

Access to Healthcare for Refused Asylum Seekers in England

A Study of Policy Implementation

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Chapter 1: Introduction

In 2004, the UK Government restricted access to healthcare for refused asylum seekers as a response to perceived abuse of the country's health service by this group.

There has been significant debate about policies that restrict access to healthcare for refused asylum seekers largely focussed on the Government's justification for these policies; the existence and scale of health tourism in the UK. Debate has also covered the UK's obligations under international law, inconsistencies with domestic legislation, and other ethical concerns not least the basic duties of a doctor. The care of asylum seekers and refused asylum seekers is an emotive and politicised issue, illustrated by the high levels of, usually negative, media coverage on this issue. Yet to date, there has been a paucity of literature examining the implementation of these policies.

The main aim of this dissertation is to assess to what extent these policies have been successfully implemented. First it will outline the provision of healthcare for refused asylum seekers under the law and describe some of the key arguments against these policies. It will then examine how successfully these policies have been implemented, drawing on information from the available literature and findings from qualitative interviews, with reference to primary and secondary care. It will also briefly examine what the consequences of any problems have been.

Theories of policy implementation suggest a series of preconditions for perfect implementation; they also highlight that much of the success of implementation depends on the policy formulation process. Drawing on this theory, and on the basis of evidence presented in this dissertation it will be argued that there have been significant problems in the implementation of these policies. This is largely a result of a chronic deficit of knowledge about, and understanding of, these policies due to the inadequate provision of information and guidance from the Department of Health (DoH) to those responsible for the implementation of these policies.

Chapter 2: Background

This chapter will look at the process for seeking asylum in the UK. It will also examine the health needs of refused asylum seekers.

The 1951 UN Convention on Refugees defines a refugee as a person who has a well-founded fear of persecution “for reasons of race, religion, nationality, membership of a particular social group or political opinion” and who is unable, or unwilling because of fear, to return to his or her own country or another where he or she has a right to live (United Nations, 1951. Article 1A). A refugee can be distinguished from other immigrants by their “lack of choice” (Jones et al, 1998. p.1444).

Refugees who arrive in the UK should apply for asylum, either at the port of entry or in-country, shortly after arrival. They are then an “asylum seeker” until a decision is made on their claim, or until any related appeals have been concluded. The Home Office will take their passport and issue alternative proof of identity.

It is estimated that the UK hosts less than three per cent of the 8.4million refugees worldwide (Refugee Council, 2008b). The UK is ranked 9th in Europe in terms of the number of asylum applications per head of population (Burnett et al, 2001a). In 2007, there were 23,430 applications for asylum in the UK, of which 16 per cent were granted asylum, 73 per cent were refused, and 11 per cent were granted humanitarian protection or discretionary leave to remain (Home Office, 2008a).

For asylum seekers who are destitute, the Government will provide accommodation and/or financial support until their asylum claim is decided. The Home Office claims that 80 per cent of claims are processed within two months, although many applications take substantially longer (Refugee Action, 2006).

For those whose applications for asylum are refused, any accommodation and/or financial support is withdrawn 21 days after this decision. During this time they are expected to leave the country. A refused asylum seeker, sometimes referred to as a failed asylum seeker, can voluntarily sign up to an assisted removal program which will assist with travel arrangements, and may offer financial support for resettlement. If they do not sign up for voluntary removal, they may be forcibly removed (Citizens Advice, 2006).

However, for a number of different reasons, many refused asylum seekers do not leave the country. There are no firm figures for how many refused asylum seekers are still in the UK; in 2005 the National Audit Office (NAO) estimated that there were between 155,000 to 283,000 (NAO, 2005) but a more recent estimate by the IPPR puts the number at 390,000 (Doward, 2007).

The Home Office recognises that some refused asylum seekers are unable to leave the UK, or at least can not be expected to do so. Under Section 4 of the 1999 Immigration and Asylum Act, the Home Office has the power to support an otherwise destitute refused asylum seeker who meets one or more of a set of conditions (Home Office, 2008c). In March 2008, there were 9,365 recipients of this support (Home Office, 2008b).

There is no other system of support for refused asylum seekers. They are not allowed to work (Refugee Council, 2008a).

Refused Asylum Seekers and their Health Needs

The general health profile of migrants entering the UK is that they are fairly young, fit and healthy with little need for healthcare services (Woodhead, 2000; Burnett et al, 2001b; Health Protection Agency, 2006; Audit Commission, 2007). Project: London, a free clinic run by Médecins Du Monde in East London, found that their clients, one in four of which were refused asylum seekers, had a very similar health profile to the rest of the UK population (Project: London, 2007).

There is, however, evidence that refused asylum seekers have some specific health needs, often as a result of their experiences in their home country, during their journey, or in the UK.

Many of this population have suffered severe mental and physical trauma related to their reasons for seeking asylum. Many are fleeing war, conflict, torture and persecution; 5-30 per cent of refugees have been tortured, and many have been sexually abused (Kelley et al, 2006). Women may be particularly vulnerable (Karmi, 1992; Burnett et al, 2001b). A number of studies report higher mental health needs for this group, such as post-traumatic stress disorder, depression and anxiety (Woodhead, 2000; Burnett et al, 2001b; BMA, 2002), as well as higher risk of suicide (Medical Foundation of Torture Victims, 2005). Experience of

immigration procedures for refused asylum seekers may also exacerbate any pre-existing mental health problems.

The British Medical Association (BMA) amongst others, have found that the health of asylum seekers may deteriorate further after they have entered the UK (BMA, 2002; Refugee Action, 2006). A large proportion of refused asylum seekers may face destitution, regardless of whether or not they are receiving Government support (Citizens Advice, 2006). Those not in receipt of support are often homeless and reliant on charity for food (Williams, 2004; Hargreaves et al, 2005; Williams, 2005). This can have a further detrimental impact on their health, including problems with nutrition and infectious diseases (Burnett et al, 2001b; IPPR, 2005; Amnesty International, 2006; Refugee Action, 2006; European Commission, 2008).

Chapter 3: Entitlement to Healthcare in England for Refused Asylum Seekers

This section will examine the provision of access to primary and secondary healthcare in England for refused asylum seekers. The UK's health service is called the National Health Service (NHS). Throughout this report the health service in England will be referred to as the NHS but it is important to note that the responsibility for health policy is devolved in Wales, Scotland and Northern Ireland.

Entitlement to Primary Healthcare

The rules for access to primary care services are outlined in the Health Service Circular (HSC) 1999/018. It is now obsolete but has not yet been replaced (DoH, 2002). General Practitioners (GPs) have the discretion whether or not to register any individual, including a UK citizen, at their practice. However, a practice with an open list can only refuse someone if they have reasonable grounds to do so. This must not relate to, amongst other things, the patient's race or appearance (House of Commons Library, 2008). GPs may choose whether to register someone as a temporary or permanent resident. In both cases, the patient will receive free primary medical treatment. GPs may refuse to register individuals as NHS patients, or choose to treat them as a private patient. The circular states that "It would be particularly appropriate to offer private treatment if it appears that the patient has come to the UK specifically to obtain treatment" (DoH, 2002. para.15).

GPs' are, however, required to provide treatment which is deemed to be 'Immediately Necessary', regardless of whether or not the person in need of treatment is registered with the GP. Treatment defined as Immediately Necessary in the HSC 1999/018 is that which is "essential...[and] cannot be reasonably delayed" (DoH, 2002. para.6). It is a clinical judgement to be made by a qualified health professional.

