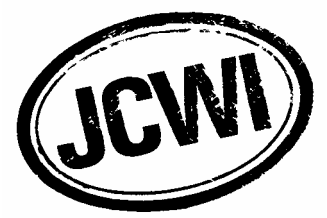

Response to the Consultation Paper on

Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services

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For further information contact Rhian Beynon, Communications Officer,
JCWI, 115 Old Street, London, EC1V 9RT. TEL: 020 7553 7464

The JCWI (Joint Council for the Welfare of Immigrants) is an independent national organisation which has been providing legal representation to individuals and families affected by immigration, nationality and refugee law and policy since 1967.

JCWI actively lobbies and campaigns for changes in law and practice and its mission is to eliminate discrimination in this sphere. JCWI has been instrumental in influencing debates on immigration and asylum issues in both the UK and at European level.

Access to services including healthcare for those individuals affected by immigration laws and policies is of central importance to JCWI and this paper highlights JCWI's primary concerns in relation to the proposed changes.

JCWI's membership consists of many black and ethnic community organisations that represent people who will be affected by the proposed changes. In producing this briefing paper JCWI has been taking the views of these organisations and will continue to do so during the consultative process.

Introduction

We are concerned that the Department of Health consultation paper continually refers to "overseas visitors" as the affected class of people. The categories of persons who will actually be affected include failed asylum seekers (including their families and children), undocumented migrants and overstayers. The Government needs to clarify this issue and differentiate between so called "health tourism" and the vulnerable groups mentioned above.

We believe these proposals need to be evaluated in the context of wider Government policy trends in healthcare, community cohesion and modernisation of work.

Government policy choices are directed towards an objective of preventing chronic health conditions through encouraging individuals to seek information and take-up primary health care i.e. NHS Direct. They are characterised by a recognition that actively tackling discrimination is integral to good access to health services i.e. the NHS framework for older people. And they contribute to a wider policy context of building health, so as to maximise individual participation in work and civic culture, and work towards the larger goal of community cohesion i.e. flexible drop-in GP services orientated toward working persons.

JCWI would contend that any moves to restrict access to "non-urgent" primary health care on the basis of residency and nationality will risk undermining these policy aspirations.

Undocumented Migrants

For example, whether migrant workers are documented or not, the functioning of the UK's dynamic and flexible economy depends on their participation across a range of sectors (for example, hospitality and cleaning services). Proposals which seek to limit undocumented migrants' access to primary health care services could limit their fitness to participate in the workforce and will strike at UK businesses and the flexible economy.

Even if the current proposals are not intended to be discriminatory nevertheless the settled communities may well experience them as such, if front-line staff make judgments about eligibility based on personal perceptions of race and nationality. Ultimately this strikes at the wider policy goal of community cohesion.

By discouraging undocumented workers from accessing certain primary health care services, the Government also risks undermining the gains of an overall preventative and holistic approach in health. Within the document there is an allusion to 'urgent' care. Already the situation has arisen in secondary care in which public health experts have expressed concern about issues arising out of entitlement regarding HIV[1] therapies. These may become applicable to conditions

[1] Whilst the clinical manifestations of some communicable diseases such as HIV may develop in a chronic manner, the speed of viral replication and propensity to mutate means that clinical care needs to be timely and, on occasion, respond to rapid viral changes not manifested symptomatically. By restricting access to 'non-urgent' HIV therapies it is conceivable that drug resistant strains of virus will develop and transmission of these drug resistant strains will be magnified. Moreover, the development of other communicable diseases commonly associated with HIV such as tuberculosis may hastened and delays

such as diabetes and asthma where denial of primary care services may exacerbate symptoms of these chronic conditions and precipitate a need for emergency care that could have been avoided by a GP's intervention.

Delays in access to care may result from faulty perceptions of nationality and entitlement held by healthcare professionals or patients. These delays are likely to result in an increased financial and epidemiological burden.

Further the Government needs to clarify its definition of urgent care and guarantee whether testing required to ascertain whether a condition or illness requires emergency or urgent care, is also provided free of charge by the NHS.

