Doctors of the World briefing: Department of Health consultation on further NHS charging – "Making a fair contribution"

February 2016

Summary

In response to the government's consultation on extending NHS charges to services including primary care and Accident and Emergency (A&E), Doctors of the World (DOTW) believes that charging for healthcare can only be considered if a cost-effective, workable system can be implemented without jeopardising care for vulnerable, excluded people living here or impacting negatively on NHS staff. The financial savings from the proposed charges are modest and overestimated, as the majority of savings will come from other areas of the NHS Cost Recovery Programme. Primary care and A&E services are our frontline defense against poor public and personal ill-health. They save the NHS money by treating patients early and well. Despite numerous commitments, the Department of Health (DH) has not published any evaluation of earlier stages of the programme and the impact on vulnerable groups including children. DOTW regularly sees vulnerable people and protected groups being denied care under the current charging arrangements. These proposed changes will only worsen this situation and make the NHS one of the most restrictive healthcare systems in Europe for undocumented migrants.

Background

The UK government is consulting on proposals to charge overseas visitors and migrants for NHS primary medical care, A&E, prescriptions and other areas of healthcare[1].

The proposal is a response to concerns that the NHS is "overly generous to those who only have a temporary relationship with the UK" at a time when NHS budgets are stretched. It also comes at a time when the government has stated its intention to make it "more difficult for 'illegal[2]' immigrants to live in the UK".

In 2014, the Migrant and Visitor NHS Cost Recovery Programme was introduced by the Department of Health (DH) following a consultation in 2013 on how migrants and overseas visitors should be identified and charged for treatment. Extending charges to primary care and A&E is the final phase of the programme. The programme built on existing systems to ensure overseas visitors and migrants contribute to the cost of their healthcare: those not "ordinarily resident" in the UK are billed for secondary care (with some exceptions) at 150% of the cost to the NHS. The Immigration Act 2014 introduced a healthcare surcharge of £200 per year for those staying in the UK for more than six months[3].

[1] Including dental care, ophthalmic services , ambulance services , non-NHS providers of care and NHS Continuing Healthcare.
[2] MdM and its partners strongly disagree with the use of the word illegal to describe a person. No one on Earth is illegal.
[3] https://www.gov.uk/healthcare-immigration-application/overview

1. The proposal will cost more money that it saves

No evidence of cost effectiveness

DH has not carried out an evaluation of the cost effectiveness of the existing charges in secondary care. In a previous impact assessment of the Cost Recovery Programme, DH stated "decisions about progressing with the later phases of the programme will be based on, and contingent upon, demonstrated achievements in the earlier phases"[4], but this has not been published.

An impact assessment of extending charges says it is not possible to quantify any income from charging patients directly for primary care. The savings anticipated for charging for A&E and pharmacy are estimated at £1.1m and £1.6m per year respectively, only 2/5th of which will come from charging patients directly

There are also significant costs involved in extending charges – such as a new IT system and the cost of training staff – that have either not been properly scoped or not been accounted for in the DH consultation document or impact assessment. These are likely to make the programme less cost-effective or even bring a negative loss to the NHS.

The wider economic impact of restricting access to healthcare

Primary care is the frontline of early detection of diseases that would, if untreated, have worsened or become more complicated to treat and required expensive secondary or emergency care. Any policy that restricts, deters or disincentives people living in the UK from accessing this care will increase overall costs for public health providers.

Similarly, many out of hospital services play a vital role in protecting public health by managing conditions in the community, for example mental health services, hospices, drug and alcohol related services, sexual and reproductive health services including termination of pregnancy, maternity and children's services, and healthcare targeted at migrants with irregular status and/or with no recourse to public funds.

Studies have shown that providing access to regular preventive healthcare for migrants in an irregular situation is cost-saving for governments[5]. Introducing charges into A&E and removing access to free prescriptions will have a similar impact. Deterred from accessing emergency care when they need it, patients are likely to need more expensive treatment later on. In addition, pregnant women, children and destitute migrants - all currently exempt from prescription charges - will be prevented from taking medication to treat conditions early on or manage long-term conditions, leading to more expensive treatment further down the line.

