they have not been. However, this is not a change in policy and these services are already chargeable if provided by hospital employed or directed staff, where hospital has a very broad definition . In any event, any impact is justified on the grounds that NHS resources are limited where people do not have a sufficient, and permanent, connection to the UK.
Gender reassignment (including transgender)	Gender dysphoria treatment may include treatment that is provided out of hospital such as family therapy, individual child psychotherapy, parental support or counselling and regular reviews to monitor gender identity development. There may therefore be an impact to this group of overseas visitors. However, as this is not a change in policy and these services are already chargeable when the staff providing the service are employed or directed by a hospital, any impact is considered minimal and in any event justified on the grounds that NHS resources are limited where people do not have a sufficient, and permanent, connection to the UK.
Race	We do not consider there is likely to be any specific adverse impact on a person with with the protected characteristic of race
Religion or belief	We do not consider there is likely to be any specific adverse impact on a person with with the protected characteristic of religion or belief.
Sexual orientation	We do not consider there is likely to be any specific adverse impact on a person with with the protected characteristic of sexual orientation.
Pregnancy and maternity	Pregnancy and maternity services are chargeable although they are considered to be immediately necessary and therefore will always be provided regardless of whether payment has been made. There may be a potential impact if this group are charged for these services when previously they have not been. However, this is not a change in policy and these services are already chargeable if provided by hospital. In any event, any impact is considered justified on the grounds that NHS resources are limited where people do not have a sufficient, and permanent, connection to the UK.
Potential impact on other vulnerable groups	
Homeless people, Gypsy and Traveller communities	We do not consider there is likely to be any specific adverse impact on other vulnerable groups save that, as mentioned above, lower income groups may be more greatly impacted by charging.
Staff We have also considered impact on staff and although there will not be any specific impact in relation to protected characteristics, there may be an impact in relation to families – these have been considered in the accompanying Family Test analysis. In relation to staff who provide services outside of hospitals there may be a need to ensure they do not discriminate against any groups through implementing the measures, particularly when identifying patients not eligible for free NHS care. The Cost Recovery Programme has introduced a number of initiatives to improve understanding and awareness of the charging rules and we will reiterate to NHS Trusts (and other relevant organisations) that all staff,	

including those who provide services out of hospital, undertake the e-learning we have developed and ensure that immediately necessary or urgent treatment is never denied. All staff will need to receive the same training to ensure there is no discrimination against any protected characteristic.

NHS-funded secondary care delivered by non-NHS bodies

Staff delivering NHS-funded care outside the NHS (such as private hospitals) will also be involved in the identification of patients who are either eligible for free NHS care or subject to charging, and in the recovery of charges from appropriate patients.

We do not consider that this will bring any additional impacts to protected groups that have not already been considered in this and the February 2017 assessment, which this analysis builds on, as long as non-NHS providers implement the regulations in the same way as NHS staff are required to do. We will therefore reiterate to non-NHS bodies that their staff receive the same training and guidance as NHS staff and have access to our e-learning, so that they do not discriminate against any groups through implementing the measures, particularly when identifying chargeable patients, and ensure that urgent or immediately necessary treatment is never denied.

Removal of assisted conception services from surcharge coverage

Assisted conception (AC) services are no longer provided free of charge to those who are exempt under the surcharge or transitional arrangements. Assisted conception services in this context do not include those commissioned for serving members of the armed forces and their families and infertility treatments for seriously injured serving members and veterens.

The regulations mean that charges will apply for assisted conception services to those covered by the surcharge/transitional arrangements, where no other exemption applies, for new courses of treatment from 21 August 2017.

Any of the potential impacts on protected groups (as referred to below) are considered to be justified as assisted conception services are high cost, would normally be considered non-urgent and are limited within the UK resident population. Therefore funding for such services should not be spent on people who do not have a sufficiently close relationship with the UK, including surcharge payers, who are not ordinarily resident here.

Some further analysis is set out below.

Potential impact on protected groups	
Disability (including carers)	People with certain health conditions which lead to infertility, and those living with HIV, may be impacted by assisted conception services no longer being free to a person exempt under surcharge arrangements. However, we believe any potential impacts are justified as NHS funds are limited and should not be spent on services for people who do not have a sufficiently close relationship with the UK.
Sex	AC treatment policies are set by individual NHS Trusts, provided either to couples or single women, adhering to NICE guidelines. The policy

	reflected in the regulations does not have any specific impact on sex though it is noted that while AC generally impacts couples, females may be more directly impacted as more procedures relating to AC are carried out on females, so they may incur the higher cost when paying for AC services. However, we believe any potential impacts are justified as NHS funds are limited and should not be spent on services for people who do not have a sufficiently close relationship with the UK.
Gender reassignment (including transgender)	People receiving gender dysphoria treatment may be more likely to access AC than those not receiving such treatment. They would therefore be more impacted by any charges for such services. We believe any potential impacts are justified as NHS funds are limited and should not be spent on services for people who do not have a sufficiently close relationship with GB.

