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HEALTH IMPACT ASSESSMENT:
**CHANGES TO NHS CHARGES
FOR OVERSEAS VISITORS
AND MIGRANTS**

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Health Impact Assessment: Changes to NHS charges
for overseas visitors and migrants

CONTENTS

- 4** 1. Background
- 5** 2. Changes to Regulations
- 5** 3. Aim of Health Impact assessment
- 5** 4. Methods
- 6** 5. Literature Review
- 6** 6. North East Regional Migrant Health and Wellbeing Health Impact Assessment (HIA) Session
- 9** 7. Recommendations
- 9** 8. Conclusion
- 10** References
- 11** Appendix

1. BACKGROUND

In 2013 the Government announced changes to the NHS charging systems for overseas visitors and migrants, with plans to recoup £500 million annually by 2017/18 from ineligible patient use of NHS services.¹

Currently the United Kingdom operates a residence based healthcare system, which allows 'ordinary residents' free NHS treatment at the point of care.³ Following a public consultation in 2013 by the Department of Health (DoH) and Home Office,⁴ changes were made to the charging regulations within the Immigration Act. The changes related to the definition of an 'ordinary resident', exemption criteria and the introduction of a 'health surcharge'.^{1,3}

The DoH conducted some quantitative and qualitative research prior to the changes, which found the previous charging systems to be: complex and inefficient; lacking systematic data collection to allow for reflective estimation of the impact on services; and inconsistent, with many trusts conducting different processes.^{3,5,6} Therefore, alongside the updated Act the DoH developed a two year phased 'Visitor and Migrant NHS Cost Recovery Programme' to be implemented from 2014.¹ The new regulations aimed to provide clearer guidance and more robust systems for identification of eligible and ineligible patients. They also placed a legal obligation on NHS bodies to make and recover charges for treatment provided to those who were ineligible for free healthcare under the Act.¹

When the changes were introduced there were a number of concerns raised around the effect of the changes and programme, and now, three years on, there has been little research around the implementation processes aside from the costings generated.⁷ The changes recouped £289 million in 2015/16, which is a significant increase on the £97 million in 2013/14. However, £164 million of this was generated from the new immigrant health surcharge from students and temporary migrants outside of the EEU.⁷

As this cost recovery programme comes to an end, the government has discussed and implemented further amendments to the charging regulations.² These include the introduction of charges for all NHS-funded services, including those provided by non-NHS organisations, except for primary care.² This will affect a range of health services including community midwifery, community mental health, specialist and public health services commissioned by local authorities.⁸ The non-NHS organisations will also be expected to check patient eligibility, and then charge accordingly. The other major change involves charging ineligible patients for their care up-front, which will have wide-reaching implications for trusts and frontline services.^{2,8}

In times of austerity the need for cost-savings and financial awareness is undisputable. However, despite the economical aspect of the changes, concerns have been raised around the ethical and public health implications of the changes and programme.⁸⁻¹³

Although little research is available on the effect of the initial changes, numerous case studies have reported eligible patients being charged for their care,^{10,13} and the stresses this brings to an already vulnerable population patient group. The issues raised support the concerns of medical professionals and migrant charities who felt the original changes may worsen and widen the health inequalities faced by migrants, result in discriminatory practices and miss prevention opportunities with respect to communicable diseases.¹⁰⁻¹² These have been echoed again with the most recent amendments to the regulations, which risk compounding and exacerbating these effects.^{8,9,13} The new changes appear to be at odds with the professed prevention and reduction of health inequalities agenda of current governmental policies.^{14,15} The expansion of charges to non-NHS organisations threatens the effective delivery of key preventative services.

2. CHANGES TO REGULATIONS

The National Health Service (charges to Overseas Visitors) Regulations 2015 or what are referred to as the Charging Regulations came into force on 6 April 2015 and apply to all courses of treatment commenced on or after the date. The regulations have most recently been amended on 23 October 2017 by the NHS (Charges to Overseas Visitors) Amendment Regulations 2017. The Department of Health published guidance in October 2017, which explains in detail what the regulations mean and a list of all exempt services, infectious diseases and individuals.¹⁶ The charging regulations do not cover treatment provided by a general practitioner (GP), dentist or optician or charging arrangements in Wales, Scotland and Northern Ireland. They also do not cover services provided by school nurses and health visitors which are free of charge to all regardless of whether the recipient is ordinarily resident in the UK or not (except where statutory charges may apply, e.g. for prescriptions). However, the charges will apply to secondary care treatment that is not deemed urgent, community maternity services and services commissioned, by the NHS but delivered by non-NHS organisations. Accident and emergency treatment will remain free at the point of care, alongside treatment for some infectious diseases that are deemed a public health issues, for example tuberculosis (TB) and human immunodeficiency virus (HIV).

