Responding to 'Access to NHS services for foreign nationals'

A Medact Briefing Document
21 May 2010

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 *Review of access to the NHS 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 full consultation document can be found on the Department of Health website. **The deadline for responses to the consultation is 30 June 2010**.

This document along with other resources to support those responding to the consultation can be found on our website at http://respondtonhscharging.wordpress.com.

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 at least 12 weeks, giving all participants sufficient time to respond and they should be publicised properly to all potential respondents.

It is important that those who are affected by the current proposals or have an interest in this subject respond to this consultation. While the government has an obligation to make this exercise clear, there are resources available to support those who would like to respond.

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 communicable diseases, and treatments which started 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 continue to have the discretion to register 'overseas visitors' 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* suggested 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, available from: http://stillhumanstillhere.wordpress.com/resources/
- 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
- DoH, Victims of Human Trafficking, April 2009 http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/DH_097596

The Proposals

- In response to an April 2009 Court of Appeal ruling which found that the Department of Health’s guidance was insufficiently clear, a new draft guidance is being consulted on. This draft includes further details about how a patient’s eligibility should be verified and how charges should be made;

- Refused asylum seekers who are supported by the UKBA because there are recognised barriers to their immediate return or because they have minor children (section 4 and Section 95) will be exempt from charges;

- Other refused asylum seekers including children will continue to be charged on the same basis as currently:

    - Immediately necessary treatment (treatment necessary to prevent an illness from becoming life threatening or needed to prevent serious damage to health) will

continue to be chargeable though treatment cannot be refused or delayed if the individual does not pay. This includes maternity care;
    - There will continue to be exemptions for treatment at an A&E department and for certain communicable diseases;
    - Urgent treatment (which is not immediately necessary but cannot wait until the person can reasonably be expected to return home) continues to be chargeable. In cases where the patient does not pay in advance for this treatment, the draft guidance suggests that treatment should be limited to that which is required to prevent the condition from worsening.

  In all cases, whether the treatment is immediately necessary or urgent will be a clinician's decision.

- All unaccompanied minors will be exempt from charging;

- The period that UK residents can spend abroad without being liable for charges will be extended from three to six months;

- The right to enter to UK may be denied to overseas visitors with extensive debts to the NHS;

- The government is considering ways to make health insurance compulsory for visitors will be considered.

These proposals relate only to secondary care. GPs continue to have discretion as to whether to add a patient to his/her list though he cannot refuse patients on a discriminatory basis.

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 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.

That the Department of Health is attempting to provide clarification in the Guidance governing when migrants have access to health care is welcome. However, problems remain. As highlighted in the Refugee Council report, employing debt collectors to collect payment for medical care from those who are wholly unable to pay causes a great deal if distress for those persons and may result in vulnerable people with severe health needs not accessing care.

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.

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).

In the current consultation document, it is stated that NHS frontline staff regularly reports examples of health tourists to the Department of Health and the UKBA reports cases where visitors arrive with hospital records and appointments—evidence that they are arriving to avail themselves of the NHS. Still, no such evidence has been submitted or made public.

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 patients had lived in the UK for just under three years before seeking treatment and presented with only routine minor complaints (Doctors of the World, 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:

- Medicins du Monde, Project London Annual Report, http://www.medecinsdumonde.org.uk/doclib/104524-report2007light.pdf
- The Guardian, *The Tourist Trap* 14 May 2008, http://www.guardian.co.uk/society/2008/may/14/nhs.society
- 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 incidence and spread of disease.

Exempting particular infectious diseases from charging will not mitigate these consequences, as people with communicable diseases present with symptoms rather than diagnoses. 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. 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—are still in the UK's jurisdiction. They therefore enjoy 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, Doctors of the World 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 patients 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.

European Convention of Human Rights

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.

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 ICESCR recognises 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. Discrimination may violate the right guaranteed by Articles 2 and 12. As the ICESCR by the UK, those provisions are binding upon this country.

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 or http://www.aidsrightsproject.org.uk/uploads/6B4BA8A4-3048-2B65-C08E25B87C1E58FA/PHALLBMJarticle.pdf

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

The DOH and NHS authorities are instituting 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.

Of grave concern is the recommendation made by the current guidance that clinicians should take into account a patient's ability to pay when deciding on what treatment to offer. The draft guidance states, "While it should not become the major factor, and where it is medically safe to do so, the financial consequences should play a role in the choice of treatment provided to chargeable overseas visitors who cannot pay or the limits imposed on their treatment, to the same extent that these considerations are taken into account for ordinarily resident NHS patients."

Later, "The clinician can [after the OVM has confirmed that they are dealing with a chargeable overseas visitor] consider what limits can safely be applied to that patient's treatment, thereby preventing the patient incurring a potentially unnecessarily large bill, or the relevant NHS body suffering a loss if debt recovery is not successful, which would mean less resources available for other patient services."

These statements seem to suggest that there might be a two-tiered system of treatment in place with those entitled to NHS services receiving a higher standard of care than those who do not. This is likely to conflict with ethical obligations of doctors. As well, in some cases inferior treatment might lead to reduced chances of recovery for patients with certain conditions

The complicity of doctors in this would constitute a major break with their now traditional roles, where patients' wellbeing is put first. Doctors may be in breach of their ethical duties, as embodied in the Hippocratic oath, principles of medical ethics as accepted by the BMA, the World Medical Associations 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.

An essential role of secondary care is to diagnose illnesses that may or may not be immediately necessary and therefore must be investigated urgently. The role of clinicians when providing secondary care is often to investigate conditions which could not be diagnosed in primary care settings. Often, only after a diagnosis has been arrived at via these investigations can a clinician determine whether the need for further treatment is immediately necessary or urgent. The current draft offers no guidance on situations where such investigations are required and is silent on the issue of diagnosis. As such, it could discourage clinicians from taking appropriate steps to establish a diagnosis for their patients.

For Further Information:

- Department of Health, *Human Rights in Healthcare: A Framework for Local Action*, Available fromhttp://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073473
- 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:. http://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 in collaboration with The Newham Project Board, available at: http://www.lho.org.uk/Download/Public/11948/1/IHU%20Entitlement%20Report%2006.pdf

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.