

Four Years Later:

Charging Vulnerable Migrants for NHS Primary Medical Services



Students and junior doctors reveal the findings of an unpublished Department of Health consultation

Global Health Advocacy Project
June 2009

'One of the consequences of the universality of the British Health Service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill-informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues? So the argument goes. No doubt a little of this objection is still based on the confusion about contributions to which I have referred. The fact is, of course, that visitors to Britain subscribe to the national revenues as soon as they start consuming certain commodities, drink and tobacco for example, and entertainment. They make no direct contribution to the cost of the Health Service any more than does a British citizen. However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats both must be classified. What began as an attempt to keep the Health Service for ourselves would end by being a nuisance to everybody. Happily, this is one of those occasions when generosity and convenience march together.'

Aneurin Bevan, 1952

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The Global Health Advocacy Project is a group of students and young healthcare professionals, affiliated to the student group Medsin. Our aim is to challenge health inequalities in the UK and overseas.

www.wheretheconsultation.org
www.medsin.org/defendprimaryhealthcare

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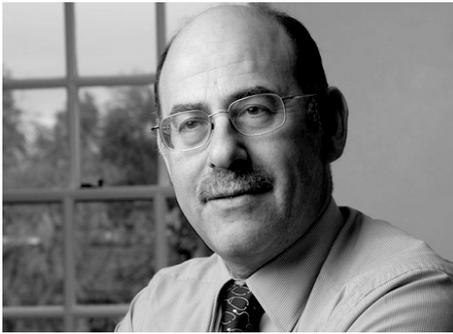
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Abbreviations

A&E	Accident and Emergency
BMA	British Medical Association
DH	Department of Health
FOI	Freedom of Information
GP	General Practitioner
NHS	National Health Service
PCT	Primary Care Trust
RCGP	Royal College of General Practitioners

Foreword



One of the signs of a civilised society is that it cares for those who are disadvantaged.

To the shame of the NHS, our government has lumped asylum seekers with “health tourists” and then denied most hospital treatment to those who have had their claims refused. This is ostensibly so that the NHS can concentrate on those who are “deserving”.

This policy is misguided, unevidenced and discriminatory as well as being impractical. Most doctors and other health workers dislike what they are being asked to do as it flies in the face of their ethical codes and all their training to alleviate suffering and promote health.

It is deeply concerning that proposals to limit access to NHS primary care are being considered. This report summarises the current position and asks whether it can be changed. Those in power should ask themselves if they feel comfortable after reading it or whether they should think again. The rest of us should read it and consider if we can help the Government alter their attitudes.



Dr Laurence Buckman

Chair, General Practitioners' Committee
British Medical Association

Background

Entitlement to access NHS services is based on ordinary residence rather than nationality. British citizens not ordinarily resident in the UK may not therefore be entitled to free NHS services. Ordinary residence is defined as 'a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or of long duration' (*Shah v Barnet LBC*).

The NHS Services Act 1974 allows the Secretary of State for Health to introduce charging regulations in the NHS without having them approved by Parliament. In April 2004, the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004 (SI 614/2004) were enacted. These regulations restricted access to NHS hospital care for a population including

- Refused asylum seekers (asylum seekers who have had both their claim for asylum and a subsequent appeal refused and are awaiting removal from the country; unable either to work legally or to claim benefits)
- Undocumented migrants (those lacking the necessary documents to reside legally in the UK, including visa over-stayers and victims of human trafficking)
- Recipients of Section IV support (refused asylum seekers who are unable to travel home, for medical or security reasons; who agree that they will return home when it becomes safe; and who receive £35 per week and accommodation from the National Asylum Support Service but are unable to work legally)

Some NHS hospital care remained freely available, including care in Accident and Emergency (A&E) departments, sexual health and family planning services (but not treatment of HIV infection), compulsory treatment for mental illness and treatment for certain infectious diseases. The 'easement clause' allowed patients to continue any course of treatment commenced whilst still entitled to NHS care.

'Immediately necessary' treatment was not free but could not be refused if people failed to provide upfront payment or to demonstrate ability to pay. What was deemed immediately necessary was poorly defined but included all maternity care. Payment could be chased as far as was considered reasonable, including the use of debt collection agencies. Whilst it should have been possible for the destitute to have debts written off, many people, scared and unsupported throughout this process, disengaged with services and some came to harm¹.

The situation in NHS primary care was not affected by the 2004 Charges to Overseas Visitors Regulations. In March 2006, the Department of Health (DH) issued a statement suggesting General Practitioners (GPs) should not register failed asylum seekers and undocumented migrants but have the discretion to do so.² There is currently no DH guidance on this but a recent document from the British Medical Association agrees that GPs retain the discretion to register refused asylum seekers and undocumented migrants

1 Kelley N, Stevenson J (2006). First do no harm: denying healthcare to people whose asylum claims have failed. Available from <http://www.refugeecouncil.org.uk/policy/position/2006/healthcare.htm> (accessed 12 April 2009).

