Safe Surgeries training: Understanding migrant rights to NHS care

Peer-to-peer trainer's guide

Doctors of the World (DoTW) UK's Safe Surgeries project aims to improve access to healthcare for migrants in vulnerable circumstances in the UK. This Guide is intended to support the delivery of the Safe Surgeries peer-to-peer training by providing additional information on the topics raised in the training slides. It is NOT a script for delivering Safe Surgeries training, but should give trainers the confidence to discuss and expand on issues if needed. In general, the information contained in the slides has not been repeated here, so please use both documents to gain a fuller picture of the topic at hand.

Each training module is designed to take approx. 1.5 hours.

Topic	Talking points
Background on DoTW UK	• DoTW UK is part of the international Médicins du Monde (MdM) network. • Established in 1980, it is an international organisation that provides medical care, strengthens health systems and addresses underlying barriers to healthcare in 80 countries. • Examples of international programmes are: Ebola response in Sierra Leone, Hurricane Mathew in Haiti, healthcare along refugee routes in Europe. • The UK programme centres around the DoTW drop-in clinic in East London, as well as a number of regular outreach clinics hosted by partner organisations across the city. • Clinic services are for people who cannot access the NHS, and include: short term medical care, GP registration advocacy and advocacy with hospitals around charging. • We use data, experience and testimonies from our clinic to inform our policy and advocacy work to improve access to healthcare.
Background on DoTW UK: Who comes to the clinic?	• In 2016, 1,906 people attended the DoTW clinics. • Mainly undocumented migrants (56%) and asylum seekers (15%). • 230 women sought support with pregnancy/family planning at our designated women and children's clinic. • Wide range of country of origins. Largest share is from the Philippines – usually domestic workers. • On average our patients were living in UK for almost **6 years** before trying to access healthcare. This contradicts misleading arguments made in the media about the prevalence of health tourism. ***Relevant resource:*** *DoTW UK. 2016 Impact report*
Defining legal 'categories' of migrant	• To understand healthcare entitlement, you need to have a basic understanding of some of the different possible immigration statuses that exist. See slides for range of legal statuses.

For more information and to let us know about training you deliver, contact Jennie Corbett, jcorbett@doctorsoftheworld.org.uk

Primary care entitlement	• If the NHS England guidance was implemented correctly by GP practices, some of the greatest barriers to access for our patients would be resolved. • Unfortunately, practice administrative procedures often clash with the guidance and many practices insist on proof of ID or address in order to register a patient. • In 2017, new questions on residency status were added to the GMS1 form, which is used to register new patients. While patients are not required to complete these questions, their addition prompts some to carry out checks on immigration status that are not necessary and can be intimidating. • In an effort to mitigate the risk that these questions deter undocumented patients, some practices routinely cross out this new section of the form. ***Relevant resources:*** *NHS England (2017) Primary Medical Care Policy and Guidance Manual* *BMA, NHS Employers & NHS England. Guidance for GMS contract 2017/18. August 2017.* *DoTW UK (2018). Healthcare Entitlement in England.*
Barriers to access in primary care	• Clinic data from 2016 gives insight into the barriers our service users faced. • 94% of service users had experienced difficulties accessing healthcare, and 89% were not registered with a GP when they came to our clinic. See slides for breakdown of barriers reported. Registration Refused study (primary care module, slide 12): • We recorded the outcome of 1,717 attempts to register patients with NHS GPs in England in 2017. • 20% attempts were refused. 16% of practices always refused GP registration and a further 14% gave inconsistent responses; sometimes they would register a patient, on other occasions they would refuse. • The biggest barrier to GP registration was inability to provide paperwork: 34% of registration refusals were because of lack of ID; 33% because of lack of proof of address; and 10% because of immigration status. ***Relevant resources:*** *DoTW UK. 2016 Impact report* *DoTW UK (2017) Registration refused: A study on access to GP registration in England*
Charging in secondary care	• Access to secondary care depends largely on whether or not a person is eligible to be charged and/or to be charged upfront for their treatment. • Charges are levied at 150% of the NHS tariff e.g. £6,500 for maternity care for an uncomplicated pregnancy and delivery. • Chargeability depends on immigration status. Undocumented migrants (incl. refused asylum seekers in England) are charged upfront for secondary care delivered in hospitals and by NHS-funded services in the community. • A number of service exemptions from charging also exist, including: primary care; A&E (including walk-in centres, minor injuries units or urgent care centres), up until the point when patient admitted; family planning services (not termination of pregnancy); diagnosis and treatment of specified infectious diseases and STIs; palliative care services provided by a registered palliative care charity or a community interest company; services

