

Delayed, deterred, and distressed:
The impact of NHS overseas charging
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Executive summary

There is now clear evidence that *The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017* are deterring vulnerable groups from accessing NHS treatment, threatening public health, and taking vital clinical time away from patient care.

A survey of BMA members' experiences of the regulations in action has found that:

- many doctors have faced pressure from OVMs (Overseas Visitors Managers) when making clinical judgements regarding a patient's need for care
- the regulations, and particularly upfront charging, are deterring patients from seeking care, including for treatments that are not chargeable
- based on their experiences thus far, our members have reported that the regulations are negatively impacting public health
- vulnerable groups are being, and will continue to be, negatively affected by the regulations
- the regulations have increased workload for doctors and wider teams, taking time away from patient care

This comes amid widescale reports of British residents being denied care under the so-called 'hostile environment' and follows other research – such as Maternity Action's *What price motherhood?* – that has shown patients from vulnerable groups are being deterred from accessing vital treatment due to fear of charging.¹

However, the Government announced in December 2018 that its review of the regulations had closed, having found no evidence of a deterrent effect.² This response is out of step with the Government's own evidence and that put forward both here and by others, which indicates that the regulations are having a profoundly negative impact on patients and clinicians. The Government has also refused to publicly publish the findings of its review.³

We believe that urgent action is needed to address this, which should include:

- a full and independent review into the impact of the regulations on individual and public health
- the full publication of the findings of the DHSC review of the regulations
- simplification of charging criteria and exemptions to improve clarity for patients and providers and reduce instances of their misapplication
- the introduction of safeguards to ensure that vulnerable populations are not deterred from seeking care, are able to access the care they are entitled to and that necessary treatment is not denied due to difficulty or delay in proving eligibility
- an investigation into OVM performance and action in cases of interference with clinical decision making
- rigorous testing of the cost-effectiveness of the regulations.

Background

In 2015, the UK Government introduced new rules governing the charging of 'overseas visitors' accessing NHS services in England, with the stated intention of ensuring NHS bodies did not lose income by providing care to those not eligible for free treatment. This introduced a charge of 150% of the national tariff for overseas visitors using NHS services, alongside powers for trusts to make and recover charges from chargeable patients.

The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017 updated these rules, expanding charging to community services, introducing upfront charging for non-urgent care, and requiring NHS services to record patients' eligibility for free treatment.

When the regulations passed through Parliament, we raised our strong concern that they risked deterring vulnerable patients from seeking care, endangering public health, and increasing the workload of doctors and NHS staff.

We reiterated these concerns in February 2018, in our response to the DHSC (Department of Health and Social Care) review into the regulations. We also strongly criticised the timing of the review, which was announced in December 2017 – less than two months after the regulations came into force in October 2017. Launching the review so soon after the regulations came into force meant that stakeholders were severely limited in their capacity to collect and assess evidence of their impact. Moreover, many trusts and community services had not fully implemented the regulations at the time of the review.

Many other organisations, such as Doctors of the World and Maternity Action, raised similar concerns at that time and have subsequently published their own evidence showing that the regulations have had a clear deterrent effect on vulnerable patients.

Despite this evidence, and without prior notice, the UK Government announced on 12th December 2018 that their review of the regulations had been completed and had found no evidence of the regulations deterring patients from accessing care. The Government announcement and subsequent communications from DHSC have also made clear that the findings of the review will not be published.

However, *The Guardian* has now reported that the DHSC review, which the newspaper accessed via court records, did in fact find evidence that the regulations had been wrongly applied in a number of cases.⁴ The unpublished review apparently found that at least 22 patients had been wrongly told that they must pay upfront for NHS treatment, due to misinterpretation of the complex regulations. This is deeply concerning, not only due to the impact the regulations have clearly had on patients, but also because of the alarming lack of transparency surrounding the review and its findings.

The Government's conclusion regarding the regulations is also out of step with the views and experiences of our membership. These views, gathered in a survey conducted in 2018, are presented here and show the impact *The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017* have had on both patients and doctors.