2 Department of Health (2006). Table of entitlement to NHS Treatment (Correct as of March 2006). London, March 2006.

as NHS patients.³ Recent guidance from one of the medical defence unions recommends General Practitioners 'prioritise the treatment of patients on the basis of need rather than considerations of legal eligibility.'⁴

In April 2008, a judicial review found that restricting access to NHS services for refused asylum seekers was unlawful. The case hinged on whether refused asylum seekers were in the UK lawfully and could be therefore considered ordinarily resident. Refused asylum seekers are not in the UK illegally. Most receive temporary leave to remain on entry and are not obliged to leave until they are issued with removal directions. This happens shortly before people are removed from the UK. Recognising this, the judgement was that refused asylum seekers can be and, in most cases, should be considered ordinarily resident in the UK. The judgement did not alter the situation of undocumented migrants.

The DH appealed the judgement and, in March 2009, the decision was overturned by the Court of Appeal. Whilst the case may go to the House of Lords, refused asylum seekers are currently in a similar situation to that which they were in prior to April 2008.

The Court of Appeal did find however that the guidance issued to trusts was unlawful regarding treatment of persons who are unable to pay and who may not be able to, or be reasonably expected to, return to their own country.

Much remains to be decided. We await not only this new guidance but also the outcome of a joint Home Office and DH review which is examining, among other issues, access to NHS services for foreign nationals. This review was launched in March 2007. One of its stated aims was limiting access to services, including healthcare, in order to 'ensure that living illegally becomes ever more uncomfortable and constrained until [people] leave or are removed.'⁵

We hope that our new document will inform the debate in the crucial months ahead.

3 British Medical Association (2008). Access to health care for asylum seekers and refused asylum seekers: Guidance from the BMA's Medical Ethics Department. Available from http://www.bma.org.uk/ethics/asylum_seekers/asylumhealthcare2008.jsp (accessed 12 April 2009).

4 MDDUS (2009). Risk Alert: GPs should not police healthcare access. Available from <http://www.mddus.com/mddus/news-and-events/notice-board/february-2009/riskalert02-09.aspx>.

5 Home Office (2007). Enforcing the rules: a strategy to ensure and enforce compliance with our immigration laws. Available from http://www.medact.org/article_refugee.php?articleID=740 (accessed 12 April 2009).

Introduction and Executive Summary

In 2004 the Department of Health consulted on *Proposals to exclude overseas visitors from eligibility to free NHS primary medical services*. The consultation document suggested limiting access to NHS primary healthcare for a group of foreign nationals that included refused asylum seekers and undocumented migrants. At the time, they claimed a summary of responses to this consultation would be published by 12 November 2004.⁶

Four and a half years after this deadline, there is no summary document. To our knowledge, it is the only DH consultation that has been shelved in this manner. The Department have repeatedly claimed that a summary of the consultation's findings will be published but have provided no explanation for the delay in doing so.

In September 2007, the Global Health Advocacy Project applied under the Freedom of Information Act (2000) for the names of individuals and organisations who had made submissions to the consultation, together with complete copies of their submissions. The DH agreed to provide a list of names. However they refused to release the submissions, arguing that the information was exempt under Section 35(1) (a) of the Act, designed to protect policy making:

*The arguments for maintaining the privacy of this information are essentially that the threat of public exposure of this information will lead to less candid and robust discussions about policy, a fear of exploring extreme options, poorer record keeping, hard choices being avoided, good working relationships and the neutrality of the civil service being threatened. Ultimately the quality of government policy making could be undermined.*⁷

This exemption applies when the public interest in protecting the policy making process outweighs the public interest in disclosure of the information. Our arguments in favour of disclosure can be found in the appendices of our previous report⁸ and online at www.wherestheconsultation.org.

Nine months after our application, in July 2008, we received a letter from the DH stating that the submissions would be released in October 2008. Little had changed in the nine months so the question of whether the information was really withheld 'in the public interest' remains. Following numerous delays, and intervention by the Information Commissioner's office, the majority of submissions were finally released to us in January 2009, at which point the Department had unlawfully withheld this information for 16 months.

6 Department of Health (2004). *Proposals to exclude overseas visitors from eligibility to free NHS primary medical services: A consultation*. Available from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4082726 (accessed 27 January 2009).

7 Information Commissioner's Office (2008). *Freedom of Information Act. Awareness Guidance 24. Policy Formulation, Ministerial Communications, Law Officers' Advice, and The Operation of Ministerial Private Office*. Available from http://www.ico.gov.uk/Home/what_we_cover/freedom_of_information/guidance.aspx (accessed 31 January 2009).

8 Global Health Advocacy Project (2008). *Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services: A summary of submissions to a Department of Health consultation whose findings were never published*. Available from <http://www.wherestheconsultation.org> (accessed 31 January 2009).

It is impossible to know why the DH behaved as they did. They will however have been aware that delays at the Information Commissioner's Office would mean their decision would go unchallenged for more than a year.⁹

We have still not been able to access a handful of the submissions, which the DH tells us have been mislaid. Notably, both the DH and the Home Office have declined to release to us a submission made by an official in the Home Office's Immigration Policy Directorate. A more detailed account of our Freedom of Information request can be found in an appendix to this report.