In May 2004, the DoH issued a consultation which included proposals to exclude particular groups, including refused asylum seekers, from access to free NHS primary care services (DoH, 2004b). As yet, the DoH has not published their findings from this consultation.

Access to Secondary Healthcare: NHS Hospital Services

Until April 2004, anyone who had been in the country for at least 12 months was exempt from charges for secondary healthcare, regardless of their immigration status. However in 2004, an important change was made which meant that to benefit from this exemption, one had to have been 'lawfully' in the UK for at least 12 months, and because refused asylum seekers were not considered to be in the UK lawfully, they were no longer entitled to free secondary healthcare (DoH, 2004d). Information for healthcare providers about the new amendment was issued in guidance to NHS Trusts (DoH, 2004a; DoH, 2008b).

The new regulations placed a legal obligation on NHS Trusts, NHS Foundation Trusts and Primary Care Trusts (PCTs) (which provide secondary care services) to establish whether or not their (potential) patient is liable for healthcare charges. The Trust is entitled to ask for documentary evidence to establish entitlement to free healthcare. The Guidance provides examples of evidence which are acceptable, although states that other forms of evidence are "equally valid", that "interviewers should be prepared to be flexible" and, in some cases, "to accept the word of the patient without supporting evidence" (DoH, 2004a. paras.5.13-5.14). The Guidance strongly encourages the recruitment of Overseas Visitors' Managers (OVMs) and Officers, whose role it would be to determine an individual's liability for charges. Often this role is performed by Private Patient's Officers.

The Guidance encourages Trusts to obtain a deposit equal to the estimated cost of the treatment, prior to commencement, unless treatment is deemed to be 'Immediately Necessary' or 'Urgent' in the opinion of a treating clinician. Examples of 'Immediately Necessary' or 'Urgent' treatment are not given in the Guidance. In such cases, the Guidance states that it must not be delayed because a patient's liability for charging is being established or because the patient has not paid any sums owing. To do so could be in breach of the patient's human rights under the 1998 Human Rights Act. Maternity services are deemed to be 'Immediately Necessary' because of the associated severe risks to the health of the mother and baby. Refused asylum seekers are, however, still liable for charges following 'Immediately Necessary' treatment, unless treatment was provided in an Accident and Emergency (A&E) Department; it is the location of treatment that is exempt, rather than the treatment. In addition to A&E treatment, there are a few other exempt locations, including sexual and mental health services.

In the interests of public health, the Guidance outlines certain diseases for which treatment is provided free of charge. HIV treatment is not exempt from charging, although the initial diagnosis test and any associated counselling is.

High Court Ruling: April 2008

In April 2008, a High Court Judgement ([2008] EWHC 855) ruled that “all refused asylum seekers granted temporary admission [are]...entitled to free treatment as long as they could demonstrate an intention to remain here” (Hundt, 2008. p.20). In doing so, Mr Justice Mitting ruled that the DoH Guidance advising Trusts to charge refused asylum seekers was unlawful. Since April 2008, refused asylum seekers who can show that they have been granted temporary admission to the UK (for example by presenting Home Office issued identification), that they intend to remain in the UK, and that they have been here for a ‘significant period’ are now entitled to free NHS healthcare. There is no specific definition of a ‘significant period’ (Dyer, 2008; Hargreaves et al, 2008; Hundt, 2008; MedAct, 2008).

The DoH has appealed this decision, and the date of the hearing is set for mid-November 2008. However, until the decision is overturned, this verdict is effectively law with immediate effect. The DoH wrote to NHS trusts in May 2008 to inform them of the new position (DoH, 2008a).

Chapter 4: Policy Implementation

Until the 1970s, there was a strong focus on the design and formulation of public policy and an assumption that once the policy had been written, the work was done. Yet there was an increasing realisation of policy failure and that the “best laid plans had all too often gone awry” (Parsons, 2003. p.457). It became increasingly clear that “Governments were better at legislating than at affecting desired changes” (Hogwood et al, 1984. p.197).

The new policy literature of the 1970s began a search to explain the cause of the ‘Implementation Gap’ (Dunshire, 1978). Over the next few decades a number of different theories were expounded. In general terms, a distinction can be made between a ‘top-down’ or a ‘bottom-up’ approach.

As described in Winter (2006), the ‘top-down’ approach developed by academics such as Sabatier, Mazmanian, Hood, Hogwood, and Gunn placed the implementation of policy as a continuation of the policy process and placed responsibility very much in the hands of policy-makers. The outcome of such an approach was generally a set of recommendations for policy-makers about how to ensure effective implementation of their policies.

Hogwood and Gunn (1984, chapter 11) outlined a series of ten ‘preconditions for perfect implementation’, although they recognised that attainment of each and all of these would be impossible. Three of these conditions are particularly pertinent to this area:

- That there is understanding of, and agreement on, objectives
- That there is perfect communication and co-ordination
- That those in authority can demand and obtain perfect compliance

The ‘bottom-up’ approach, developed by academics such as Dunleavy, Elmore, and Lipsky criticised the ‘top-down’ approach as not having sufficient regard to the agency of actors involved in policy implementation, highlighting that these actors have a significant level of discretion when it comes to applying a policy and ensuring its effective performance. Lipsky argued that street-level bureaucrats were crucial for the implementation of most policies and Bardach characterised this process as the ‘implementation game’ where actors are trying to win control in order to achieve their own goals and objectives (Parsons, 2003; Winter, 2006). Winter goes on to describe how academics, including herself, later developed an integrated approach.

The focus on implementation has been criticised, however, for not placing enough emphasis on policy formulation and design, instead blaming implementation for all policy failure. Winter argues that the “roots of implementation problems can often be found in the prior policy formulation process” (Winter, 2006. p.208). Hogwood and Gunn (1984) also believed that the divide between formulating and implementing a policy was much narrower than many suggested and asserted that if, at the policy design stage, more thought was given to the potential problems of policy implementation and there was greater interaction between stakeholders, there would be a greater chance, although no guarantee, of success.

They also suggested that any policy could be put at risk, and fail, as a result of ‘Bad Policy’, ‘Bad Execution’ or simply ‘Bad Luck’. Policies to restrict access to healthcare for refused asylum seekers have been heavily criticised on both grounds of ‘Bad Policy’ and ‘Bad Execution’.

Bad Policy

Hogwood and Gunn (1984) define a ‘Bad Policy’ as one which is based on ‘inadequate information, defective reasoning, or hopelessly unrealistic assumptions’. Policies to restrict access to healthcare for refused asylum seekers has been criticised on these grounds and others, including their initial justification, their inconsistency with both the UK’s international obligations and domestic policy, and the lack of support from healthcare professionals and advocacy groups.

Health Tourism

A significant point of contention has been the justification for these policies. The DoH has clearly and repeatedly stated that their objective behind these increasingly restrictive policies is to reduce the abuse of NHS resources, a response to the perceived problem of ‘health tourism’, i.e. when individuals visit this country purely to access free healthcare. The consultation on proposals to introduce secondary healthcare charges for refused asylum seekers indicated that a key aim was to save the NHS money (DoH, 2003). John Hutton MP, then Health Minister, declared: “There is absolutely no doubt in my mind...that there is a significant amount of abuse going on” (BBC News, 2004). However, it appears that the Government has little or no evidence to substantiate these claims. Home Office research found little evidence that asylum seekers in the UK had detailed knowledge about the UK or of their entitlement to welfare (Robinson et al, 2002).