	provided as part of the NHS111 telephone advice line; and treatment required for a physical or mental condition caused by: torture; FGM; domestic or sexual violence. • Non-EEA migrants pay a visa health surcharge rather than being charged upfront. EEA nationals have a right to free healthcare (EU + Switzerland). ***Relevant resources:*** *DoTW UK (2018). Response to the Department of Health and Social Care formal review of 'The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017.* *DoTW UK. Briefing on Amendment of the National Health Service (Charges To Overseas Visitors) Regulations 2015* *Department of Health (2017) Guidance on implementing the overseas visitor charging regulations.* *DoTW UK (2018). Healthcare Entitlement in England.*

Groups exempt from charging	• These are the groups that are exempt from charges altogether:
	    • Refugees and asylum seekers;
	    • In England, a small number refused asylum seekers, i.e. those receiving the following types of government support for which there is a very high threshold:
	        o Section 95 – Home Office support for refused destitute families;
	        o Section 4(2) – Home Office support for destitute and unable to return to country of origin;
	        o Support under the Care Act - refused asylum seekers who get accommodation from their local authority due to a disability.
	    • Survivors of trafficking;
	    • Survivors of sexual or domestic violence, FGM, torture - only for treatment related to experience of violence;
	    • Children looked after by a local authority;
	    • People being treated under the Mental Health Act;
	    • People held in immigration detention.

Urgent or immediately necessary care	• Care that is classified as 'urgent or immediately necessary' by a clinician must be given regardless of ability to pay. It should not be denied, delayed or discouraged even if a patient cannot afford to pay. • This does not mean it is free, but that the patient does not have to pay in advance. • This may be the area in which clinicians' have the greatest power to affect their patients access to treatment, as the definitions of 'urgent' and 'immediately necessary' are relatively broad. They are: • Immediately necessary: Life-saving; will prevent a condition becoming life-threatening or will prevent permanent serious damage. • Urgent: Cannot wait until they can leave the UK; Should take into account pain, disability, and the risk of the delay exacerbating their condition. • For undocumented migrants assume may not be able to return within 6 months. ***Relevant resource:*** *Department of Health (2017) Guidance on implementing the overseas visitor charging regulations, p. 64-65.*

Evidence of the deterrent impact of charging	• Independent research conducted at DoTW clinic in 2016 showed that hospital charging deters and delays vulnerable migrants from seeking the healthcare that they need. • Over 1/3 DoTW service users affected by charging were deterred from timely NHS care as a result (n=49/143). • Patients who reported delaying or avoiding care included heavily pregnant women and people suffering from cancer, diabetes, cataracts, kidney failure, fibroids and post-stroke complications. • Almost 2/3 pregnant women hadn't had any antenatal check at 10 weeks (n= 34/55), which is when the National Institute for Health and Care Excellence recommends a pregnant woman should be seen. 1 in 4 had not been seen at 18 weeks; and one woman didn't have her first appointment until 37 weeks of pregnancy. • Over 1/2 service users with a bill had not settled it after 1 year (n=18/32) and in one case, 7 years later. If a patient has a debt of over £500 after two months, they are reported to the Home Office. • Interviews revealed that in at least four cases, migrants had offered to set up repayment schemes —following debt advice— to hospitals and had received no response in return. ***Relevant resource:*** *DoTW Research brief. Deterrence, delay and distress: the impact of charging in NHS hospitals on migrants in vulnerable circumstances.* *NICE. Antenatal care for uncomplicated pregnancies. Clinical guideline [CG62] March 2008 (Updated: January 2017).*
Policy context and the 'hostile environment'	• NHS charges have existed in various forms since the 1980s. • Recent legislation has increased charging as part of wider policy agenda, developed under Theresa May, to create a 'hostile environment' for undocumented migrants in the UK. • The 'hostile environment' policies were mainly implemented by the 2014 and 2016 Immigration Acts and extended borders via data-sharing and immigration checks into a number of sectors that are essential parts of daily life, such as banks, housing, workplaces, schools, higher education, applying for a driving license and health services. • New rules came into force in August and October 2017, which legally required all hospitals and community services receiving NHS funding - including charities and social enterprises - to check every patient's eligibility for charging before they receive healthcare. • The regulations introduced an obligation to charge up-front for the first time, meaning those who cannot pay will have treatment withheld unless it is classified as urgent or immediately necessary. • Looking to the future, the government has indicated its intention to introduce charges into primary care and to further consult on charging in A&E departments. ***Relevant resource:*** *Amelia Hill. 'Hostile environment': the hardline Home Office policy tearing families apart. The Guardian.* *Department of Health (2017) Making a fair contribution: Government response to the consultation on the extension of charging overseas visitors and migrants*