We recommend this report be read in conjunction with the longer report¹⁰ we released in August 2008. This new report adds to the debate on charging foreign nationals for NHS services by:

1. Demonstrating that many of the findings of our August report (see boxed text on page 10) remain valid when applied to this larger set of submissions. Notably that:
 - a) refused asylum seekers and undocumented migrants represent a particularly vulnerable group that should be considered separately from other overseas visitors with regards to charges for healthcare services.
 - b) the unknown public health impact of charging vulnerable migrants for healthcare demands a thorough health impact assessment be undertaken before any restrictions on access are introduced.
 - c) the resources required to implement a charging regime, both financial and administrative, may well exceed any savings made.
 - d) charging vulnerable migrants for healthcare may damage the doctor-patient relationship and place healthcare professionals in violation of professional codes of conduct.
2. Outlining the position of key stakeholders including the British Medical Association, the Royal College of General Practitioners and the Royal College of Midwives, none of who were in favour of the proposals.
3. Refuting the following assertions by the Department of Health:
 - a) that the submissions to the consultation were divided.¹¹ Almost twice as many submissions to the consultation were opposed to the proposals as were supportive of them;
 - b) that the majority of submissions showed 'strong support for clarifying the rules'.¹⁰ Only 40% of submissions stated there was a need for greater clarity and many expressed concern that the proposals would only add to existing confusion;

9 Only thirteen per cent of valid cases received by the Information Commissioner's Office in 2007/8 were closed within 365 days – see Campaign for Freedom of Information (2008). Delays in investigating FOI complaints. Available from <http://www.cfoi.org.uk/icobriefing241108.html> (accessed 31 January 2009).

10 Global Health Advocacy Project (2008). Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services: A summary of submissions to a Department of Health consultation whose findings were never published. Available from <http://www.wherestheconsultation.org> (accessed 31 January 2009).

11 Letter from Stephen Fay, Customer Service Centre, Department of Health (2 October 2007). This can be found in an appendix to our August 2008 report [8].

- c) that 'health tourism' is a significant and growing problem.¹² Only 18% of healthcare providers expressed concern at the number of overseas visitors accessing NHS services whereas 64% expressed concerns about the cost effectiveness of the proposals or the administrative burden that the Department's proposals would place upon health services.

We condemn the Department's attempt to prevent this evidence entering the public domain. Furthermore, like many of the key stakeholders, we are alarmed that they might proceed with radical policy change in the absence of adequate evidence.

Restrictions on access to NHS secondary care were introduced in 2004 in response to supposed 'health tourism'. The Government has presented no evidence that the use of NHS services by foreign nationals presents a significant problem. Despite dozens of case studies¹³ demonstrating harm to individuals as a result of these restrictions, the Government has published no research into the impact of the 2004 regulations on those who are denied care.

The Joint Committee on Human Rights noted that 'no evidence has been provided to us to justify the charging policy, whether on the grounds of costs saving or of encouraging refused asylum seekers to leave the UK'.¹⁴ The only assessment of the likely impact of charging foreign nationals for NHS primary care concluded that 'the current proposals to streamline charging procedures at primary medical services with those in place at hospitals should be reconsidered'.¹⁵

Where the lives and wellbeing of individuals are at stake, we find it unacceptable that policy be made on the basis of ideology rather than evidence.

We call upon the Department of Health to repeal the 2004 regulations on charging in secondary care (Statutory Instrument 614) and to abandon all plans to introduce a charging regime in primary care. We also call upon MPs to support any parliamentary initiatives that will restore access to NHS services for vulnerable migrant communities.

12 See for example, BBC News Online (2004). Are health tourists draining the NHS? Available from <http://news.bbc.co.uk/1/hi/health/3356255.stm> (accessed 31 January 2009).

13 Kelley N, Stevenson J (2006). First do no harm: denying healthcare to people whose asylum claims have failed. Available from <http://www.refugeecouncil.org.uk/policy/position/2006/healthcare.htm> (accessed 12 April 2009).

14 Joint Committee on Human Rights (2007). The Treatment of Asylum Seekers. Volume 1: Report and Formal Minutes. Available from <http://www.parliament.the-stationery-office.com/pa/jt200607/jtselect/jtrights/jtrights.htm> (accessed 1 February 2009).

15 Hargreaves S, Friedland JS, Holmes A, Saxena S (2006). The identification and charging of Overseas Visitors at NHS services in Newham: a Consultation. Available from <http://www.newhampct.nhs.uk/docs/publications/IHUEntitlementReport06.pdf> (accessed 1 February 2009).