Failed Asylum Seekers

A policy of preventing failed asylum seekers from accessing certain services is particularly unfair and impractical. Such individuals are often unable to return home because their home country is a conflict zone, as is the case with many Iraqis and Somalis; or because they are incapacitated by ill-health. And, as we show later in the report there are a number of impracticalities of denying health care to other vulnerable groups such as children and some groups of women.

Role of migrant workers in National Health Service

We are saddened to read in the invitation to participate in this consultation that the UK Government feels the need to state that the NHS is a "national" not an "international" service. We would point out that some essential posts in NHS services would remain unfilled if it were not for official migrant workers from poor countries such as Uganda and the Philippines. Thus an anomalous situation is arising whereby we access key workers from developing countries while needy migrants from these same countries who contribute, albeit unofficially, to our thriving economy are denied the right to access preventative primary therapies.

Further, there does not appear to be sufficient evidence on the cost to the NHS of the groups of people to be affected under these proposals[2].

in care result in ongoing transmission – opinion of Dr Richard Coker, DFPHM MSc MD FRCP, Senior Lecturer, Public HealthLondon School of Hygiene & Tropical Medicine, provided to JCWI

[2] A Home Office report shows that people born outside the UK, including asylum seekers contribute 10% more to the economy in National Insurance and taxes than they consume in benefits and public services –www.refugeecouncil.org.uk – News: press myths.

Response to Questions

Who will be eligible for free NHS primary medical services?

3.1 Do you agree that strengthening the rules around access to free NHS primary medical services for overseas visitors, to better match those for hospital treatment will bring clarity to both the overseas visitor and the frontline staff working in practices and PCTs?

We fundamentally disagree with preventing failed asylum seekers, undocumented immigrants and overstayers from accessing free secondary and primary medical services.

3.2 If not, please specify your reasons.

It is very difficult for frontline staff, who are not trained in immigration law to assess who is and is not eligible to free treatment. The system is confusing. We have already encountered clients, who since 1 April 2004 have been refused secondary health care to which they are entitled because frontline staff were not properly informed or trained in immigration law and entitlements.

For example as there are many different types of limited leave, and most state that the holder is to have no recourse to public funds, there may be an assumption made that this also means no entitlement to NHS services, not just public funds, under the definition of the immigration acts.

We anticipate that if this is extended to primary medical services, the confusion will increase and more people who are entitled to primary health care will either be prevented from doing so or will have to suffer delay and require intervention by an external body, whether legal representative or otherwise, before accessing care.

This could result in less people accessing care, thinking that they are not entitled or in people, who are entitled to free treatment, paying for it.

Instead, the Government should be seeking to clarify the current position and ensure that healthcare professionals and frontline staff are allowing those eligible for healthcare to access their services.

Primary medical services for visitors ineligible for free NHS care

3.3 Do you agree that a system of charging should be introduced?

No

3.4 If you have answered yes, what would be your preferred option and why?

a. *NHS charged primary medical services*
b. *Private charged primary medical services*

3.5 If you have answered no, what would be your reasons?

It is established (eg Ethnic Disparities in Health and Health Care[3]) that the health of asylum seekers and black and ethnic minority groups is poor compared to the white resident population.

Furthermore, those groups most likely to be affected, undocumented migrants and failed asylum seekers, will generally be poor and/or vulnerable members of society, with little or no access to good housing, a balanced diet or other factors associated with living a balanced and healthy life.

These groups who are therefore more likely to suffer illnesses and poor health associated with poor diet and poor living conditions (such as heart disease and diabetes) will be denied all medical services until it reaches crisis point and they are admitted to hospital as an emergency. In the long term it is our view that this is likely to place more of a financial burden on the NHS than if they are able to obtain the non-urgent primary care services free of charge.

We cite as examples, diabetic patients, who will not be able to access insulin. They will only come to the attention of healthcare professions if they suffer periodic diabetic comas, which are more expensive to treat than maintenance doses of insulin. (See info BMA[4]). The British Medical Journal cites the example of an HIV infected infant who has developed pneumonia.[5]

Alternatively, the burden may be placed on members of their family/extended family, who may be members of the settled communities and who will need to find the finance to pay for these services. Ethnic minorities are already statistically more likely to be unemployed or in poor paid employment than the white population. We see this would place further burden on some members of these groups.

