The NHS charging system deters people from seeking healthcare and risks undermining the government's pandemic response

The system of charging migrants for healthcare in England has become increasingly stringent in recent years. Since the introduction of the new rules, there is a growing body of evidence highlighting their adverse impacts. Through interviews with people with direct experience of NHS charging, healthcare workers, and policy professionals **Marley Morris** *offers further evidence of systemic problems with the current system.*

As concerns heighten over the rapid spread of the Omicron variant, the NHS faces another deeply challenging winter. In recent days, the government has responded with extending the vaccine booster rollout and introducing new 'Plan B' measures to buy time for the boosters to be administered and take effect. But as IPPR's new report warns, there is one critical gap in our defences against the pandemic that has received minimal attention: this is the system for charging people in England for making use of the NHS.

In principle, the NHS is a universal system free at the point of use. Its founder, Nye Bevan, famously wrote that 'no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means'. But in the last few decades, charges have been introduced for secondary care (i.e. care typically in hospital) for people who are not 'ordinarily resident'. The rules have become particularly stringent in England in recent years, coinciding with the Home Office's introduction of the 'hostile environment'.

The current system of charging in England is notoriously complex. The central idea is that people who are not 'ordinarily resident' in the UK are charged 150% of the NHS national tariff for secondary care (with some exempt services such as A&E). Patients are charged upfront unless this would prevent or delay urgent or immediately necessary treatment, in which case they are billed afterwards. 'Ordinary residence' is defined as living legally and voluntarily in the UK for settled purposes as part of the regular order of one's life for the time being. For those who are subject to immigration control, they must have indefinite leave to remain (though EU citizens with pre-settled status also count as being ordinarily resident).

People on temporary immigration routes, while in general not ordinarily resident, usually get access to healthcare by paying an immigration health surcharge as part of their visa application. This means that in practice, the two main groups who face charges at the point of use are short-term overseas visitors and people without immigration status (often referred to as undocumented migrants). While there are no reliable estimates of the number of people without status in England, most attempts put the number in the hundreds of thousands.

The current system of charging therefore places substantial financial barriers to healthcare for large numbers of people living in the country. The IPPR report highlights evidence that this has led to patients being deterred from seeking care, delays in treatment, and the imposition of excessive charges on people who simply cannot afford to pay, forcing them into prolonged indebtedness. Even in normal times, this would be deeply concerning. But in the context of the pandemic, it poses a major threat to the government's efforts to contain the virus.

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While there are, in principle, exemptions to charging for certain infectious diseases such as COVIC-19, our interviews with experts – including NHS practitioners and people with direct experience of the charging system – indicated that many were unaware of these exemptions or were otherwise reluctant to come forward for fear of being charged for treatment for a different condition. A 2020 survey of 78 Filipino migrants with precarious status by the charity Kanlungan found that around a quarter of respondents would not seek healthcare if they came down with COVID-19 symptoms, citing both concerns over unaffordable charges and the risk of being reported to the authorities. One undocumented Filipino man is reported to have died of coronavirus because he was afraid to seek help.

The charging system also appears to have deterred people from coming forward for the vaccine, even though this should be free for all. A recent qualitative interview study of vaccine uptake among precarious migrants identified fears over charging – along with concerns over immigration checks – as a barrier to getting the vaccine for people who were undocumented.

It is therefore clear that the current NHS charging system is not fit for purpose: it deters people from seeking healthcare, distracts clinical staff from their primary roles, and risks undermining the government's pandemic response. While there have been some welcome efforts by the government to encourage everyone – including those without immigration status – to get the vaccine, ultimately this is unlikely to be enough to counter entrenched distrust over the charging regime.

A new approach is therefore needed. As I argue in IPPR's report, the charging system in England should be reformed so that the definition of 'ordinary residence' is expanded to include people living in the UK without immigration status. This would mean that all residents, regardless of their immigration status, would be entitled to free secondary care at the point of use. Overseas visitors may still be charged for their care, but people living in the country would not. This reform would help to simplify the system, encourage people to come forward for treatment, and protect the founding principles of the NHS: to treat people on the basis of clinical need, not the ability to pay.

Moreover, as it becomes clear that the pandemic is not yet over, a reformed charging system could be an important tool in the government's ongoing battle against the virus. By basing charging on residency, rather than immigration status, undocumented patients could be encouraged to both take the vaccine and to come forward for NHS treatment if they are seriously ill with COVID-19. If we want to maximise vaccine uptake, control the spread of the virus, and treat those who are susceptible to serious illness, we need a truly universal NHS.

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