Recommendations from our last Report, August 2008

1. A large majority of healthcare providers express concern that denying care would place them in breach of professional codes of conduct. Consequently, we suggest that denial of healthcare should not be used as a means of enforcing immigration policy.
2. Respondents expressed widespread concerns about the public health implications of these proposals. We therefore recommend that the government reconsider the risk of communities unable access primary care, as this could seriously undermine efforts to tackle infectious diseases.
3. The majority of respondents felt settled refused asylum seekers were a distinct population to overseas visitors. We recommend that these persons fall outside the remit of these proposals. In the event that Government wishes to proceed with implementing these recommendations, we suggest special consideration be given to vulnerable groups including children and pregnant women.
4. Eighty-seven per cent of respondents suggested there would be significant practical problems associated with these proposals. Front-line healthcare workers and administrative staff have insufficient knowledge of the asylum process to implement these proposals. The Government must recognise that administering a charging regime would place a significant burden on front-line NHS services.
5. The majority of submissions questioned the overall cost-effectiveness of implementing such a charging regime. Consequently, we recommend that the government undertake a full cost benefit analysis of both the existing charging regime in secondary care and the proposed changes in primary care, before these are introduced.
6. As the proposed regulations disproportionately affect particular ethnic groups, the Government must honour their commitment to conduct a full race impact assessment prior to implementation.
7. Given concern that the proposals may contravene several international human rights agreements, we suggest independent legal opinion is obtained and published.
8. Very few of the submissions we obtained were supportive of the proposed changes and some organisations have informed us they no longer hold these views. In light of these developments, we call upon the Department of Health to: (i) substantiate their claim that opinions expressed in submissions to the consultation were divided by publishing all submissions in full; and (ii) carry out further public consultation prior to implementation of the proposals.

Methods

In January 2009, we obtained 274 submissions to the 2004 Department of Health Consultation '*Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services*'.¹⁶ These submissions were summarised using a set of questions related to key themes common to many of the submissions.

1. Does the submission broadly support or broadly oppose the proposals?
2. Does the submission include concerns about the public health impact of the proposals?
3. Does the submission suggest that implementing the proposed charging regime would be impractical, create significant administrative work or that implementing the charging regime would not be cost effective?
4. Does the submission argue that vulnerable groups (such as refused asylum seekers) should be excluded from any charging regime?
5. Does the submission express concern that administering a charging regime is not the role of healthcare professionals or that to do so would require them to violate professional codes of conduct?
6. Does the submission suggest that the current rules on access to primary medical services for foreign nationals lack clarity?
7. For submissions made by healthcare providers: does the submission express concern about the number of 'overseas visitors' that seek or attempt to seek free NHS primary medical services?

In order to assess consistency and bias in answering the above questions, a sample of our summaries (19%) was checked by an independent organisation, the National AIDS Trust. Eighty one per cent of questions were answered in the same manner by both organisations and no systematic bias was found. In half of the cases where a disparity existed, the primary summary was more favourable to the DH proposals. Our analysis is based upon the primary summaries.

16 Department of Health (2004). Proposals to exclude overseas visitors from eligibility to free NHS primary medical services: A consultation. Available from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4082726 (accessed 27 January 2009).

It is likely that the inconsistencies were a consequence of the inherent difficulty in summarising complex responses according to a narrow set of criteria. It may be that these problems were compounded by significant disparity, in some submissions, between answers given to specific questions and the overall sentiment of the response. This may be attributable to the way in which some of the consultation questions were phrased, as observed by a number of respondents:

'[questions]...have been phrased in such a way that they are clearly 'leading'; and... replies...will be used selectively to reinforce the views which underpin the Government's aim of supporting implementation of the proposals'

Churches' Commission for Racial Justice

Our aim in undertaking a quantitative analysis of the submission responses is to provide a broad sense of the scale of support or opposition to the proposals as well as to challenge a number of assertions made by the DH. Whilst we found this to be a useful and illuminating exercise, this report prioritises qualitative analysis. It is important to remember that the sample is a self-selected group of individuals and organisations which chose to respond to the consultation and may not therefore reflect the views of wider society or of professions as a whole.

Chapter 7 focuses on evidence given by key stakeholders, such as the British Medical Association (BMA) and Royal College of General Practitioners (RCGP). We feel it is critical to detail the views of organisations representing the healthcare workers who would have to implement the proposals. Full copies of these submissions from key stakeholders, as well as electronic copies of this document, can be found at www.wherestheconsultation.org.

If the reader wishes to undertake their own analysis of this data, we would be happy to supply copies of all the submissions. The DH has assured us that the submissions will be made available shortly on their website.

CHAPTER 1: KEY ISSUES

VULNERABLE MIGRANT GROUPS

A large proportion of respondents (42%) stated specifically that vulnerable populations, including failed asylum seekers, should be exempt from charging regulations.

'Either by accident or design these proposed regulations will prevent 'failed asylum seekers' from obtaining 'primary care services' unless urgent. To even consider to deny access to this group...is...particularly cruel and...should be beyond any civilised government.'

Ron Singer, Medical Practitioners' Union

Many were concerned that the consultation document failed to distinguish clearly between different population groups affected by the proposals:

'a clear distinction between the true 'health tourists' and vulnerable people groups such as failed asylum seekers is necessary – between those who have come here specifically to access free treatment and may be able to pay, and those who are here because of other circumstances and have no means to pay or return to their own country for treatment.'

