Doctors of the World UK Evidence to the Public Accounts Committee Inquiry on 'Recovering the cost of NHS treatment for overseas visitors'

Doctors of the World (DOTW) is an international humanitarian organisation providing medical care to vulnerable populations. In the UK, we run a volunteer-led clinic with GPs and nurses that helps the most vulnerable members of the community to get the healthcare they need. We work with migrants, asylum seekers, refugees, homeless people and sex workers. In 2015 we saw 1,601 people who were unable to access healthcare. DOTW sits on the DH delivery reference group advising DH on the impact of the programme on vulnerable people.

Key messages

- DOTW sees the impact of the Department of Health's cost recovery programme on vulnerable people living in the UK and is concerned this hasn't been fully considered in the implementation of the programme. We regularly see pregnant women frightened to access antenatal care, sick people not accessing urgent hospital care, people wrongly denied urgent care, people threatened their information will be shared with the Home Office and people who are destitute receiving large bills they are unable to pay being pursued by debt collectors. The programme impacts on people who should be exempt such as victims of trafficking and BME populations risk being discriminated against. Not only does this have an ethical and human rights impact it has a cost implication of delayed care, public health risks and increased health inequalities. Despite numerous commitments to evaluate this unintended impact, only a scoping study has been commissioned and hasn't been published.

- Only a quarter of the programme's income comes from directly charging non-EEA nationals at hospital trusts. The cost implications of this element of the programme have not been properly identified or evaluated. Any further implementation should at a minimum reconsider the cost of trusts providing a quality process which does not discriminate, pressure already busy NHS staff or exclude vulnerable patients living in the UK.

Recommendations

- DH commit to commissioning an in-depth independent evaluation which includes the impact of charges on vulnerable groups, the cost of implementation and wider cost implications such as public health risks before any further expansion of the programme is initiated.
- DH immediately mitigate some of the cost of unintended consequences by exempting vulnerable pregnant women, children and destitute people from the charging programme and stop all information sharing with the Home Office. Consider all trusts being instructed to write off bills and provide independent advice for destitute people.
- Any new forms of identifying chargeable patients should be piloted and evaluated, including the impact upon vulnerable patients and NHS staff before being rolled out.

1. Impact on vulnerable patients

1.1. DOTW welcomes the current exemptions to protect vulnerable groups but it is clear these are not working. The Major Projects Authority recommended that DH commissioned research on the impact of the programme on vulnerable

groups. The Home Affairs Committee also made it a condition of the charging regulations that DH undertake a review on the impact on vulnerable children. The UN Committee on Economic, Social and Cultural Right *2016 Concluding Observations* recommended 'the State party take steps to ensure that temporary migrants and undocumented migrants, asylum seekers, refused asylum seekers, refugees and Roma, Gypsies and Travellers, have access to all necessary health-care services, and reminds the State party that health facilities, goods and services should be accessible to everyone without discrimination, in line with article 12 of the Covenant.'

1.2. DH has commissioned a scoping review of the impact of the programme on vulnerable groups which was limited to a few days interviewing key stakeholders, did not involve any direct work with patients, recommended further work needed to be taken and did not have a particular focus on children. A final version of the scoping review has not been published.

1.3. Since the programme was launched DOTW's casework has increased significantly. We advocate on behalf of vulnerable patients who should be exempt from charges such as refugees, asylum seekers and victims of trafficking, but still receive bills, patients who need 'urgent or immediately necessary treatment' including maternity care, cancer treatment and cardiac surgery but are being denied it, patients who receive bills for treatment that is exempt from charges, and we advocate on behalf of patients who have received treatment and are being aggressively pursued by hospitals and debt collectors even though they are destitute and have proved they have no income.

1.4. The programme has increased the contact hospitals have with the Home Office [i]. When DOTW patients receive letters threatening to report them to the Home Office they become too afraid to engage with healthcare. It also places doctors in a difficult position; if they are not able to reassure a patient their information will not be shared the doctor-patient relationship is undermined.

