Briefing on the 'hostile environment' policies affecting access to NHS services: Overseas Visitors Charging in the NHS

May 2018

Summary

- The current ID-checking and charging regime causes delays to urgent treatment and deters vulnerable people from accessing vital care, damaging health;
- Eligibility checks and charging in the NHS present a dangerous public health risk, they are leading to racial discrimination, and are effectively unworkable, putting a significant extra burden on already-stretched NHS staff;
- There is insufficient evidence that the regulations provide a cost-saving for the NHS;
- Health and social justice organisations are calling on Government to withdraw the 2017 regulations and implement a full-scale independent review of all patient charging Regulations, with a focus on public and patient health.

Background

The Government recently agreed to amend the Memorandum of Understanding (MOU) which governed data-sharing between the NHS, the Department of Health and Social Care (DHSC) and the Home Office, following pressure from doctors' groups, cross-party MPs and civil society organisations. The amendments mean that there are now more limited circumstances in which patient records can be shared for the purposes of immigration enforcement, and are a significant step in improving access to healthcare and restoring patient trust and medical confidentiality in the NHS.

This is an important victory, but as Jon Ashworth MP rightfully declared, much remains to be done to address the 'hostile environment' policies currently undermining patient care.

The NHS (Charges to Overseas Visitors) (Amendment) Regulations 2017 built on the earlier 2015 Regulations and introduced eligibility checks and obligatory upfront charging across NHS secondary care services in England, in hospitals and community settings. Unless deemed urgent or immediately necessary, treatment is now withheld if the patient is unable to pay the full amount in advance. These Regulations require a flag to be placed on patient records of those who are chargeable. Patients are billed at 150% the cost of care. Unpaid debts of over £500 lead to patient details being shared with the Home Office and can be used to deny any future application to enter or remain in the UK.

The suspension of the data-sharing MOU is a welcome development. However, it does very little to mitigate the harm caused by the Overseas Visitors Charging Regulations, and does not affect data-sharing in cases where patients carry NHS debt.

A number of key medical stakeholders have shared concerns about these charging rules, including the British Medical Association Royal College of Paediatrics and Child Health, the Royal College of GPs, the Royal College of Midwives, the Faculty of Homeless and Inclusion Health, the Faculty of Public Health, the Faculty of Sexual and Reproductive Health, Trade Union Congress, Unite the Union and UNISON.

This briefing has been prepared by a group of organisations, including frontline providers, with long experience of research, advocacy and campaigning on the above issues.

We call on Labour to take note of the substantial body of evidence supplied below that the 'hostile environment' policies behind the NHS Overseas Visitors Charging Regulations are seriously undermining patient care, are unworkable and are costing the NHS money. We seek your support in calling on Government to withdraw the 2017 Regulations and implement a full-scale independent review of all patient charging Regulations, with a focus on public and patient health.

Hospitals delay and withhold urgent treatment due to ID checks and inability to pay

If a patient cannot prove that they are entitled to free care, they will receive an estimated bill for their treatment and it will be withheld until the patient pays in full, unless their treatment is 'urgent' or 'immediately necessary', as determined by doctors. This affects people who are fully entitled to free care but who may not have easy access to paperwork and passports, such as homeless people, elderly people, those living with mental health conditions and asylum seekers.

Case studies collected at DOTW's clinic and by the Brixton Health Inclusion Clinic, a specialist GP service (see Appendix), show that urgent and immediately necessary care is being delayed and erroneously withheld from child refugees, victims of trafficking living legally in the UK and other vulnerable migrant patients due to the obligation on hospitals to charge upfront and determine eligibility.

In other instances, exemptions from charging that are designed to protect vulnerable patients (survivors of torture, FGM, domestic violence) and reduce risks to public health are not being applied in practice.

Charging, eligibility checks and data-sharing deter patients, including pregnant women, from accessing necessary treatment

Many of the people affected by charging are in vulnerable circumstances, often living in destitution or exploitative conditions. Fear of being reported to the Home Office deters many from seeking timely healthcare.

Independent research conducted at the DOTW clinic showed that of patients who were affected by healthcare charging in 2016-2017, over one third had been deterred from seeking healthcare and had delayed treatment as a result. These patients included heavily pregnant women and individuals suffering from a range of acute conditions, such as cancer (including breast, cervical, prostate, oral, kidney and brain cancers), diabetes, cataracts, kidney failure, fibroids, end stage renal failure and post-stroke complications.