Christian Medical Fellowship:

Others noted that refused asylum seekers were unlikely to be able to pay for healthcare:

'Asylum seekers, whether failed or otherwise, should not be grouped with those people on holiday...as their circumstances differ greatly. Those on holiday are free to return to their countries without repercussions and have the means to support themselves independently, whereas asylum seekers are fleeing persecution and generally do not have the means to support themselves independently...We therefore believe that asylum seekers should not be part of this consultation.'

Refugee and Asylum Seekers Health Action Group

KEY POINTS: VULNERABLE MIGRANT GROUPS

- **42% of all respondents were concerned that vulnerable groups, such as refused asylum seekers, could be charged for NHS primary care under the proposals.**
- **The distinct needs of such groups were not explicitly recognised in the consultation document.**
- **The restricted financial means of most refused asylum seekers means the proposed charging regime would equate to a denial of healthcare.**

PUBLIC HEALTH

'The actual public health outcome will not be either to deter new migrants nor encourage those illegally here to leave. It will be to create a pool of poor, marginalised, exploited and increasingly sick people, with adverse social consequences both for themselves and for those amongst whom they live and work.'

National AIDS Trust

Forty three per cent of all respondents, including 41% of healthcare providers, expressed concerns about the negative consequences limiting access to NHS primary care would have for public health.

'It is clear that there are potential risks to public health if people are delaying getting treatment for infectious diseases as a result of being unable to pay for health care'

Citizens' Advice

Echoing concerns outlined in our August report, there was a consensus that the introduction of a charging regime could serve to delay diagnosis of infectious diseases, as well as reduce the uptake of vaccinations with subsequent loss of 'herd immunity'. Herd immunity is the protection afforded to the entire community when a sufficient proportion of people are vaccinated to limit the circulation of the disease.

Many pointed out that diseases posing a clear public health risk, which should fall under the category of exempt diseases, are often indistinguishable from other diseases on initial presentation.

'Although treatment for TB, hepatitis and other communicable diseases are still free to all, how are people infected by them going to be detected if they do not have access to primary care? It is very likely that they can only be detected in A&E department at a later stage of their medical condition. Such a system of detection implies high risks in terms of public health.'

Medécins du Monde

Identification of such conditions is often impossible without initiating care. If healthcare entitlement is to be decided at presentation, communicable diseases will often be left undiagnosed and ultimately untreated.

'Public health hazards also need to be addressed. This cannot be done by reception staff and such hazards often only come to light after further investigation of non-specific symptoms during a series of consultations with primary care staff.'

Royal College of General Practitioners

'Although the proposals state that some conditions will be exempt on public health grounds, this assumes that a diagnosis has already been made. However, conditions such as tuberculosis may develop slowly with chronic cough, for example. How does a failed asylum seeker with an undiagnosed cough convince a receptionist that he or she has a condition for which he or she is eligible for treatment? Especially if he or she does not speak English.'

Dr Sarah Montgomery, General Practitioner, Folkestone

KEY POINTS: PUBLIC HEALTH

- **43% of respondents expressed concerns that the proposals would have a negative impact on public health.**
- **Identification of conditions 'exempt' from charging is difficult if communities are not engaging with services.**
- **There is a risk that a charging regime would result in delayed diagnosis and therefore increased spread of conditions such as measles and tuberculosis.**

ADMINISTRATIVE BURDEN AND COST-EFFECTIVENESS

'In order to avoid accusations of racial discrimination, proof of eligibility will need to be asked on every visit from every patient - otherwise it is likely such requests to prove eligibility will be targeted solely at those who are non-white, non English speakers - and hence applied in a racially discriminatory fashion.'

East Midlands Consortium for Asylum and Refugee Support

Fifty five per cent of the submissions explicitly expressed concerns that the proposed charging regime would not be cost-effective or would not be practical to implement, imposing a significant administrative burden on healthcare providers.

The complexities of differentiating between conditions for which charges are levied and those conditions that are exempt were raised by many submissions.

'Emergency and immediately necessary treatment...it can be extremely difficult to define these categories and every day in every general practice in the country, patients and staff disagree about the nature of an emergency. In many situations it is only possible to make such a judgement retrospectively when the patient has been seen and assessed by a doctor. The potential for dispute between patients and the staff of practices will be greatly increased and this will be much resented by staff who are already working in very stressful and demanding situations.'

The Royal College of General Practitioners

Many respondents also felt that NHS staff lack both the time and the training to determine a potential patient's immigration status with accuracy.

'[Establishing a person's immigration status] is a specialist area where many different forms of documentation are used (e.g. ARC cards, IS96s, EU travel documents, passports, vignettes, IND status letters etc). Healthcare staff would have to have a very wide knowledge of the fast-changing documentation used both by IND staff, the EEA and various other countries that may or may not have mutual health agreements with the UK.'

Refugee Action

'If this consultation is merely about saving money, it should be noted that it could create more problems than it solves through the implementation process and running costs. Any perceived cost savings must be offset against the additional bureaucracy of introducing and processing charging. New charges are invariably complicated, with many eligible exceptions and there is the cost of administration.'

Christian Medical Fellowship

'I would like to point out the NHS staff in question are not immigration officers and experience great difficulty when determining as to who is a visitor and who is not. They are not familiar with the various categories of visas issued by the Diplomatic Services worldwide and the immigration status of each.'