Reciprocal agreements – easement clause not applying in the event the agreement is terminated

Our previous analysis set out in the assessment that supported the consultation response which was published in February 2017, that this proposal would not impact on protected groups other than potentially low income groups (which may also correlate with the protected characteristics of age and/or disability), who may struggle to pay for the remainder of a course of treatment begun while they were exempt from charge under the terms of a reciprocal agreement. However, it follows that individuals of a certain nationality will be specifically impacted if there are changes with reciprocal agreements affecting their particular country.

We believe any such impact is justified on the grounds that when a reciprocal agreement terminates, free healthcare should not continue to apply just because a course of treatment is underway especially as that might include non-urgent sections of treatment that would not have been exempt under the agreement itself. To mitigate any adverse impact we will ensure that should any agreements end in the future, we will update sources of information so that where possible those impacted by them can find out before they travel.

Amendment to Regulation 15 regarding refugees, asylum seekers and supported individuals

This amendment is to place beyond doubt that the dependants of refugees, asylum seekers and some supported failed asylum seekers are also exempt from charge, even if the dependent does not have refugee status, has not made an asylum application or is not receiving support as a failed asylum seeker. Dependants may be more likely to be women and children. However, since this amendment potentially extends the exemption category to these protected characteristic groups, there will be a positive impact on them.

Duty on providers to identify and flag a patient's chargeable status

Our previous analysis, set out in the assessment that supported the consultation response which published in February 2017, concluded that any potential impacts on protected groups (which included lower income groups who would be better identified and homeless people, gypsy and traveller communities, who may struggle to demonstrate their non-chargeable status) are justified as we consider that ensuring the long term sustainability of the NHS is a legitimate aim and ensuring that those who are required to pay for NHS healthcare are identified and charged correctly, is a proportionate way of achieving this aim. This analysis remains the same.

Shipowners

Our previous analysis which supported the consultation response published in February 2017, concluded that there are no specific protected groups impacted due to charges in respect of ship workers. The main impact will be on shipowners who are likely to be companies. This analysis remains the same.

In engagement with stakeholders, it was brought to our attention that the policy could result in a behaviour change by shipowners, whereby they may dismiss ship workers in their employment who are in need of healthcare so as to avoid becoming liable for their healthcare costs. We would expect employers not to act unscrupulously in this manner and to abide by appropriate laws given their position as employers of ship workers. We have not been made aware of any evidence of non-UK registered ships dismissing staff to avoid liability for charges. Should shipowners act in such a way, there is a risk it would have a greater adverse effect on those shipworkers who are more likely to need healthcare services, such as those with a disability, those who are transgender and require gender dysphoria treatment or those who are pregnant. However, any dismissal of shipworkers for these reasons would be in breach of UK employment legislation. We consider the provision is justified on the grounds that NHS resources are limited where people do not have a sufficient connection to the UK and it also seeks to ensure parity of treatment for all registered shipowners. The removal of the exemption for ship workers from UK-registered ships is therefore considered a proportion way of achieving these legitimate aims.

Barbados

The reciprocal healthcare agreement with Barbados was terminated after mutual agreement between both countries from 1 October 2016. Clearly that has had a greater impact on nationals of Barbados than on other nationalities visiting the UK, but this is considered justified as necessary in order to fulfil both country's decision to terminate the agreement as no longer appropriate and necessary. Notice was provided on relevant Government websites in the UK and Barbados ahead of termination to advise the public of the change. Also, those receiving a course of treatment at the time of termination free of charge under the terms of the agreement were able to complete that course of treatment free of charge.

SUMMARY OF ANALYSIS

Eliminate discrimination, harassment and victimisation

Our stakeholder engagement throughout the Cost Recovery Programme raised concerns regarding the risk of potential race discrimination in relation to the application of NHS charging rules; there are anecdotal suggestions that residency questions may more commonly be asked

to those of BME backgrounds, rather than everyone being asked the same questions equally. Stakeholders have been concerned that this may potentially be exacerbated if charging is extended to more settings. We are clear that racial profiling is wrong and is an unacceptable practice and that processes to determine a patient's chargeable status should be asked of everyone in the same way.

