Public Health Review Questions

Introduction

These questions form part of a review of ‘The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017’. They have been provided to focus your responses on the issues covered by the review for which you, as a stakeholder with expertise in public health, may have relevant information. There may be some questions for which you do not have any relevant information; in this case leave this question unanswered.

Many of the questions ask for evidence. As stated in the document we have made available outlining the scope of the review we will consider all types of evidence, including, quantitative data, case studies, research and personal experience.

If you are unclear about what a question is asking or if you have information that you think is relevant to the review but is not asked for in these questions please contact alexander.sinclair@dh.gsi.gov.uk (0113 254 5760).

The requirement for all relevant bodies to charge upfront for non-urgent treatment

‘Relevant bodies’ are those organisations to which the Charging Regulations apply. The questions in this section apply to all relevant bodies.

It has been best practise for relevant bodies to withhold treatment from chargeable overseas visitors until the estimated full cost of the service has been paid, unless doing so would prevent or delay immediately necessary or urgent services, since the 1980s. The 2017 amendment regulations made it a legal requirement for relevant bodies to act in this way. Please bear in mind that the following questions are seeking to evaluate the effect of requiring relevant bodies to charge upfront for non-urgent treatment, rather than the practise of charging in advance for non-urgent treatment per se.

Response

1a. Do you have any evidence that the amendment regulation requiring all relevant bodies to charge upfront for non-urgent treatment has caused a public health risk as a result of some chargeable overseas visitors being deterred from presenting for treatment that is exempt from charge, such as the diagnosis and treatment of the specified infectious diseases?

The Faculty of Sexual and Reproductive Healthcare (FSRH) is the representative body for over 15,000 doctors and nurses working in sexual and reproductive healthcare, supporting healthcare professionals to deliver high quality care. We provide national qualifications in sexual and reproductive healthcare, clinical standards and evidence-based clinical guidance to improve sexual and reproductive healthcare for the whole of the UK in whatever setting it is delivered.
Fundamentally, FSRH believes that the current health and care system must be accessible to everyone, regardless of their citizenship status. In some cases this may mean providing confidential, free and non-judgemental sexual and reproductive healthcare (SRH) services for vulnerable patients, including paperless migrants, in hard-to-reach areas.

The amended regulations have only been in place since late 2017. Obviously, this has given very little opportunity to gather evidence on the impact of the regulations. We therefore draw from considerable prior evidence of the effects of NHS charging, as well as from the recent experience of our members.

These regulations must also been seen in relation to the 1st January 2016 Memorandum of Understanding published by the Home Office and NHS Digital that sets out how the Home Office may request information on immigration offenders from the NHS. The DH will be aware of in-depth media coverage of this topic – coverage based on research carried out by Maternity Action and Doctors of the World. There is a growing awareness among patients of this memorandum. In these circumstances, patients will undoubtedly be fearful of presenting to services whether chargeable or free of charge; this includes vital sexual and reproductive healthcare services.

Given this awareness, FSRH is concerned that the amendments to NHS regulations on charges for overseas visitors, especially up-front charging and mandatory proof of eligibility for free care, will place an extra burden on migrants, especially vulnerable women and girls who already find it difficult to reach out to SRH services. Confusion over who is entitled to free care will deter women and girls from seeking medical advice and receiving the care they need. The public health consequences of such confusion are plain.

FSRH associates itself with the view of BMA members that:

‘Systems to charge patients deter many people from presenting in the first place, including documented and undocumented migrants. They may not present at all, but more often, it means that they present later, when their condition has advanced further’

As a result, opportunities to apply preventive care are missed. Such care includes vital access to SRH services such as safe and effective contraception and abortion care, which are vital for women and girls to avoid unplanned pregnancies, curbing future costs in the NHS system.

To put this another way, opportunities to save money are lost. When patients with infectious illness present later or unplanned pregnancies occur, this increases the risk not just for them, but also for the wider population and for the NHS - costs which would not have been incurred if problems had been dealt with more promptly.

---


1b. Are there any actions the Department of Health could undertake to mitigate this public health risk?

FSRH endorses the views expressed by organisations (e.g. Maternity Action, Doctors of the World) and medical researchers (e.g. Hiam and McKee 2017) that these proposals should be withdrawn until a thorough impact assessment has been carried out.¹

Specifically

The Department of Health should:

- Suspend the extension of charges pending a full impact study - this present consultation lacks the scientific rigour to be such a study and cannot be a substitute for it. This should include further in-depth research on the impact of charging for maternity and postpartum care on migrant women and their families.

- Develop more effective public health campaigns, involving health awareness and promotion, to make clear to vulnerable groups that there are no charges of any kind associated with the diagnosis and treatment of STIs.