1.5. *In 2016 we saw a 46 year old woman who had was trafficked into the UK 15 years ago for sexual exploitation. After 12 years she had cleared her debt to her trafficker and continued to work as a sex worker. She discovered a lump in her breast but was too afraid to access healthcare because of her immigration status. She came to DOTW when the lump was so painful she could no longer work. We supported her to access hospital care where she was diagnosed with secondary terminal breast cancer and given palliative care.*

1.6. *In 2016 we saw a 17 year old boy diagnosed with a tumour in his shoulder refused treatment unless it was paid for in advance. His family were undocumented and on a low income so explained to the hospital they would not be able to pay the full amount in advance. The hospital discharged him. The patient came to DOTW three years later with extreme pain and wasting of his left arm. We are still advocating on his behalf.*

1.7. *In 2015 we received an email from a Sri Lankan man: '"I am an asylum seeker in the United Kingdom and my claim have not been decided yet. In the mean time I have now been admitted in the XXXXXX hospital having been diagnosed with colorectal cancer. Doctors say that my condition is critical. Also doctors said I am not entitled for the NHS treatment as I am an asylum seeker. Therefore they have not been commence any*

treatment yet, but my condition is deteriorating day by day.." DOTW contacted the hospital and the OVM stated that the Home Office had informed them he was a refused asylum seeker. We managed to get legal advice for the patient. In the end he was able to access care but after a delay.

1.8. *A 25 year old asylum seeker who was scheduled to have cardiac surgery. When her asylum application was refused the Home Office immediately notified the OVM and the Hospital cancelled the surgery 5 days before the surgery was due. DOTW challenged the hospital that the operation should have been treated as 'urgent or immediately necessary'; the OVM admitted they had cancelled the surgery without waiting for a clinician's decision over whether the treatment was 'urgent or immediately necessary'. Her operation has not been re-booked.*

1.9. *In 2015 DOTW saw a 17 year-old from Somalia living undocumented in London since 2007 was rushed to A&E and diagnoses with meningitis. His mother received bills totalling over £5,000 for her son's treatment: 'they said we needed to pay the money immediately. If we failed to pay, they would take us to court; add charges and even send [the matter] to the Home Office.' Terrified and unable to pay, she turned to DOTW. DOTW volunteers took up the case, as an infectious disease meningitis should be excluded from charging and the charges were cancelled.*

1.10. *In October 2014 a 35-year-old woman from the Philippines came to our clinic, she had worked as a nanny in the UK for 18 months. She had recently been diagnosed with breast cancer requiring urgent chemotherapy, the hospital refused to provide this and gave her a letter which said she 'is not entitled to treatment under the NHS'. After our intervention the chemotherapy went ahead and she was billed for the care. In April 2015 she came to see us again as she required a further cycle of chemotherapy and the hospital had refused the care again. We contacted the hospital and reiterated the definition of 'urgent' and they agreed to progress the treatment which she has been billed for again, she cannot pay and the hospital have threatened legal action.*

1.11. *In July 2015 DOTW saw a 54-year-old man from Uganda who had been in the UK for 23 years, he had been granted indefinite leave to remain 13 years ago. He was refused palliative care for oesophageal cancer by an NHS trust as they wrongly classified him has being chargeable for NHS care. After accessing legal advice he was eventually provided with the care and compensation.*

1.12. *An asylum seeker from Sri Lanka who needed surgery came to DOTW after receiving a £3423 bill for scans and tests and a letter from the hospital cancelling her surgery. DOTW contacted the hospital and the OVM claimed the Home Office had wrongly informed them that the patient was a refused asylum seeker. The hospital then cancelled the bill.*

1.13. *In November 2015 were contacted by the friend of a 32-year-old asylum seeker from Sri Lanka, he had been admitted to hospital in London and diagnosed with end-stage colon cancer. His doctor advised he needed palliative chemotherapy but the referral could not be made as the Overseas Visitor Manager (OVM) had checked with the Home Office and they had incorrect information on his immigration status which resulted in the hospital saying he was not eligible for NHS care. After DOTW made a number of calls to the OVM his status was clarified and they referred him for the care he needed after a delay.*