3. AIM OF HEALTH IMPACT ASSESSMENT

To consider and explore the potential effects of the changes to the NHS charging practices on migrant populations including refugees and asylum seekers, in the North East. This will be done through a rapid health impact assessment.

4. METHODS

The methodology is in line with a rapid HIA, a literature search was conducted using Ovid Medline (1946-November 2017), Embase, (1974-November 2017) and Psycinfo (1967- November 2017). A toolkit from NHS Plymouth¹⁷ was used to consider the impacts. An engagement event with stakeholders at the North East Regional Migrant Health and Wellbeing meeting was held, where there was open discussion on the potential implications of the changes. All the information was compiled and analysed, with some suggested recommendations.

5. LITERATURE REVIEW

A literature search using multiple databases was conducted. Searches included 'migrant/asylum seeker/refugee' and 'NHS charges' alongside other related health terms. The search was conducted in November 2017, and returned a small number of articles, which was expected, given the changes are relatively new. Of the returned articles, eight were identified on title screen to be of relevance, and then on further reading only one article was identified as original research. The remaining articles were centred on specific health topics and not related to charging, or commentaries/letters about the proposed changes.

The original research was a qualitative study involving 22 interviews of non-EEA migrants and civil society organisation representatives.¹⁸ They aimed to explore the policy reform changes and its implications. Overall they found positive experiences of 'vulnerable migrants' who were able to access services with caring staff. However, there was general confusion around entitlements and challenges for the registering migrants due to the recent changes.¹⁸

In the wider literature there is a consensus of concern around the impact of changes.¹⁹⁻²² It is feared the changes are complex and will introduce further access barriers for vulnerable migrants, as they may not understand the different eligibility criteria for services. There is a fear the changes will result in poorer health for migrants and have wider social ramifications, affecting social integration, living standards and employment. There is also a concern that the changes will have effects on public health in relation to the under identification and treatment of infectious diseases leading to spread.

The search identified there is a literature void in this area and further work is required.

6. NORTH EAST REGIONAL MIGRANT HEALTH AND WELLBEING HIA SESSION

The North East Regional Health and Wellbeing Migration meeting is a multidisciplinary forum where professionals meet to discuss topics that affect migrant health both locally and nationally. At the November meeting attendees were split into two groups to discuss the potential impacts and implications of changes to the NHS charging policies for migrants, the discussion was based around the following topics:

- 1. How will the changes to the NHS charging regulations affect people with a focus on migrants (including overseas visitors)?**
- 2. How will it affect services and service use?**
- 3. How can we mitigate or reduce the negative implications of the changes?**

Prompts were used to help promote discussion and each group was facilitated by a lead who also recorded the discussions on paper. Each group fed back after their discussions and the following themes emerged from the data.

I. Access

Concerns around access to healthcare were prominent; many felt that the new changes would cause confusion and act as a deterrent for migrants to access services in fear of being charged. The changes were considered to be complex for healthcare professionals and migrants to understand, which could lead to people not seeking care despite some services remaining free (such as GP and infectious disease treatment), or wrongly being charged/denied treatment. Overall, it was felt that the changes would reduce access to health services for an extremely vulnerable population.

II. Quality of Life

There were concerns the changes will negatively affect migrants' quality of life, both directly through poorer health due to decreased access and increased self-management. But, also indirectly with adverse impacts on income if paying for medical care, causing a poorer standard of living and reduced disposable income. Some felt it could lead to vulnerable people taking exploitative jobs, committing crime including fraud, if they were charged or feared being charged.

Another concern was around the mental health stress being charged or fear of being charged could bring. In some services such as maternity, the likelihood of large invoices regardless of a migrant's ability to pay is high. This could lead to adverse stresses and worry on already vulnerable populations for use of services, which are unavoidable. It may also deter or delay people accessing services they need, for example, a pregnant woman may present late to try to avoid costs. The changes were therefore felt to be in contrast to the NHS constitution,²³ with decisions potentially being made based on ability to pay rather than clinical need. There were also concerns that the changes may cause racial profiling through stereotyping leading to increased segregation within communities, especially if a public perception of ineligibility for care is created. There were fears this could lead to tensions within communities and again negatively affect migrants' quality of life.