Harrow and Brent PCT

It has been documented elsewhere that under the existing charging regime, people entitled to care have been denied it and come to harm.¹⁷

In addition to the administrative burden, the cost-effectiveness of primary care charging was repeatedly questioned. These concerns are borne out by what research there is on this issue.¹⁸ Many were concerned that limiting access to primary care services would result in greater pressure on more expensive secondary care services.

'We are concerned that the withdrawal of primary care will result in a greater pressure on Accident and Emergency (A&E) departments and secondary care services, as those denied treatment and assistance at the primary care stage become seriously ill and approach A&E departments directly.'

Refugee Council

Many noted that creating structures to recover costs may not prove cost effective, particularly given refused asylum seekers and undocumented migrants are known to have very little disposable income.¹⁹

'.....In the case of failed asylum seekers the most likely outcome is lots of unpaid bills and an enormous waste of money and effort trying to recoup them.'

Dr Diane Hopper, General Practitioner, Leeds

KEY POINTS: ADMINISTRATIVE BURDEN AND COST-EFFECTIVENESS

- **Fifty five per cent of submissions expressed concerns that the proposals would not be cost-effective or would create a significant administrative burden.**
- **NHS staff lack the skills and knowledge to assess immigration status.**
- **The cost of operating a charging regime could be greater than the money recuperated.**

17 Kelley N, Stevenson J (2006). First do no harm: denying healthcare to people whose asylum claims have failed. Available from <http://www.refugeecouncil.org.uk/policy/position/2006/healthcare.htm> (accessed 12 April 2009).

18 Hargreaves S, Friedland JS, Holmes A, Saxena S (2006). The identification and charging of Overseas Visitors at NHS services in Newham: a Consultation. Available from <http://www.newhampct.nhs.uk/docs/publications/IHUEntitlementReport06.pdf> (accessed 1 February 2009).

19 Refugee Action (2006). The Destitution Trap. Research into destitution among refused asylum seekers in the UK. Available from <http://www.refugee-action.org.uk/campaigns/destitution/intro.aspx#download> (accessed 12 April 2009).

THE ROLE AND DUTY OF HEALTHCARE PROFESSIONALS

A significant number of healthcare providers in this larger data set share the concerns of the smaller sample analysed for our first report. In this analysis, thirty one percent of submissions from healthcare providers expressed concerns that implementing a charging regime was not their role or that the proposed charging regime would place them in breach of professional codes of conduct.

'Who will make the decision as to whether a failed asylum seeker needs such treatment? Clearly it cannot be personnel without training, such as receptionist or PCT staff...But Doctors are bound by a professional ethic that obliges them to put the needs of their patient before other considerations, and thus they could not be expected to police such a system, and decline to treat patients.'

Dr Peter Le Feuvre, General Practitioner, East Kent

Many healthcare providers felt that questioning patients about their immigration status could damage the doctor-patient relationship.

'The general practice reception area is not the place to determine the asylum status. This will not only cause administrative problems, but more importantly will put a strain on the patient-doctor relationship which should be a trusting and caring one. We will not take on policing roles to determine the asylum status but will continue to provide primary medical care to those in need, urgent, immediate or routine needs without discriminating the most vulnerable and destitute patients on our list.'

Dr Silke Bannuscher, General Practitioner, Glasgow

KEY POINTS: THE ROLE AND DUTY OF HEALTHCARE PROFESSIONALS

- **Thirty one per cent of healthcare providers expressed concern that denying care would place them in breach of professional codes of conduct.**
- **Many were concerned that this would damage the doctor-patient relationship.**

HEALTH TOURISM

The 2004 consultation document stated a desire to 'close existing loopholes that have allowed overseas visitors with no substantive connection with the UK to receive free NHS hospital treatment' [section 1.3].²⁰

A minority of healthcare providers who responded to the consultation (18%) were concerned about the number of foreign nationals accessing NHS services. Many respondents however commented on the lack of data regarding 'health tourism' and the inherent difficulty in debating this issue in the absence of a sound evidence base.

'The Department of Health has not produced evidence that suggests that inappropriate health tourism is a major problem in primary health care. If such evidence exists then this would make a helpful contribution to his debate.'

Royal College of General Practitioners

What research there is suggests there is no evidence of significant levels of health tourism to the UK.^{21 22 23 24} The DH has previously been unable to produce evidence of health tourism.²⁵

KEY POINTS: HEALTH TOURISM

- **The majority of submissions from healthcare providers (82%) did not express concerns about the numbers of foreign nationals accessing NHS services.**
- **Many respondents were concerned that the proposals were being discussed in the absence of evidence of significant levels of health tourism.**
- **More were concerned about the cost effectiveness of the proposals than with number of foreign nationals accessing NHS services.**

20 Department of Health (2004). Proposals to exclude overseas visitors from eligibility to free NHS primary medical services: A consultation. Available from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4082726 (accessed 27 January 2009).