People excluded from healthcare are particularly vulnerable and are living with health problems that require treatment. 29% of people attending the DOTW clinic reported their health as bad or very bad and 26% reported their psychological health as bad or very bad. Of the patients who saw a clinician, 63% had at least one health problem that hadn't received any treatment and 39% had a chronic condition which had never been reviewed by a doctor. In 2014, DOTW sent 41 patients immediately to A&E from their London clinic because they were acutely unwell.

A DOTW report from 2014 on the experiences of pregnant migrant women in the UK shows the deterrent effect of charging and entitlement checks in a population with little access to primary care[6]. Antenatal care is frequently received late and often does not meet the minimum standards for care and subsequently puts

[4] https://www.gov.uk/government/publications/recovering-costs-of-nhs-healthcare-from-visitors-and-migrants
[5] EU Agency for Fundamental Human Rights, Cost of exclusion from healthcare 2015
[6] http://www.doctorsoftheworld.co.uk/page/-/DOTW%20Maternity%20Report%202015_FINAL3.pdf

women and their unborn children at increased risk of costly pregnancy-associated complications. Fear of costs and language barriers were cited by service users as the main barriers for accessing antenatal care.

CASE STUDY

Lucy, 22, from China had not accessed healthcare whilst in the UK because her passport had been taken by an agent and she feared getting hospital bills that she could not pay. She came to the DOTW clinic when she was three months pregnant. She had severe abdominal pain and was weak. DOTW sent her directly to A&E where she had a scan and received treatment. DOTW then helped Lucy register with a GP practice and access antenatal care.

When DH consulted on extending charges in 2013, "all major NHS stakeholders and professionals from health and public health expressed concern that deterring people from accessing care through GPs would have a significant and negative impact on individual and public health and costs to the service of delayed treatment"[7].

The proposal also intends to extend cost recovery to EEA nationals unable to present an EHIC cards, therefore increasing the pool of people who will face barriers to accessing healthcare.

DOTW is concerned that the process of identifying chargeable patients will also deter people from accessing healthcare as it will involve primary care and A&E staff routinely asking questions about immigration status. Last year, 11% of patients who came to DOTW's clinics had not accessed NHS care because of a fear of authorities[8].

CASE STUDY

Luciana, 44, from the Philippines had lived in the UK for six years when she came to the DOTW clinic. We arranged for her to register with a GP and recommended a two week referral to the breast clinic. Luciana was then diagnosed with breast cancer requiring treatment. During the hospital appointment she was asked to show her passport. She called us to say she was too frightened to go to any further appointments and, despite our encouragement to continue treatment, refused. She is now uncontactable.

The overall impact of restricting free access to primary care, A&E and prescriptions will be to deter people from accessing the healthcare they need, removing the vital cost saving function of primary care, and driving up the cost secondary care.

2. The proposal is unworkable

DH stated an overriding principle of the Cost Recovery Programme was to be 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". DOTW believes that the current proposal fails to achieve this principle as it is administratively and clinically unworkable, and will distract staff from treating patients.

The existing charging system in secondary care shows how difficult and time consuming identifying chargeable patients is, requiring a role solely dedicated to this – the Overseas Visitors Manager. It is difficult

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268630/Sustaining_services__ensuring_fairness_-_Government_response_to_consultation.pdf
[8] https://www.doctorsoftheworld.org.uk/files/uk_report_2014_web.pdf

to imagine how this function would be fulfilled in out of hospital setting without additional staff (and cost), or in A&E without distracting from giving care.

DH has conducted a pilot study of primary care reception staff asking for EHIC cards which found this added an extra 30 minutes a day to staff workload and lengthened each registration by 1-2 minutes. Because of the complex and changing nature of immigration status, this additional work is likely to take longer and will need to happen each time a patient accesses NHS care. In order to avoid charges of discrimination through application of racial (including linguistic) profiling by staff, everyone in England will have to prove eligibility each time they go to the GP.