- As a matter of urgency, the DH should take all possible steps to ensure that clear messages are conveyed to vulnerable groups that key services such as sexual and reproductive healthcare services are not chargeable, and that no identity checks will be carried out on those who use them.

- Ensure any barriers to care pathways between and within services are removed. Examples of this include: ensuring women who have recently had an abortion have access to post-abortion contraception; ensuring women who have recently given birth have access to timely postpartum contraception; and ensuring that there are no deterrents or additional barriers for women and girls accessing SRH services through their GP or any other service.

- In addition the DH should support the removal of the obligation for NHS Digital to share patient data with the Home Office.


2a. Do you have any evidence that the amendment regulation requiring all relevant bodies to charge upfront for non-urgent treatment has caused a public health risk as a result of some chargeable overseas visitors being unable or unwilling to pay in advance for treatment that is not exempt from charge?

It is too soon for this question to be robustly answered.

However, there is ample research evidence (Britz and McKee 2016) that NHS stakeholders are concerned that implementing charging for migrants in England could deter medically necessary treatment, leading to threats to public health and increased health care costs. Feldman (2016) points out that charging deters many pregnant women from accessing maternity care, or results in late booking and missed appointments. Early booking and continuity of midwifery care are essential, especially for women with high-risk pregnancies due to underlying medical conditions and complex social factors. This includes access to postpartum contraception and other vital components of SRH care. Charging, in practice, denies access to care, information and services and creates a public health risk.

To further emphasise a point made in 1a, this problem has been exacerbated by Home Office policies designed to create a hostile environment for migrants, which have had a deterrent effect on accessing healthcare, and have created new public health risks. As FSRH have highlighted, this has already resulted in increased patient awareness, and a consequent reluctance to engage with NHS service provision. As explained above, the preponderance of BAME patients in this situation makes relevant questions of protected characteristics.

FSRH members have noted that access to maternity care and related sexual and reproductive healthcare is being limited by requirements for confirmation of status documentation to be produced. One member states:

‘Patients are now being asked to produce 2 forms of ID when they go for their booking. This affects the most vulnerable as many of our eligible patients don’t have 2 forms of ID - the homeless, addicts, sex workers, asylum seekers - who should be eligible. Some, who are not used to UK healthcare or who would be expected to pay in the country of origin, don’t understand the instruction and are concerned that they will have to pay - and do not have the finances to do so - and will then not attend.’

Another member writes:

‘We have seen a couple of pregnant asylum seekers in Bradford who were entitled to free care who have failed to attend after the first visit when they were asked to pay. The hospital team have then spent significant amount of time trying to track them down before then the women attending late in pregnancy - and one in labour - with no antenatal care. These women are very high risk and vulnerable.’

The FSRH emphasises that confusion will affect patients’ access to wider services even when they may currently be free of charge. This includes access to vital SRH services such

---

4 J. Britz and M. McKee (2016) Charging migrants for health care could compromise public health and increase costs for the NHS. Journal of Public Health 38 (2) 384-390
as those providing contraception and early access to safe and legal abortion care. The example of maternal care given by our members, is just one example of how a system of confusion will deny vulnerable women, and girls accessing essential healthcare services.

It is crucial that the Department of Health understands that GP services are often the first point of contact with the health system that vulnerable groups may make. Often denial of access to these services will prevent crucial signposting to other key services such as those specialising in SRH.

The problem of entitlement not being recognised by NHS institutions has been picked up by other FSRH members. Healthcare providers appear not to understand, and are not correctly implementing, current guidance; call-centre and clerical staff frequently lack understanding of relevant legislation and make decisions which disadvantage eligible patients. This problem is compounded for patients by language difficulties. There are many GPs who find that the patients for whom they arrange healthcare do not keep their appointment, and that the requirement that the patients produce two forms of ID is a factor in their unwillingness to attend.

As one GP member of FSRH states:

‘Anxiety about how to navigate health services coupled with a distrust of them results in non-attendance and increasingly poorer health. The government decision clearly compounds the inverse care law in this country, where by patients requiring care the most are the least likely to receive it.’

The operation of the “inverse law” has clear public health consequences, in creating a social group which lies outside the scope of effective medical care.

2b. Are there any action that the Department of Health could undertake to mitigate this public health risk?

See answer to question 1b above. The charges should be suspended, pending a rigorous impact study. In order to track any impact upon public health, deterrence and attendance rates need to be tracked over time to allow time identification of any emerging patterns or trends. This current formal review of immediate effects is no substitute for longer-term monitoring and research.

3a. Are there any conditions which you think present a particular public health risk, as a result of the requirement for relevant bodies to charge upfront for non-urgent treatment?