	using the NHS in England.
The sharing of NHS patient data with the Home Office	• In January 2017, a Memorandum of Understanding (MOU) between Department of Health, NHS Digital and the Home Office came into force which required NHS Digital to share confidential patient information with the Home Office for immigration enforcement. This included a patient's last known addresses, date of birth, and GP's details. • From December 2016-November 2017, patient records led to 4,413 people being traced by immigration enforcement, following requests from the Home Office for the details of over 6,000 patients. • There was no public consultation on the MOU or any efforts to establish potential impacts on patients, NHS staff and public health. • Following condemnation from our #StopSharing campaign, medics, key bodies like RCGP & BMA and cross-party MPs following a Health Select Committee inquiry, the MOU was amended in May 2018. The government promised that requests for patient information would now only be approved in much more limited circumstances, primarily in cases involving 'serious criminality'. • This is a significant step forward, and means that many more vulnerable people can access healthcare (particularly GP care) without fear of detention or deportation. *However, there are still urgent concerns around NHS datasharing practices for migrant patients.* • Patient distrust as a result of the MOU remains, and there are indications that the new MOU's threshold for breaking confidentiality in cases of 'serious criminality' is still much lower than for non-migrant patients (governed by the General Medical Council guidance on confidentiality). • In addition, hospitals still notify the Home Office of bills £500+ and outstanding for over 2 months. This information is then taken into account for any future immigration applications that the patient makes. • Fear of being reported to the Home Office is still a major factor which deters patients from healthcare and as described, in many cases this fear is still justified. ***Relevant resources:*** *DoTW UK (2018). Government will halt NHS datasharing with Home Office except for serious crime.* *DoTW UK (2018). Response to the Independent Chief Inspector of Borders and Immigration's call for evidence: Impact of NHS-Home Office datasharing due to patient debts.* *Health and Social Care Committee. (2018). Memorandum of understanding on data-sharing inquiry.* *Department of Health and Social Care and Home Office. Information requests from the Home Office to NHS Digital.*
Why is access to healthcare so important?	• Access to services is essential to protect public health through screening, treatment and vaccination for communicable diseases; drug and alcohol teams; mental health services. • Poor access to healthcare costs the NHS money: health inequalities are estimated to cost NHS £5 billion per year and delayed access to care means

	conditions are not caught early and require more intensive treatment. • Billing patients costs the NHS money: admin staff and debt recovery agents are costly. FOIs found 1/3 of hospitals spent more on cost recovery admin than they recovered in 2015. • One of the three founding principles of the NHS, launched by Aneurin Bevan in 1948, states that the NHS should "be based on clinical need, not ability to pay". ***Relevant resource:*** *Frontier Economics (2009) Overall costs of health inequalities. Submission to the Marmot Review.*
What is the real impact of migrants on NHS budgets?	• DH research in 2013 is still the most comprehensive available to estimate the cost of migrants to NHS. • Estimated annual cost of all migrants to the NHS was £1956m. This is 1.83% of total NHS budget and includes students, British ex-pats, EU migrants, visitors and undocumented migrants. • Numerous research studies have supported the contention that the cost of migrants to the NHS is widely exaggerated and that 'health tourism' is not a significant drain on NHS resources. ***Relevant resources:*** *Lee, G. (2018) Are migrants causing the A&E crisis? Channel 4 FactCheck.* *Milne, C. (2016) Health tourism: what's the cost? Full Fact.* *Dayan M (2016) 'The facts: EU immigration and pressure on the NHS'. Nuffield Trust and Full Fact briefing.* *The King's Fund (2015) What do we know about the impact of immigration on the NHS? The King's Fund Verdict.* *Department of Health (2013) Quantitative Assessment of Visitor and Migrant Use of the NHS in England: Exploring the Data. Summary Report. Prederi.*