**Exploring the Issues Presented by the NHS Upfront Charging Policy in East London**

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**Abbreviations**

* **A&E:** Accident and Emergency
* **BMA:** British Medical Association
* **Bn:** Billion
* **C-section:** Caesarean section
* **DOTW:** Doctors of the World
* **EEA:** European Economic Area
* **EHIC:** European Health Insurance Card
* **FGM**: Female Genital Mutilation
* **GP:** General Practitioner
* **IV1:** Interview 1; migrant advocacy group 1
* **IV2:** Interview 2; migrant advocacy group 2
* **IV3:** Interview 3; activist group 1
* **IV4:** Interview 4; activist group 2
* **M:** Million
* **MoU:** Memorandum of Understanding
* **NGO:** Non-Governmental Organization
* **NHS:** National Health Service
* **O&G:** Obstetricians and Gynecologists
* **OCP:** Overseas Charging Policy
* **OVM:** Overseas Visitors Manager
* **QMUL:** Queen Mary’s University of London
* **RLH:** The Royal London Hospital
* **STI:** Sexually Transmitted Infection
* **TB:** Tuberculosis
* **UK:** United Kingdom

**Abstract**

**Introduction:**

In 2015, the Overseas Visitor Hospital Charging Regulations were introduced. These regulations commenced the charging of non-urgent hospital healthcare for non-EEA temporary migrants at a rate of 150% of the standard NHS tariff. In 2017, these regulations were updated so that payment would be required in advance. The policy has received criticism from an array of healthcare organizations and activist groups due to its contradiction of NHS principles, the effect on NHS staff and its impact on access to healthcare for vulnerable migrants.

**Aims and Objectives:**

The aim of this research was to gain a greater understanding of the issues created by the OCP, maintaining a particular focus on East London. East London is an informative context through which to explore the policy as a large proportion of the population is born abroad, and are thus more likely to be affected by the issued discussed.

The objectives of the study include conducting a review of the research and grey literature to build an evidence base for issues created by the OCP, alongside collecting primary qualitative interview data to evaluate this evidence in terms of its applicability to East London.

**Methods:**

Ethical approval from QMUL was required to conduct the primary research. However, as all interviewees were non-vulnerable adults the application was eligible to be fast-tracked. Participants were recruited through contacting relevant organizations and requesting new contacts from previous interviews. In total, 4 semi-structured interviews lasting between 30-90 minutes were conducted. These findings augmented a literature review for the issues of the OCP. The documents used in this review were found through recommendations given during the interviews. Google and Google Scholar were used to find all supporting evidence.

**Findings:**

The research established a number of issues with the OCP. The literature review found that the policy causes reduced access to healthcare for illegal immigrants due to fear of both being charged and reported to the Home Office. Furthermore, it found that the policy contributes to poor health outcomes, both for the individuals affected and for public health. These findings were supported by the interview data collected locally in East London. Moreover, the literature review reported that there were issues with the implementation of the policy, providing multiple cases of migrants who were wrongly charged, not informed of their charging liability, and inconsistencies in debt repayment practices between NHS trusts. This was reflected in the interview data, alongside the additional finding that NHS trusts were uncertain on their authority to write off medical debt for destitute migrants. A further issue emerging from the findings was the impact of the policy on the NHS, revealing concerns from staff over the time-consuming nature of the policy, the potential for the overuse of exempt services, and the contradiction of the constitutional values of the NHS.

**Conclusion:**

The research concludes that the OCP creates a multitude of issues that are applicable to the population of East London. The study suggests that, in line with recommendations from a number of professional bodies, the OCP is suspended until an independent review of the impacts has been published.

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**Introduction**

In 2015, the Overseas Visitor Hospital Charging Regulations (1) were introduced. These regulations acted to consolidate existing laws allowing for the charging of non-urgent hospital healthcare for non-EEA temporary migrants at a rate of 150% of the standard NHS tariff (2). This means those who have not been granted indefinite leave to remain (permanent residency status in the UK) from countries outside of the EEA are personally liable for healthcare considered not to be immediately necessary[[1]](#footnote-1) or urgent[[2]](#footnote-2) (3). In 2017, these regulations were amended so that payment would be required upfront (4); data published by the Guardian showed that 2,279 patients were charged in advance for their healthcare between October 2017 and June 2018 as a result of this policy (5). The policy states its overall aim is to increase cost recovery for the financial sustainability of the NHS (2). However, it has received criticism from healthcare organizations and activist groups because of its contradiction to the NHS principles of ‘free at the point of use’ care and the inadvertent consequential effects for vulnerable populations (6) (7) (8).

Included in the arguments against the OCP is the disproportionate effect on immigrants illegally residing in the UK, the majority of whom are destitute (6). The introduction of charges to this group acts as a barrier in accessing healthcare, resulting in the delay of seeking treatment until the situation deteriorates into an emergency, or not seeking treatment at all. Moreover, delays in accessing healthcare are propagated by fears of being reported to the Home Office for illegal immigrants who owe over £500 to the NHS (9). The deterrent effect on accessing healthcare not only results in poor health outcomes for the individual, but also poses a public health threat if communicable diseases are not diagnosed and treated. Furthermore, NHS staff are required to identify chargeable patients and determine whether treatment is immediately necessary or urgent, while previously the focus would have been patient care (10) (11) (12) (13).

In this dissertation, I will be using the current body of research as an evidence base to explore the fears and criticisms that have been made regarding the OCP. This will be reinforced by primary data collected from interviews carried out with activist groups and NGO’s in East London. East London is an informative context through which to explore the impact of the policy because a large proportion of the population was born abroad, and are therefore more likely to be affected by the issued discussed. For example, in Tower Hamlets 43% of the residents were born abroad (14) and in Hackney this figure is 39.1% (15); this is much higher than the UK average of 14.4% (16). Furthermore, East London has a high level of deprivation and therefore health outcomes for the resident population, particularly for vulnerable illegal immigrants, are likely to be worse (17). This research is timeous because currently the evidence base for the impact of the charging policy on migrant populations is minimal. In fact, the government have been accused of covering up data as reports commissioned by the Department of Health in 2017 into the health effects of the OCP have yet to be published despite having finished in 2018 (18).

**Background**

In order to explore the issues presented by the OCP, it is necessary to understand the policy itself and the history upon which it was built. The following section provides a description of the NHS and its involvement in migrant charging starting from its creation in 1948 (19).