The process of removing free prescriptions also cannot be implemented in a way that is simple and cost-effective. It would require primary care and other prescribers to maintain up to date information on a person's chargeable status, have access to this when issuing a prescription, and at that time issue a prescription on an alternative prescription pad. This would mean each prescribing clinician across the country would have to have two prescription pads. The impact assessment does not include assessment of the impact of this change on NHS staff.

We also believe that the proposal is unworkable from a clinical perceptive and will divert staff from treating patients. We welcome the proposal to retain free access to GP and nurse consultations for all, but are concerned about the impact of charging for diagnostic testing and treatments, such as X-rays, phlebotomy, spirometry, minor surgery and physiotherapy. Dividing primary care in this way undermines its value in preventative and early intervention medicine.

3. The proposal will impact on vulnerable groups, pregnant women and children, safeguarding and health inequalities

Vulnerable groups

In 2013, NHS England and Public Health England both raised serious concerns about the impact of charging proposals on public health and worsening inequalities. Further research has shown these proposals are likely to impact upon undocumented migrants living without legal status in the UK, who are often marginalised, vulnerable to abuse and exploitation, and have poor health outcomes[9] [10] [11] [12].

The risk of this negative impact has been identified by DH and a Major Projects Authority review of the Cost Recovery Programme made a clear recommendation for a piece of research into the impact of the programme on vulnerable groups. The Home Affairs Committee also made it a condition of the new charging regulations that a review on the impact of the programme on vulnerable children was undertaken[13]. Neither of these evaluations have taken place.

DOTW believes that extending charges into primary care and A&E will have an impact on vulnerable groups including victims of torture, trafficking, modern-day slavery, FGM, domestic and sexual abuse, and undocumented migrants, deterring them from accessing healthcare.

9 Prederi. Quantitative Assessment of Visitor and Migrant use of the NHS in England: Exploring the data. London: Prederi, 2013
10 Deblonde J, et al. Restricted access to antiretroviral treatment for undocumented migrants: a bottle neck to control the HIV epidemic in the EU/EEA. BMC Public Health 2015; 15: 1228.
11 Britz JB, McKee M. Charging migrants for health care could compromise public health and increase costs for the NHS. European Pub Health 2015; doi: 10.1093/pubmed/fdv043
12 Poduval S et al. Experiences Among Undocumented Migrants Accessing Healthcare in the UK. International Journal of Health Services; April 2015 vol. 45no. 2 320-333

We already know that under the current arrangements access to primary care is challenging for vulnerable migrants. In 2014, 97% of people of people who visited the DOTW's clinic experienced barriers in accessing healthcare and 83% were not registered with a GP[14].

This is due to a number of factors including: 52% who did not try at all because of perceived barriers, 29% who experienced administrative difficulties (no formal proof of address or ID), 17% who didn't understand how to access the health system, 14% who experienced a language barrier, 11% who feared arrest if they accessed healthcare and 12% who tried to access healthcare and had been refused. Fear of arrest has increased following public reports that UKBA made 7,766 successful requests for traces in 2010-13[15].

These vulnerable groups are usually living below the poverty line with little or no access to social support. Often they will be vulnerably housed or sleeping rough and are likely to experience extreme social isolation. Of the patients we saw in DOTW clinics last year, two-thirds were living in poverty and in unstable accommodation and almost a third didn't have someone else they could consistently rely on if they needed help[16].

CASE STUDY

In April 2015, DOTW saw a 36-year-old woman from India who had been trafficked to the UK. She had a letter from her solicitor saying she was in the process of being referred to the National Referral Mechanism as a victim of trafficking and describing the medical needs which had arisen from her experiences. Despite this, her local GP practice refused to register her as she didn't have formal proof of address. With support from NHS England, DOTW was able to get her registered with a GP.

Vulnerable group exemptions not respected

The DH has put in measures to protect vulnerable groups; "urgent and immediately necessary care" will not be withheld and certain vulnerable groups will be exempt from the charges[17]. However, these measures are insufficient and do not work in practice. DOTW often sees people from exempt groups, including refugees and asylum seekers, who have received bills for their treatment.

