16 August 2013

Doctors of the World UK

The importance of equitable access to healthcare for people in England: a policy briefing

"Everyone should have the same opportunity to lead a healthy life; no matter where they live or who they are." Jeremy Hunt, Secretary of State for Health, March 2013

"Every person is entitled without discrimination to appropriate medical care." (Article 1a of the World Medical Association Declaration on the Rights of the Patient)[1]

"The NHS was created out of the ideal that good healthcare should be available to all, regardless of wealth. When it was launched by the then minister of health, Aneurin Bevan, on July 5 1948, it was based on three core principles: that it meet the needs of everyone, that it be free at the point of delivery, that it be based on clinical need, not ability to pay."[2]

Background and summary

The Government is consulting on proposals to remove access to NHS services for visitors and migrants, and is seeking to ensure that anyone who is not eligible for free treatment is charged for the care they receive.

The proposals have been drafted in response to concerns about the cost and perceived scale of so-called 'health tourism' at a time when NHS budgets are stretched to the limit.

While the consultation is taking place, the Government also intends to undertake work to determine what those costs are: current estimates vary greatly, although last year the NHS estimates it spent £33 million treating foreign nationals and wrote off £12 million of this sum. This represents about 0.01% of the £107 billion NHS budget. These sums are considerably less than the net contribution made to the UK by migrants of 1.02% of GDP, or £16.3 billion, according to the OECD.

Since the announcement in the Queen's Speech last year of the Government's intention to limit access to NHS healthcare services, concern has been voiced by clinicians and public health professionals and other healthcare workers, as well as by voluntary organisations[3] working with vulnerable groups to this and previous similar consultations.

We believe that limiting access to primary care is detrimental for individual and public health, will increase health inequalities in many areas, will damage the doctor/patient relationship and will cost far more to enforce than the NHS is likely to recoup.

The public health stakes:

Good public health benefits us all. Doctors of the World believes that proposals to limit access to primary care for anyone present in the UK would be damaging for wider public health, and would drive up costs in secondary and emergency care. A summary of public health issues includes:

- GPs provide an efficient front-line defence in the early detection and treatment of disease. Restricting access to primary care removes this preventive, cost-effective public health management tool.
- Individuals denied access to primary care will eventually present to emergency health services with advanced illnesses which are more complicated and take longer, and cost much more, to treat.

[1] http://www1.umn.edu/humanrts/instree/patient.html
[2] Principles and values that guide the NHS
[3] E.g. see "Still human, still here", http://migrantsandthenhs.wordpress.com/the-background/review-of-access-to-the-nhs-for-foreign-nationals/organisational-responses/

Emergency services are already under considerable strain and are not a substitute for primary care provision.

- The longer someone has an untreated infection, or the greater the number of children without access to immunisation schemes, the greater the likelihood that they may unwittingly pass infections on.
- Illness will be driven underground because of worries about eligibility or ability to pay. Doctors of the World research found that two thirds of people using its clinical services reported difficulty accessing healthcare in the past year because they didn't know how, or they faced administrative barriers and were denied access. In its London clinic, one in five (20%) feared arrest if they sought help for illness and more than 40% did not even try accessing mainstream healthcare services before asking for our help. Restricting access to primary care even further will exacerbate this problem and is a real concern for those providing services in diverse communities.

The health inequality risks:

Exclusion and poverty cause ill health. Inequalities in access to healthcare have serious implications for vulnerable populations as well as for society more broadly. In England for example, people living in the least deprived areas have life expectancy of 7 years higher than those living in the most deprived areas (Fair Society, Healthy Lives, Marmot Review[4]).

While new migrants to England are typically young and healthy,[5] they often face difficult economic circumstances and labour conditions in the UK which put them at risk of poor health. Investing in public health for everyone present in England will support migrants to be economically productive while they are here.

The Marmot Review reported that health inequalities may cost the NHS more than £5.5 billion per year, not including the broader economic costs to society.

The Health and Social Care Act of 2012 established a legal duty for the Secretary of State for Health to reduce health inequalities in England. This duty also applies to the NHS Commissioning Board (NHS England) and Clinical Commissioning Groups.

This effort could be seriously compromised by restrictions to the NHS - and in particular, to primary healthcare - for some people present in the UK.

The economics of removing access to primary care for migrants:

Investing in primary care for all is a very cost-effective way of ensuring a good overall standard of health for everyone living in England. Primary care services are at the frontline of early detection of diseases that would, if untreated, have worsened or become more complicated to treat and have required expensive secondary or emergency care.

A Doctors of the World study into diabetes[6] showed that providing undocumented migrants with entitlement to primary healthcare would lead to earlier diagnosis and prevent diabetes-related complications, saving the NHS at least £1.2 million and 832 years of healthy living (quality-adjusted life years) in relation to type II diabetes alone.

Restricting access to primary care will increase the pressure on parts of the NHS which already struggle with demand and are far more expensive to run. This fact lay behind the Government's decision last year to make HIV treatment free to anyone diagnosed with the virus in England, regardless of their eligibility for NHS care.[7]

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[4] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review Page 16: "In England, people living in the poorest neighbourhoods, will, on average, die seven years earlier than people living in the richest neighbourhoods."