Figure 1 Timeline of migrant charging in the NHS

1.1 Creation of the NHS and the origins of migrant charging

In 1945 Aneurin Bevan was appointed health minister and given the responsibility of establishing a nationalized health system, leading to the creation of the NHS on 5th July 1948 (19). The founding principles of the NHS are that healthcare should be comprehensive, universal, free at the point of use and financed by general taxation; the core ideology underpinning the NHS is that care should be based on the clinical need of the person, not their ability to pay (20) (8). These initial beliefs still govern the NHS today and are embodied in the NHS constitution (Figure 2) (8).

Figure 2 Constitutional principles of the NHS (8)

Constitutional principles of the NHS:

1. Provides a comprehensive service available to all
2. Based on clinical need, not ability to pay
3. Aspires to the highest standards of professionalism and excellence
4. The patient is at the heart of everything the NHS does
5. Works across organizations in the interest of patients, communities and the wider population
6. Provides the best value for taxpayers’ money with the most effective, fair and sustainable use of resources
7. Accountable to the public, communities and the patients that is serves

The introduction of migrant charging for healthcare began in 1977 under Jim Callaghan’s Labour government, in the form of revisions to the NHS Act (21). These revisions gave power to the Health Sectary of State to introduce regulations for charging healthcare to those not ordinarily living in the UK. Although granting legality for migrant charging, it was not until 1982 that these regulations were put into effect. At this time, policy was made so that anyone not ‘ordinarily resident’[[3]](#footnote-3) in the UK was not entitled to free hospital treatment in the NHS; however, this was not rigorously or consistently enforced (22).

1.2 The Immigration Act

The Immigration Act of 2014 (23) introduced a range of measures aiming to identify and reduce the number of illegal immigrants in the UK. These measures are collectively known as the ‘hostile environment’ policy, and included processes that restrict illegal immigrants from renting property, acquiring a driving license, opening bank accounts, and accessing benefits or the NHS. The aim of the hostile environment policy was to ‘deter people without permission from entering the UK and to encourage those already here to leave voluntarily’; in the words of Theresa May, the Home Secretary at the time, ‘we don’t want a situation where people think that they can come here and overstay because they’re able to access everything they need’ (24). Included in the Immigration Act was the introduction of healthcare charging in the form of an obligatory health surcharge for non-EEA temporary migrants; the annual payment of £400 per person per year entitles temporary visa holders use of NHS services until visa expiry.

1.3 NHS information sharing as a tool for immigration enforcement

Information sharing between the NHS and the Home Office began in 2012 under the Health and Social Care Act (25); this created NHS Digital, allowing for patients’ details (provided confidentially by the patient) to be shared with the Home Office (26) (27). In 2016, NHS Digital signed an MoU with the Home Office and the Department of Health (28) allowing patients’ non-clinical data such as name, date of birth and last known address to be used to locate people breaking immigration rules (28) (29) (27). The NHS was not required to obtain patient consent before sharing this information (30). The concerns articulated with this agreement included a lack of legal basis for the transfer of personal information, the deterrent effect on illegal immigrants using health services, and the perception by NHS staff that they have become de facto border control agents (29). Because of these concerns, the MoU was suspended in 2018 and updated for use only to trace people being considered for deportation because they have committed a serious crime (31).

However, the suspension of the MoU did not mark the end of information sharing between the NHS and the Home Office. In October 2011, the government introduced a policy that if an overseas visitor owed the NHS an unpaid debt of over £1000, this information would be transferred to the Home Office and used as grounds for refusal of visa renewal until the debt is paid (4). In 2016, this was reduced to a minimum of £500 outstanding debt (9), thus sustaining the concern that information sharing discourages migrant use of health services.

1.4 Overseas Charging Policy

The ‘Charges to Overseas Visitors’ regulation first came in to force on 6th April 2015. This regulation placed a legal obligation on NHS bodies to establish which patients not ‘ordinarily resident’ in the UK should be charged for their secondary care, and if chargeable to recover these costs at a rate of 150% of the standard NHS tariff. Revisions to this policy in October 2017 updated requirements so that when a patient is liable, the costs must be recovered in advance unless care is deemed immediately necessary or urgent (4). Failure to provide emergency care is unlawful under the Human Rights Act (32) (4), and so must be provided to all patients regardless of their circumstance. Figure 3 (4) demonstrates the health services that are exempt from charging under the policy.

Figure 3 Exempt services from Overseas Migrant charging (4)

Exempt services in the Overseas Charging Policy for migrants:

* A&E
* Primary care or GP services
* Family planning services
* Treatment of certain communicable diseases necessary for the protection of public health
* Treatment for STIs
* Compulsory psychiatric services
* Treatment for physical or mental illness caused by: torture, FGM, sexual abuse or domestic violence
* Palliative care provided by charities
* NHS 111 telephone advice line

Exemptions for overseas visitors who are not ordinarily resident in the UK include non-EEA migrants who have paid the obligatory health surcharge, those with a right to free healthcare through EU agreements, vulnerable patients (including refugees, asylum seekers, failed asylum seekers supported by the Home Office, prisoners, immigration detainees and victims of modern slavery), UK government employees and those covered by a reciprocal healthcare agreement in a non-EEA country. It is the responsibility of the organization providing the care to identify and charge in advance of treatment to overseas migrants; sanctions introduced in the 2017 charging amendments initiated fines to be levied against NHS trusts found to be failing to identify chargeable patients (4).

NHS organizations may choose to write off medical debt in unique circumstances; for example, if the patient has died and the debt is irrecoverable, if the patient is destitute and debt recovery would not be cost effective, or if all reasonable steps to recover debt have been taken to no avail. In these cases, despite the debt being written off in the eyes of the NHS, the information is still sent to the Home Office as an unsettled debt of over £500, providing grounds for visa refusal of destitute illegal immigrants (4).

