Responding to 'Access to NHS services for foreign nationals'

A Medact Briefing Document
[Date]

This short document has been written as a guide for health professionals and others considering making a submission to the Department of Health public consultation *Access to NHS Services for foreign nationals.*

The document includes discussion of issues that we have identified as being of concern in the proposed scheme. We have organised it into individual topics. Each topic has a summary of the issue in bold followed by further details and finally, additional resources and further information.

The arguments and references are intended as suggestions only and we would encourage individuals to make their own points and refer to personal experiences. Please consider making individual as well as any organisational submissions, to increase the chances that the views of stakeholders are taken into consideration.

The deadline for responses to the consultation is [date].

Versions of this document in [list of languages] and links to the documents that we have referenced can be found at [website].

What is a Consultation?
A government consultation is an exercise to encourage dialogue with those affected by or who have an interest in a specific area of policy (stakeholders). Your responses should provide evidence to inform the development of this policy. Consultation documents should make clear what is being proposed, the costs of the proposals and the expected benefits of going ahead. The results of a consultation should be clearly analysed and feedback should be given to participants. The exercise should normally last for 12 weeks, giving all participants sufficient time to respond and they should be publicised properly to all potential respondents.

It is important that you respond if you are affected by the proposals for limiting access to NHS services for foreign nationals or if you have an interest in this subject. While the government has an obligation to make this exercise clear to you, if you are having difficulties understanding how to respond, there is support available to assist you including the current document.

Comment [Ezinda1]: We will have to figure out what these resources are and how we can assist. EFH

For Further Information:
- HM Government, *Code of Practice on Consultation*: http://www.berr.gov.uk/files/file47158.pdf

Background
In April 2004, regulations were introduced in the NHS which made 'overseas visitors' from certain countries liable to be charged for accessing most hospital services. A number of vulnerable groups, including refused asylum seekers and victims of trafficking, were affected by these regulations. This included both children and also refused asylum seekers in receipt of Section 4 support because they are acknowledged to be unable to travel safely home.

A number of treatments were exempt from charging. These included treatments delivered in A&E departments, family planning services, treatments for certain infectious diseases, and treatments commenced before an asylum claim was refused.

Treatment deemed 'immediately necessary' was chargeable. However, it could not be refused if upfront payment was not made or patients were unable to demonstrate ability to pay. Bills could be chased as far as was 'reasonable', including the use of debt collection agencies, though destitute individuals could have uncollectable debts written off. It was not clear what 'immediately necessary' meant. However, it did include maternity and antenatal care.

Access to primary care was not affected by the 2004 regulations. General practitioners can register 'overseas visitors' at their discretion and treat them without charge under the NHS.

In March 2009, the Court of Appeal judgement in *Regina(A) v West Middlesex University Hospital NHS Trust* muddied the water somewhat by suggesting that trusts should make an assessment of when an individual can reasonably be expected to return home before denying them treatment that is not 'immediately necessary'.

In April 2009, the charging regulations were amended to make victims of human trafficking exempt from NHS charging.

For Further Information:
- Still Human, Still Here Briefing
- Table of Entitlement to NHS Guidance, April 2009, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_079284.pdf
- [Include Consultation paper when we have it- will include information on regulations and guidance]
- DoH, Victims of Human Trafficking, April 2009 http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/DH_097596

The Proposals

[Add when we have them]

Human Impact

Evidence of the human impact of the charging regulations comes principally from case studies. The largest published set can be found in a document published by the Refugee Council (See For Further Information in this section). They suggest that misapplication of the regulations is common and that individuals entitled to NHS services but with limited understanding of or ability to communicate their rights have also come to harm.

