FPH briefing on the NHS Charging regulations for overseas visitors in England

Background:

As the leading professional body for public health specialists and practitioners in the UK,[1] the Faculty of Public Health (FPH) has an important role in ensuring that all policies improve the health of the UK population, including undocumented migrants. This briefing documents the implications of the 2015 and 2017 NHS Charging Regulations on each of the three domains of public health, and makes recommendations for DHSC and for public health practitioners.

Public health is concerned with the health of whole populations, rather than any particular individual. It is commonly conceived as including three 'domains':

- *health improvement*, concerning structural and proximate determinants of health to reduce health inequalities;
- *health protection*, the prevention and control of communicable disease; and
- *health and care public health*, ensuring health services are appropriate for population need.[2]

While most migrants tend to be in good health at the start of their journey, the experience of migrating through transit and receiving countries can negatively affect both physical and mental health states.[3] Refugees and asylum seekers are known to have higher mental health needs than the general population,[4] and constitute an important group for effective public health practice.[5] Undocumented migrants are a group whose health needs are challenging to assess and meet. By definition their number is very difficult to estimate but a 2012 study estimated that 120,000 undocumented children were living in the UK.[6]

The 2014 immigration Act and subsequent regulations have substantially restricted access to healthcare for a large group within England (see *Box 1*). Implementation of these 'charging regulations' will affect people who are entitled to free care but who may not have easy access to identity paperwork: including homeless people or those living with mental health conditions.

Box 1: Eligibility for NHS Care in England

The Immigration Act (2014) restricted access to free-at-the-point-of-use care to those with indefinite leave to remain.[1] In 2015, an accompanying regulation was published which provided for anyone who was ineligible for care to be billed for secondary healthcare, at 150% of the cost according to the NHS Tariff.

NHS Trusts are legally obliged to charge non-EEA nationals who are in the UK for six months or less, or who are in the country without a visa, for care. Since 2017, Trusts must collect this money up-front before care can be provided. In some cases this has resulted in hospitals checking patients' eligibility for care prior to providing treatment.

[1] Previously anyone who was lawfully living in the UK with a settled purpose was eligible for free NHS care. There are a few exceptions for post-2014 eligibility, such as asylum seekers awaiting processing of their claim.

Since October 2017, these arrangements apply not only to secondary care but also to all community services including community midwifery and mental health services, as well as NHS-funded services provided by NGOs and charities. Following media interest the Department of Health confirmed that health visitor and school nurse services remain free of charge to all.[7]

The main exception to this arrangement is where the care is deemed "urgent" or "immediately necessary" by a healthcare professional, in which case care is provided and can be charged retrospectively. Furthermore, exempt services include A&E, family planning (not including terminations), treatment and diagnostics for certain infectious and sexually transmitted diseases, and treatments for conditions arising from torture, FGM, or sexual or domestic violence. No charge should be made for these services.

Implications for health services

The charging regulations present substantial implementation challenges for health care providers, risk the disengagement of migrants from all services, may lead to poor health outcomes and are not supported by good financial or ethical justifications.

In enacting the charging regulations, health care providers must assess all patients' immigration status and then define whether the care they require is urgent or immediately necessary. These definitions require providers to assess both their patient's clinical situation as well as when they are likely to leave the UK, which may require in-depth knowledge of immigration law and/or the asylum appeal process. This places a duty on clinicians that is clearly beyond the scope of their role. An independent report has found that the government's training of staff in the scheme has been limited,[8] and providers are therefore ill-equipped to appropriately define whether a patient is entitled to their care. It remains unclear who will be held responsible for harm caused by the incorrect withholding of urgent care.