[5] http://www5.carleton.ca/sppa/ccms/wp-content/ccms-files/chesg-mcdonald.pdf

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

[7] See: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212952/DH-Guidance-HIV-and-NHS-Charging-fORMATED.pdf HIV treatment for overseas visitors: guidance for the NHS, Department of Health,

If people are barred from free access to GPs and are unable to meet the cost of care themselves, they will be left with no choice but to seek care at A&E services. This places unnecessary pressure and costs on emergency services and limits their ability to deal effectively with emergency cases.

It is not yet clear how the Government intends to ensure that those accessing NHS services are eligible to do so, and that those who aren't, are prevented from seeing a doctor if they do not have the means to pay. Media reports have suggested that an individual's immigration status will be checked by the health service with the immigration authorities before care will be provided. This will prove difficult for doctors bound by medical confidentiality and professional ethics. It may also deter patients from seeking the treatment they need. In our experience, similar procedures in other European countries have proved an additional barrier to patients with multiple vulnerabilities – the very patients who need to see a doctor most.

Past experience suggests that any new system is likely to come with a considerable cost attached, and be difficult and time consuming to implement. The NHS in England has just undergone significant change, and these new systems are only just settling down. This is not the time to introduce additional complexity into a system already under strain[8].

The health tourism myth:

Seven years of data[9] from Doctors of the World's walk-in clinic in east London shows that service users had, on average, been living in the UK for three years before they tried to access healthcare. Only 1.6% of people using the service had left their country of origin for personal health reasons.

Research carried out by Terrence Higgins Trust and George House Trust found that people living with HIV using their services had been resident in England for between 12 - 18 months before testing positive for HIV. If access to HIV drugs had been their motivation for coming to England, they would have been unlikely to wait so long to become eligible for life-saving treatments.

Research by Doctors of the World's European network indicates no correlation between accessibility of healthcare to migrants and migration patterns.

An analysis of data about vulnerable people's access to healthcare in 14 cities in 7 European countries is available here.

Ethical and human rights issues:

In light of Article 24 of the UN Convention on the Rights of the Child, every child present on UK territory is entitled to the same healthcare services as nationals.

According to the European Union Agency for Fundamental Rights, "migrants in an irregular situation should, at a minimum, be entitled by law to access necessary healthcare. Such healthcare provisions should not be limited to emergency care only." (2011)

As health professionals, we work according to our medical ethics and will give appropriate medical care to all people without discrimination.

September 2012 ; and : http://www.nat.org.uk/media/Files/Policy/2012/April-2012-QandA-Changes-to-NHS-charging-rules-for-HIV.pdf

[8] This opinion is shared by the WHO health system experts who conducted the UK (England) health system review (2011) – see their conclusions: http://www.euro.who.int/__data/assets/pdf_file/0004/135148/e94836.pdf

[9] See "Access to healthcare in Europe in times of crisis and rising xenophobia" (Doctors of the World International Network, 2013) – the full report including all UK statistics can be downloaded at www.mdm-international.org

Who would be affected by restrictions to healthcare?

It is likely that these proposals would affect the following groups:

- visitors from within the EU. There already exists the ability to charge back the costs of any healthcare incurred with visiting England to the country of origin within the EU. However, these costs are not always recovered. Doctors of the World believes that Government proposals to make the current charging regime work harder is sensible.
- foreign students in the UK.
- economic migrants. Some people coming to the UK to work will be covered by health insurance provided by their employer. Others - and particular those in lower-paid jobs or undertaking seasonal work - will be very unlikely to have employer-paid health insurance.
- refugees or asylum seekers. This group is eligible for NHS care, although they often face difficulties in accessing it because of a lack of knowledge about how to do so, administrative barriers or language difficulties.
- undocumented migrants or those who have no recourse to public funds. This group is the most vulnerable to ill health, the least likely to have any health insurance, and the least likely to be able to pay for their own care. Invariably this group does not try and access healthcare services for fear or arrest or sanctions.
- those born in Britain but now resident in another country (unless they are able to prove that they have already paid more than 10 years of National Insurance contributions), which is likely to be a small number.[10]

It should also be noted that in order to avoid charges of discrimination, everyone in England seeking any service from the NHS will have to prove eligibility under any schemes designed to remove free access for a few.

Women, girls and boys:

We are especially concerned about the potential impact of the proposals on vulnerable women and children.

The UN Convention on the Rights of the Child has been ratified by all the EU member states. The EU also has an obligation to promote the protection of the rights of the child, in line with the Treaty on European Union. In 2006, the European Commission proposed a strategy for protecting the rights of the child and in 2011 adopted the 'EU Agenda for the rights of the child'.

According to Article 24 of the Charter of Fundamental Rights of the European Union, children have the right to such protection and care as is necessary for their well-being. Their views must be taken into account on matters that concern them, and a child's best interest must be a primary consideration in any action taken relating to them.