Our survey

In 2018, we surveyed our members to better understand the experiences and views of the medical profession regarding the regulations, and to provide a clearer picture of the impact they have had in practice.

This research was conducted through our quarterly omnibus survey, which is circulated to a panel of 2,300 members representing most areas of medical practice. Members were asked questions on a range of topics relating to the application of the regulations. The quotes provided by respondents have been anonymised.

This evidence was initially intended to be submitted directly to DHSC. However, following the Government announcement in December 2018 regarding the review of the regulations and the subsequent refusal to publish its findings, we have decided to publish our own research.

Pressure from overseas visitor managers

We asked members whether they had been required to make judgements about the urgency of an overseas visitor's treatment in the past six months and, if so, whether they had experienced any undue interference or pressure from OVMs or other non-clinical staff when making the decision.

Of the 93 members that had made a judgement about whether a chargeable patient's needs were non-urgent, urgent or immediately necessary, over a third had experienced undue pressure from OVMs at some point, with 15% experiencing it either 'sometimes' or 'frequently'. This is despite the guidance from DHSC stating that this should solely be a doctor's decision.

Members' free-text responses also highlighted concerning issues about how the regulations are being implemented on the frontline, including non-clinical staff making the judgement about urgency. Some comments suggested that urgent care had been denied to patients after they had been deemed to be chargeable.

The following is a selection of quotes from respondents who had experienced undue interference or pressure from OVMs or other non-clinical staff:

'Patient (English born, 60 years old, lived abroad outside EU for 20 years) told immediately before an operation it would cost her £6,000. No interaction with clinical staff regarding immediacy. Patient left distraught being wheeled down for operation.'

'Patients referred to my service from GP, seen in clinic and booked for treatment are then denied treatment when the overseas patient office announces they aren't entitled to the planned cancer care. 1 – that's urgent and 2 – why not stop me seeing them in the first place if that is what you want.'

'Refusal to admit adolescent patient for morphine-based syringe driver for treatment of oncology related pain as would be unlikely to retrieve costs.'

'A patient born in the USA to UK parents returned to the UK. Suffers from a rare and serious kidney problem. Managers would not allow me to see him until eligibility had been clarified.'

Deterrent effect of upfront charging

Survey participants were asked whether, based on their frontline experiences, patients who are ineligible or unsure of their eligibility for free NHS treatment are deterred from accessing health care services because of the introduction of upfront charges for some care. Of the 285 respondents to this question, 35% answered that ineligible patients or those unsure of their chargeable status are being deterred from accessing care because of upfront charging, while only 24% felt that they are not.

Respondents commented that asylum seekers would be deterred and may feel more vulnerable. Others cited specific examples from their experience, including inappropriate use of emergency departments and delayed presentation to services. A number of respondents also reported blockages in onward referral to specialist care and pressure on primary care due to managing patients or issues that should properly be treated in secondary care. Negative impacts on UK residents who are eligible for free NHS care were also highlighted, including being deterred from accessing care after

being inappropriately charged and instances of stress-related illnesses in those caring for and financially supporting overseas visitor relatives with health issues.

'I have had a few patients tell me, they delayed coming to A&E for an acute problem as they thought they would be charged.'

'In [my area] women have not accessed antenatal care, present to hospital in labour, then do not access postnatal care nor care for infants.'

'Patient on overstayed visa did not access maternity care until reached term.'

'I had a patient who did not seek help for a rare eye cancer as she was ineligible for NHS treatment. She died in her 40's as a result of this.'

'American patient declined to seek antenatal care here due to cost. She was complicated, had a heart and haematological condition and therefore needed secondary care, but could not pay for that. She was insisting that her whole care and delivery should be GP.'

Impact on public health

Survey participants were asked, based on their experience, what impact the introduction of the regulations was likely to have on public health. Around 45% of the 284 respondents to this question felt the regulations would have a negative impact on public health, while fewer than 8% felt that their impact would be positive.