- **For Further Information**:
- *Kelley and Stevenson. First do no harm: denying healthcare to people whose asylum claims have failed. Refugee Council, 2006. Available from http://www.refugeecouncil.org.uk/policy/position/2006/healthcare.htm.*

Health Tourism

The 2004 charging regulations were predicated on claims that there was a growing problem with 'health tourism' -- people coming to the UK mainly in order to receive NHS treatment. However, two recent reviews of the evidence both concluded there was no evidence of significant health tourism. Specifically, there is no evidence that the asylum process has been used by large numbers of people simply in order to access NHS care. The current legislation has had greatest impact on those who are not health tourists but are of the most vulnerable migrant groups.

Comment [E2]: Should we change this to "immigration processes"?

Health tourists are defined as people coming to the UK specifically to avail themselves of free NHS treatment. We have almost no information on who makes up these groups and what numbers are involved. We can presume however that they include expatriates returning to the UK for health care in the mistaken belief that they are entitled to do so and family members of settled migrant communities (Hargreaves S, June 2006). There will also be some other people who can afford to make the trip specifically to obtain NHS care.

To date the Government has not provided any reliable data to show that this is an issue of significance. The following is a quote from evidence given by then Health Minister, Melanie Johnson, to the Health Select Committee:

"*It is very difficult to produce figures. Historically, figures have not been collected by the Health Service, over decades—never, basically—about levels of people using the service who are not resident or normally resident in the UK. That is partly because, obviously, some of the people who use those services are genuine tourists—and I am not just talking about HIV/AIDS here; I am talking more generally, because it is quite difficult, again, to make distinctions between this and a number of other things for which people need treatment. It is impossible therefore to disaggregate data as to whether a tourist came over and broke their foot and received treatment through an A&E department or whether somebody came in and received another service as a so-called health tourists*]" (Health Select Committee, February 2005).

Whether intentionally or not, the legislation has had the most profound impact on groups who are not health tourists but are instead the most vulnerable of migrants groups. These include failed asylum seekers, trafficked people, and undocumented migrants. Project London provides care to undocumented migrants at its London clinic. Their first end of year report on this service found that the majority of their clients had lived in the UK for just under three years before seeking treatment and presented with only routine minor complaints (Médecins du Monde, 2007).

Asylum seekers are entitled to full access to free NHS care during the period their asylum claim is being reviewed. If health care was a major consideration in coming to the UK they would seek treatment during this initial period and not wait until after their claim has been refused. Asylum claims even today take time to process and appeals will further extend this period. If, as John Reid claims in *Enforcing the Rules*, 15 women a month enter the UK in the late stages of pregnancy solely with the intention of obtaining free NHS care, these women are not failed asylum seekers.

For Further information:

- [Health Tourism briefing]
- Medicins du Monde, Project London Annual Report, http://www.medecinsdumonde.org.uk/doclib/104524-report2007light.pdf
- The Guardian, *The Tourist Trap* 14 May 2008
- *National AIDS Trust. The Myth of HIV Health Tourism. National AIDS Trust, 2008. Available from http://www.nat.org.uk/Our-thinking/People-in-greatest-need/Asylum%20and%20migration.aspx.*

Public Health

There will be public health consequences to regulations that prevent a section of the community routinely accessing secondary care. If people are unable to have non-specific symptoms investigated in secondary care, diagnosis and treatment of infectious diseases will be delayed and the result will be increased morbidity and spread of disease.

Comment [E3]: I think we should use a word more accessible to laypersons. Perhaps "increased incidences". Please suggest

Exempting particular infectious diseases from charging will not mitigate these consequences, as people with communicable diseases present with symptoms rather than diagnoses.

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While exemption is made for other sexually transmitted diseases, it is notable that HIV treatment remains chargeable, though testing and related counseling are free. Requiring payment for treatment extends to the provision of antiretroviral therapy to prevent pregnant women passing the virus to their child at birth, despite the obvious long term benefit of doing so both for the individual concerned and the health system in whatever country they later reside. (Pollard A, 2004). There is no proof that these groups come to the UK seeking treatment for HIV. On the contrary, diagnosis is more often the result of an opportunistic infection with a resulting late diagnosis. Earlier presentation during an asylum claim or while a work visa is valid would have ensured treatment was available.

