DrugScope response to "Sustaining services, ensuring fairness", a Department of Health consultation on migrant access and financial contribution to NHS provision in England

About DrugScope

1. DrugScope is the leading UK charity supporting professionals working in drug and alcohol treatment, drug education and prevention and criminal justice. It is the primary independent source of information on drugs and drug related issues. DrugScope has around 450 members, primarily treatment providers working to support individuals in recovery from drug and / or alcohol use, local authorities and individuals.

2. DrugScope's members represent the full spectrum of provision of drug and alcohol services, including voluntary sector providers, NHS Trusts and local authorities, as well as every mode of treatment from low-threshold harm minimisation to intensive structured day programmes, therapeutic communities and residential services.

About the drug and alcohol treatment sector

3. Community drug and alcohol treatment is generally provided by a mixture of voluntary sector organisations and NHS Trusts. As a consequence of the Health and Social Care Act 2012, since April 2013, new funding and commissioning arrangements have been in place which mean that the majority of drug and alcohol services in the community are now both commissioned and funded by local authorities, using both the Department of Health Public Health Allocations, and in many cases supplementary funding from other local authority budgets.

4. Regardless of the new commissioning and funding mechanisms and despite in many cases being direct access, drug and alcohol services are generally categorised as secondary healthcare services and as such appear to fall within the scope of this consultation. Our assumption is that 'NHS provision' refers to all NHS funded provision, whether delivered by the NHS or by independent providers. In addition, we assume that – in line with the NHS Constitution, for example – references to NHS and NHS-funded services are intended to include public health services commissioned by local authorities. Clarification of the intended scope would be welcome.

5. Drug dependency and the impact of alcohol use are included separately as priority areas in *Our Priorities for 2013-14*, produced by Public Health England.[1]

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192676/Our_priorities_final.pdf p.6

6. Drug treatment is cost effective. The Home Office Drug Treatment Outcomes Research 2010 indicated a benefit to cost ratio of 2.5:1[2], primarily through reduced offending (particularly acquisitive crime) and through lower costs as a result of reduced use of other NHS services.

7. In addition to its core role of providing drug and alcohol treatment, the sector makes an important contribution to other areas of public service delivery, including supporting broader public health outcomes, works closely with the criminal justice system (for example through the co-delivery of the Drug Interventions Programme and through work with recently elected Police and Crime Commissioners and through the provision of CARAT services in prisons), as well as supporting social inclusion through its work with local authorities, young peoples' services, housing providers, homelessness agencies and employment, training and education services. It provides sexual health (including HIV) advice and often serves as a gateway to services for some of the most socially excluded individuals.[3]

8. Just over 300,000 people in England are thought to be opiate and / or crack cocaine users (OCUs)[4]. This number, although substantial, reflects a substantial fall in the number of opiate and crack users that has taken place over a decade. Penetration of treatment services into the OCU population is high, and the number of individuals in England successfully completing treatment has increased from 11,208 in 2005-6 to 29,855 in 2011-12.[5] In addition, there are an estimated 1.6 million people dependent on alcohol in England, with 108,906 adults participating in structured alcohol treatment in England in 2011/12.[6]

9. Despite the United Kingdom offering effective, high-quality and innovative drug and alcohol treatment services, DrugScope is not aware of any evidence to suggest that availability of drug and alcohol services (or 'health tourism') is a significant factor in influencing migration or travel.

10. DrugScope is aware that the overwhelming majority of community based drug and alcohol service users are UK nationals, with overall very low numbers of foreign nationals making use of these services. Overall numbers are understood to be substantially below 10% for all foreign nationals (EU and others) although the percentage of the population in treatment varies substantially between one local authority and another, with London generally having higher numbers of non-UK and non-EU nationals in treatment.

About this response

11. As the membership organisation for the drug and alcohol sector, we have limited our response to matters that relate directly to the drug and alcohol treatment sector and its service users, although we have given consideration to areas that touch on this, with a particular focus on the potential public health implications of restricting or charging for access to services.

---

[2] http://www.nao.org.uk/wp-content/uploads/2010/03/0910297es.pdf p.8

[3] http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/Challenge%20of%20change_policy%20briefing.pdf

[4] https://www.gov.uk/government/publications/drug-misuse-findings-from-the-2012-to-2013-csew/drug-misuse-findings-from-the-2012-to-2013-crime-survey-for-england-and-wales

[5] http://www.nta.nhs.uk/uploads/commentaryfinal%5B0%5D.pdf

[6] http://www.alcoholconcern.org.uk/campaign/statistics-on-alcohol

Question 1: Are there any other principles you think we should take into consideration?

12. There are welcome inclusions in the list of overarching principles, including the assurance that the needs and interests of vulnerable or disadvantaged patients will be protected and that no person should be denied timely treatment necessary to prevent risks to their life or permanent health damage.[7]

13. However, notwithstanding the assurance that the Department will be mindful of its responsibility to reduce inequalities by improving the health outcomes of marginalised groups, we would welcome further reassurance that in addition to the protected characteristic groups, the Department will also take into consideration the 'deep' inequalities experienced by many individuals who experience drug and / or alcohol dependency.