1.5 Aims and hidden aims of the OCP

The stated aim of the charging policy is to increase cost recovery of NHS services provided to overseas visitors, with the overall goal of increasing the financial sustainability of the NHS. The NHS is chronically under-resourced and under-staffed as a consequence of under-funding, accentuating the requirement for financial sustainability (33). Current expectations based on the 2013 NHS England report projects a funding gap of £30 bn by 2020 (34). Moreover, in December 2017 NHS trusts reported a year-to-date deficit of over £1.2 bn and over 100,000 job vacancies (35). The government predict that migrant charging will recover £500 million for the NHS per year; this figure is comprised from £200 million recovered through the immigration surcharge, £200 million recovered from charging EEA countries for care provided to patients with an EHIC, and £100 million from the overseas charging of non-EEA temporary migrants for secondary care (36). The policy states its target for non-EEA temporary migrants are ‘health tourists’, meaning people specifically coming to the UK to access free healthcare (2). Therefore, given the context of inadequate resources and funding for the NHS, the argument of providing NHS services exclusively to the taxpayers funding the system and charging the cost of care to those not contributing appears logical. However, a closer examination of the policy reveals its failures and hidden agendas.

Despite the predicted cost recovery of £500 million for the NHS through migrant charging, in actuality the total amount is much less. In the year 2015/16, £289 million was charged to overseas migrants (£164m from the obligatory health surcharge, £56m from patients presenting with an EHIC, and £69m charged to non-EEA citizens) with no reliable data detailing what amount had actually been recovered (36). Even if the total predicted £500m was recovered, this accounts for just 0.4% of the NHS budget (£116.4 bn (37)) and therefore would not have a material impact on the financial sustainability of the NHS. Specifically examining the charges for non-EEA temporary migrants, if the total £69m charged was recovered, this still represents less than 0.06% of the NHS budget. This amount is essentially negligible, particularly so when factoring in the administration costs of finding and charging overseas migrants (>£18m (38)) and the low rates of actual cost recovery (40% (4)). The OCP therefore fails in its stated aims of cost recovery, and consequently it is necessary to search for its hidden agenda.

Although the policy specifies ‘health tourists’, in reality by far the largest group affected are illegal immigrants (failed asylum seekers liable to deportation, those overstaying their visas or illegal entrants to the UK) the majority of whom cannot afford the bills for healthcare (6). Although by nature difficult to quantify, this group is estimated to account for 1.1 million of the population in the UK (39) (40). The effect of charging illegal immigrants is extensive; for example, a charity organization in East London have described cases such as a homeless man overstaying his visa charged £84,750 for his cancer treatment, a mother illegally residing in the UK being sent a bill of £97,000 for her daughter’s liver transplant, and £20,305 charged to a destitute woman overstaying her visa for the treatment of lupus (41). These demands are evidently being sent to people with very little chance of cost recovery, causing them a great deal of stress and impacting their mental well-being. In many cases these people are offered a debt re-payment plan, for example the woman charged for her daughter’s liver transplant is paying off the charges at £5 a week (41). This would take 400 years to pay off the total debt owed, thus further demonstrating the limited overall cost recovery of the policy. Instead, it is evident that the hidden agenda is part of the wider hostile environment policy aiming to make life difficult for illegal immigrants in the hope that they will voluntarily leave the UK, or discourage them from migrating in the first instance (24).

1.6 Overseas charging practice in East London

The current practice in Barts Health NHS Trust is to ask every patient (including those in A&E) for details of their GP, address, and if they have resided in the UK for the previous year. If the patient has not lived in the UK for the entirety of the past year, they are given a Pre-Attendance Questionnaire asking for details of their immigration status. This questionnaire is passed on to the OVM, who assesses if they are eligible for free NHS treatment either by checking against their own records, or by sending patient details to the Home Office. Barts Health NHS Trust currently pass up to 100 patients’ details on to the Home Office each week to check eligibility for free care. If the patient is not eligible for free NHS treatment, they are invoiced for an estimated cost of the care in advance of treatment. If the patient cannot pay the bill, they are offered a payment plan. In all cases, Barts Health NHS Trust informs the Home Office of patient debt, thereby affecting the immigration application outcomes for migrants who owe money (42).

**Rationale**

Clearly, this policy creates a range of issues including effects on NHS staff, public health and health outcomes for illegal immigrants and is consequently a valid area of research. Furthermore, since the policy is relatively new, there is a huge evidence gap in the reporting of these issues- exceptionally so for the specific outcomes in East London. Therefore, the justification for this research is formed from its contribution to the existing evidence base, alongside being the first study examining the specific outcomes of the OCP in East London.

2.1 Aims

The research aim is to gain a greater understanding of the issues created by the OCP, with a particular focus on East London.

2.2 Objectives

* Use research literature and grey literature to begin to build an evidence base on the impacts and issues created by the OCP
* Collect primary qualitative data to evaluate this evidence and determine the applicability in East London
* Produce recommendations for further research in this area

**Methodology**

The methodological approach to this policy research uses a relativist perspective to understand the impacts of the OCP through the interaction of the social actors involved and the interpretations of their experience. Relativists propose that different interpretations of the same experience generates multiple realities that can be studied qualitatively to generate explanations and gain understanding for social phenomena (43). For this reason, the triangulation of primary interview data collection alongside a literature review for the issues experienced by the policy was chosen for this research. The aim of this approach was to gain an insight in to the multiple realities of the impacts of the OCP, by comparing the similarities and differences in the experiences of the social actors involved across multiple sources.

The key documents used in the literature review were found via recommendations given during interviews when collecting primary data. Searches on Google and Google Scholar using the key words displayed in Figure 4 were used to find additional data supporting these documents. The findings of the literature review were stratified by themes developed from issues that were repeatedly discussed in the papers analyzed. Although these papers gave significant deductions for the negative impacts of the policy overall, the number of studies in total providing this information was minimal. Furthermore, this evidence was lacking for the specific impacts of the policy on the inhabitants of East London. Therefore, the collection of primary research not only provided an alternate source to study the different experiences of the OCP, but also provided an East London specific evaluation of the data.

Figure Key words used to search for literature

Examples of key words used to search for literature on Google and Google Scholar:

* Overseas Charging Policy
* Access to healthcare
* Healthcare charging
* Impact assessment
* Fear of the Home Office
* Barts Health NHS Trust
* Hostile Environment Policy

Ethical approval from QMUL was required to conduct this research, as participants were all non-vulnerable adults, the application was eligible to be fast-tracked. The full ethical application can be found in appendix A. To recruit the interviewees, the first step was a Google search for East London charities and activist groups involved with the OCP. Next, a generic email (found in appendix B) was sent to these groups explaining the research, inquiring about involvement with migrant charging and providing details to respond for more information. If no response was received within 24 hours, a phone call was made to the organization to clarify involvement with migrant charging and willingness to participate in the research. Through this process, some of the organizations shortlisted were discounted as healthcare or healthcare charging was not included in the roles of the charity. Furthermore, many organizations contacted did not respond to emails or phone calls and therefore could not be used in the study. Through this process, a total of 3 people matching the inclusion criteria were found and interviews organized at a location convenient for them. The 4th interviewee was recruited through snowball sampling, with their details being acquired from a previous participant. All interviews were conducted between February-March 2019.