For Further Information

- *Gazzard B, Anderson J, Ainsworth J, Wood C. Treat with respect: HIV, public health and immigration. UK Coalition of People Living with HIV and AIDS, 2005. Available from http://www.irr.org.uk/pdf/HIV_Treat_With_Respect.pdf.*

Human Rights

As many vulnerable migrants and refused asylum seekers are unable to work and often destitute, they are unable to pay for healthcare privately. Outside the NHS, there is little health care provision available to these groups. Therefore under the legislation vulnerable migrants will essentially become an underclass with no access to health care. This is contrary to international human rights obligations.

As Parliament's Joint Committee on Human Rights report makes clear - all asylum seekers including those whose claims have been refused and the Home Office intends to remove from the UK, are still 'within the jurisdiction' and therefore beneficiaries of the rights set out in international human rights treaties that the UK has adopted (Joint Committee Human Rights, 2007). Thus, any policy that denies them access to healthcare that others can freely access is a breach of their right to the highest attainable standard of health, as guaranteed by the International Covenant on Economic Social and Cultural Rights. Such policies can also threaten other rights, such as the right to life, which is guaranteed by the Human Rights Act.

The only free health care provision currently available outside the NHS are those services provided by the Refugee Council, Médecins du Monde UK and the Helen Bamber Foundation. The care that these organisations can offer is limited. The primary purpose of each is to act as an advocate to facilitate entry into NHS care for clients unable to access care themselves. While neither the voluntary sector nor the Government have any idea of the numbers involved, they are likely to be significant enough to overwhelm the few non NHS services currently available.

(ECHR)
Articles 2 (protection of life), 3 (protection from torture and degrading treatment) and 8 (protection of private and family life) of the ECHR are all applicable to the provision of healthcare (Joint Committee Human Rights, 2007). Additionally, Article 14 requires that the rights and freedoms set forth in the ECHR be secured without discrimination.

International Covenant on Economic, Social and Cultural Rights *(ICESCR)*
The Magna Carta of health rights is the ICESCR which, in recognising the right of everyone to the highest attainable standard of health, puts governments under a specific obligation not to limit equal access to health care. Any discrimination violates their rights, as guaranteed by Articles 2 and 12 of the ICESCR (United Nations.1976) . Although not yet justiciable (*liable to court trial or legal decision*), in the UK, the ICESCR is binding on every government that has ratified it.
A great deal has recently been written about health and human rights in the UK, not least by the Department of Health (DOH , Human Rights in Health Care, 2007) and the BMA (Asher J, Hamm D, Sheather J, 2007) but there is a disconnect between what is published and what goes on in hospitals and the community.

For Further Information:

- *Hall P. Failed asylum seekers and health care. BMJ 2006; 333: 109-110. Available from http://www.bmj.com/cgi/content/full/333/7559/109.*
- Shadow Submission on the Right to the Highest Attainable Standard of Health in the UNITED KINGDOM for the International Committee on Economic, Social and Cultural Rights 42nd Session, 4th – 22nd May 2009 By The People's Health Movement - UK
  http://www2.ohchr.org/english/bodies/cescr/cescrs42.htm

Role of the Healthcare Professional

Many healthcare professionals feel it is improper that the denial of services is being used as a means of enforcing immigration policies, a strategy outlined in the Home Office document *Enforcing the Rules.* There is also concern that healthcare professionals lack the detailed knowledge of immigration law necessary to accurately determine eligibility. We know that mistakes are already being made and that people have come to harm as a result (see *First Do No Harm*, referenced above). Health workers are worried that, if they assess eligibility for care, they are violating of professional codes of conduct, such as the doctor's duty to make the care of the patient their prime concern. There is also concern this will damage the relationship they have with their patients.