Respondents highlighted the potential for increased infectious disease transmission because of late detection and patients not attending for fear of being charged. They also emphasised that the exemption of certain public health services from charging was not well understood by the public, and so did not counter the overall deterrent effect of the regulations.

Several respondents also flagged issues of fragmentation between chargeable and exempt services and provided specific examples of how this had negatively impacted on patients, in their experience.

'I work in infectious diseases and any delays can have public health impact. Even though ID are excluded, patients do not know this, and even then it is only the investigation of these that is excluded, if found to have something else they become chargeable.'

'People won't access health services until too late; example in HIV...where we're trying to reduce "late diagnoses"... The two policies are not compatible together...'

'E.g. Not accessing sexual health services as scared of being charged increases risks of untreated STIs and unplanned pregnancy'

Impact on vulnerable groups

We asked survey participants, based on their experience, what impact the introduction of the regulations will have on vulnerable groups. Around 70% of the 282 respondents to this question felt the regulations would have an overall negative impact on vulnerable groups, with over 25% of respondents answering that the impact would be significantly negative. Only around 2% felt that the impact would be positive.

Respondents' comments pointed to evidence of an increased deterrent effect and negative impact of the regulations on vulnerable groups, underlining the concerns

raised by the BMA when the regulations were progressing through parliament. These included specific examples of how the regulations compound barriers to care and health inequalities for vulnerable patients, leading to poorer health outcomes, such as patients not presenting for care until at more advanced stages of illness. Comments also pointed to a particular risk for patients with mental health conditions, homeless people, pregnant women, asylum seekers and those with chronic conditions.

'A homeless man with Bipolar Disorder, lived in UK since age 13 was ineligible so couldn't access hostel (as no housing benefit), and couldn't get free prescriptions so couldn't get his medications for several months. Eventually was found eligible to remain and benefits re-instated'

'chronic conditions may be under treated if care is only sought when deemed worth paying for by vulnerable groups - either because of financial situation or concerns about the impact on seeking treatment on other aspects of life including residential status'

'We already know that vulnerable groups find it the most difficult to access health services (harder to register with GP, less likely to attend appointments, complain about symptoms late). These will be yet more barriers. Even if they are not frightened off, we are now supposed to ask about EHC and other forms which we do not understand to complete the new GMS1 registration form'

Impact on workload

Those respondents that had made a judgement about the urgency of a chargeable patient's care under the new regulations were also asked about their impact on the workload of clinical staff; whether there was an impact on the overall workload, of either the individual or team, associated with the patient's treatment when there was an obligation to charge for non-urgent care. 35% felt that the regulations had negatively impacted on the overall workload of either the individual or team associated with the patient's treatment when there was an obligation to charge for non-urgent care. Only around 24% reported that there had been no impact on workload.

Free-text responses revealed concerning examples of increased workload related to informing and negotiating with patients and family members to find solutions and doctors being asked to police and administer the system, again contrary to DHSC guidance. Other comments highlighted examples where procedures had been cancelled or rearranged, leading to delays for patients and wasted effort for medical staff. Several responses flagged the impact on the whole team, including additional time spent raising invoices, processing payments and in some cases refunds for inappropriate charges.

'Clinical staff expected to do the screening and collect information'

'More paperwork more hassle detracting from the real issue of caring'

'Increased discussions with patients regarding funding models, and consideration of provision of outpatient therapy and weighing up risks and benefits of this.'

Awareness

According to our survey there is a high degree of awareness of the new regulations within the medical profession, with over 80% of 556 respondents answering that they were aware of the introduction of both the regulations and upfront charging.

However, as nearly 18% answered that they were not aware of either, there is still an issue regarding the communication of these new policies to frontline doctors. It is

of particular concern that the lowest rates of awareness were amongst staff grade (71%) and associate specialist doctors (75%), who make up an important proportion of frontline medical staff in secondary care settings.