Deterrence and disengagement. Published case studies and evidence suggest that the regulations will result in migrants disengaging from health care services, including from those that they are entitled to.[9] The aggressive cost recovery system, which includes threats of passing information to the Home Office, has been given in many case studies as a reason for disengagement.[10] Many migrants' poor knowledge of the regulations means they are unlikely to distinguish between care that they are or are not entitled to, with the result that they become deterred from all services.[10] Poor adherence to the regulations by health care providers has also resulted in services being withheld inappropriately, including the high profile case of Albert Thompson, whose cancer treatment was withheld despite its clear urgency.[11]

Public health implications. Migrants' disengagement from health care has a number of consequences for public health, notably including missed prevention and early stage disease treatment. This may result in significant harm to those affected, with knock-on implications for family or community carers. Despite the fact that undocumented migrants' precarious immigration status may present barriers to them sharing their stories, increasingly such cases studies are emerging through civil society groups.[9,10] Evidence from Spain estimated a 15% increased mortality in undocumented migrants following the implementation of similarly restrictive policies.[12]

Restricting access to health care for a group goes against the NHS founding principles, the 2011 NHS constitution,[13] and is in breach of international human rights law.[14] Such a restriction also affects the UKs ambition to achieve universal health coverage, a key target in the WHO's Sustainable Development Goals.[15]

No evidence for financial savings. The Department of Health and Social Care has sought to justify charging regulations on the basis of cost recovery for the NHS through tackling 'health tourism'. The government estimates the use of the health service by irregular migrants to cost 0.3% of the NHS's budget,[16] and although these estimates are based on crude calculations, they suggest that this population places a negligible burden on NHS funding. This is backed up by data from Doctors of the World showing that migrants attending their service wait an average of 6 years before accessing care.[17] Likewise, the National AIDS Trust have found no evidence of migrants travelling to the UK for HIV treatment.[18]

Such evidence calls into question the financial justification of the policy in England. Indeed, the cost of employing Overseas Visitors Teams (to enact the policy) in over 200 trusts will significantly offset any recovered funds; such costs have been disregarded in analysis of the scheme's financial implications.[8] When the longer-run is considered, the costs incurred through missed prevention and early treatment are likely to be substantial. Indeed, evidence from Germany demonstrated that excluding asylum seekers and refugees from health care ultimately results in greater health system costs than granting regular access.[19]

Implications for health protection

Despite exemptions for charging for many infectious diseases, the regulations risk undertreating and underdiagnosing infectious diseases in undocumented migrants, which may present a risk to both the wider migrant and general populations.

The charging regulations specifically exclude the management of many infectious diseases from being chargeable to overseas visitors. However in practice, the details of this exception are not clear to many patients and health care professionals and very little training or resources have been provided to health care staff to provide clarification.[8] There is the added confusion that prior to referral to secondary care, it is not always clear whether the diagnosis may be one of the excluded infectious diseases. As previously discussed, migrants may be refused investigation and/or treatment and the general hostility within health care may result in their disengagement.[10] Both situations may result in untreated infectious diseases.

For example, while the management of HIV is exempt from charging, many of the services where HIV diagnoses are made are not. Increasingly, HIV diagnoses are being made in setting such as antenatal care, drug and alcohol services and broader in- or out-patient services rather than in sexual health services, especially in Black African patients.[20] The requirement for upfront charging is of particular concern here: whereas previously patients may have accessed such settings, been assessed and potentially tested for HIV; they are now to be refused these services upfront meaning that opportunities for HIV diagnosis will be missed.

Migrants coming to Europe are known to have low vaccination rates[21] and are therefore at increased risk of contracting certain infections. While the risk of transmission to the host population of infections such as Tuberculosis has been shown to be negligible,[22] recent incidents involving other diseases such as measles have been linked to migrant cases.[23] The presence of a 'hostile environment' in the health system – which

discourages undocumented migrants from seeking early treatment or vaccination – thus poses a risk to the health protection of the whole population. The World Health Organisation highlights that European countries are well equipped to manage the 'threat' of diseases such as Ebola or Middle East Respiratory Syndrome (MERS) and advises that their response to large scale migration should instead be to ensure the access of vulnerable groups to acute health care.[24]

Implications for health improvement

The NHS Charging Regulations have the potential to negatively affect population health improvement. By increasing financial debt and precluding early detection of conditions, they are likely to further health inequalities experienced by undocumented migrants in the UK. The fact that these impacts appear to be affecting pregnant women and new mothers has particularly stark implications for public health given the importance of pregnancy and infancy health for future health status.