The Joint Committee on Human Rights (JCHR) noted that “the Government has not produced any evidence to demonstrate the extent of what it describes as “health tourism” in the UK” (JCHR, 2007. para.129). In addition, the House of Commons Health Select Committee (HCHSC) “were astonished that by the Department [of Health]’s own admission, these changes [were] introduced without any attempt at a cost-benefit analysis” (HCHSC, 2005. para.138).

The majority of other studies have also found no evidence of health tourism. The National AIDS Trust found no correlation between immigration and HIV status and that most migrants come to the UK unaware of their HIV status and do not test for HIV until, on average, five years after arrival (Personal Communication, National AIDS Trust). Project: London also found that their average service user had been in the UK for three years before seeking care (Project: London, 2008b).

The Centre for Policy Studies did, however, find widespread anecdotal reports of abuse of healthcare in hospitals (Sergeant, 2003). And a study by the BBC in 2005 found that an increasing number of women from overseas were travelling to the UK to give birth (Thomson, 2005. p.1).

International Obligations and Domestic Policy

It has been raised that through these restrictions to healthcare for refused asylum seekers, the UK is contravening its obligations under international law, particularly with regard to the European Social Charter (ESC) and the UN International Covenant on Economic, Social and Cultural Rights (UNICESCR), to both of which the UK is a signatory (Doctors for Human Rights, 2008).

The ESC guarantees that “Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable” and that “Anyone without adequate resources has the right to social and medical assistance”. The Council of Europe’s Committee of Social Rights has confirmed that because “healthcare is an essential precondition...to human dignity”, signatories must extend the right to healthcare to all “foreign nationals, even if they are undocumented migrants” (European Observatory on Access to Healthcare, 2007).

The UNICESCR guarantees the right to the highest attainable standard of physical and mental health. The UN Committee on Economic, Social and Cultural Rights is clear that signatories must “refrain from denying or limiting equal access” to healthcare, including for “illegal immigrants” (Project: London, 2007).

Furthermore, elements of these policies are inconsistent with international assurances. The UK Government is “one of the key backers” for the Global Fund to fight HIV and AIDS, Tuberculosis (TB) and Malaria and has pledged £1.5 billion for HIV and AIDS between 2005-2008 (DfID, 2008). This contrasts sharply with domestic policy to restrict access to HIV treatment for refused asylum seekers.

There is also concern that these policies may undermine domestic policy goals. “Stopping Tuberculosis in England” (DoH 2004c) is an action plan whose key aims are to “reduce the risk of new infections” and “provide high quality treatment and care for people with TB”. Denying refused asylum seekers access to healthcare clearly has the potential to impede progress on these aims.

Lack of Support from the Healthcare Profession and Advocacy Groups

There has been significant resistance to current and proposed restrictions on access to both primary and secondary care for refused asylum seekers. A repeated objection is that the NHS is being used as a ‘branch of the immigration service’. It is argued that it is the Home Office’s responsibility to control access to this country, but once someone is in the country they should be treated regardless of their status (Taylor, 2006; Kmietowicz, 2004).

An Early Day Motion (EDM) “against any measures that would compel general practitioners, and other primary care staff, to be forced to charge refused asylum seekers...for NHS care” has, to date, been signed by 92 MPs (EDM 220, 2007). There is also an online petition, with 760 doctor’s signatures, calling for the Government to reject any proposals to restrict access to primary care for refused asylum seekers and pledging to “Continue to see and examine asylum seekers and to advise them about their health needs, whatever their immigration status” (Arnold, 2007).

Although the Government’s response to the consultation to restrict access to primary healthcare has never been published, the Global Health Advocacy Project (GHAP) recently collated and published a number of organisations’ responses to the consultation. Amongst the

38 responses they were able to obtain, only five responded positively to the proposed changes and some of those raised concerns about implementing the proposals (GHAP, 2008).

Doctors have also raised concerns about the ethical implications of the policies. There would seem to be an obvious contradiction with both the General Medical Council's (GMC) 'duties of a doctor', the first of which is to "make the care of your patient your first concern" (GMC, 2008), and a modern version of the Hippocratic Oath frequently used in medical schools; "I will apply, for the benefit of the sick, all measures [that] are required" (The Hippocratic Oath: The Oath of Lasagna, 2008). According to the organisation 'Doctors for Human Rights'; "Conforming with legislation that denies access to healthcare goes against the instincts of many doctors, affronts common decency, and infringes international and domestic ethical codes" (JCHR, 2007. para.133).

Bad Execution

Hogwood and Gunn (1984) outlined that a second reason a policy may fail is due to 'Bad Execution'. They defined 'Bad Execution' as where a policy is ineffectively implemented. They distinguished between non-implementation and unsuccessful implementation. They suggested that non-implementation was where a policy was not applied as intended because 'those involved in its execution have been uncooperative and/or inefficient' or because they were faced with unassailable obstacles over which they had 'little or no control'. Conversely, unsuccessful implementation occurs where the policy is applied as intended but fails to produce the desired results.

Perfect communication was a precondition for success for Hogwood and Gunn, yet they concluded that perfect communication is unattainable, suggesting that although successful information systems can ensure effective dissemination of information, they cannot ensure the information received is either interpreted as intended, or indeed understood at all.

Responses to the Government's consultations on proposals to limit access to both primary and secondary healthcare for refused asylum seekers have raised concerns about implementing these policies, identifying potential problems for frontline staff in accurately identifying refused asylum seekers and correctly implementing the policies as intended (Refugee Council, 2003; GHAP, 2008). There have been widespread calls for more information and training for healthcare staff (Greater London Authority, 2001; Hargreaves et al, 2006b; Kelley et al, 2006; PICUM, 2007).

There is very little literature that examines the actual implementation of these policies, with the notable exception of reports studying access to maternity care. Instead, the vast majority of the literature focuses heavily on debating these policies themselves, as outlined above.

The remainder of this study will argue that, primarily as a result of imperfect communication, these policies have suffered from “non-implementation”, with “inefficiency” caused by a massive deficit of information. The following sections will show how a lack of guidance and direction from the DoH and some PCTs to those responsible for implementation has led to incorrect interpretations and a series of unintended consequences.

It could also be argued that the problems with the implementation of these policies might be due to a lack of “understanding of, and agreement on, objectives” between policy-makers and doctors, that “those in authority” have been unable to “demand and obtain perfect compliance” and that “those involved in its execution have been uncooperative”. However, despite there being significant evidence of a backlash amongst doctors, this is less relevant to the implementation of these particular policies, as in practice it is the non-clinical frontline, administrative and managerial staff who are responsible for delivery. Primary care may be an exception to this because GPs have more control over who is registered with their practice. However, with time, this rebellion by doctors may force a revocation of these policies.

Chapter 5: Methodology

A qualitative study of professionals working with refused asylum seekers was chosen to supplement the evidence given by the literature. A semi-structured interview process was selected as this approach allows participants to speak freely on issues that concern them and often provides rich qualitative data. It also allows the researcher to explore further any relevant issues which arise during the course of the interview. A topic guide was designed using the literature to ensure that specific areas of interest were covered during the interview. This allowed comparison across interviews. A copy of the topic guide can be found in the Appendix.