While a number of factors, such as where respondents work and the prevalence of overseas visitors in those areas, may influence rates of awareness, these findings nonetheless raise concerns about the degree to which individual NHS Trusts and NHS England have informed those working on the frontline.

Conclusion

The BMA recognises that in certain cases it may be appropriate to charge overseas visitors for the use of certain NHS services. However, it is vital that this system is cost-effective, practicable and does not unduly burden NHS workers. Access to urgent treatment must also always be prioritised over administrative concerns and safeguards must be in place to protect vulnerable populations, mitigate any public health risks and ensure that patients are not deterred from seeking care.

It is our strong and longstanding view that existing overseas charging regulations fail to meet these criteria and, moreover, have had a negative impact on both NHS staff and patients, including the most vulnerable. The findings of our survey strongly reinforce these concerns.

Our research indicates that the introduction of up-front charging has had a profound deterrent effect on patients, driving many to avoid seeking care altogether, including care they are entitled to or which remains free of charge. The experiences of our members illustrate that in many cases the regulations are also discouraging patients, particularly those from vulnerable groups, from accessing care until their conditions have worsened significantly.

These effects pose a risk not only to patients themselves, as they may present only when their condition has become especially severe, but also to public health more widely if treatment for communicable diseases is delayed. Treatment for conditions at an advanced stage is also far more extensive and expensive than preventive care or early intervention. The potentially high cost of delaying care must therefore be factored into any assessment of the cost-effectiveness of the cost recovery system.

The role of doctors and all clinical staff should be to provide care to patients, not to police their access to, or payment for, treatment. However, our research shows that in many cases clinicians are facing pressure from OVMs regarding the care patients require. This undermines doctors' clinical judgment, is incompatible with the regulations themselves, and shows that in some cases Trusts and OVMs may be placing financial concerns ahead of patient care.

This survey also shows that the workloads of doctors and other clinical staff are increasing as a direct result of the regulations. Navigating the complexity created by the regulations is taking vital clinician time away from delivering patient care in a period when the NHS and frontline staff are under immense and ever-growing pressure. The regulations also appear to have driven greater demand to already over-stretched GP practices, where care remains free of charge for all. This is despite the fact that primary care is often not the appropriate setting for managing a given condition, and that pressure on general practice remains severe.

This comes alongside extensive evidence put forward by Maternity Action, Doctors of the World, and others, clearly showing that the regulations have had, and continue to have, a negative impact on patient care and public health.

Urgent action is needed to address these issues, as has been argued by a range of advocacy groups and medical royal colleges, including the Royal College of Physicians, Royal College of Paediatrics and Child Health, Royal College of Obstetricians and Gynaecologists, Faculty of Public Health and Academy of Medical Royal Colleges.

We strongly believe that this action should include:

- a full and independent review into the impact of the regulations on individual and public health
- the full publication of the findings of the DHSC review of the regulations
- simplification of charging criteria and exemptions to improve clarity for patients and providers and reduce instances of their misapplication
- the introduction of safeguards to ensure that vulnerable populations are not deterred from seeking care, are able to access the care they are entitled to and that necessary treatment is not denied due to difficulty or delay in proving eligibility
- an investigation into OVM performance and action in cases of interference with clinical decision making
- rigorous testing of the cost-effectiveness of the regulations.

References

- 1 Maternity Action. *What Price Safe Motherhood? Charging for NHS Maternity Care in England and its Impact on Migrant Women*. September 2018. Available at: www.maternityaction.org.uk
- 2 Stephen Hammond MP (Minister of State for Health). *Review of the amendments made to the NHS Overseas Visitor Charging Regulations in 2017: Written statement – HCWS1174*. December 2018. Available at: www.parliament.co.uk
- 3 Stephen Hammond MP (Minister of State for Health). *Health Services: Foreign Nationals: Written question – 202322*. December 2018. Available at: www.parliament.co.uk
- 4 The Guardian. *Migrants wrongly told to pay for NHS care upfront, minister admits*. February 2019. Available at: www.theguardian.com

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