The interviews were semi-structured and lasted between 30-90 minutes, depending on the discussion and the availability of the interviewee. The organizations and participants have been anonymized in the findings to ensure the maintenance of confidentiality of any cases discussed. Interviews were audio-recorded using Voice Memos on iPhone, and transcribed using the dictation software Wreally (44). Analysis of the interviews was done using the pre-identified themes from the literature review; the aim of this was to allow a direct comparison between the experiences reported in the the literature review and the findings of the interview data. Furthermore, it allowed for the comparison of the East London specific interview data to the country-level literature review to determine local applicability of the impacts of the OCP.

The methodology for primary data collection ensured all data collected would be specific for East London, thus conducive to the research aim and contributing to the minimal evidence base. Furthermore, unlike some of the studies in the literature that focused solely on maternity, the interviews allowed for data to be gathered on a range of chargeable conditions. However, a major weakness of the study was the small sample size of 4 interview participants. Moreover, the argument is likely to be skewed considering many of the interviewees advocate for destitute migrants unable to afford healthcare bills, not health tourists from whom the policy might benefit. Therefore, any conclusions drawn from this research would benefit from further examination. Nevertheless, despite these limitations the findings are important, representing the first study to examine the effects of charging migrants for healthcare specifically in East London.

**Findings**

This section provides a review of the current body of literature for the arguments against the OCP, augmented by the results of primary interview research to provide an East London specific evaluation of the issues discussed.

3.1 Reduced access to healthcare for the most vulnerable migrants

One of the main issues with the OCP is the effect on access to healthcare for illegal immigrants, a population that already struggles to interface with essential health care services in the UK (45). NGO’s, activist groups and health organizations have expressed concerns that charging for health and sending information to the Home Office for those who owe debt will result in both a fear of being unable to pay the charges and fear of being deported, consequently deterring this group from accessing healthcare. In 2016-17, two studies were conducted by DOTW’s UK clinic assessing the effect of charging on migrants and on their timely access to healthcare (12). DOTW is an international charity working to facilitate access to healthcare for marginalized groups; the UK clinic specifically offers primary care consultations and health and social advice from healthcare professionals to vulnerable people (46), thus is an appropriate source to obtain pertinent information. The results of these studies showed that 1 in 5 (21%) users of the DOTW clinic were affected by healthcare charging, and of these, 1 in 3 (34.3%) were deterred from seeking healthcare because of charging and concerns that through it their information would be shared with the Home Office. The charges reported in these studies ranged from £40- £80,000; those affected were unable to afford these bills, with 2 in 3 participants living in poverty and 1 in 2 living in insecure accommodation (47) (12). Many vulnerable migrants (including asylum seekers) are not permitted to work in the UK and are living in destitution (48), totally unable to pay for NHS secondary care. The studies analyzed had a large sample size of 1,801 migrant case-notes and 21 interviews with people involved with migrant charging (12), suggesting the data will be reliable in concluding the charging policy reduces access to healthcare for illegal immigrants. Furthermore, the DOTW UK clinic is located in Bethnal Green and therefore the results are particularly applicable to East London.

Another study, conducted in 2017 by Maternity Action, reviewed the impact of charging migrant women for NHS maternity care. In this study, information was obtained from 32 professionals working with charged migrants via interviews or through case reports, and 19 migrant women who had been charged were interviewed. Many of the cases in the study describe women deliberately missing appointments for antenatal care in order to save money, with one woman giving birth at home to avoid charges (22). Not only does this evidence a restricted access to healthcare through fears of charging, but also how charging can result in poor health outcomes for the individual due to the well-established relationship between lack of antenatal care and maternal mortality (49) (50). Similarly to the DOTW study, 2 in 3 participants in the Maternity Action research were living in poverty and completely unable to afford their maternity care (22), further demonstrating how the policy targets the most vulnerable in our society with practically no likelihood of cost recovery.

Research conducted by DOTW on NHS charging found that 11% of the patients using the London clinic had not accessed any NHS care due to fear of interacting with authorities in 2014 (6). This fear followed public reports that between 2010-2013 the Home Office made over 12,587 requests for records from the NHS to trace illegal immigrants (51). In 2016, as part of the MoU, 8,127 requests for patients details were made by the Home Office contributing to 5,854 people being traced by immigration enforcement (52). It can hypothesized therefore that since the transfer of information had increased, fear of authorities leading to reduced access to healthcare for illegal immigrants also will have increased. Unfortunately there is no quantitative data supporting this, although anecdotal evidence described in the studies reports fear of information transfer to the Home Office as a strong deterrent in accessing health services (22) (6) (12). For example, the DOTW 2016-17 study describes a case of a woman presenting to the clinic already in labour, having never received antenatal care due to fears of being reported to the Home Office (12). Moreover, any quantitative data gathered will probably underestimate the true value because the most vulnerable migrants fearing deportation will not approach any state actor or entity that reacts with the state at all, including health advocacy groups or the DOTW clinic, and thus would not be represented in any of the data samples (53). There has been no evidence produced into how fear of being reported to the Home Office has affected migrant access to healthcare since the MoU was suspended in 2018, thus representing a gap in the current evidence base. Evidently, there is a need for further study into the true effects of information sharing on migrant access to healthcare.