1.14. *In October 2016 we saw a patient with kidney cancer whose surgery to remove the tumour had been cancelled by the hospital because of his immigration status. He has been living in the UK for 17 years. As a refused asylum seeker the Home Office had tried to return him twice but his country of origin has refused to accept him. DOTW contacted the hospital who confirmed that the there was a likelihood of the tumour spreading but that surgery would be withheld until the patient paid for the surgery in advance. DOTW continues to advocate for this patient.*

1.15. *A patient presented at our clinic, 23 weeks pregnant. She was too scared to go for antenatal care as she was worried about being arrested by the Home Office. She was referred to A&E by DOTW clinician due to concerns about her health. She was admitted to a nearby hospital and then discharged after a few days but went into premature labour and lost her baby in the early neonatal period. She received a bill for £2,620.*

2. Delayed care

2.1. It is a well-documented that providing good access to healthcare saves money in the long run[iiiii]. The programme impacts on people who have been living in the UK from a long time, who don't have access to any other healthcare system and who are unlikely to return to their country of origin. Healthcare needs left untreated often require more complex, expensive treatment or emergency care later on.

2.2. The DH Safer maternity care action plan launched by Jeremy Hunt in October 2016 highlighted the importance of maternity care in reducing rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths. In 2015 a DOTW report evidenced that the programme impacted on pregnant migrant women's access to antenatal care[iv]. Charges and entitlement checks deterred women from accessing the NHS and antenatal care was frequently received late (62% after 12 weeks and 34% after 20 weeks of pregnancy), often not meeting the minimum standards for care and subsequently putting women and their unborn children at increased risk of pregnancy-associated complications. Of the women surveyed (34) two women lost their babies, one at 42 weeks and the other in the early neonatal period. Both of these mothers received a bill for their hospital care.

3. Healthcare professional's engagement and time

3.1. It is inescapable that doctors, nurses and midwives will play a role in the charging process, support administrative staff to identify chargeable patients, identifying patients who should be exempt from charges such as victims of trafficking and they making assessments as to whether care is 'urgent or immediately necessary'.

3.2. There is still much work to be done to engage clinicians with the charging programme and the cost of engaging healthcare professions with the programme and the increased resulting workload has not been quantified.

- *"Of those staff who knew that some patients are chargeable, 48% of hospital doctors, 27% of nurses and 36% of administrative staff said they did not have a role with regards to chargeable patients."*
- *"Some front-line staff at trusts were reluctant to ask patients questions to establish their chargeable status because they could be perceived as discriminatory, or because*

it would undermine trust. Many staff, including clinicians, considered that it was not part of their job to support the charging of overseas visitors."

4. Public health

4.1. Public health measures such as vaccinations, screening and preventative treatment save money but must be accessible to the whole population. This has been recognised in the Department of Health's national strategy for sexual health, HIV treatment is free to everyone and this saves *between £500,000 and £1 million per patient.3.*

4.2. The programme exempts communicable diseases from charges, however, this exemption is of limited value in practice. The deterrent effect of the programme undermines public health mechanisms and limits their ability to save money for the NHS.

5. Health inequalities

5.1. The 2012 Health and Social Care Act established a legal duty for the Secretary of State for Health to reduce health inequalities which are estimated to cost the NHS more than £5.5 billion per year[v].Recognising that the programme presented a risk to health outcomes for migrants and worsening health inequalities, one of its overarching principles was *"not [to] increase inequalities - In developing these proposals we shall ensure the needs and interests of vulnerable or disadvantaged patients are protected.'*

6. Discrimination

6.1. The programme is at risk of being applied in a discriminatory way. Those who do not look or sounds British may be disproportionately targeted by entitlement checks. Some will be fully entitled to care but unable to provide evidence to prove this. Black and Minority Ethnic (BME) people in the UK already have worse health outcomes[vi] and BME women already have worst maternal outcomes [vii].