Purposive sampling, using snowball sampling, was used to identify participants with the relevant experience for this study (Holloway, 2005). Snowball sampling is a method used when the desired characteristics for survey participants is difficult to find, as was the situation in this case (Research Methods Knowledge Base, 2008). By initially contacting a few individuals appropriate to this study, subsequent contacts were made with other potentially relevant participants.

Overall, 17 individuals were interviewed from 14 different organisations over three weeks. Four of the interviewees worked with organisations that dealt solely with HIV/AIDS, another focussed purely on maternity services, and the remaining ten worked on the full range of health issues. The majority of interviewees were from advocacy organisations, one was a lawyer, and others worked for a local authority or the NHS directly. Across the range of interviewees, numerous different ethnic groups were represented.

The interviews each lasted between 20-65 minutes, were carried out over the telephone, and were recorded with permission. Participants were assured that any information they gave would only be used for the purpose of this dissertation and would be anonymous if presented. All interviews were carried out and transcribed by the author. Themes emerging from the evidence were identified during this process and common and divergent experiences were compared.

Chapter 6: Findings and Discussion

This chapter will use existing literature, supported by findings from the interviews of key informants, to examine and discuss how successfully policies to restrict access to healthcare for refused asylum seekers have been implemented, and where they are not being implemented as intended. It will first examine access to primary care, and then access to secondary care, before assessing the consequences of these findings.

Access to Primary Care

This section will look at the knowledge and confusion of primary care staff about refused asylum seekers' entitlement to primary healthcare and the sometimes ambiguous and contradictory guidance about the regulations given to primary care services. It will look in detail at where the policy is being implemented incorrectly, with particular focus on requests for identifying documentation. It will also suggest that, in some cases, non-implementation of this policy is having positive results for patients.

Primary Care Staff and Knowledge about Entitlement

The literature suggests that there is widespread confusion amongst healthcare providers at a primary care level about whether or not refused asylum seekers are able to register at a GP surgery as an NHS patient. A study of NHS services in East London, found over half of GPs were unsure what the procedure was for identifying and charging refused asylum seekers, and 85 per cent requested more clarity on the existing rules (Hargreaves et al, 2006b).

One reason for this confusion may be that the consultation to restrict access to primary care for refused asylum seekers was published around the same time as the 2004 charging regulations for secondary care were introduced, resulting in some practices applying the proposed restrictions on primary care as if they were in force (Project: London, 2008b).

Perfect communication has been identified as a precondition for perfect implementation (Hogwood et al, 1984), yet guidance from the DoH has been accused of being both ambiguous and inherently contradictory; it mentions that refused asylum seekers should not be registered, yet it also states that GPs have the discretion to register them if they so wish (Carrillo de Albornoz, 2006; Reeves et al, 2006; JCHR, 2007). The BMA identified

“considerable confusion about overseas visitors’ eligibility for NHS primary medical services...largely because of a lack of clarity in the NHS regulations” (BMA, 2006. p.2).

Interviewees confirmed that guidance given to GP surgeries was often unclear and confusing. The following case illustrates this concern and also further demonstrates that professionals are unclear about where responsibility for these policies lies, confusing the Home Office and the DoH:

“One of the problems...is the lack of clear Home Office guidance about what people are entitled to or not entitled to, so you'll find that most of the time people are being refused purely because the practitioners or the frontline staff don't actually know [who is entitled]” (Interviewee B)

Other interviewees remarked that the guidance given to GPs by PCTs can also be unclear, contradictory, and difficult for frontline staff and practice managers to interpret. As a result, the policies are often implemented incorrectly:

“What routinely happens [is that] we have someone who has read something, has been given some document [from the PCT] and doesn't entirely understand it...[The guidance issued by PCTs is] definitely misleading and definitely confusing...some [guidance documents] are quite confusing, some are almost impossible to understand, [and] some are incomplete so leave you with a bit of a misimpression” (Interviewee G)

Responses to the 2004 primary care consultation collated by the Global Health Advocacy Project (GHAP) highlighted a common “concern that primary care services did not have the...technical expertise to accurately determine a patient’s immigration status” and many responses “repeatedly questioned” the ability of primary care staff to assess eligibility for care (GHAP, 2008. p.25). The following interviewee agreed that a key problem was the level of understanding amongst frontline staff about the immigration system in general and that there was a need for further education for healthcare services staff:

“Admin staff largely don't know the system at all, they don't know the asylum seeker system at all...I think the problem is that there's not a lot of educating about asylum seekers and failed asylum seekers and what their entitlements are to a large group of health professionals” (Interviewee C)

As a result, many refused asylum seekers are often unable to register as NHS patients (Kelley et al, 2006; JCHR, 2007). Indeed, Project: London was established with the expressed purpose of providing “practical assistance to vulnerable people to help them access NHS...services” because of the difficulties that some vulnerable groups experience when trying to register with a GP (Project: London, 2008c). Interviewees confirmed that this was a problem for their clients, with all respondents replying that some of their clients had experienced difficulties registering with a GP surgery.

Documentation

The DoH HSC 1999/018 makes no mention of any document requirements for registration, yet many refused asylum seekers are often denied registration because they are unable to produce documentation requested by GP practices. There are considerable differences between GP practices as to which documents are required for a patient to register (Hargreaves et al, 2006b).

One interviewee indicated that this confusion was caused by guidance issued by the PCT which indicated that surgeries need certain documents to register patients:

“Largely what I’m seeing now is that PCTs are issuing policies or guidance documents to GP surgeries which reception staff and practice management...are finding very difficult to interpret and implement because they give the impression that all sorts of identity documents are required before someone can be registered, which is incorrect,...it almost contradicts itself saying it’s your discretion, you can register these people without this stuff, but you need to see, you know, X, X, X, and X. It’s just really difficult for [frontline staff to understand]” (Interviewee F)

All of the interviewees mentioned their clients’ difficulties with providing documents requested by GP surgeries to prove their identity and current address. In the case of a passport, if the client hasn’t lost it whilst fleeing their home country, the Home Office is likely to have it. The vast majority of refused asylum seekers will not have other forms of identification, such as a utility bill or a driving license.

The following interviewee highlighted their client’s difficulties when trying to meet document requests:

“The main [obstacle] is bureaucratic...in terms of being required to provide, or being given impossible requirements in terms of identity documents or proof of address or stuff that they simply can't provide...I think in most cases they're asking for them because they think they need them...” (Interviewee F)

Variation between Practices

Although there is no literature which specifically points to positive experiences for refused asylum seekers when trying to register at the GP surgery, which perhaps reflects a bias in the literature on this issue, some interviewees did mention that they knew of GP surgeries within their areas where refused asylum seekers were always accepted as NHS patients.

“It entirely depends on which GP they're trying to access...We do have...one particular surgery with high numbers of asylum seekers who we used to do an outreach at, and have a good relationship with, and they would be very generous” (Interviewee K)

Interviewees also reportedly positively on the sometimes rebellious attitude of local GPs:

“Some of GPs...had actually made a pact that they weren't going to follow the guidance as put out by the Home Office because they believed it to be unethical...some of the GPs have applied their own philosophy to the situation” (Interviewee B)

This could be seen as a clear example of where the lack of support for a policy has manifested itself in the non-implementation of this policy, in this case providing a positive outcome for the patient.