The deterrent effect of antenatal care charges was particularly stark. Almost 2 in 3 of the pregnant women had not yet accessed antenatal care at 10 weeks of pregnancy (34/55) despite the National Institute for Health and Care Excellence recommendation for a first appointment by that time. One quarter had not accessed antenatal care at 18 weeks and in one case, antenatal care was not accessed until 37 weeks of pregnancy, posing a grave risk to the health of mother and child. Maternity Action's research, involving 55 case studies of women affected by charging, similarly found that fear of high bills routinely deters vulnerable migrant women from seeking timely and regular maternity care.

As DOTW UK has reported, efforts by patients to make their debt more manageable are sometimes hampered by resistance on the part of the hospital to set up repayment plans. Additionally, patients who are repaying their debts in instalments may still be reported to the Home Office (guidance on this matter is unclear). This leaves many patients in impossible positions, obliging them to make a trade-off between getting the treatment they need and the risk of putting their future in the UK in jeopardy.

Eligibility checks and charging present a significant public health risk

The 2015 NHS Charging Regulations and 2017 Amendments seek to restrict access to free healthcare for those considered to be ineligible for treatment. Putting in place structural barriers to medical treatment for anyone in a population is a serious public health risk that has not been assessed by the Department of Health and Social Care.

Evidence submitted to the DHSC over the duration of their formal review into the 2017 Amendments has clearly shown that certain communities are disproportionately impacted by charging, particularly those with protected characteristics. This includes pregnant women, those with mental health disorders, and those from ethnic minority communities. This directly contradicts the government's duty to work to improve public health.

While the treatment of illnesses related to infectious diseases is officially exempt from charging, there is widespread concern among health professionals that this exemption will be ineffective. Patients present with symptoms rather than diagnoses, and if those who would otherwise be ineligible for NHS treatment are deterred from seeking medical advice or if treatment is delayed, this poses a significant risk to individual patients as well as to the surrounding community.

The charging rules are unworkable in practice and are currently leading to discrimination

To avoid breaching equality legislation, hospitals and community healthcare services need to ask every patient, British citizen or person under immigration control, to prove they are entitled to free NHS care before they receive treatment. Yet testimony from NHS professionals and patients suggests racial profiling is being used by staff to identify chargeable patients. DoTW UK currently see hospitals targeting patients that don't look or sound British, and NHS staff have reported being directed to scan booking lists for names that don't appear British. Such an approach threatens to undermine the Prime Minister's recent call for change following the Race Disparity Audit, which highlighted the different treatment and outcomes of ethnic groups across public services.

Furthermore, a survey by Medact in the North West of England found a majority of health professionals could not confidently define the difference between patients eligible for free care and those who are not; or identify which NHS services are currently chargeable. This demonstrates an alarming knowledge gap.

Bridging this knowledge gap and ensuring that eligibility checks do not lead to racial profiling would necessitate an extensive, time-consuming and costly staff training programme and lead to a huge increase in NHS staff workload, taking health workers away from their primary duty of caring for patients.

From a clinical perspective, delays in treatment due to confusing guidance about what is considered 'immediately necessary' - weighing up the need for treatment with inaccurate estimates of when a patient's immigration status may be resolved - may lead to deteriorating health conditions and prolonged pain. This directly contradicts health professionals' primary duty of care toward their patient, and NHS workers and health bodies have expressed this concern.

Government has stated that administrators are responsible for checking patient entitlement and that this burden will not fall on medical professionals. However, this does not take into account the fact that administration teams will largely be absent in out-of-hours services, and that only medical professionals can make a judgement about whether treatment is 'urgent' or 'immediately necessary'.

Insufficient evidence that the regulations represent value for money for the NHS

We recognise the need to safeguard NHS resources, but there is little evidence that this policy will save the NHS money.