CASE STUDY

In November 2015, we were contacted by the friend of a 32-year-old asylum seeker from Sri Lanka, admitted to hospital and diagnosed with end-stage colon cancer and advised he needed palliative chemotherapy. The palliative chemotherapy was then not provided as the hospital's Overseas Visitors Manager (OVM) had contacted the Home Office who told them he was not eligible for NHS care. After a number of calls to the OVM, his status was clarified and they referred him for the care he needed.

In 2015, DOTW saw a number of patients who had been denied urgent and immediately necessary treatment, showing that this protective measure is also not working.

[14] https://www.doctorsoftheworld.org.uk/files/uk_report_2014_web.pdf

15 http://www.theguardian.com/uk-news/2014/jul/13/home-office-nhs-records-illegal-immigrants

[16] https://www.doctorsoftheworld.org.uk/files/uk_report_2014_web.pdf

[17] Asylum seekers, individuals receiving support under section 95 of the Immigration and Asylum Act 1999 (the 1999 Act), failed asylum seekers receiving support under section 4(2) of the 1999 Act or those receiving support from a Local Authority, children who are looked after by a Local Authority, victims, and suspected victims, of human trafficking (plus their spouse/civil partner and any children under 18 provided they are lawfully present in the UK), treatment required for a physical or mental condition caused by: torture; female genital mutilation; domestic violence; or sexual violence (except where the overseas visitor has travelled to the UK for the purpose of seeking that treatment).

CASE STUDY

Joyce, 35, from the Philippines, came to work in the UK as a nanny from the Philippines 18 months ago. She became unwell and was diagnosed with cancer requiring immediate chemotherapy. Joyce came to the DOTW clinic after she received a letter from her consultant which said she was "not entitled to treatment under the NHS". DOTW intervened on the grounds that the chemotherapy was urgent and should not be withheld or delayed because of the patient's chargeable status. The chemotherapy went ahead and Joyce was billed for the care. In April 2015, she came to see DOTW again as the she required a further cycle of chemotherapy but the hospital again refused the care. We contacted the hospital and reiterated the definition of "urgent" and they agreed to progress the treatment. Joyce received a bill for all of her treatment which she cannot pay. The hospital has threatened legal action.

Pregnant women and children

In a previous consultation response, DH said "anything that limits access to primary care will have a disproportionate effect on children as they are heavily reliant on primary care services for both prevention services (surveillance, screening and immunisation) and treatment".[18]

As well as creating barriers to healthcare, there are significant ethical and moral concerns about children being charged for healthcare. Studies have pointed to a higher prevalence of unmet health needs among migrant children, often related to reduced use of healthcare services and delayed or inadequate preventative medicine[19].

Barriers to healthcare for pregnant women can have significant implications on both maternal and child health. Research shows that pregnant migrant women in Europe experienced worse pregnancy outcomes than their peers, with a 45% higher risk of low birth weight, 24% increased risk of pre-term delivery, and 50% increased risk of perinatal mortality[20].

A DOTW report on the experiences of pregnant migrant women in the UK showed they already experience reduced access to antenatal care: 98% did not have access to a GP, 62% had their first antenatal appointment late and 50% had five or fewer antenatal appointments (which is less than the minimum level of antenatal care)[21]. Extending charges into primary care will make this situation worse.

CASE STUDY

Josephine, 37, fled her husband in Uganda to come to the UK when she was 27 weeks pregnant. Despite being pregnant, she had difficulty accessing healthcare. She was told by friends that accessing healthcare was "tough" in the UK. She tried to register with a GP three times, "every time they would chase me away. They told me I wasn't entitled and that if they worked on me I would have to pay." She was 35-weeks pregnant by the time she had her first antenatal check at the hospital, arranged by DOTW. After her first appointment Josephine received a bill for her treatment.

[18] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268630/Sustaining_services__ensuring_fairness_-_Government_response_to_consultation.pdf

[19] IOM. Maternal and Child Healthcare for Immigrant Populations. Background Paper. Brussels: International Organization for Migration, 2009

[20] Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature. Soc Sci Med; 2009;68(3):452–61. Available from: http://www.sciencedirect.com/science/article/pii/S0277953608005406. Accessed March 11, 2015.