Access to Secondary Healthcare: NHS Hospital Services

This section will look at refused asylum seekers' experiences of accessing NHS hospital services. It will first examine the general level of staff knowledge about refused asylum seekers' entitlement to free NHS treatment, before looking at the specific cases of 'Immediately Necessary' treatment and access to maternity care, before finally looking at the practice of assessing a patient's liability to pay, the timeliness of charging a patient for their treatment and how the hospital may recover any sums owing. It will also assess what impact the April 2008 High Court ruling has had on this group's experiences of accessing secondary healthcare.

Hospital Staff and Knowledge about Entitlement

Entitlement for refused asylum seekers to access secondary care is quite clear; unless the treatment is included in the list of exemptions then the patient will need to pay for that treatment. If the treatment is deemed to be 'Immediately Necessary' or 'Urgent', then care should be given without waiting for either the patient's liability for charging to be determined or for a deposit. In all other cases, a hospital is encouraged to get a deposit from the patient equal to the cost of the treatment before treatment commences.

In practice, different hospitals have interpreted the policy in very different ways, often dependent on the individual members of staff working there on the day and how well they understand the regulations. One interviewee reported that this decision to charge, or not to charge, seemed haphazard:

"We used to explain that there is a risk that if they need to get access to secondary care they could be charged, but that risk is dependent on who [gets] picked up by the private patient's officer, and its really arbitrary how they pick people up as well, it could be the name, it could be the NHS number and how long you've been registered, so it's really just sit and see" (Interviewee C)

Some interviewees were keen not to blame healthcare professionals, instead highlighting the limited time that many practitioners have available to digest long and complicated guidance documents. The following interviewee commented on how complex legislation was becoming:

“Part of the question here is that it's so bloody complicated, the legislation round this is getting extremely hard so obviously for practitioners it ends up being quite a nightmare trying to actually navigate through it” (Interviewee B)

Other interviewees highlighted that the underlying culture of the NHS, to provide a universal service free at the point of use, meant that some practitioners found it difficult to reconcile this tenet with the current situation, and that this may have led to confusion:

“In fairness to the healthcare professionals, most of them would tell you...that one of the great things about the NHS is that the issue of entitlement is one that has just never been something that they were prepared to deal with, something that they were trained about, something that they were educated about. Most people entered the NHS at a time when there was no question about entitlement and everyone was treated the same...I think they're really struggling with something that a few years ago would have seemed to them unthinkable” (Interviewee G)

As before, the literature does not provide examples where refused asylum seekers have had positive experiences of accessing secondary healthcare, or indeed where they have been able to access chargeable services without having to pay. However, some interviewees did report cases of clients accessing secondary healthcare without being charged. Some of these reports were largely associated with the, again sometimes rebellious, attitude of doctors with interviewees describing instances of where doctors had actively tried to find ways around the legislation.

Again this is evidence of where these policies do not have the full support of practitioners, possibly due to ethical concerns some doctors may have. However, in every case it was the attitude of the healthcare practitioner that was important, rather than the frontline, administrative or managerial staff, highlighting an important difference between those usually responsible for implementing the policy and the doctors. Every interviewee, such as the one below, confirmed that this was an important distinction:

“If I meet a...consultant..., they say that they would never turn anyone away themselves. But of course, they're not the ones that are answering the phone, they're not the ones that are making the appointments” (Interviewee G)

One interviewee reported that none of the refused asylum seekers that they represented had been charged for HIV treatment, even though this is chargeable under the regulations, and highlighted that this was a result of doctors' general attitudes in certain settings:

“HIV clinics are either in GUM [Genitourinary Medicine] or STI [Sexually Transmitted Diseases] departments or Infectious Diseases Units and both have long histories of discretion, confidentiality and advocacy for marginalised people...There's usually a can-do culture that keeps many people away from the eyes of the Overseas Patients Managers” (Interviewee A)

However, the majority of research and comments from interviewees portray a negative picture where refused asylum seekers are unable to access healthcare in line with their entitlements.

Immediately Necessary Treatment

Whether or not a treatment is deemed to be 'Immediately Necessary' is a decision to be taken by the patient's treating clinician. Currently, only maternity services are specifically defined as 'Immediately Necessary' in the Guidance, although there have been calls by the National AIDS Trust for HIV treatment to be included within this definition because of the life-threatening health risks associated with treatment delay and the health implications for others (Personal communication: National AIDS Trust). The BMA has also recommended that treatment for cancer should always be seen as 'Immediately Necessary' (Project: London, 2007).

There is a lack of clarity about what constitutes 'Immediately Necessary' treatment and examples are not given in the Guidance (DoH, 2004a; Refugee Council, 2006). Rosie Winterton MP, then Health Minister, told the JCHR that the DoH was clear that “it is a clinical decision as to what treatment is necessary to save lives” (JCHR, 2007. para.133). This has been reinforced by a DoH spokesperson: “Clearly it is not acceptable if someone in need of Immediately Necessary treatment, whether maternity or otherwise, has had that treatment delayed or withheld because of their chargeable status. That is entirely contrary to our guidance on this issue” (JCWI, 2008. p.1). Furthermore, in a UKBA response to the Independent Asylum Commission (IAC), they stated that “treatment needed to save life or to prevent a condition from becoming life-threatening, including maternity care, will be given regardless of ability to pay” (IAC, 2008. p.20).

However, some managers have interpreted ‘Immediately Necessary’ to mean that “unless someone is at death’s door you shouldn’t treat them” (Cassidy, 2008. p.322). There is also some concern that these decisions are being made by administrative staff, rather than qualified clinicians (HCHSC, 2005; Hargreaves et al, 2006b; Cassidy, 2008).

Consequently, some refused asylum seekers who are seriously ill can experience considerable difficulties when trying to access healthcare, and are often turned away (Kelley et al, 2006). Interviewees reported numerous cases where their clients had been unable to access healthcare for conditions which perhaps should have been considered to be ‘Immediately Necessary’.

In the case below, the interviewee implied that their client had been told to go away until his condition was severe enough to be considered to be ‘Immediately Necessary’:

“[We had a client who] had bowel cancer and the experience that he had was quite devastating but he was told that he had this problem and that he was very very ill and “You will likely die from this if nothing’s done but you’re not close to death yet so wait until it gets worse and then come back”” (Interviewee G)

Maternity Care

The DoH Guidance clearly states that maternity care, including antenatal care, should always be considered to be ‘Immediately Necessary’. This has also been repeated by DoH spokespersons, as seen in the statements above.

However, research has shown that many women have been denied access to care because they could not pay for their treatment upfront, or have been deterred from accessing treatment by the prospect of large bills (Kelley et al, 2006; JCHR, 2007; PICUM, 2007; Project: London, 2007). Project: London found that 68 per cent of their patients had been unable to access antenatal care, almost a quarter of pregnant women had not received any antenatal care by 18 weeks, and nearly one in 20 were more than 30 weeks into their pregnancy before receiving antenatal care (Project: London, 2008b). This is particularly concerning given the high chances of maternal death and complications at delivery for women who have not received timely antenatal care (Bragg, 2008).