Question 20: Do you agree we should extend charges to include care outside hospitals and hospital care provided by non-NHS providers?

14. We do not believe that charging for drug and / or alcohol treatment is desirable for the following reasons.

Drug and alcohol services as a contributor to public health

15. Drug and alcohol services play an important role in supporting public health, including preventative or protective measures and enabling testing for and accessing treatment for communicable diseases. The *Tuberculosis in the UK 2013* report by Public Health England indicates that whilst rates of infection have stabilised, they are at a historically high level at 8,751 cases reported in 2012, that London in particular has exceptionally high levels (representing 39% of all recorded cases), and that the impact of migration on these figures is substantial, with 73% of new cases being born outside the UK.[8]

16. The same report considered four 'social risk factors' – a history of homelessness, imprisonment, drug use and alcohol use, finding that 7.7% of non-UK born cases were affected by one factor or more. Whilst a higher proportion of UK-born cases were affected by social risk factors, only 43% of the non-UK born case group with additional social risk factors had started directly observed treatment. Additionally, non-UK cases tend to be more resistant to first line treatment and particularly to be multi-drug resistant, with 89% of multi-drug resistant cases being non-UK born.[9]

Drug and alcohol services – costs and benefits

17. Drug and alcohol services contribute to reducing costs, particularly through costs to the NHS (for example as a result of reduced acute admissions, reducing HIV, respiratory disease, liver disease and so on) and acquisitive crime. Public Health England estimated in 2012[10] that drug related

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210438/Sustaining_services__ensuring_fairness_consultation_document.pdf p.15
[8] http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317139689583 pp.7&8
[9] http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317139689583 p.17
[10] http://www.nta.nhs.uk/uploads/whyinvest2final.pdf p.4

crime costs society £13.9bn per year, or that each OCU not in treatment commits crime worth an average of over £26,000 per year.

18. Public Health England estimated the cost of drug use to the NHS at almost £500m per year.[11] Even with a relatively small number of non-EU nationals currently in treatment for drug and / or alcohol dependency, at a mean cost of £4,900 per person in treatment (figure from 2010[12]), potential costs elsewhere, either directly to the NHS or through increased offending, could outweigh the ostensible savings made by either restricting or charging for access.

The role of hospitals in drug and alcohol services

19. Hospital in-patient care is often a component of medically assisted detox from alcohol in particular. Supervised, medical detoxification from alcohol is often recommended on clinical grounds, as the consequences of rapid, unmedicated detoxification can be fatal, rather than merely extremely unpleasant. The adoption of any charging mechanism that might influence an individual or service in making that decision, or that might drive a client to disengage from services entirely and try a 'do it yourself' approach would be unwelcome and in all likelihood extremely dangerous.

Criminal justice and drug and alcohol treatment

20. We note and welcome the exemption for prison services under the new proposals, and do not believe prisoners should be required to make a financial contribution as a condition of accessing drug and alcohol services. This would be a regressive step, particularly given the strong and welcome policy focus on engaging offenders with histories of substance with drug and / or alcohol treatment to reduce re-offending. However, we also note the apparent anomaly that, if payments were introduced, someone might be charged for an NHS service in the community but receive the same service free in prison.

21. Clarification about the status of interventions such as Drug Rehabilitation Requirements (plus any other interventions that might arise from on-going reform in the criminal justice sector) would be welcome. Charging for a community drug or alcohol intervention imposed by a court whilst not charging for a similar prison-based intervention would be inequitable. Conversely, providing 'free' access to treatment for offenders but charging for non-offenders would raise potentially serious perverse incentives that may only be remediable by providing free access to both.

Charging for drug and alcohol services as a disincentive to engage

22. Charging for services, whether by a migrant health levy or upon use of the service may in effect be the same as restricting access to them. The nature of the causal relationship between poverty and drug and / or alcohol dependency is complex and, not fully understood, but the ability to pay for services is open to question. Whilst drug and alcohol use shows little or no correlation with income or socio-economic group, the more severe forms, including dependency and

[11] Ibid p.4
[12] http://www.nao.org.uk/wp-content/uploads/2010/03/0910297es.pdf p.8

problematic use, tend to cluster in areas of economic deprivation and have a particular impact on the very poorest.[13]

This response was prepared by Paul Anders, Senior Policy Officer at DrugScope, based on consultation with DrugScope members and others with experience of and an interest in providing drug and / or alcohol treatment to migrant communities.

For more information, please contact:

Paul Anders
paul.anders@drugscope.org.uk
DrugScope, 4th Floor Asra House, 1 Long Lane, London SE1 4PG

[13] http://www.jrf.org.uk/sites/files/jrf/poverty-culture-behaviour-full.pdf p.32