Financial debt. An important structural driver of health and health inequalities is the material resources and conditions available to individuals and groups.[25] Financial debts are known to drive psychological distress and have been shown to be associated with development and progression of physical health conditions.[26] Research with a group of undocumented migrants accessing healthcare at an NGO clinic in East London suggests that the Charging Regulations increase debts: 56% of patients who received a bill after discharge hadn't settled it one year later, and in many cases patients who offer to set up repayment schemes are prevented from doing so by hospitals.[9,10]

Qualitative research with this group suggests the result can be feelings of despondency, inability to cope, and compounding of physical symptoms.[10] Furthermore, this increased financial pressure is likely to increase the risk of exploitation that this group already face. International evidence shows that traffickers use threats around limitations on healthcare access as a means to keep victims within trafficked situations.[27]

Early detection and management of long-term conditions. Long-term physical and mental health conditions are leading drivers of burdens of disease in the UK, and among undocumented migrants in particular.[28] 'Secondary prevention' efforts – which are important to reduce the impact of disease and slow or stop its further development – often happen in community-based care or through population-based screening programmes. By presenting financial barriers to such services, the Charging Regulations are likely to deter people from seeking early care, thus precluding the possibility of such secondary prevention. Indeed, a quasi-experimental study in German showed that people subject to financial charges were less likely to attend screening or seek care early, obstructing the possibility of secondary prevention.[19] In-depth qualitative research has confirmed a similar 'deterrent effect' in the UK.[9,10,29] The implication of this is likely to be worsening of disease progression.

Maternal health and early child development. A life-course approach to public health suggests that pregnancy and the first years of infant development are particularly important for health improvement and the promotion of health in later life.[30] However the charging regulations may exclude or deter women from key health promotion interventions during this period. NICE guidance recommends that women with complex social factors should be reached though antenatal care provided in the community,[31] yet precisely these services are now chargeable for women.

International evidence suggests that undocumented migrant women choose not to access antenatal and postnatal services where they are chargeable: in Switzerland for example, undocumented migrant women did not access chargeable preventive measures, resulting in unintended pregnancies and poor vaccination coverage.[32] Research at the East London NGO clinic found many pregnant women had waited much longer than the 10-weeks recommended before accessing antenatal care.[10] Qualitative research with undocumented mothers found much increased stress due to debt caused by NHS charges, which is particularly concerning given the implications of maternal stress for child development.[9] Restrictions on access to Health Visiting services could have similarly harmful effects during this period, as highlighted by the National Children's Bureau.[33]

Conclusion and Recommendations:

The evidence reviewed here suggests that the NHS charging regulations present serious risks for health protection, reduction of health inequalities and for quality, equitable health services within England. The implementation of these charges risks pushing migrants to disengage from formal health services, which may lead to poor health outcomes and deterioration of conditions. This, together with international evidence, undermines financial or ethical justifications from a health services point of view. The regulations pose a risk for health protection as infectious disease are likely to be undertreated and underdiagnosed, despite being officially excepted. Finally, by increasing financial debt and precluding early detection of conditions, the regulations are likely to increase health inequalities experienced by migrants and their children.

In light of this, the Faculty of Public Health recommends that:

Members of the Faculty, including Consultants in public health working in Local Authorities or CCGs, should

- request assurance from local Trusts that implementation of the Regulations is not being done in a way that undermines quality of care or introduces discrimination.
- note the issues raised in this briefing when assessing and addressing the health needs of migrants locally

The Department of Health and Social Care (DHSC) should

- suspend the National Health Service (Charges to Overseas Visitors) Regulations of both 2015 and 2017 pending a full review of their impact on individual and public health.
- commission a fully independent review of the 2015 and 2017 regulations: covering their scope, purpose, delivery and impacts.
- make exempt from charging regulations all services that protect public health, including public mental health services, drug and alcohol treatment services and community midwifery services. Providers of these services should be enabled to make clear to the public that such services are exempt from charges, so as to avoid deterrence.

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