The findings of the literature review were strongly supported by the interview data collected. For example, data from IV1, conducted with an employee from an East London charity providing advice, case-support and health advocacy for immigrants, reinforced the findings from Maternity Action (22):

‘Pregnant mothers know they are liable to be charged for antenatal care so they aren’t accessing any medical services until the moment they are due to give birth’ (IV1)

This suggests that the OCP contributes to poor health access for pregnant women in East London resulting in poor health outcomes. Furthermore, supporting the literature review, the interviews found that fear of the Home Office acts as a deterrent in accessing healthcare for migrants. IV2, conducted with a volunteer at the same East London charity as IV1, stated:

‘People are aware that there was or still is a link between accessing the NHS and the Home Office so they go under the radar and don’t access healthcare… to go to an institution and put your name down, they would get freaked out so instead they just don’t get treatment’ (IV2)

The findings from IV1 and IV2 correlate with the results from the literature review, thus suggesting that the issues discussed previously are applicable to East London. Moreover, both of the interviews suggested that the majority of migrants using the services are destitute illegal immigrants, representing the most vulnerable migrants in society. The services were described as intensely oversubscribed, summarized in IV1 by the following:

‘We see 20 people a week at the moment… demand for our services is incredibly high…we open our doors at 10am on a Wednesday morning but most weeks the queue is full by 7am, sometimes people queue overnight… most weeks there's 5 or 6 people in the queue by 5:30am’ (IV1)

These findings suggest that the most vulnerable migrants are disproportionately affected by the policy as the majority demographic the charity provides for are destitute illegal immigrants. Moreover, since the demand for services is so high it can be expected that not all of the migrants in need of support can be accommodated, thus resulting in the creation of an even more vulnerable group of migrants unable to access healthcare or health advocacy organizations. Since these findings represent just one East London charity providing support for migrants, further research should be conducted with organizations offering similar services to verify the results.

3.2 The impact of charging on health outcomes

A further issue of OCP is that the health outcomes of migrants who are charged can be negatively affected. As referred to above, the Maternity Action study described multiple cases of women missing antenatal care appointments in order to save money (22). This has poor outcomes for both the individual’s health and the health of their child, considering the evidence base highlighting the association between maternal mortality, perinatal mortality, and a lack of antenatal care (49) (50) (22). Furthermore, the women in this study had higher than expected rates of medically complex pregnancies as well as a significant amount of the children born developing serious health problems. For example, of the total 55 case-studies collected from migrant women who had been charged (via interviews and case-notes), several women required emergency C-sections, three women gave birth pre-maturely, one woman had a still birth, one woman gave birth to a child who died at 3 weeks old, and two babies were born with Down’s Syndrome (22). This study only assessed 55 cases, and the state of health of those charged before and during the pregnancy was not uniformly available, so it is not possible to conclude these poor pregnancy outcomes were directly associated with healthcare charging. Previous literature has shown that undocumented migrant women have higher risk pregnancies due to a combination of health and social risks (6) (22), and so one would expect that further research would demonstrate how charging increases these risks resulting in adverse pregnancy outcomes.

The research conducted by DOTW in 2016-17 had similar findings; 2 in 3 pregnant women in the sample had not accessed antenatal care at 10 weeks, 1 in 4 had not accessed care by 18 weeks, and in one case antenatal care was not accessed until 37 weeks of pregnancy (12). These findings are again reinforced by the DOTW research from 2016, concluding antenatal care is frequently received late and is of a poor quality for undocumented migrant women, putting them at risk of pregnancy-associated complications (6). Maternity care appears to be the most commonly charged service under the OCP (41), and thus the conclusions drawn on the health impacts for undocumented migrant women is very important. However, there is clearly an evidence gap for the health outcomes from other chargeable conditions. Since maternity care is always deemed ‘immediately necessary’ and therefore must be provided regardless of ability to pay, conclusions cannot be drawn for migrants refused treatments for non-urgent secondary care due to cost. One would expect a relationship between poor outcomes for health for migrants and refusal of non-urgent secondary care, however no research has been conducted providing evidence for this.

Not only are there concerns for the health outcomes of the individuals being charged, but also the resultant impact on public health if communicable diseases are not being diagnosed and treated. For example, migrants with latent TB are at the highest risk of progressing to active, infectious disease during their first year of arrival in the destination country; therefore, early detection and treatment is essential to protect public health. This is particularly pertinent to the UK as it has one of the highest rates of TB in Western Europe. Evidently, the deterrent effect of the OCP on migrant access to health services will only exacerbate this problem, particularly considering 75% of the patients diagnosed with TB in 2015 were born abroad and thus are more likely to be effected by charging (54). Although threat to public health is cited as an issue of the policy by many (45) (12) (54) (10), there is no data to measure this threat, thereby representing a gap in the existing body of literature and leaving a tangible risk unquantified. It should be noted that a reform in Spain in 2012 restricting access to public healthcare for illegal immigrants resulted in a rise in mortality rate in this group by 15% (55) (56); one would expect therefore, that the OCP with similarly limiting access to public healthcare will have comparable outcomes for public health in the UK.

Although the literature was unable to provide evidence for the association between poor health outcomes and refusal of non-urgent secondary care, IV2 (conducted with a volunteer from a charity providing advice and health advocacy for immigrants) was able to provide a case study supporting this theory:

‘We have one case of a woman who owes a lot of money for the delivery of her child. Her other son who is 3 or 4 now has an ear problem and needs grommets in his ears. The hospital trusts are not providing this treatment as it is not an emergency and she still owes money from the previous birth… This kid is getting developmental issues as the problem with his ears means he can’t speak or hear properly and so he’s struggling with verbal communication… the lack of treatment is having a really long term impact on his life’. (IV2)

This case very poignantly demonstrates how the charging policy impacts the health of not only those who can’t afford care, but also the lives of their dependents.

A reoccurring theme emerging in the interviews was a concern over the public health impact of the charging policy in East London, particularly for the spread of TB. IV1 (conducted with the same charity as IV2) stated:

‘I am concerned that TB and other communicable diseases are going to rise amongst vulnerable migrant populations of East London because people aren’t accessing treatment to begin with… people are reluctant to go and get themselves checked out, for example, if a person has TB- even though its exempt from charging- they do not know that it is TB and therefore do not know it will be free’. (IV1)

Incidence of TB is exceptionally high in East London (57) (58) and therefore the threat to public health is particularly relevant to the area. However, as discussed in the literature review there is no data available to quantify this risk. Furthermore, as discussed in IV4 (with the access to healthcare campaigner at an organization campaigning against the OCP):

‘It’s [public health outcomes] hard to evidence as the people that face the charges are usually people that do not want to be found, who are scared of talking up as it puts them in a more vulnerable position’. (IV4)

Evidently, further research into the public health outcomes of the OCP, particularly in East London, is necessary for the wider protection of population health.