All of the interviewees who had pregnant women as clients reported that their clients had faced difficulties when trying to access maternity care. They asserted that many of their clients had been denied access to maternity care because they had been unable to pay costs upfront, or that their treatment had been delayed whilst their liability to pay was being assessed, both of which are explicitly prohibited in the Guidance. This interviewee confirmed reports in the literature:

“What we keep seeing is that...pregnant women...[are] told, “Fine you can have your baby here but we’ll require an upfront deposit of anywhere between £3000 to £8000”...even though the regulations say that inability to pay should not be a barrier to the provision of treatment” (Interviewee G)

The JCHR found that “It is clear to us that there is considerable confusion” about entitlement to maternity care (JCHR, 2007. para.142). The following interviewee indicated that they believed the reason for this confusion was that staff responsible for dealing with these women did not know what their entitlements were:

“It’s pretty clear that many of the people who are discussing these issues with the women don’t actually know what the rules are [for maternity care] so in many cases the women have been asked to pay and told that they cannot receive care unless they pay” (Interviewee H)

Assessing Liability to Pay, Timeliness of Charging and Recovery of Costs

The Guidance instructs NHS Trusts to ensure they have procedures in place for the identification of patients liable to be charged. To establish liability, the Guidance states that it is necessary to interview potentially liable patients. These interviews are to be “handled sensitively and by staff who have received appropriate training” (DoH, 2004a. para.3.3.). However, some organisations have reported that Overseas Visitors’ Managers (OVMs), those usually tasked with assessing liability to pay, are often less than sensitive (JCHR, 2007).

Interviewees also reported negative experiences with OVMs, often reporting that the attitudes of these, and other frontline staff, were quite negative. There are also anecdotal reports of OVMs being very pleasant towards a patient when an advocate is present, but behaving very

aggressively when the patient is not supported (Personal Communication, *Medécins de Monde*).

DoH guidance states, “It is important that patients are [made] aware as soon as possible that there may be a charge for treatment...Failure to do so, resulting in a bill being presented to a person who was not aware that they were liable, could result in accusations of maladministration” (DoH, 2004a. para.5.2). Evidence suggests this is not always happening and some refused asylum seekers are unexpectedly receiving large bills (Kelley et al, 2006). In the following case, an interviewee described a client who originally accessed free A&E treatment for what she thought was a minor problem, but then required further chargeable treatment but was not told she would have to pay until after the operation:

“[A] girl from Nigeria had a gammy knee...it seemed like there was an infected wound and she was admitted to A&E...They realised there was something quite badly wrong and she was taken upstairs for an operation which found that she had bone cancer and so her leg was amputated...She was charged [£20,000] for that treatment after coming out”
(Interviewee F)

The Guidance instructs Trusts to recover the full cost of treatment provided to refused asylum seekers and states the debt cannot simply be ‘waived’; “It is not acceptable not to bother raising an invoice for treatment provided to a chargeable overseas visitor simply because it is believed that they are unable to pay” (DoH, 2004a. para.8.16). All “reasonable measures” must be taken to pursue this debt, including employing a debt recovery agency if appropriate.

There are, however, provisions to ‘write off’ the debt “in cases where all reasonable steps have been taken to recover [the debt]” (DoH, 2004a. para.8.16). This has been re-iterated and clarified by a spokesperson from the DoH that, where it is “clear that the patient has no means to pay and that it will not be cost effective to pursue payment, the NHS trust can write off the fee” (Taylor, 2006). However there is a disincentive for the hospital to ‘write off’ the debt as this will appear on their books as un-recovered costs. There is ample evidence to show that Trusts are continuing to pursue, often aggressively, refused asylum seekers who have no means of paying large hospital bills (HCHSC, 2005; Kelley et al, 2006; National AIDS Trust, 2007).

An interviewee provided the following case study of a couple who were persistently pursued for payment for maternity care, both before the delivery of the baby, and after. Despite their Home Office case worker becoming involved, the hospital refused to write off the charge:

“[The hospital] basically used to call [our clients] every week to ask where the money was...it was almost every week to the point where the husband used to answer the phone and say “Don’t call my wife, you’re actually really stressing her out and don’t forget she’s pregnant”, and letters used to come as well...invoices...bills...all still prior to delivery. Once she’d delivered the baby she still continued to get these calls to say you need to pay the bill, you need to pay the bill, you need to pay the bill...[their] case worker at the Home Office [even] wrote a letter to explain that...“They’re never going to be able to pay this bill because they’re not allowed to work so it’s futile to pursue this cost””
(Interviewee C)

The next interviewee felt the demands for payment were akin to harassment, and recounted threats he had heard some clients receive from the hospital to try to get them to pay for treatment:

“It’s pretty clear harassment, there’s all the threats for a start, “We’re going to contact the Home Office, we have contacted the Home Office, we’re going to get you deported, we’re going to get you sent to prison, we’re going to contact your family,...we have our agents, we’ll go there and do bad things to them”...and then there’s the constant phone-calls and scary letters from credit collection companies and threats of court action”
(Interviewee F)

This evidence clearly suggests that the guidance is not being followed as intended.

Impact of the High Court Ruling

The April 2008 High Court ruling means that some refused asylum seekers are now entitled to access secondary healthcare free of charge. However, there is concern that this landmark ruling has not been effectively communicated to healthcare professionals, refused asylum seekers or other professionals working within this community, and that some refused asylum seekers are still being denied access to treatment (Cassidy, 2008; Stephenson, 2008). However, because it still so recent, there have been no studies as to what impact this ruling has had.

One interviewee was not aware of the high court ruling and others reported they had not seen any evidence to suggest the situation had changed. However, some did mention that the ruling had been very helpful and was allowing them to inform clients they could now access free secondary care. No-one mentioned that their clients had been aware of the ruling.

It has been reported anecdotally that there has been a big push amongst advocacy groups working with HIV+ refused asylum seekers to inform their clients of the ruling and encourage them to seek treatment (Personal communication, Médecins du Monde).

Only a few interviewees reported that they felt healthcare professionals were aware of the ruling, and usually only those who had regular dealings with refused asylum seekers. Many highlighted the widespread confusion amongst healthcare staff, perhaps exacerbated by frequent changes in the legislation and problems with the guidance on this ruling given by the DoH (2008a). One interviewee reported a case where, after the ruling, an OVM had tried to charge a refused asylum seeker for care because they did not understand the current situation. Another reported that the guidance was quite impenetrable. The following interviewee reported that the guidance had not reached those it needed to:

“I think the problem has been [that] the judgement information was provided to the executives and the chief execs and the directors but...it hasn't trickled down [to frontline staff]” (Interviewee C)

Another mentioned that it had not reached GPs.

Consequences

The evidence above illustrates that problems in the delivery of these policies have led to some refused asylum seekers being denied access to healthcare. Refused asylum seekers may also not access care because of worries they will be denied access or because they are scared by the prospect of large bills (JCHR, 2007; Bragg, 2008). Interviewees confirmed that many of their clients put off accessing care. The following interviewee reported that for some patients it was a balancing act between whether the fear of accessing treatment, or the pain, was greater:

“Often we see people who...don’t get any care until quite late until things have gotten worse and the pain has gotten much worse and the pain, if you will, is stronger than the fear” (Interviewee G)

These barriers are in addition to those already faced by refused asylum seekers when trying to access healthcare created by problems of: language and interpretation (Burnett et al, 2001b; Bischoff et al, 2003; Kelley et al, 2006), concerns about confidentiality (Bhatia et al, 2007), discrimination by staff (Erwin et al; 1999; Cowen, 2001; Hargreaves et al, 2006b), concerns about authority (Reeves et al, 2006) and their lack of knowledge about entitlements to healthcare (Merrell et al, 2006; Reeves et al, 2006; European Observatory on Access to Healthcare, 2007).