Another factor to bear in mind is that many of these people may have been present in the UK for a significant amount of time and may have contributed through tax and national insurance contributions towards the British economy.

If charges are introduced a worrying possibility is the development of a black market in provision of healthcare that may be cheaper than paying privately through the NHS, with the NHS picking up the pieces through A & E when things go seriously wrong.

How would the proposed new scheme operate?

3.6 Should the onus of proving eligibility for free NHS primary medical services be the responsibility of the overseas visitor?

No

3.7 If not, please specify your reasons.

[3] 'Ethnic Disparities in Health and Heath Care, A focused review of the evidence and selected examples of good practice.' Peter J Aspinall and Dr Bobbie Jacobson, London Health Observatory July 2004 - [3] For example, maternal mortality rates are three times higher for Asian women than white women. Infant mortality rates for Pakistanis is 12.2 per 1000 live births, more than double that in general population (5.5 per 1000 live births)-.
[4] BMA raises questions about ID cards and access to healthcare: Press Release 23 July 2004 (BMA London)
[5] BMJ 7 August 2004 p346

Frontline staff would have to police the system forming another layer of immigration control. It is also not clear whether there would be an expectation or requirement to inform the Immigration Service about the presence of the immigrant. This would place an unfair burden on frontline staff and medical professionals and could impact on the take up even of emergency services.

3.8 What practical difficulties do you envisage that practices would have in operating proposals outlined in this document?

Immigration law and the different categories of leave granted is a complex area. A health provider cannot be expected to understand all different statuses. Further it places a burden on staff, who may not wish to deny medical services to anyone, to request documentation and then prevent the patient accessing services.

Frontline staff may be placed in the difficult position that they will be expected to turn away ill, non-emergency patients from their surgery[6].

3.9 What other measures do you think the Government should consider which would reduce the instances whereby persons who are not ordinarily resident in this country access and receive free NHS primary medical services?

We do not agree with the current or proposed definition of ordinarily resident and believe this needs to be clarified and amended in light of the concerns raised in this document.

It is our view that the Government should take steps to regularise certain groups of failed asylum seekers, overstayers and undocumented persons who may already be working and contributing to our society. They should be officially recognised.

Preventative and holistic health care appears to be Government's aim. These proposals contradict this aim.

It is also important, in our view, that the Government differentiates between "health tourism", as far as it exists and failed asylum seekers, undocumented migrants and overstayers, who may be contributing to the economy and who may have lived for a considerable amount of time in the UK.

A failed asylum seeker, who cannot return to their country of origin is in a completely different position to someone who has allegedly come to the UK to access free health care and the two groups of people should not be classified in the same way.

[6] In a press release The BMA's Head of Science and Ethics, Dr Vivienne Nathanson, said

"The BMA is not opposed to an ID card system and indeed such a scheme might be useful in providing an un-bureacratic method for GPs to assess eligibility to healthcare.

"However we are worried about the practicalities of the system and more importantly about vulnerable patients falling through the net and not getting the treatment they need." – BMJ 7 August 2004 p 346

3.10 Would you agree that a form of self-certification would help reduce the number of people who receive free NHS primary medical services to which they may not be legitimately entitled?

We would want to know exactly what this means and involves[7]

3.11 If not, please specify your reasons.

3.12 Should members of EEA countries or "insured" Swiss residents visiting the UK be required to carry a form E111 completed by their home country, or from 1 June 2004, the European Health Insurance Card?

No

3.13 If not, please specify your reasons.

As it is citizenship of an EEA country is sufficient to establish eligibility to primary and secondary medical treatment.

How would eligibility be confirmed?

3.14 Are there any other options that the Government should consider for the checking of a person's eligibility, and if so what are they?

We would suggest that the only form of evidence required should be proof of address within the GPs area to establish ordinary residence within UK and evidence of a person's identity.

Existing Overseas Visitors who currently receive free primary medical services

3.15 Do you agree with this approach to overseas visitors who currently receive free services?

Yes

3.16 If not, please specify your reasons
N/A

3.17 Are there any alternative options for handling existing overseas visitors who currently receive free NHS primary medical services that the Government could consider, and, if so, what are they?