III. Unintended Consequences

It was felt that the changes will have many wider impacts including:

- **Shift of demand:** Some people noted the changes may lead to migrants inappropriately using health services, which could lead to an increased demand for free services. For example, people may use A&E for minor issues/concerns if they fear being charged at a GP or have been unable to register, thus resulting in an over reliance on A&E services. Another concern was that if GP services are free, but specialist services are not GPs' may be in a difficult position regarding referral and management of conditions, which require secondary care placing unnecessary stress and demand on an already extremely busy service.
- **Public Health:** Not only were there concerns that there would be negative implications on migrants health, some felt that the changes pose a risk to the general public as it may deter people seeking healthcare for infectious and communicable diseases leading to further spread.
- **Short-term savings versus Long term Costs:** Despite some of reasoning for the changes relating to costs, the introduction of charges could deter people seeking healthcare at an earlier stage of illness leading to the need for more complex and costly treatment in the long run due to a lack of preventative interventions. It was therefore felt the changes will have a detrimental effect on preventative medicine. Particular issues of concern were maternity care (the risk of concealed or late presenting pregnancies) and chronic conditions. It also results in shifting costs to other parts of the health system.
- **Resources and Practicalities:** The charges will apply to NHS commissioned services including third sector organisations; therefore, the services will have a duty to so check entitlements of people to services. To ensure people are not racially profiled or stereotyped every person's eligibility will have to be checked increasing resource demands. This potentially could have negative implications on organisations if they are already operating at capacity.

Suggestions on how to mitigate the Impact of these changes

Stakeholders discussed measures they felt could help reduce the potential adverse or unintended consequences.

Discussions included:

i. Education and Information

Clear educational and informative messages about the changes need to be communicated to the migrant communities. These messages need to be in an appropriate and accessible format, including leaflets and audio-visual resources in multiple languages. Facilitated sessions in community hubs with trusted community members were also thought to be helpful.

Education for health care staff is also essential to ensure the changes are implemented correctly to reduce incorrect practices, for example ensuring GP practices are aware migrants are entitled to free primary care or ensuring hospital administration understand the different exemption criteria. This could be achieved through face-to-face teaching, but also e-learning modules, which are already freely available through the DoH. Similar provision and support is needed for the extended organisations that will have to introduce eligibility checks. As previously noted, the programme affects a vulnerable patient cohort; errors and poor understanding can affect patient experience and therefore, have wider reaching implications through deterring others within a community based on experience.

ii. Best Practice Events

Sharing of best practice was advocated, as through working together organisations can support each other implement the changes smoothly and efficiently. In addition, a consistent approach could be adopted to help reduce confusion and support those trying to navigate the system. One example of this would be to use template letters provided by the DoH. Another element considered was working with partner organisations, such as those housing migrants, to help ensure they support their tenants to access health services. This could be considered as part of contractual obligations, such as provision of leaflets or sessions to help migrants navigate the health system.

iii. Use of Community Champions

Community champions was another suggestion, working closely with community members including religious leaders may help access vulnerable migrant communities to help provide support and information around the changes. Often these vulnerable communities are hard-to-reach, but using trusted members can help relay information and support improving access. A similar consideration within organisations was also thought to be useful with specialist positions promoting organisational compliance and supporting implementation. Within the NHS cost recovery programme each trust is advised to have an Overseas Visitor Manager who would oversee and manage the changes, but this role has been interpreted differently resulting in varied ways of working across trusts. In smaller organisations a role like this is also, not feasible, so healthcare champions could work on the frontline with specialist knowledge to help ensure appropriate implementation.

iv. Lobbying and Influencing National Policy

Another big topic of discussion is the need to lobby/work with the government to ensure they are aware of the implications of the changes and the practicalities of implementing them. Therefore, it is important to gather evidence, case studies and continually audit and evaluate the changes, as to support feedback through the appropriate channel