[21] http://b.3cdn.net/droftheworld/5a507ef4b2316bbb07_5nm6bkfx7.pdf

Safeguarding

Healthcare professionals play a vital role in safeguarding children and vulnerable adults. Restricting access to healthcare professionals would be both dangerous and compromise a number of government initiatives to support vulnerable individuals.
Policies restricting access to healthcare in the UK run directly contrary to the UK government's pledge to 'work to end female genital mutilation (FGM) worldwide within a generation'[22] . Health professionals are key to identifying and providing support to victims of FGM and intervening to prevent girls and women from being harmed. Indeed, the government's Multi-Agency Practice Guidelines see GPs and practice nurses as being well placed to identify and protect those who may be at risk[23].

The proposal also runs contrary to the government's drive to address trafficking and modern-day slavery. The Minister for Public Health said: "the NHS may be the one public agency to which a victim can turn for assistance not only to address their health needs, but also to seek care and protection from this abhorrent practice"[24]. That victims have access to healthcare is of particular importance both to protect their health and because it offers an opportunity to secure advice and support to escape their abuse. The current exemption from NHS charges for victims of trafficking only applies to those formally accepted as victims or potential victims by the National Referral Mechanism. Thus, many victims, including those not yet identified, will face being barred from accessing healthcare services because of charges[25].

Section 11 of the Children Act 2004 places a statutory duty on the NHS to safeguard and promote the welfare of children. The Victoria Climbie Enquiry Report 2003 (9.104) stresses the importance of GP registration for every child and contact with health services is important in identifying children who may have been trafficked or sexually exploited, which children are particularly vulnerable to[26].

Health inequalities

The 2012 Health and Social Care Act established a legal duty for the Secretary of State for Health to reduce health inequalities in England. One of the overarching principles of the Cost Recovery Programme was "not [to] 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.'

While new migrants to England are typically young and healthy, they often face difficult economic circumstances and labour conditions in the UK which put them at risk of poor health. Investing in public health for everyone present in England will support young migrants to be economically productive while they are here.

DOTW believes proposals to introduce charges for access to primary care and A&E and to remove prescription charges will increase health inequalities in England and undermine ongoing and past policies to reduce inequalities.

[22] DFID, UK to help end female genital mutilation https://www.gov.uk/government/news/uk-tohelp-end-female-genital-mutilation
[23] Department of Health. Multi-Agency Practice Guidelines: Female Genital Mutilation. 2011)
[24] https://www.gov.uk/government/news/supporting-victims-of-modern-slavery-through-healthcare-services
[25] In 2012, around two-thirds of trafficking victims identified by the Serious Organised Crime Agency (SOCA) had not been referred to the National Referral Mechanism (additionally, we assume, victims not identified by SOCA had also not been referred): see SOCA, A Strategic Assessment on the Nature and Scale of Human Trafficking in 2012, August 2013, p6 (paragraph 8) available at http://tinyurl.com/ojfa8e8
[26] 2004 meeting of the Population Division of ESA, UNICEF reported that child trafficking for labour is attractive because children are "easier to abuse, less assertive, and less able to claim their rights than adults'

Recommendations

- Retain free access to primary, emergency and other essential care for everyone living in the UK. No-one should be charged primary, out of hospital or emergency care**.**

- Retain exemption for prescription charges for pregnant women, children and those on low incomes living in the UK.

- Exemptions from all healthcare charges for pregnant women and children living in the UK.

- No changes should be implemented until a full evaluation of the impact of the Migrant and Visitor NHS Cost Recovery Programme, including the impact upon vulnerable groups has been completed.

- NHS information should not be shared with the Home Office and accessing treatment should never be used as a means of immigration enforcement.

- Health professionals should be supported and trained to take care of all patients regardless of their administrative status.

Doctors of the World is part of the Médecins du Monde network, an international humanitarian organisation providing medical care to vulnerable populations. In the UK, we run a volunteer-led clinic and advocacy programme with GPs and nurses that helps the most vulnerable members of the community to get the healthcare they need. We work primarily with migrants, asylum seekers, refugees, homeless people and sex workers.

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