



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. Further information and a longer version of this briefing along with other resources can be found at our website at <http://respondtonhscharging.wordpress.org>.

The deadline for responses to the consultation is 30 June 2010.

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.

The Current 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 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

The current charging regulations have already had an impact on some of the most vulnerable sectors of society as noted by the Refugee Council in their report, *First do no harm*¹. 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 of distress for those persons and may result in vulnerable people with severe health needs not accessing care or disengaging from health services.

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. 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

¹ 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>.

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.² Until firm evidence of substantial health tourism to the UK is presented to the public, it should not be used as a justification for divesting vulnerable migrants of access to healthcare.

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.

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.³ 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.

Exempting certain vulnerable groups from access to health care is likely to conflict with Articles 2 (protection of life), 3 (protection from torture and degrading treatment) and 8 (protection of private and

² Doctors of the World, Project London Annual Report. Available from:

<http://www.medicinsdumonde.org.uk/doclib/104524-report2007light.pdf>

³ Parliamentary Joint Committee on Human Rights, *The Treatment of Asylum Seekers*, Tenth Report on Session 2006-2007. Available from: <http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf>

family life) of the ECHR which are all applicable to the provision of healthcare. Identifying who has entitlement to the NHS is also likely to conflict with the rights of foreign nationals against discrimination.

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. There is also concern that healthcare professionals lack the detailed knowledge of immigration law necessary to accurately determine eligibility. Health workers are worried that, if they assess eligibility for care, they are violating professional codes of conduct, such as the doctor's duty to make the care of the patient their primary concern.

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.

The Department of Health 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 appears 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. 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 traditional roles, where patients' wellbeing is put first. Doctors may be in breach of their ethical duties and could be liable to claims against them for breaching these duties.

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 policies could discourage clinicians from taking appropriate steps to establish a diagnosis for their patients.

For further information and resources, visit our website at: <http://respondtonhscharging.wordpress.org>

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.