21 Home Office (2007). Enforcing the rules. A strategy to ensure and enforce compliance with immigration laws. Available from <http://www.medact.org/content/refugees/EnforcementStrategy.pdf> (accessed 3 April 2009).

22 Robinson V, Segrott J (2002). 'The decision-making of asylum seekers', Home Office Findings No 172. London: Home Office.

23 Terrence Higgins Trust and George Health Trust (2003). Recent migrants using HIV services in England. Available from <http://www.tht.org.uk/informationresources/publications/policybriefingpapers/recentmigrantsusinghivservices.pdf> (accessed 3 April 2009).

24 Project London (2008). Report and Recommendations 2007: Improving Access to Healthcare for the Community's Most Vulnerable. Available from <http://www.medecinsdumonde.org.uk/doclib/104524-report2007light.pdf> (accessed 3 April 2009).

25 Johnson M (2005). Evidence to Third Report from the Health Committee: patient and public involvement in the NHS. Question 211. Available from <http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/252/5021008.htm> (accessed 3 April 2009).

A LACK OF CLARITY IN THE CURRENT SYSTEM

The 2004 consultation paper proposed strengthening rules regarding access to primary care to better match those in secondary care. It was suggested that this would produce 'simpler, more transparent rules' (Section 2.2).²⁶ Respondents were asked specifically whether '*strengthening the rules around access to free NHS primary medical services for overseas visitors, to better match those for hospital treatment, [would] bring clarity to both the overseas visitor and front line staff working in practices and PCTs?*'.

In correspondence with us in October 2007,²⁷ the DH asserted that submissions showed 'strong support for clarifying the rules'. We found that only 40% of submissions stated a need for greater clarity, despite specific questioning on this matter.

Some respondents felt that the question was designed to elicit a specific response, such that analysis of the submissions would lead to an inaccurate interpretation of their true feelings.

'In our opinion the question is loaded to elicit the answer 'well yes of course we all want to see rules that give clarity', but it gives no opportunity to respond to the real question which is 'which groups of people should be considered as overseas visitors?'

Jackie Grieg, Redbridge Refugee Forum

Those commenting on clarity recognised that the status quo may result in inconsistent application of the rules or discriminatory practices.

'We welcome a new set of rules regarding overseas visitors as the current system, based on guidance only, is subject to wide variances in interpretation and is therefore perceived as inconsistent and unfair.'

Suffolk Practitioner Service Unit

26 Department of Health (2004). Proposals to exclude overseas visitors from eligibility to free NHS primary medical services: A consultation. Available from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4082726 (accessed 27 January 2009).

27 Letter from Stephen Fay, Customer Service Centre, Department of Health (2 October 2007). This can be found in an appendix to our August 2008 report [8].

Some respondents suggested that the proposed changes would not alleviate the current difficulties and confusion would persist.

'I remain confused as to what is considered as treatment which is immediately and necessarily required. Whilst treatment for chronic ongoing ailments would not be included there are many situations where complications or an exacerbation of a previously known chronic problem occurs. Into which category would that fall?'

Sheffield Local Medical Committee

Many felt that, given the complex nature of immigration procedures, the proposed changes could exacerbate the current confusion.

'The Refugee Council noted in a survey of 81 NHS Trusts carried out in 1997 in Manchester and London that 67 per cent of the respondents (NHS staff) wrongly believed that refugees and asylum seekers were not entitled to free health care ...The Refugee Council believes that the proposed amendment will exacerbate this lack of awareness and will result in asylum seekers and refugees not only being questioned about their immigration status inappropriately but also being refused services to which they are entitled.'

Refugee Council

'Even before amendments to secondary care came into force, (1st April 2004) there was evidence of confusion among NHS staff and among beneficiaries about entitlement to healthcare. The new proposed changes to entitlement are only likely to increase this confusion and to see health services turn away people who remain legally entitled to free NHS treatment.'

Medécins du Monde UK

These comments highlight the potentially damaging effect of extending the charging regime for groups whose legal status is both dynamic and poorly understood by front line staff with little training in complicated immigration issues.

KEY POINTS: A LACK OF CLARITY IN THE CURRENT SYSTEM

- **Only 40% of respondents felt that the current situation lacks clarity.**
- **Many respondents felt that extension of the charging regime would not address the source of current confusion and could make matters worse.**

CHAPTER 2: GOOD POLICY-MAKING

The Cabinet Office document *Professional Policy Making for the Twenty First Century*²⁸ argues that 'core competencies' for 'professional policy making' include:

"[taking] a long term view, based on statistical trends and informed predictions, of the likely impact of policy' and [using] best available evidence from a wide range of sources and [involving] key stakeholders at an early stage." [Page 13]

In *Guidelines on Scientific Analysis in Policy Making*²⁹ the Chief Scientific Advisor to the Government argues:

"...we must ensure that:

- key decision makers can be confident that evidence is robust and stands up to challenges of credibility, reliability and objectivity*
- key decision makers can be confident that the advice derived from the analysis of evidence also stands up to these challenges*
- the public are aware, and are in turn confident, that such steps are being taken"* [Paragraph 2]

On page 25 of the same document, the Chief Scientific Advisor continues:

"there should be a presumption at every stage towards openness and transparency in the publication of expert advice. Departments should also ensure that procedures for obtaining advice are open and transparent. It is good practice to publish the underpinning evidence for a new policy decision, particularly as part of an accompanying press release."