3.3 Inconsistent charging policy and practice

The literature reveals that there are inconsistencies between hospital trusts and their policies for debt repayment schemes (22) (12). The guidance for the policy provided by the Department of Health states that if an invoice is particularly large, or if the patient is willing to provide payment but is unable to meet the debt in full, a meaningful payment plan should be agreed at the earliest opportunity taking into account the financial circumstances of the individual (59). However, the Maternity Action paper says repayment plans ‘appear to be at the hospital’s discretion’ (22), with one hospital refusing any payment plan under £50/ week, clearly out of reach for destitute immigrants. The paper gives an example of one hospital that did not accept a proposed payment plan from a destitute undocumented migrant of £5-£10/ week, saying the minimum repayment amount must be £70/month. As she was unable to afford this, her information was sent to the Home Office as an unpaid debt of over £500 resulting in the refusal of her visa application (22). These findings are supported by the 2016/17 DOTW research presenting at least 4 cases of migrant debt repayment schemes not being accepted by hospitals (12). These examples demonstrate the contradictory nature of the debt repayment guidance; it is impossible for a repayment scheme to be both meaningful in terms of the amount paid over a realistic timeframe to ensure total debt recovery, as well as accounting for the financial circumstances of those that can’t afford it. There is an urgent need for clarification from the Department of Health in respect of repayment schemes for migrants who are unable to afford the minimum repayment costs.

The Department of Health has also recently acknowledged that there have been cases of migrants wrongly charged in advance of their treatment, despite being eligible for free NHS care. This acknowledgement was revealed in an unpublished government review of the policy demonstrating 22 people who were forced to pay upfront for their care despite their condition qualifying as urgent or immediately necessary (5). Similar cases of wrongful charging have been reported elsewhere in the literature, for example, a Sri Lankan asylum seeker was not given palliative chemotherapy as the Home Office contacted the OVM to say he was not eligible for free treatment. DOTW reported having to make multiple phone calls to the OVM to clarify his eligibility as an asylum seeker before these charges were dropped (6). Evidently, in these cases of wrongful charging the most vulnerable migrants will be disproportionately affected, as they avoid contact with any form of authority who could advocate on their behalf (53). Furthermore, there has been multiple accounts of women being charged upfront for maternity care (60) (12) (22), despite Department of Health guidance that all maternity services, including routine antenatal care, must be treated as immediately necessary (60) (61). Clearly, these misapplications of the charging policy will directly result in the migrants unable to afford care missing out on treatment, subsequently resulting in poorer outcomes for their health. There is both a need for clarification from the Department of Health on chargeability rules including the definitions of urgent or immediately necessary care and an increased understanding of the existing rules within NHS trusts.

A final issue in the charging practice of NHS trusts is that in many cases, patients are not told that they will be charged for their care. For example, Maternity Action interviewed 16 migrant women who faced charges for their maternity care in 2018; 12 of these women received an invoice with no prior indication that they could be charged as it was not discussed in the hospital (60). A different study also conducted by Maternity Action reported similar experiences (22). A corollary of this is that those who have the means to afford healthcare can be frustrated when they unknowingly receive an invoice for their care, because had they been told about the charging in advance then they would have accessed healthcare privately (22). The study also described a case of a woman who was upset when she was charged after giving birth as she ‘was not given the choice to not attend antenatal care to avoid bills’ (22). This puts healthcare workers in an ethical dilemma, with a choice of informing the patient about charging and risking that they will avoid care as a result, or not informing the patient to ensure healthcare attendance but condemning them to potentially unaffordable debt. This research clearly provides evidence that there is a lack of awareness regarding charges for maternity care; however, conclusions cannot be drawn for other chargeable conditions since both of these studies only examine cases of maternity, thus representing a gap in the literature.

The interview data collected generally paralleled the literature review. IV2, with a volunteer working at a charity advocating for migrants, commented on the inconsistencies in debt repayment schemes saying:

‘We have got someone who is paying £15 a month… this will never amount to the total cost, making it feel like a total false economy’.

Similarly, the interviews discussed two cases of migrants wrongly charged for their healthcare; in both cases, migrants were charged upfront for investigative procedures that were necessary to determine if the condition was urgent or immediately necessary. As the conditions could not be defined as non-urgent without these investigations, they should not have been charged. Furthermore, supporting the literature, IV1 and IV2 (conducted with the same charity for migrant advocacy) found that people were not being informed about healthcare charging:

‘Most of the time, the people we see have no idea that they were going to be charged’ (IV2)

‘On (his) discharge, without a word having been said to him up until that point, he was presented with a bill for £86,000’ (IV1)

It seems clear from these results that the issues regarding debt repayment plans and patients not being informed of their charging liability are valid for East London.

The analysis of the interviews identified an issue with charging practice that had not been previously considered in the literature review. Despite the policy document stating NHS organizations may choose to write off medical debt for destitute migrants (4), IV1 and IV2 disclosed:

‘We write regularly to individual trusts pointing out that someone is destitute and does not have the ability to pay their debt off. The response we get is generally that the trust is not allowed to do that’. (IV1)

‘We write to the hospitals asking for a fee waiver, but they write back saying they don’t have the power to do that’. (IV2)

This suggests a lack of understanding of policy legislation from East London NHS Trusts, resulting in problems regarding debt and failed immigration applications for migrants unable to afford any repayment plan. Evidently, further research is necessary to determine whether this issue is exclusive to East London or if it is a problem experienced nationally.

3.4 Impacts on the NHS

A primary concern of the OCP is how it contradicts NHS constitutional principles of ‘free at the point of use’ care, based on clinical need, not ability to pay (56) (8), exampled by the multiple accounts of vulnerable migrants being refused healthcare (6) (12) (60). Furthermore, there are concerns that identifying chargeable patients and the process of charging is time-consuming for staff at a point when the central focus should be patient care. The inefficiency of implementing the OCP is demonstrated by the necessity for the creation of a new role, the OVM, solely dedicated to identifying chargeable patients. Although there is very little evidence for the additional workload created by the policy, a recent survey of members of the BMA (the majority of whom are healthcare professionals) showed that 35% of participants considered their workload was increased by the policy (13). Furthermore, a pilot study conducted by the Department of Health demonstrated that 30 minutes/ day was added to staff workload when primary care receptionists asked each patient to present their EHIC (6). Since determining immigration status is more complex than presenting an EHIC, one would expect that significantly more time must be necessary to determine eligibility for free secondary care. Finally, the last concern of the charging policy is the risk of overuse of exempt services such as GP and A&E. This concern is reinforced by the DOTW study in 2016/17, with interview participants reporting a displacement effect from planned consultations to A&E, presenting at a later stage of disease that is both a greater health risk to the individual and more costly for the NHS (12).