There should be a system in place to ensure that PCTs are aware that they can continue to assist these people. Our experience with regard to secondary medical

[7] See e.g. New York Times (nytimes.com), US is Linking Immigration Patients' Status to Hospital Aid by Robert Pear, August 10 2004.

care is that hospitals are not aware and have turned patients away as a result. This causes unnecessary distress to patients.

We came across one case of a failed asylum seeker refused secondary medical treatment following the coming in to force of the Regulations[8] on 1 April 2004.

In her case she had a communicable disease and was refused hospital treatment that had already begun when she was an asylum seeker[9]. The matter was resolved through our intervention. However it cannot be expected that legal practitioners or community organisations will intervene in all cases.

We would expect the same confusion to arise if eligibility for free primary medical services is taken away.

Public Health

3.18 Are there any primary medical services which you consider should continue to be freely available on public health grounds?

We are opposed to restricting eligibility to primary medical services for a variety of reasons but view the following groups of people as particularly vulnerable:

1. Pregnant women and nursing mothers
2. Children
3. Victims of domestic violence
4. People with potentially life threatening illnesses
5. HIV/AIDS sufferers and others with chronic communicable diseases
6. Victims of torture and war-related trauma.

It is our view that public health in general will be affected by preventing the above from accessing free primary medical services.

In addition we believe and indeed have seen no evidence to the contrary that the costs to the NHS may well indeed increase rather than decrease due to a likely increase in use of A&E services.

Vulnerable Groups

Our particular concerns for these groups are highlighted below.

1. Pregnant women and nursing mothers

[8] National Health Service (Charges for Overseas Visitors)(Amendment) Regulations 2004 SI No 614

[9] A, a failed asylum seeker has a form of viral hepatitis (one of the communicable diseases listed as one that can be treated free on NHS – see Annex D in Consultation paper). Prior to refusal of her asylum claim she was receiving treatment for her condition. The hospital's position was clearly wrong (on two fronts – communicable disease that is exempt from payment and already receiving treatment [reg 4(2) &(3) of SI 2004 No 614[9]]). We intervened and A is now receiving the treatment to which she is entitled.

The GP is generally the first port of call for any pregnant woman. If she is denied access to her GP as a result of her immigration status she will be unable to access other primary care services such as midwives and will not be monitored during her pregnancy. Any health issues will not be spotted unless an emergency arises.

It is not clear whether delivery of the baby would be considered as an emergency. However, we recently came across the case of an overstayer, married to a person lawfully present, himself entitled to medical treatment, being told that the birth of her child would cost £2,500, despite the fact that no airline would permit her to fly home. The position is the same for British born children if born to one of the groups excluded.

The denial of free access to primary and secondary health care to pregnant women is very worrying and may lead to an increase in home births with no qualified medical intervention[10].

Furthermore, if a pregnant woman cannot access her GP and wants an abortion she may well be faced with an unwanted pregnancy if she does not have access to the finances to pay for a private abortion[11].

Similar health issues would arise following the birth of the baby.

2. Children

Children and babies should have unlimited free access to doctors, midwives and health visitors. It is our concern that if these services are not provided free of charge then:

a) Babies will not have access to the services of a health visitor and therefore developmental issues (eg problems with vision, hearing, feeding, autism, slow physical growth) will not be detected. This will impact on a child's future quality of life if not addressed.

b) Babies and young children will not be immunised therefore increasing the likelihood of the spread of certain illnesses of concern to public health such as cholera, diphtheria, mumps, measles and rubella

c) Babies and children will only have access to emergency services therefore making A & E the first and only port of call for parents and carers concerned for their child's health. This is likely to place a greater burden on Accident and Emergency departments of hospitals or walk-in A & E centres.

[10] Yasmin Alibhai-Brown recently commented, in the Independent, 26 July 2004 on having witnessed the birth of a baby in a garage, to an 18-year-old Congolese asylum seeker who felt unable to use mainstream medical services. If these provisions go ahead we would expect an increase in this type of birth with a reluctance to approach a doctor or a hospital for fear of unaffordable charges and their presence being reported to the Home Office.