7. Proportionality

7.1. The amount of income from direct charges made up only 24% of the total amount charged for treating overseas visitors and although the amount charged directly has increased this will not necessarily continue. [viii]: The estimate was based on the amount invoiced £69m rather than the amount actually recovered, which was £29m. The difference between the amount charged and the amount actually recovered is an important consideration. Many people who are issued with bills will not be able to pay. DOTW support patients who receive healthcare bills, 80% of whom are living below the poverty line.

8. The cost of implementation

8.1. The NAO report states *"[the programme] does not take account of the costs of implementing the cost recovery programme. The Department estimated in its impact assessment that additional costs would be low, but the net gain for the NHS is not clear."*

8.2. DOTW's experience is that the process of charging patients is complicated, practice is variable across hospital trusts and to be implemented requires management and

administrative staff with expertise in identifying chargeable patients and raising invoices incurring employing and training costs. It also requires frontline medical staff to be involved.

8.3. Findings of Freedom of Information requests which 152 trusts responded to have been made to all hospital trusts in England and shared with DOTW, they found a third of trusts spent more on the team than they recovered from direct charges, and a further 28% spent over 60% of the income recovered on their overseas team.

8.4. St Georges Hospital Trust has recently announced it will be carrying out a pilot in its obstetrics department to increase identification of chargeable patients. The Trust acknowledged that to ensure the pilot is not discriminatory, all women will be required to provide two forms of ID to prove their eligibility when attending maternity services. Admin staff will be trained to carry out eligibility assessments and spend time carrying these out on every patient at reception. This is an example of the substantial direct costs involved in implementing the programme which have yet to be quantified.

Recommendations

- DH commit to commissioning an in-depth independent evaluation which includes the impact of charges on vulnerable groups, the cost of implementation and wider cost implications such as public health risks before any further expansion of the programme is initiated.
- DH immediately mitigate some of the cost of unintended consequences by exempting vulnerable pregnant women, children and refused asylum seekers from the charging programme and stop all information sharing with the Home Office. Consider all trusts being instructed to write off bills and provide independent advice for destitute people.
- Any new forms of identifying chargeable patients should be piloted and evaluated, including the impact upon vulnerable patients and NHS staff before being rolled out.

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i NAO report states "Trust staff we spoke to said that an effective way of enforcing payment was the Home Office record of people with outstanding debts,)." The report also notes "there is currently little evidence on the feasibility, costs and benefits of [this] approaches."

ii EU Agency for Fundamental Human Rights, Cost of exclusion from healthcare 2015

iii Economic evaluation of extending entitlement to healthcare to irregular migrants. A case study of Type 2 Diabetes. Final report October 2011 by Matrix Evidence.

iv http://b.3cdn.net/droftheworld/5a507ef4b2316bbb07_5nm6bkfx7.pdf

vi Nazroo, J. (1997) The Health of Britain's Ethnic Minorities: Findings from a national community survey, London: Policy Studies Institute.; Sproston, K. and Mindell, J. (eds) (2006) Health Survey for England 2004. Volume 1: The health of minority ethnic groups, London: The Information Centre.

vii Bharj, K.K. (2007) Pakistani Muslim Women Birthing in Northern England: Exploration of experiences and context, unpublished thesis, Sheffield: Sheffield Hallam University; Redshaw, M., Rowe, R., Hockley, C. and Brocklehurst, P. (2007) Recorded Delivery: A national survey of women's experience of maternity care 2006, Oxford: National Perinatal Epidemiology Unit; Commission for Healthcare Audit and Inspection (CHAI) (2007) Women's Experience of Maternity Care in the NHS in England, London: Commission for Healthcare Audit and Inspection; and Commission for Healthcare Audit and Inspection (CHAI) (2008) Towards Better Births: A review of maternity services in England, London: Commission for Healthcare Audit and Inspection.

viii "the increase in amount the trusts invoiced to patients directly is likely to be due to a change in the charging rules that allowed trusts to charge 150% of the tariff prices for treatment in 2015-16, rather than because trusts were implementing the regulations more effectively."