7. RECOMMENDATIONS

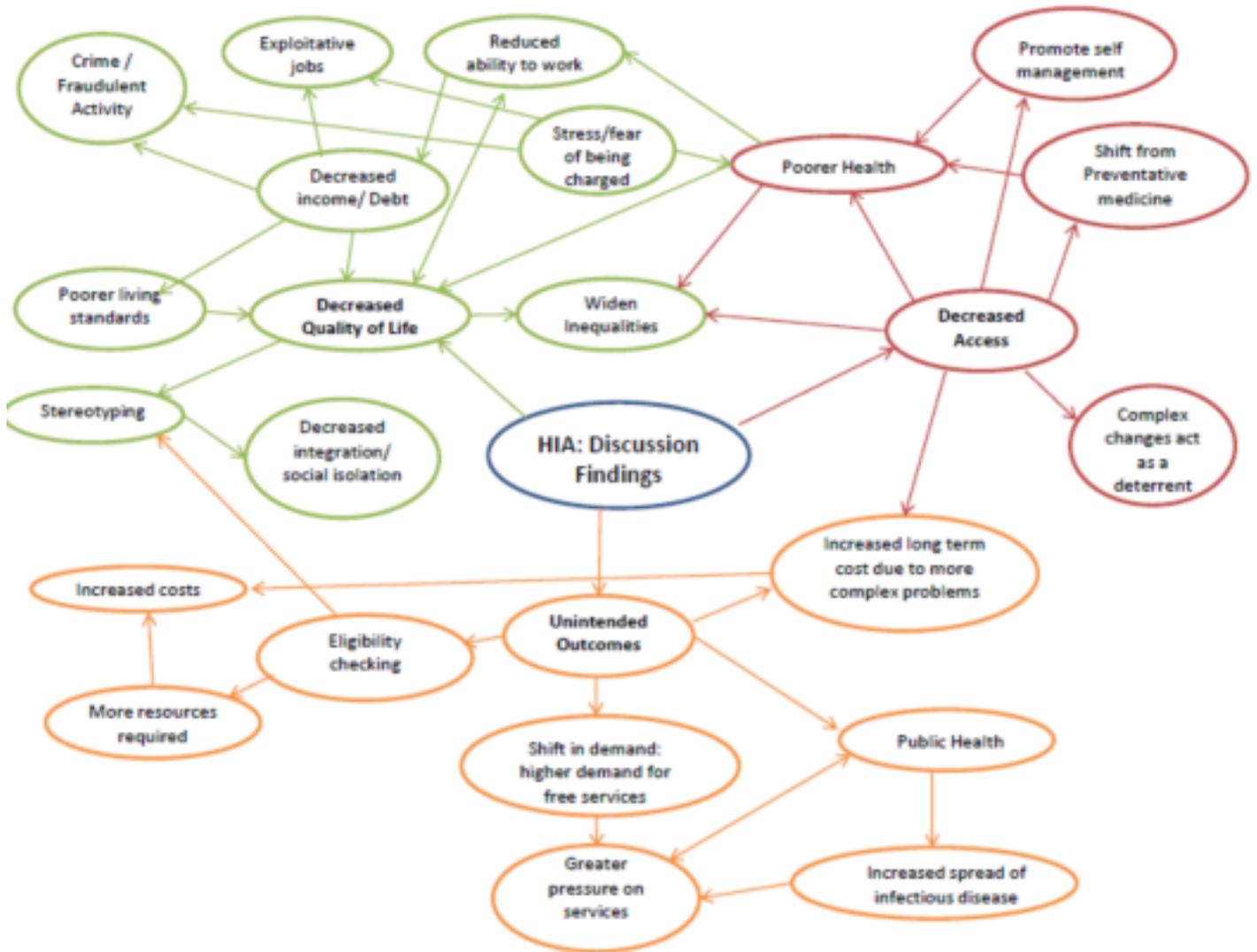
- i. We recommend that a multi-agency/organisation approach be utilised, allowing close partnership working to provide a consistent system and implementation of the changes across all involved including organisations indirectly involved such as housing associations. Regular cascading of information both within organisations and within migrant communities is needed, alongside multiple education initiatives including utilisation of 'advocates' both within health organisations and communities. Sharing of best practice and standardisation of practices across all health services in the North East is also advocated to ensure equitable access and support service navigation.
- ii. We also recommend that there is robust evaluation and data collection at both local and regional level, to enable feedback to the national team, therefore allowing for comprehensive national assessment on impact. We also advocate support of organisations lobbying for change.

8. CONCLUSION

NHS bodies and other settings receiving DoH funding including local authorities are now legally bound to implement the guidance,² so it is important this is done smoothly and consistently to minimise change and disruption to those affected. Collaborative working with patient groups, specialist teams and the public health workforce are integral to the success. A focus on sharing best practice and aligning practices would be beneficial. Key focuses on training and evaluation are required to ensure smooth and correct implementation, but also facilitate understanding of the effect and implications the guidance has had, allowing timely feedback to the DoH. Given the concerns raised through this piece of work, it is feared the changes will have negative consequences, widening health and social inequalities. Education and communication of the changes within the vulnerable communities will be essential to support access to services and mitigate the negative impact of these recent amendments to the regulations. Further research is required, a focus on qualitative work to gain a greater understanding of the effects of the change is needed especially with patients and community groups affected by the guidance.

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