Controlling Immigration – Regulating Migrant Access to Health Services in the UK - Consultation Response

Summary:

The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians, and 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of five optical representative bodies: the Association of British Dispensing Opticians (ABDO), the Association of Contact Lens Manufacturers (ACLM), the Association of Optometrists (AOP), the Federation of Manufacturing Opticians (FMO) and the Federation of Ophthalmic and Dispensing Opticians (FODO). As a Confederation, we work with others to improve eye health for the public good.

Operating as we do in an integrated NHS and private system, as far as NHS sight testing and community eye health services are concerned, we cannot see that there is any need for change to the basis on which migrants access eye health services in the community.

Moreover the proposal to introduce charges could potentially complicate or duplicate the current arrangements which are fully functional and efficient, adding to costs for both the NHS and providers without any public benefit.

This is because all persons seeking a sight test and other community eye care
- are only entitled to an NHS-funded sight test if they fall within certain eligibility criteria (linked to UK benefits)
- if the optical practice has doubts, it can contact the relevant NHS authority for advice in particular cases
- otherwise sight tests have to be funded privately (which, in case of overseas visitors, they can claim back from their home insurance system, if eligible)
- for other locally-commissioned eye care services, a patient has to be registered with a local NHS GP to access the service or pay privately and upfront.

In addition, all NHS community eye health services are subject to post payment verification (PPV) and anomalous patterns can be detected and investigated, and patients can be fined if found to be misrepresenting their NHS eligibility status.

We have no evidence that misuse of this system by overseas visitors is a major problem in our sector. We cannot therefore see how the costs to the NHS and providers of introducing a more rigorous system upfront checking, charging and netting-off charges against payments due to the provider could possibly be offset by any misuse prevented or NHS funds saved.

The proposal of a mechanism for determining those migrants who are chargeable would require considerable engagement with our sector, especially with regard to the practicalities of accessibility and operability by all high street ophthalmic contractors (4.31, page 35).

It is against this background that we respond to the consultation questions below.

Questions:

Question 1: Are there any other principles you think we should take into consideration?
No comment.

Question 2: Do you have any evidence of how our proposals may impact disproportionately on any of the protected characteristic groups?
No comment.

Question 3: Do you have any views on how to improve the ordinary residence qualification?
No comment.

Question 4: Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK?
Yes.

Question 5: Do you agree with the principle of exempting those with a long term relationship with the UK (evidenced by National Insurance contributions)? How long should this have been for? Are there any relevant circumstances under which this simple rule will lead to the unfair exclusion of any groups?
No comment.

Question 6: Do you support the principle that all temporary non-EEA migrants, and any dependants who accompany them, should make a direct contribution to the costs of their healthcare?
Yes, in principle.

Question 7: Which would make the most effective means of ensuring temporary migrants make a financial contribution to the health service?
a) A health levy paid as part of the entry clearance process
b) Health insurance (for NHS treatment)
c) Other – do you have any other proposals on how the costs of their healthcare could be covered?
No comment.

Question 8: If we were to establish a health levy at what level should this be set?
a) £200 per year
b) £500 per year
c) Other amount (please specify)?
No comment.

Question 9: Should a migrant health levy be set at a fixed level for all temporary migrants? Or vary according to the age of the individual migrant?
c) Fixed
d) varied
No comment.

Question 10: Should some or all categories of temporary migrant (Visa Tiers) be granted the flexibility to opt out of paying the migrant levy, for example where they hold medical insurance for privately provided healthcare? ?
Yes.

Question 11: Should temporary migrants already in the UK be required to pay any health levy as part of any application to extend their leave?
Yes, unless they have separate private health insurance.

Question 12: Do you agree that non-EEA visitors should continue to be liable for the full costs of their NHS healthcare? How should these costs be calculated?
Yes.

Question 13: Do you agree we should continue to charge illegal migrants who present for treatment in the same way as we charge non-EEA visitors?
Yes.

Question 14: Do you agree with the proposed changes to individual exemptions? Are any further specific exemptions required?
No comment.

Question 15: Do you agree with the continued right of any person to register for GP services, as long as their registration records their chargeable status?
Yes.

Question 16: Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs?
Yes; they already do so for sight tests and other eye health services.

Question 17: Do you have any comments or ideas on whether, and if so how, the principle of fair contribution can best be extended to the provision of prescribing, ophthalmic or dental services to visitors and other migrants?
Please see our comments above.

Question 18: Should non-EEA visitors and other chargeable migrants be charged for access to emergency treatment in A&E or emergency GP settings?
Please see our answer to Question 1.

Question 19: What systems and processes would be needed to enable charging in A&E without adversely impacting on patient flow and staff?
No comment.

Question 20: Do you agree we should extend charges to include care outside hospitals and hospital care provided by non-NHS providers?
No comment.

Question 21: How can charging be applied for treatment provided by all other healthcare providers without expensive administration burden?
This would add significantly to costs in our sector without demonstrable public benefit.

Question 22: How else could current hospital processes be improved in advance of more significant rules changes and structural redesign?
No comment.

Question 23: How could the outline design proposal be improved? Do you have any alternative ideas? Are there any other challenges and issues that need to be incorporated?
No comment.

Question 24: Where should initial NHS registration be located and how should it operate?
No comment.

Question 25: How can charges for primary care services best be applied to those who need to pay in the future? What are the challenges for implementing a system of charging in primary care and how can these be overcome?
Please see our comments above.

Question 26: Do you agree with the proposal to establish a legal gateway for information sharing to administer the charging regime? What safeguards would be needed in such a gateway?
No comment.

Question 27: Do you agree that we should stop issuing S1 forms to early retirees and stop refunding co-payments and if not, why?
No comment.

The Optical Confederation is happy for this response to be made public and we would be very happy to discuss this consultation further with both the Department of Health and the Home Office.

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