[11] Although the sums involved to pay for an abortion privately may be relatively small (ranging from £450 to £685 at e.g. Mary Stopes clinics) it is clear that this sum is unlikely to be available to a destitute or near destitute failed asylum seeker or overstayer.

3. Victims of Domestic Violence

Prevent victims of domestic violence from disclosing abuse and from seeking help

a) Prevent women from seeking help in relation to domestic violence: Research has found that victims of domestic violence are likely to have experienced 33 incidents of abuse before they contact the police. Victims are most likely to approach primary health care providers before this stage.

b) Southall Black Sisters (SBS)[12] have found that G.P's are the most likely and possibly only frontline service that victims of domestic violence, especially those with uncertain immigration status, are likely to go to disclose abuse and seek help for any physical or mental health problems. As a result, women are far less likely to go to the police or social services for fear of adverse treatment because of their overstayer status. This development flies in the face of commitments the Government are making to tackle domestic violence. As a result victims are more likely to first disclose domestic violence when the abuse has escalated and only attend A & E when there are serious physical injuries.

Prevent health professionals from detecting early signs of abuse and preventing harm to mother/unborn child/new born child

c) Pregnant and post natal women: research also shows that domestic violence often starts/escalates during pregnancy and after birth - prohibition on using a GP will mean that health professionals will be unable to detect danger signs and risk to unborn/new born child and mother at the earliest stages

Prevent victims with uncertain immigration status obtaining immigration/criminal and civil protections available

d) There is a domestic violence immigration rule that allows persons subject to the 2 year probationary period to apply for indefinite leave to remain (ILR) if they can prove domestic violence. There is some discretion that allows overstayers of less than 6 months to apply under the Rule. Southall Black Sisters are lobbying the Home Office to extend this to all overstayers. The Home Office specifies the kinds of evidence required to prove abuse, one of which is a letter from a GP. SBS have found that this is one of the most common forms of evidence available to support an application. Government proposals will effectively prevent many victims from using the Rule as they will be unable to provide evidence that previously would have been available.

[12] Southall Black Sister campaign on issues of relevance to immigrant women and were responsible for campaigning on rights of women married to British nationals/those settled in the UK and who were victims of domestic violence being able to remain in the UK. As a result the Immigration Rules were amended to make provision for this group of person to be entitled to apply for and obtain indefinite leave to remain if they had to leave their spouse, due to domestic violence, during the probationary period.

e) Evidence from a GP is also commonly used as proof of abuse during criminal proceedings and applications for injunctions. Victims with uncertain immigration status may find it even more difficult to provide evidence of past abuse making it more difficult for them to obtain protection or hold perpetrators accountable.

Prevent victims from accessing diagnosis/treatment and support for mental health problems

f) Research shows that Asian women are approx 3 times more likely to self harm or attempt/commit suicide than other women in the UK. Victims of domestic violence with uncertain immigration status from the Asian sub continent are recognised as belonging to a high risk group for suicide and self-harm. Preventing these women from accessing primary health care will mean that without proper diagnosis, treatment and support that risk is likely to increase.

4. People with potentially life threatening illnesses

It is our fear that anyone who suffers from diabetes, asthma, epilepsy etc who cannot afford to pay for medication will only be able to access medical care when a situation arises that they must approach a hospital's accident and emergency department. This will place further burden on hospitals. It is more expensive to the NHS and causes more distress to the individual to wait to be treated in an emergency by A & E than to receive medication such as insulin, asthma pump etc from GP

5. **HIV/AIDS and others with chronic communicable diseases**

a. Pregnant women are usually routinely tested for the HIV virus. If a mother is HIV+ the disease may be passed on to their unborn child.

The risk of transferring the virus can be reduced through for example treatment during pregnancy, opting for a caesarean section birth, avoiding breastfeeding and ability to take informed decision about health.

Although HIV diagnostic testing is not excluded in the proposals put in this consultation, even assuming that a pregnant woman would approach an STD clinic for testing, this will be of very limited value if no treatment is available to the woman and if the mother has to pay thousands of pounds for a caesarean section birth.