The Department needs to understand (see answer to Question 5) that policies intended to identify chargeable treatments have a knock-on effect on entitled but unsure users of non-chargeable treatments. This includes women and girls accessing vital SRH services. Barriers to SRH information, advice and care, e.g. in accessing a range of contraception, will increase the rate of STIs as well as unintended pregnancies and consequent unsafe abortions. The public health risks are obvious.
3b. Are there any action that the Department of Health could undertake to mitigate these risks?

See answer to 1b.

Extending charging into community services

The 2017 amendment regulations expanded the bodies required to make and recover charges from overseas visitors to include non-NHS providers of relevant services\(^6\). The 2017 amendment regulations also removed the exemption for relevant services provided outside a hospital or by its staff. As a result, some services provided in the community are now chargeable to overseas visitors who are not exempt from charge.

5. To what extent do you think there is a public health risk as a result of the extension of charging into relevant community services?

There is plainly a public health risk if vulnerable groups are deterred from accessing sexual and reproductive healthcare services. It has been established that public knowledge of charging policies is incomplete, and that charging has a deterrent effect even on groups entitled to free health care. There is no reason to think that take-up of sexual and reproductive healthcare services will not be similarly affected.

6. Do you have any evidence that the extension of charging into relevant community services has caused, or is likely to cause, a public health risk as a result of overseas visitors being unable to pay for relevant

a) Community midwifery services
b) Community mental health services
c) Drug and alcohol treatment services
d) District nursing services
e) Outreach services
f) Any other relevant community services
g) Are there any actions that the Department of Health could undertake to mitigate the risks you have identified in parts a-f?

In relation to mitigation, see 1b.

---

\(^6\) Only ‘relevant services’ are within the scope of the Charging Regulations. ‘Relevant services’ are defined in regulation 2 of the Charging Regulations to mean accommodation, services or facilities provided under the National Health Service Act 2006 ("the NHS Act") other than primary medical, dental or ophthalmic services provided under Parts 4, 5 or 6 of the NHS Act, or equivalent services provided under the NHS Act.
7a. Do you have any evidence that the extension of charging into relevant community services has caused, or is likely to cause, a public health risk as a result of overseas visitors being deterred from seeking treatment in community services which is not chargeable, such as community sexual health services, outreach services which diagnose or treat infectious diseases, school nursing or health visiting?

We know that asylum seekers and refugees as a marginalised group within the UK are considered to be at higher risk of HIV and STIs owing to their past experiences and to risk taking behaviour that includes unprotected sex.7

We know also, from evidence cited above, that charging has a deterrent effect on access to services – including community sexual and reproductive healthcare services due to widespread clinician and patient confusion and patient fear.

It is reasonable to anticipate on this basis that a larger proportion of STI cases, unintended pregnancies and wider SRH needs will not be adequately treated under a charging regime.

7b. Are there any actions that the Department of Health could undertake to reduce the likelihood of overseas visitors being deterred from receiving community service treatment that is not chargeable?

See 1b above.

8a. Are there any conditions, the treatment of which is exempt from charge8, which you think present a particular public health risk, as a result of the extension of charging into relevant community services?

See 7a.

8b. Are there any action that the Department of Health could undertake to mitigate these risks?

See 1b.

9. Are there any infectious diseases which you think should be added to the list of infectious diseases, the treatment of which is exempt from the charging, as a result of the extension of charging into relevant community services?

7 K. Burke (2011) Asylum Seekers and Refugees Sexual Health Needs Assessment. NHS Bolton

8 The list of conditions that are currently exempt can be found in the ‘Guidance on implementing the overseas visitor charging regulations’ in Chapter 4 (pages 30-31). The guidance document can be accessed from the following site: https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations
10. Please share any further comments or evidence relating to the issues covered by the review, as set out in the review scope document, that you have not had the opportunity to share in the previous questions.

Public Health England states that:

‘Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.’

It is evident that charging for services is exacerbating inequalities by driving a section of already vulnerable migrants into a situation in which their health is damaged or threatened. Vulnerable groups are denied access to sexual and reproductive healthcare services, being prevented from gaining information, advice, care and crucial signposting. They are equally denied from accessing other services which play the same vital functions. This is a tendency which runs counter to the interests of public health, and of social justice. It should be a priority to identify and suspend policies which contribute to such inequalities.

For more information please contact:

Harry Walker
Head of External Affairs & Standards
FSRH
27 Sussex Place
London NW1 4TG

Telephone: +44 (0)20 3751 8077
Email: externalaffairshead@fsrh.org

https://www.england.nhs.uk/about/equality/equality-hub/resources/