The argument that the OCP produces a tension in contradiction with NHS principles was reinforced in the interview data. For example, IV4 with the access to healthcare campaigner at an organization campaigning against the OCP divulged:

‘The policy introduces entitlements based culture in the NHS, moving away from the idea that care is universal and based on need and instead care provided based on your personal right’. (IV4)

Furthermore, IV4, who had previously worked as a nurse at the RLH, recalled his experience with the time-consuming nature of the policy:

‘Even though A&E is exempt, patients are still presented with a form at the door…my own patients have had delays in A&E from filling out these forms before they can access any care’ (IV4).

This suggests that the use of Pre-Attendance Questionnaires in Barts Health NHS Trust (42) validates the concerns from the literature that the charging policy is time-consuming and distracts from patient care. Contradicting the literature review, the interview data indicates that the policy results in an overuse of A&E but an underuse of GP services. For instance, IV1 stated:

‘We’re seeing an underuse of GP services… the people we see aren’t accessing any services to diagnose what’s wrong with them, and consequently (they) aren’t receiving treatment at an early stage when it’d be easier to tackle… they are presenting at hospitals much later when the treatment is more complicated, expensive and time consuming’. (IV1)

Clearly, further research is required to measure the extent of the issue locally to East London as well as determining the applicability nationally. Overall, the primary data mostly correlates to the literature with regard to impacts on the NHS, however in the future studies should directly interview NHS staff for a more fruitful account of their experience with the OCP.

**Discussion**

Overall, it is clear that the OCP falls short of a desirable standard in many ways; it fails in its stated aims of cost recovery, it fails to gain the support of the healthcare professionals it implicitly involves and it fails to protect the most vulnerable people in our society. In this discussion, I will be arguing that the social suffering resulting from this policy is an intentional consequence engineered by those in power as part of the wider hostile environment policy, and how this undermines the constitutional principles at the heart of the NHS. The theory of social suffering is defined by the human consequences of institutional, economic and political power (62); or in other words, ‘it is the painful part of the lived experience of social domination and exclusion’ (63). The findings of the literature review and the primary interview data clearly shows how the OCP, operated through political and institutional power, has a causal link to human suffering through poor physical health, poor access to health, and living in fear of debt or authorities.

As discussed in the findings, the most vulnerable migrants are often disproportionately affected by the OCP as they have the strongest fear of the government and the lowest income, resulting in the least access to care and the worst outcomes for health. Furthermore, poor public health outcomes will be more significant in the most vulnerable migrant groups as they are exposed to greater risk factors for the spread of infection together with being less likely to access treatment due to fears of charging. For example, risk of acquiring TB is associated with social risk factors such as homelessness, poverty, overcrowding and lack of access to appropriate health services (64), all of which are more common amongst undocumented migrant populations (65). These examples effectively demonstrate, as Kleinman describes in the theory of social suffering, how sociopolitical forces (the OCP) can at times cause disease (66). Moreover, social suffering considers that the poorer the community, the harder it is to identify any distinction between health and social problems (66), successfully summarizing how limiting health access by right to reside in the most vulnerable migrants is interlinked with the health issues of deprivation causing poor health outcomes.

Having demonstrated that the OCP disproportionately causes suffering for the most vulnerable migrants, one must consider why the UK government allow these inequalities to thrive. Moreover, one must consider how this policy is considered acceptable by the government despite directly contradicting the constitutional principles of the NHS, for which the government remains accountable to as ‘all NHS bodies and the Secretary of State for Health are required by law to take account of the constitution in their decisions and actions’ (67). The OCP directly challenges the principles that the NHS should provide a service available to all that is based on clinical need not ability to pay, nor does it put the patient at the heart of the service (8). This represents a paradigm shift away from universality of care to an entitlements based culture in the NHS. Inevitably, by dismantling the fundamental principles that were created to respond to suffering, suffering at the hands of the NHS will only be made worse.

As described previously, it is evident that the OCP does not achieve any legitimate aim for cost recovery and instead is part of the wider hostile environment aiming to discourage illegal immigrants from residing in the UK (24). One can conclude therefore, that the social suffering experienced by the most vulnerable migrants is an intentional consequence of the policy orchestrated by those in power. The government must realize however, that the creation of a hostile environment as a way of deterring migration is a one-dimensional outlook of the migratory process, believing that if conditions worsen, migration will stop. This is arguably not true, as articulated by IV1:

‘Removing healthcare from the situation for illegal immigrants isn't going to make people want to go home. We see migrants who outstayed their visitor's visa because life in the UK is better here; they stay without access to benefits or jobs with an inherent worry of immigration control, feeling unsafe during this period…  but this is still better than the life they left in their home country. We tend to be far more forgiving for people moving to a different country because their children might be killed by bombs or guns, but not for people who are afraid their children might be killed by poverty, malnutrition or disease… in a civilized society, this (policy) is something we should be deeply ashamed about’. (IV1)

Overall, it is clear that the policy is unsuccessful. It fails in both its stated aims and its hidden aims, as well as causing suffering for all those affected by it. The findings suggest that this suffering is widely applicable to the population of East London, particularly for the most vulnerable destitute migrants. However, further research must be conducted to support this conclusion considering the currently limited evidence available. Figure 5 demonstrates a summary of the suggested topics for further research as discussed in the findings, with the overall aim of closing the existing gaps in the literature.

Figure 5 Summary of recommendations for future research

**Summary of the recommendations for future research into the issues of the OCP**

To address the concerns that the OCP reduces access to healthcare:

* Conduct a study to determine how access to healthcare is affected by fear of the Home Office, specifically examining whether fear has been reduced since the suspension of the MoU in 2018.

To address the concerns that the OCP results in poor health outcomes:

* Conduct a study to establish the association between refusal of non-urgent healthcare and poor health outcomes.
* Conduct a study to determine the relationship between poor pregnancy outcomes and maternity healthcare charging.