The Department of Health Impact Assessment prior to introducing of the Regulations anticipated a financial saving of just 0.00016% of the NHS annual budget, and evidence suggests these figures may have been overestimated. Moreover, the Impact Assessment failed to take into account the administrative costs of the regulations, or - more importantly - the additional cost of delayed treatment and increased presentation for emergency care. A number of independent studies looking at similar policies in Europe showed that providing preventative and primary healthcare to everyone, including migrants, is more cost-effective than restricting it.[i]

The Department of Health and Social Care 'formal review' of the regulations is inadequate

After considerable pressure to follow through on commitments to an assessment of the unintended consequences for vulnerable people of extending NHS charges, the DHSC conducted a 'formal review' of the impact of the regulations. However, the review has been narrowly publicised and too limited in scope to capture anywhere near the full range of impacts.

Recommendations

- The 2017 Amendment Regulations should be withdrawn immediately; and full assurance should be given that charging will not be extended to any other services.
- A full-scale independent review of the 2015 NHS Charging regulations should be conducted, with particular focus on public health outcomes, the impact on vulnerable groups, and the cost-effectiveness of charging regulations.

What can MPs do?

- Write to the Health and Social Care Select Committee asking for an inquiry into the impacts of the charging regulations.
- Call for full Parliamentary scrutiny of charging in the NHS.

Appendix: Case studies

Djibril, refused asylum seeker with cancer

Djibril says that when he was refused cancer treatment he was "very scared and desperate [...] and worried that [his] days were numbered". He had arrived in the UK 17 years earlier, fleeing political persecution in his home country. He claimed asylum, but this was turned down. Twice the Home Office has tried to return him to his home country – yet on each occasion the local authorities refused to allow him back. Unable to return home, he remained living in limbo in the UK.

In 2016 he was diagnosed with cancer and told he needed surgery, but the hospital cancelled the operation because his asylum case had been refused. Djibril's medical notes explained that there was a risk of the cancer spreading if he did not receive treatment. Despite this, the hospital declined to treat him unless he paid for the surgery in advance. Unable to pay or return home for treatment, Djibril came to Doctors of the World. The treatment was provided after a significant delay and after we supported Djibril to get legal help to challenge the hospital's decision.

Adaeze, survivor of trafficking with leave to remain in the UK

Adaeze is a 47 year-old woman with complex medical and mental health problems. She was a victim of trafficking and had been granted 12 months of leave to remain. She was seen regularly at a London hospital, as she was on the waiting list for an organ transplant.

Following the identification of some worrying symptoms by her GP, she was referred urgently to a specialist clinic at the same hospital for investigations. When she arrived, the receptionist informed her that she could not be seen as the computer stated that she was not entitled to NHS care. Our patient explained to the receptionist that there was a mistake.

An Overseas Visitors Manager asked Adaeze for proof that she had leave to remain, which she did not have on her. She was told that she could not be seen, but was never given the opportunity to discuss clinical need or urgency with a doctor. Fortunately Adaeze could speak fluent English and was fully aware of her entitlements due to her complex medical problems. She stood her ground and was insistent that she had to be seen. The doctor in the clinic eventually ignored the overseas officer and assessed the patient.

Burhan, Syrian infant refugee with serious congenital condition

Recently, a Syrian family arrived in the UK as part of the Syrian Vulnerable Persons Relocation Scheme (SVPRS). Their youngest son was born with a serious and life-threatening congenital illness and due to a deterioration in his condition, the family were fast tracked to the UK by the UNHCR for urgent specialist treatment and a possible organ transplant.

On arrival, the family attended an urgent appointment at a specialist unit in London, along with their allocated Arabic speaking support worker. The family have been granted refugee status and are entitled to free NHS secondary care.

At reception, the family were asked for proof of ID. The support worker was able to provide their UNHCR documents, but the Home Office had not issued their ID cards yet. The staff were not satisfied with this and queried whether the baby would be entitled to free NHS treatment. It took 40 minutes for the issue to be resolved and for the baby to finally be allowed to attend his appointment. The support worker felt if she had not been present to advocate, the family would have been turned away and the baby, who required urgent medical attention, would not have been seen.

The support workers for the SVPRS have reported a number of Syrian refugees, who have been asked for ID and documentation when attending their hospital appointments. As many of them have recently arrived in the UK, they often do not have this paperwork, and if they did not have an advocate present, would have been turned away from their appointments despite being entitled.

Source: Doctors of the World UK

---

[i] Trummer, U, Krasnik, A (2017) Migrant health: the economic argument. European Journal of Public Health. 27(4) p590-591.