Health professionals have a duty to provide care for their patients without discrimination. The GMC requires doctors to protect

Comment [Ezinda4]: One thing that I haven't seen that I think would be really useful is s summary of doctors' obligations to patients with reference to actual documents. Might Dr. Peter Hall be a person to approach to support us in this? EFH

and promote the health of patients and the public as a duty ranked second only to making the care of patients their first concern (General Medical Council, 2006). Neglecting people's human rights is bad for their health (Department of Health. Human Rights in Healthcare, 2007).

The DOH and NHS authorities may be tempted to institute formal processes to task hospital administrative officers and Doctors with assessing patients' eligibility for free NHS care and to pass judgment on whether care is immediately necessary.. Doctors may be obliged by their employers to cooperate in these processes, with sanctions in case of non-compliance. This information may subsequently be used by enforcement officers or their agents. Deciding that a treatment is not medically immediately necessary, coupled with the perception by poor or destitute patients that there is a threat of enforcement of payment or debt collection by NHS authorities, is likely to lead to the situation where a number of patients fail to seek care, with subsequent avoidable harm to health.

Complicity of Doctors in this would constitute a major break with their now traditional roles, where patients' wellbeing is put first. Doctors would breach their ethical duties, as embodied in the Hippocratic oath, principles of medical ethics as accepted by the BMA, the World Medical Associations (refs 1-3) and the GMC. Doctors may be liable to GMC proceedings. In business terms, such processes may "outsource" legal and reputational liability to Doctors, where harm to health and death ensued.

Comment [5]: I think, whilst interesting, this is too speculative to include, particularly as we argue earlier that only small numbers of people will be affected. Tom

Comment [E6]: Gilles, would you be happy to take this out on the basis of Tom's comment above?

For Further Information:

- *Home Office. Enforcing the Rules: A strategy to ensure and enforce compliance with our immigration laws. Home Office, 2007. Available from* http://www.medact.org/content/refugees/EnforcementStrategy.pdf.
- *Declaration of Ottawa on Child Health, World Medical Association, 2009*
- *WMA Statement on Inequalities in Health, World Medical Association 2009*
- *World Medical Association International Code of Medical Ethics, World Medical Association 2006, all at:. www.wma.net*

Cost Effectiveness and Workability

There is a significant administrative cost associated with operating a charging regime. Given the high levels of destitution seen in some migrant communities, there is doubt that these costs can be recovered.

When the Joint Committee on Human Rights examined this issue in 2006-7, they concluded 'No evidence has been provided to us to justify the charging policy, whether on the grounds of costs saving or of encouraging refused asylum seekers to leave the UK.' The cost benefits of implementing a suitable system must also be viewed in the light of a study showing that, in a borough with a high migrant population, it was estimated that approximately 100 GP visits across the borough might be chargeable equating to perhaps £3,000 of income.

For Further Information:

- *Joint Committee on Human Rights. The Treatment of Asylum Seekers: Tenth Report of Session 2006-07. Parliamentary Stationary Office, 2007. Available from http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf.*
- The identification and charging of Overseas
  Visitors at NHS services in Newham: a Consultation FINAL REPORT June 2006
  Sally Hargreaves, Jon S Friedland, Alison Holmes International Health Unit, Imperial College Sonia Saxena
  Department of Primary Care and Social Medicine, Imperial College
  And in collaboration with The Newham Project Board, Newham Primary Care Trust, London Borough of Newham
  http://www.lho.org.uk/Download/Public/11948/1/IHU%20Entitlement%20Report%2006.pdf

We would be happy to assist individuals and organisations in making submissions to this consultation. Please address queries to [CONTACT HERE].

Medact is a global health charity tackling issues at the centre of international policy debates. Led by its health professional membership it undertakes education, research and advocacy on the health implications of conflict, development and environmental change. For more information, including details of our work on access to NHS services, see www.medact.org.