To determine the extent of the inconsistencies in charging policy and practice

* Conduct a study to determine whether not being informed about healthcare charging is a maternity specific or a universal charging issue.
* Conduct a study to examine the degree of understanding of the policy by NHS Trusts, focusing specifically on the comprehension of their power to write off medical debt.

To determine the impact of the OCP on the NHS:

* Conduct an interview study on NHS staff to examine different experiences of the issues with the OCP.
* Conduct a study to measure the additional time required for NHS staff to implement the OCP.
* Conduct a financial audit of the OCP to establish overall cost effectiveness.

To further address the impacts of the OCP specifically in East London:

* Conduct an epidemiological study examining incidence of communicable diseases in East London before and after policy introduction.
* Conduct a study to investigate whether underuse of GP services as a result of the OCP is an East London specific or nationwide issue.

**Conclusion**

In conclusion, it is clear that the OCP creates a multitude of issues; it leads to reduced health access and thereby health outcomes for the most vulnerable migrants, it increases risk to public health if communicable diseases aren’t being diagnosed and treated, it opposes the constitutional principles of the NHS and it creates problems for NHS staff who are burdened with the responsibility of delivering the policy. Moreover, the policy does not achieve any legitimate aim; it does not contribute to cost recovery for the NHS, but instead is part of the wider hostile environment in the UK. If the policy continues unchecked, the protection of public health, the maintenance of a welfare state and the safeguarding of the most vulnerable in our society will be under urgent threat. It is of the highest importance, parallel with recommendations from the Royal Colleges of Physicians, Paediatric and Child Health, O&G and the Faculty of Public Health (68), that the OCP is suspended until a full independent review of its effects has been published and it’s impacts considered.

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**Appendix A; ethical application for conducting primary research**

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| --- | --- |
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| **\*Department** | **Global Health** |
| **\*Title of study** | **What are the issues experienced by third sector staff in East London with regard to the NHS upfront charging policy?** |
| **\*300-word minimum summary of the research:** In April 2015 regulatory changes occurred within the NHS meaning that patients who are not ordinarily resident in England (an overseas visitor) must now pay upfront for healthcare at a tariff of 150%. There has been much criticism of this policy, with third sector organizations arguing that this could lead to patients overuse of exempt services such as A&E and primary care, or avoiding health services entirely due to fear of being charged thus resulting in poorer outcomes for health. This issue is particularly pertinent to East London, where NHS services are provided to a predominantly immigrant population, many of who may be overseas visitors affected by this policy. To explore these issues further, I would like to conduct 5-10 interviews with key NGO staff from relevant third sector organizations in Tower Hamlets. In doing so I will gain a greater understanding of the impact that this policy has on the lives and health of migrants, using specific case-study examples of the clients that they support. I will be using a snowball sampling technique to approach my study subjects- this will ensure that my informants will be both maintained within the NGO sector and that the data I collect will be most conducive to my aim. The interviews will be standardized and semi-structured up to a maximum of 30 minutes conducted by myself. They will be audio-recorded and transcribed, then analyzed by the pre-identified themes. This will be supplemented by additional themes emerging from a review of all of the transcripts. The results from this research will then be used to supplement my dissertation reviewing the grey literature of the policy.  |
| **\*Supervisor’s (Principal Investigator) Name** | **Megan Clinch** |
| **\*Supervisor’s email address** | **\*\*\*\*\*\*\*\*@qmul.ac.uk** |
| **\*I confirm that Queen Mary University London is responsible for this study and that I am not receiving any funding for this project (other than that provided by myself or through my course)** | **x Yes****[ ]  No** |
| **If in receipt of funding – who is the funding body****Level of funding**  |  |

**If the answer is Yes to any of questions 1-13 an application to the full ethics committee will be required, the form can be found at** [**http://connect.qmul.ac.uk/research/ethicscommittee/index.html**](http://connect.qmul.ac.uk/research/ethicscommittee/index.html)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Principle** | **Yes** | **No** | **Comments** |
|  | Are the participants under 16 |  | **x** |  |
|  | Could the participants be classified as vulnerable adults |  | **x** |  |
|  | Do the participants have learning difficulties |  | **x** |  |
|  | Does the research involve using or collecting human tissue |  | **x** |  |
|  | Could this research uncover illegal activities (drug use, immigration etc.) |  | **x** |  |
|  | Could this research cause stress or anxiety in the participant  |  | **x** |  |
|  | Will you be asking questions relating to issues of a personal sensitive nature |  | **x** |  |
|  | Could this research bring the University into disrepute |  | **x** |  |
|  | Does the research involve the person taking a drug of any description – even over the counter medicines  |  | **x** |  |
|  | Does the research involve an intervention e.g. exercise, hypnotherapy |  | **x** |  |
|  | Does the research rely on covert observation of the participants |  | **x** |  |
|  | Will this research be conducted in the participants home |  | **x** |  |
|  | Will the participant be paid – not just expenses  |  | **x** |  |
|  | Will the data collected be sent or used overseas |  | **x** |  |

**Appendix B; generic email sent for the purpose of interview recruiting**

Dear…

My name is Lydia Warren; I am currently conducting dissertation research on the effects of NHS overseas charging on the local population of east London.

My aim is to gather primary data that will contribute to the growing evidence base on the impact of this policy for migrant health (including access to healthcare). Part of this work involves interviewing NGO staff who have first-hand experience working with those eligible for charging.

I am emailing to request if you, or anyone else from your organization, are willing to be interviewed. The interviews would take approximately 30 minutes at a location convenient for you. The interview will be audio recorded, anonymized, transcribed and then analyzed in final project write up.

If you would like to participate or request more information, please email me or call on 07\*\*\*\*\*\*\*\*\*.

Thank you for your time,

Lydia

1. Immediately necessary means the patient needs treatment quickly in order to: save their life, prevent a condition from becoming immediately life-threatening, or prevent permanent serious damage to themselves or the community (69) [↑](#footnote-ref-1)
2. Urgent treatment means that the clinician does not consider it immediately necessary, but cannot reasonably wait until the person will be leaving the UK (69) [↑](#footnote-ref-2)
3. Ordinary residence is defined by case law from 1982, when Lord Scarman described it as ‘a man’s abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration’ (70) (30). [↑](#footnote-ref-3)