Research has found that physicians tend to perceive “Black patients as less intelligent than White patients”, even when other factors are controlled for, such as sex, age, income and education. Patient’s race was also found to impact on a physician’s feelings of affiliation towards their patient (van Ryn et al, 2000. p.822). A recent survey of Africans in England found that a major barrier to getting tested for HIV was the belief that Africans who are HIV+ would be deported. Only 42 per cent of survey respondents were aware that this is not the case (Sigma Research, 2007). Such misunderstandings might have an obvious impact on an individual’s willingness to get tested for HIV.

The consequences of not accessing healthcare are well documented and there is a significant amount of research highlighting the negative impacts of refused asylum seekers being unable to access care. This section will briefly highlight some areas of concern, including public

health, maternal mortality, and the extra burden placed on other services. It will also look at the knock-on impact of widespread staff confusion on other patients.

Public Health

There is significant concern about individuals who have infectious diseases, including HIV or TB, who are not accessing care both for individual and public health reasons. Anti-retroviral therapy for HIV leads to a reduced viral load and reduces the infectiousness of HIV+ individuals. It also reduces the chances of HIV+ pregnant women passing the infection on to their unborn child (O'Farrell et al, 2004; Pollard et al, 2004; Taylor, 2006). In addition, there is concern that, because HIV treatment is not provided free of charge for refused asylum seekers, many are reluctant to get tested in the first place (HCHSC, 2005). The following interviewee confirmed that this was happening and highlighted the incurring risks:

“A lot of people go underground...If somebody has HIV, if they don't go and get tested, that means they are moving with HIV, have unprotected sex and therefore a lot of people are getting infected” (Interviewee E)

There are further fears for public health with regard to TB (Carter, 2006; Reeves et al, 2006; Hinscliff, 2008). TB in the UK is of growing concern with the number of reported cases increasing each year; in 2005, one in six reported cases were among people born abroad who had arrived in the UK in the last two years (Short, 2006).

Maternal Mortality

Not seeking timely, or indeed any, antenatal care can be extremely dangerous to both mother and baby. The latest UK Confidential Enquiry into Maternal and Child Health (CEMACH) found that one in five maternal deaths were in cases where women had had a late booking for antenatal care, poor attendance at antenatal care, or no antenatal care at all (CEMACH, 2007). Furthermore, it was likely that the most recently arrived refugees would be most affected (Ameh et al, 2008).

There are also increasing numbers of reports of women giving birth at home, sometimes unattended (Kelley et al, 2006; Bragg, 2008). Interviewees corroborated these concerns.

Burden on Other Services: GP services and A&E

GP services that register refused asylum seekers and offer good services will quickly become well-known within their communities. Accordingly, they may find themselves overburdened with requests for healthcare (Dale et al, 1995; Woodhead, 2000; Project: London 2008b).

There is evidence to suggest a growing trend that for those unable to access primary care services, A&E is providing an alternative source of healthcare leading to inappropriate attendance at A&E (Blog, 2002; Hargreaves et al 2005; HCHSC, 2005; Hargreaves et al, 2006a; Hargreaves et al, 2006b; Hargreaves, 2007; IAC, 2008; JCHR, 2007). Interviewees reported that this was happening amongst their client group.

Using A&E as an alternative source of healthcare is concerning for a number of reasons, not least because it is more costly to treat someone at A&E than at a primary care level; the average cost of a GP consultation is £20 compared with £110 for the average A&E attendance (Yates et al, 2007a). It has been repeatedly shown that effective preventative care is significantly cheaper than providing care for a health condition that has become more serious (Colin-Thomé, 2007). Because refused asylum seekers are having difficulty accessing preventative care, some are not receiving treatment until their condition has become more serious, and consequently, more expensive (Norredam et al, 2005; Carter, 2006; BMA, 2008; Project: London, 2008b).

In addition, some interviewees reported that their clients had experienced difficulties accessing A&E because of their immigration status and the confusion about entitlement to care amongst staff, leaving these patients with literally nowhere else to go.

Impact on Other Patients

Widespread confusion amongst staff about refused asylum seekers' entitlement to healthcare has had a knock-on effect on other groups. Studies show that groups with absolute entitlement to healthcare, such as asylum seekers and even British Citizens, have been denied access, sometimes with fatal consequences (HCHSC, 2005; JCHR, 2007; PICUM, 2007; Morris et al, 2008; Project: London, 2008b).

The National AIDS Trust has noted that “how rigorously you are questioned about entitlement to treatment will depend on your name, accent and the colour of your skin” (Yates

et al, 2007b p.299). Another researcher found that some hospital staff simply looked at the list for ‘foreign sounding names’ (Personal minutes, 2007). Interviewees confirmed these findings with reports of eligible patients, including British citizens, being denied treatment or being asked to pay for treatment, often on the basis of assumptions due to patients’ appearance or lack of English.

Shortcomings and Recommendations for Further Research

This study is likely to be heavily biased in favour of refused asylum seekers, and more likely to report negative experiences as a result of the groups that were interviewed; as one interviewee put it “*I only see the ones that have gone wrong*”. In addition, the majority of literature in this area is mainly from advocacy groups.

For that reason, further research should be carried out and this should include working with OVMs and frontline staff. Further qualitative research should also take place with refused asylum seekers directly. For reasons of time and resource constraints, this unfortunately was not possible for this study.

There is also further work to be done in examining access to mental health services and dental care for refused asylum seekers, areas which have not been probed in this study for reasons of space. It would also be useful to look at the experiences of refused asylum seekers in Wales, Scotland and Northern Ireland as health is devolved in each of these regions. In Wales, for example, there has been a recent decision to allow refused asylum seekers to access free secondary healthcare (BBC News, 2008b; Williamson, 2008).

There has been little work done on the availability of alternative forms of provision for refused asylum seekers, for example by third sector agencies such as Project: London (McColl, 2006a). Unlike in many other European countries, there is not a wide “safety net” for those unable to access formal healthcare (McColl et al, 2006b; Hull et al, 2006; European Observatory on Access to Healthcare, 2007; European Commission, 2008). The more that refused asylum seekers and other vulnerable groups find difficulties accessing NHS healthcare services, the higher the burden will be on alternative services (Hargreaves et al, 2006b). It is therefore important that the capacity of such provision be formally measured before policies to further restrict access to care for refused asylum seekers are introduced.

Chapter 7: Conclusions

This dissertation has looked at the experiences of refused asylum seekers who have tried to access healthcare in England, by reviewing existing literature and interviewing professionals who work closely with this client group.

It has been argued that policies to restrict access to healthcare for refused asylum seekers fail as a result of both 'Bad Policy' and 'Bad Execution'.

There has been substantial interest in this area by a number of different groups including doctors and advocacy groups and there has been widespread condemnation of these policies on a number of grounds. This includes the lack of supporting evidence for the introduction of the policies, conflicts with human rights legislation, inconsistencies with domestic and international pledges, and a lack of support from doctors and advocacy groups on these and other ethical grounds. Numerous parties have recommended that refused asylum seekers be given access to free NHS healthcare. This heavily suggests that these policies do not have 'understanding of, and agreement on, objectives'.