In our experience women and children are more likely to have experienced discrimination and sexual and gender-based violence. Our data shows certain forms of violence more frequently reported by women such as psychological violence, sexual assault and rape. Pregnant women often aren't able to access the antenatal care they need to protect themselves and their unborn babies. Even under existing NHS arrangements, 95% of the pregnant women we saw at our London clinic in 2012 had not accessed antenatal care.[11] The evidence supporting current government policy shows that 'pregnancy and the first years of life are one of the most important stages in the life cycle'. The policy highlights intervention and prevention as imperative and outlines that 'this is particularly true for children who are born into

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[10] A Home Office Report in November 2012, "Emigration from the UK" found an estimated 4.7 million UK-born people live abroad with the largest stocks in Australia, the USA, Canada, Spain and Ireland. The UK ranks eighth highest in the world in terms of the number of its nationals living abroad (World Bank, 2011). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/116025/horr68-report.pdf

[11] See "Access to healthcare for vulnerable groups in the European Union in 2012" (Doctors of the World International Network, 2013) – the full report including all UK statistics can be downloaded at www.mdm-international.org

disadvantaged circumstances.'[12] Our experience across Europe shows that vulnerable people do not know how to access vaccinations for their children. The more barriers there are to people accessing healthcare, the less likely they will access healthcare for their children.

Alternative proposals:

It is clear that confusion over current entitlement among those seeking care and those providing it in some cases is already leading to areas with poor public health or greater health inequalities. Equally, it appears that there is little or no evidence to support either the cost or existence of so-called 'health tourism' to England, nor is there any understanding of the costs of proposals to tackle it.

In order to avoid burdening the NHS with implementing proposals likely to be costly to the public purse and to public health, Doctors of the World suggests consideration is given to the following recommendations:

1. No-one should be barred from primary healthcare. GPs are our frontline defense against poor public and personal ill-health. They save the NHS money by treating patients early and well. Overseas visitors who can pay should pay, like tourists; and others, like students, should be insured. Vulnerable, excluded people – who invariably face multiple risks to their health - should be provided with the care they need if they are living here, regardless of their income or immigration status.
2. Clear guidance and training should be made available to physicians and healthcare staff by the Department of Health about the rules of entitlement to healthcare, anti-discriminatory practices, and providing sensitive care to excluded people.
3. The National Commissioning Board should collaborate with Health and Wellbeing Boards to develop a co-ordinated national strategy for reducing health inequalities that is shared by everyone with a role to play and reflected in Joint Strategic Needs Assessments (JSNA), from healthcare providers to housing associations, as JSNAs must reflect the health needs of the population they seek to meet.
4. Financial support should be made available for research and innovation in clinical service delivery that meets the unmet health needs of excluded groups, especially those of sex workers, Gypsies and Travellers, homeless people and vulnerable migrants. We are especially concerned within these groups about the unmet health needs of pregnant women, women who have experienced gender-based violence, and mental health provision – all areas which may be exacerbated if these groups are further alienated from primary healthcare. More resources, for example, could be assigned to mobile clinics to meet the needs of vulnerable populations who are underserved by traditional services, including mobile communicable diseases clinics.
5. Best practice in engaging with vulnerable communities and people using services through citizens panels, inter-agency co-operation, public engagement using social and local media should be disseminated and outcome measures established to measure success in these areas.
6. The Department of Health should establish an inter-agency working group of NHS agencies, including the National Commissioning Board, Health Protection England, relevant Government departments and charities, to establish and share consistent and robust criteria for data collection about the health needs and demographics of groups excluded from mainstream healthcare, to inform future policy-making and service provision.
7. Resources should be realigned or increased in order to scale effective programmes to reduce health inequalities and reach vulnerable populations.
8. Measures to reduce health inequalities are most effective when goals and responsibilities to do so are shared: progress could be incentivised through award schemes, opportunities for authorities to compete or collaborate on innovation, and creating the structures for health and social care services to innovate together through the JSNA.
9. Establish a strong system of accountability to carry out the Government's commitment to reducing health inequalities, overseen by NHS England and Public Health England.

[12] The Healthy Child Programme (DH, 2009)

Conclusion

It is clear that the NHS is under considerable and increasing financial pressure as it struggles to cope with the pressures of an aging population with increased expectations of care. But scapegoating vulnerable groups as “health tourists” is a misdiagnosis, and is likely to have unintended consequences on the health of the nation.

The NHS is a national service, not an international one. But if existing arrangements to recover the costs of treating overseas nationals were better implemented, we could reduce the costs of treating all those resident here without placing considerable extra burden on NHS systems.

We urge caution over proposals which, if implemented, could have a severe impact on health inequalities in many areas and on public health more broadly. Doctors are not immigration officials; their first duty is to all of their patients without discrimination and irrespective of residence status. Trust between doctor and patient is crucial for the effective delivery of health services. We propose that a modest investment in primary care for all will repay the public purse and health of the nation several-fold.

Doctors of the World

We are part of the Médecins du Monde network, an international humanitarian organisation providing medical care to vulnerable populations in both developing and developed countries. In the UK, we run a volunteer-led clinic and advocacy project that helps the most vulnerable members of the community to get the healthcare they need. We work primarily with migrants, asylum seekers, homeless people and sex workers.

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