Our supporting guidance to the regulations will continue to make clear that, to ensure fairness, it is important that decisions about eligibility and chargeability are made systematically and questions are asked equally of all new patients and registrants, regardless of who they are and where they are from. This will include staff who provide services in settings outside hospitals. The creation of an IT 'flag' on the patient record will also help in this regard.

We will continue to update and promote the Equality and Diversity e-learning module to all providers of NHS-funded services to avoid rules being applied in a discriminatory way by staff and affecting certain groups more than others. This module should be seen as part of NHS providers' wider work to inform and educate their staff on equality and diversity issues and behaviours.

The expansion of charging for people who do not have a sufficient connection with the UK into a wider range of services will mean that this group will be more often required to answer questions and provide evidence: this will inevitably be challenging for those without documentation. We will work to ensure that this group do not face discrimination, harassment or victimisation as they try to access NHS services. Providing clarity on who can obtain which services without charge will be key, especially for people who are vulnerable and entitled to free NHS care but who struggle to prove this to NHS frontline services. We will work with stakeholders to refine our approach.

Advance equality of opportunity

Introducing consistency across NHS healthcare providers will, in the longer-term, advance equality of opportunity. It will mean that all patients face the same questions and the same residency requirements, rather than certain groups with particular characteristics facing greater scrutiny. Creating the fair application of systematic questions to every single person will reduce the dangers of discrimination by individual healthcare providers or NHS staff. Ensuring that the rules are standardised so that NHS-funded care is chargeable to non-exempt visitors wherever, and by whomever, it is provided, including for care that is provided outside hospitals will help ensure consistency.

Upfront charging will make clear to everyone at the same stage in the process what their cost of treatment will be. This will increase choice and help ensure that no one receives an invoice at a later stage that they were either not expecting at all or one that is much higher than expected. It should be noted that the current policy already requires upfront charging but the regulations now puts this on a statutory footing so there has been no change in the underlying policy.

In addition, we will ensure that potentially life-threatening conditions are always treated without delay regardless of a person's ability to pay. All maternity services, including routine antenatal treatment, will also be provided, regardless of eligibility status or ability to pay.

Promote good relations between groups

The regulations will make cost recovery more efficient and effective and help ensure that everyone makes a fair contribution.

We believe that extending charging across non-NHS providers of NHS services will make the situation fairer for all groups. Everyone who accesses these NHS services will be making a fair

contribution in some way (or else will be exempt from charging for valid reasons). We expect the changes to reduce any current hostility or misconception about what visitors and migrants receive at the expense of the UK tax-payer.

What is the overall impact

There is some evidence that overseas visitors with a protected characteristic may be adversely impacted by the regulations, as set out in the analysis above. In particular those who lack resources to pay or who are more likely to require healthcare will be more impacted by the changes.

However, it is believed that any such impacts should be considered in the context of ensuring the long term sustainability of the NHS. This is a legitimate aim and the policies being implemented by these regulations are a proportionate way of achieving this aim.

Overall, the regulations should have a positive impact on the NHS by ensuring consistency with how charging is implemented for relevant NHS services provided in hospitals and by other non-NHS providers of NHS-funded care. The introduction of upfront charging may have some negative effects on overseas visitors with low or no income or who are undocumented migrants and may be unable to pay, however, immediately necessary or urgent treatment wil not be denied or delayed regardless of the patient's ability to pay and exemptions remain for certain groups of people.

Charging rules will be applied irrespective of disability, age, race, sex, sexual orientation, gender reassignment, pregnancy and maternity, religion or belief, or marriage or civil partnership status. Improved identification of patients will also benefit those who are entitled to free NHS-funded care but who may struggle to understand or access the healthcare system currently and will assist in the reduction of questioning to establish the chargeable status of a patient.

Addressing the impact on equalities and action planning for improvement

Our equalities analysis in February 2017 to support the consultation response on the extension of charging overseas visitors and migrants using the NHS in England, which this assessment has built upon by adding some further analysis, sets out our justifications of the policy and our mitigating actions to minimise the impact of charging proposals on the most vulnerable people. In addition to the actions previously set out, when the regulations commence we will update our charging guidance and e-learning package.We will re-iterate that all staff, including those who provide services outside hospital settings, should have the necessary training and awareness of the guidance and ensure that questions are asked equally of all new patients and registrants, regardless of who they are and where they are from.