Preventing mothers with HIV from accessing ante-natal and HIV treatment could impact on the number of babies born with the virus. The incidence of HIV/AIDS could increase further among the immigrant population.

b. Delays incurred as a consequences of perceived restrictions on access to treatment. Research from the US suggests that, for individuals with tuberculosis, a perception that restrictions may apply, delays in seeking care are likely to result and consequently the period of transmission be prolonged. Such delays are conceivable with other chronic communicable diseases such as HIV and viral hepatitis.

c. Development of drug resistance. Barriers, whether real or perceived, to care for chronic communicable diseases may result in erratic, delayed, or intermittent treatment. These promote the development of drug resistant strains of disease. The public health challenge that results from drug resistant communicable diseases may be substantial and very costly both in financial and human terms.

6. Victims of torture and war-related trauma.

This group of people will often be asylum seekers, failed asylum seekers or victims of domestic violence and therefore some of our concerns are outlines above.

Figures on the number of asylum seekers who have suffered torture and rape is difficult to estimate[13]. There is no reason to suppose that simply because someone has been unsuccessful in their asylum claim, and therefore become a "failed asylum seeker" that the effects of torture, war-related trauma and rape will subside. In fact it may well worsen.

To deny primary care to victims of torture, rape and war-related crimes will result in many people being unable to access mental health care including counselling and anti-depressants, unless their condition becomes so bad that they fall to be treated under the Mental Health Act 1983.

Without adequate housing, food etc and with the knowledge that the trauma and torture experienced has been dismissed as inconsequential or even disbelieved, the mental health of this group of people is likely to deteriorate. There is likely to be a sense of hopelessness that a failed asylum seeker may experience, that is further exacerbated by the suffering experienced through the torture, rape or war-related trauma.

This may ultimately place a greater burden on the NHS by way of A & E (eg suicide attempts, mental/nervous breakdown etc) and/or the possibility of more need to use provisions of Mental Health Act 1983.

[13] Experience in Newcastle indicates that one third of asylum seekers give a history of torture and 22% of women give a history of rape. Letter in The Guardian August 9 2004, The Health of Refugees, Dr Phillip Matthews, Dr Sarah Montgomery and Dr Peter Le Feuvre

Conclusions

We feel the document is misleading in its continual reference to “overseas visitors” whereas those potentially affected include:

- Failed asylum seekers
- Undocumented migrants
- Overstayers and

The above categories of people are already prone to exploitation in the unregulated economy and have progressively become devoid of civic and social rights. Consequently their health needs may be greater. Amongst them, the following groups of people are particularly vulnerable:

- Pregnant women and nursing mothers
- Children
- Victims of domestic violence
- People with potentially life threatening illnesses
- HIV/AIDS sufferers and others with chronic communicable diseases
- Victims of torture or war-related trauma

The proposals, if implemented, not only jeopardise the government’s overall preventative approach to health in which it has made substantial advances over the last seven years, but also puts at risk the livelihoods of those who are already on the margins of society and deserve the protection of a basic safety net of health care which will not be provided by “emergency or immediately necessary treatment”.

JCWI is concerned that the Government is making these proposals without concrete evidence of figures in relation to the cost of so-called “health tourism” on the National Health Service and without an analysis of the impact of recent changes in eligibility to secondary care that came about on 1 April 2004. There does not appear to be any concrete evidence to show that these proposals will bring about a reduction in costs to the NHS.

The Government needs to differentiate between so called “Health Tourism” and the vulnerable groups discussed in this document.

We are also worried about the impact these proposals are likely to have on immigrant communities, children, particularly immigrant children. There is also potential impact on the public health of British society in general, the consequences for its economy if workers of any immigration status are excluded from access to primary health services, and the effects on community cohesion, It is feared that while there is not a discriminatory intention behind these proposals nevertheless the changes could make people feel that they are being discriminated against.

We foresee that given the complex nature of identifying immigration status a foreign national is far more likely to encounter problems in providing evidence of eligibility (eg passport could be with Home Office, while an application to vary leave is being made), and there is more chance that front line staff will dispute someone’s eligibility.