These policies have also suffered from 'Bad Execution' for a number of reasons. Some refused asylum seekers are having difficulty registering at a GP surgery as an NHS patient, either because frontline staff are unaware that they have the discretion to register refused asylum seekers if they wish, or because they believe they need certain documents before they can register patients. It has been shown that a major source of this confusion is the lack of information and poor quality contradictory guidance given to primary care staff.

Some refused asylum seekers have also been unable to access appropriate secondary care as a result of being asked to pay for treatments upfront which they cannot afford. In addition some patients have had distressing experiences in relation to frontline staff and OVMs. In each of these cases, it is apparent that staff are unaware of, or do not fully understand, the guidance from the DoH on this group's entitlement to secondary healthcare. There does not appear to be the same widespread confusion amongst secondary care staff in the same way as was found for primary care staff, although some areas such as 'Immediately Necessary' treatment are more ambiguous than others. Instead, in other areas where the Guidance appears quite clear, for example for access to maternity care, it would appear that staff are simply not following the guidance.

Problems that refused asylum seekers face when trying to access either primary or secondary care have led to many either going without treatment, or leaving it until the last possible moment. This dissertation has briefly outlined some of the consequences from patients not accessing care, including concerns around public health issues, increased maternal mortality and the increased burden on other forms of healthcare provision.

Widespread confusion amongst staff has also had a knock-on effect with other patients who are entitled to healthcare, such as asylum seekers and British citizens, being unable to access free NHS care.

Hogwood and Gunn (1984) highlighted that information systems cannot ensure any guidance is interpreted or understood, and subsequently implemented, as intended. This dissertation has shown that for these policies this is a particularly pertinent issue; they are suffering from 'Bad Execution', primarily as a result of imperfect communication.

Although it could be argued that the lack of support and non-cooperation by healthcare practitioners has contributed to the unsuccessful implementation of these policies, this dissertation has shown that, perhaps with the exception of primary care, primary responsibility for these policies lies with frontline administrative staff, rather than with doctors. This highlights an important divide between those objecting to these policies, and those responsible for delivery.

It is clear that these policies are not being implemented as intended with negative and sometimes fatal consequences for refused asylum seekers. It is also clear that in order to rectify these problems, a significant amount of time and effort will need to be taken in order to ensure that those on the frontline are aware of, and understand, this group's entitlement to healthcare. There are already numerous barriers to accessing care for refused asylum seekers, but this evidence demonstrates that the unsuccessful implementation of these policies have created another.

“Thank you...for an interesting tour through this statutory thicket”

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Mr Justice Mitting at the closing of the April 2008 High Court case

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Appendix: Interview Topic Guide

- Introduce myself and my dissertation. Ask if interviewees are happy to be recorded
- State that all responses are anonymous and are solely for use in my dissertation
- Mention that the interview may take 30 minutes or so
- Remind interviewees that we are focussing on refused asylum seekers

Introductory questions

1. Name
2. Organisation
3. What is your current role within the organisation?
4. Description of the work that the organisation does including dominant focus of the organisation and key characteristics of the client group. (Nationality? Health issues? How referred?)
5. Do you think there are any particular health needs for refused asylum seekers? Can you describe these?

Primary healthcare

6. Have you had any clients who have tried to access primary healthcare services/a GP since their applications have been refused?
7. What are the experiences of your clients when trying to access primary healthcare services?
Explore:
 - Service availability
 - GP registration and document requests
 - Interactions with frontline staff
 - Interactions with GPs
 - Quality of care
 - Discrimination
 - Any evidence of different experiences of different groups? Different nationalities, gender, new/settled nationalities?
 - Charges levied
8. Can you think of a specific example of an individual? Can you tell me more about their experiences? (Age, gender, ethnicity, location) e.g. Were they able to make an appointment with the GP? What questions did they have to answer? Were they asked to provide documentation? Which types of documents?

Secondary healthcare

9. Have you had any clients who have tried to access secondary healthcare services since their applications have been refused?
10. What types of services were they trying to access? E.g. Maternity?
11. What are the experiences of your clients when trying to access secondary healthcare services?
Explore:
 - Service availability

- Registration and document requests
 - Interactions with frontline staff
 - Interactions with doctors and consultants
 - Quality of care
 - Discrimination
 - Any evidence of different experiences of different groups? Different nationalities, gender, new/settled nationalities?
12. Were your clients asked to pay for healthcare?
- If yes, for which services? Were they asked to pay upfront, prior to treatment? Were any of your clients subsequently invoiced for care? Were they aware they would be invoiced? Were they able to pay?
 - If not what happened? Explore – were they denied care until able to pay? Were they then subsequently invoiced for treatment? Were they chased for the payment?
13. Can you think of a specific example of an individual?
- What was their experience of trying to access secondary healthcare?
 - What questions did they have to answer?
 - Were they asked to provide documentation? Which types of documents?
 - Were they able to access healthcare?
 - Were they asked to pay? How much were they asked to pay? Were they able to pay? If no, what then happened? If they weren't asked to pay, were they then presented with a bill?

Access to Accident and Emergency

14. Have you had any clients who have tried to access A&E healthcare services since their applications have been refused?

15. What was their experience?

Explore:

- Were they treated without question?
 - Were they asked to pay?
 - Registration and document requests
 - Interactions with frontline staff
 - Interactions with doctors and consultants
 - Quality of care
 - Discrimination
 - Any evidence of different experiences of different groups? Different nationalities, gender, new/settled nationalities?
16. Can you think of a specific example of an individual? Can you tell me more about their experiences?

Entitlement to healthcare

17. Do you think your clients know what health services they are entitled to?

- Are your clients aware of which services they will be charged for, and which ones they are able to access free of charge?
- What level of knowledge do your clients have about what services are chargeable?
- Where did they get this information from? How do they find out about them?

17a. Do you think healthcare professionals know what refused asylum seekers are entitled to?

17b. Do you think there is any variation in the level of knowledge of entitlements between healthcare professionals? For example, do frontline staff seem more knowledgeable than consultants/GPs or vice versa?

18. Do you think your clients find our system confusing?

19. Do you think your clients are wary of accessing healthcare in this country? Why?

20. What are the impacts of these different issues?

Explore:

- Use of alternative services e.g. A&E
- Use of voluntary and third sector healthcare services
- Unwillingness to use health services
- Not accessing healthcare
- Impact on health status
- Views and reactions of refused asylum seekers of the British healthcare service and of seeking asylum in this country

21. What has been the impact on your clients since the high court ruling? (May need to explain that refused asylum seekers are now classed as “ordinarily resident” and are entitled to secondary healthcare. Appealed by the DH)

22. Do your clients understand how the position has changed?

23. Are your clients still wary of trying to access healthcare services?

24. Have you had any clients try to access secondary healthcare services since the ruling?

25. What types of services were they trying to access? E.g. Maternity?

26. What was their experience?

Explore:

- Registration and document requests
- Interactions with frontline staff
- Interactions with doctors and consultants
- Quality of care
- Discrimination
- Payment for services

And finally...

27. Have you seen any evidence of “health tourism” within your client group?

28. Ask for recommendations regarding how the system can be improved to meet the needs of target group?

29. Any other comments?

Thank you!