A number of respondents to the consultation expressed concern that principles of good policy making were not being implemented in considering the proposals to introduce charging in primary care. There was also concern that these principles had been ignored in the decision-making that had already led to tighter restrictions on access to secondary care.

The King's Fund were critical of the policy making process in primary care.

"The Cabinet Office recently published a useful document which contains basic principles of good policymaking, which do not seem to have been followed with respect to the development of this policy."

The King's Fund

28 Strategic Policy Making Team (1999). *Professional Policy Making for the Twenty First Century*. Available from <http://www.nationalschool.gov.uk/policyhub/docs/profpolicymaking.pdf> (accessed 13 April 2009).

29 HM Government (2005). *Guidelines on Scientific Analysis in Policy Making*. Available from <http://www.berr.gov.uk/files/file9767.pdf> (accessed 13 April 2009).

A number of different concerns were expressed in submissions to the consultation:

1. The lack of evidence of significant levels of 'health tourism', the core rationale for charging in both primary and secondary care (see chapter 5).
2. The lack of any regulatory impact assessment.
3. The lack of evidence that charging for primary or secondary care will result in the supposed cost-benefits (see chapter 3).
4. The lack of consistency in policy-making between government departments.

Regulatory Impact Assessment

Inclusiveness as a core component of good policy making means *"ensuring that policy makers take as full account as possible of the impact the policy will have on different groups – families, businesses, ethnic minorities, older people, the disabled, women – who are affected by the policy... Considering the effect of policies on different groups is done formally through impact assessment techniques"*.³⁰

Several respondents raised concerns regarding the lack of appropriate health or equality impact assessments of the recent changes to secondary care charging regulations.

"There is no evidence that the Department of Health has undertaken a public health impact assessment of the new charges, either those introduced in hospitals or those proposed for GPs. This is an extraordinary omission...Until such a thorough and scientific public health impact assessment is completed, it would be highly irresponsible for the proposed charging scheme to go ahead."

National AIDS Trust

'We note, with some surprise, that there is no Regulatory Impact Assessment accompanying the consultation document'.

Citizens' Advice

'Because the issues are difficult, we would like to see the Department of Health presenting research to justify the efficacy of the proposals'.

Royal College of General Practitioners

Inconsistency

Good policy-making entails consistency between sectors of government. The Strategy Policy Making Team (1999) recommends that 'policy makers take a holistic view, looking beyond institutional boundaries to the Government's strategic objectives and seek to establish the ethical, moral and legal base for policy'.³¹ In their submissions to the consultation, many cited examples of inconsistency.

30 Strategic Policy Making Team (1999). Professional Policy Making for the Twenty First Century. Available from <http://www.nationalschool.gov.uk/policyhub/docs/profpolicymaking.pdf> (accessed 13 April 2009).

31 Strategic Policy Making Team (1999). Professional Policy Making for the Twenty First Century. Available from <http://www.nationalschool.gov.uk/policyhub/docs/profpolicymaking.pdf> (accessed 13 April 2009).

'...we consider the proposed rules to run counter to the Government's strategy for the successful integration of new refugees, as set out in the recent Home Office consultation paper Integration Matters: A National Strategy for Refugee Integration.'

Citizens' Advice

'These proposals go against all that the Government is trying to do to combat the rise in sexually transmitted diseases...'

Dr Sarah Montgomery, General Practitioner, Kent

'We feel that the proposed measures run counter to international, regional and national commitments...to combat HIV.'

African HIV Policy Network

'The proposals do not indicate if they apply to children. If they do then denial of opportunities for developmental screening, immunisations and routine childhood healthcare is likely to be in direct contravention to the Children's Act 1989 and the UN Convention on The Rights of The Child.'

Christian Medical Fellowship

'...We would also like to point out that World Health Organisation targets and goals and the Government national Public Service Agreements for Local Authorities would be affected by this.'

Refugee and Asylum Seekers Health Action Group

Reference should be made to our previous report, which details concerns that the proposed new charging regime would breach international human rights agreements ratified by the UK.³²

KEY POINTS: GOOD POLICY-MAKING

- **Some respondents were concerned about the policy making process with respect to charging 'overseas visitors' for primary care.**
- **Some expressed similar concerns about how the regulations in place in secondary care had been developed.**
- **Submissions expressed concern that no health or equality impact assessments had been undertaken and that little consideration had been given to the effects of introducing a charging regime on national and international targets and commitments.**

32 Global Health Advocacy Project (2008). Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services: A summary of submissions to a Department of Health consultation whose findings were never published. Available from <http://www.wherestheconsultation.org> (accessed 31 January 2009).

CHAPTER 3: EVIDENCE GIVEN BY KEY STAKEHOLDERS

The qualitative data that this report brings into the public domain is, we feel, our most valuable contribution to the debate surrounding access to free NHS services for overseas visitors. Whilst our quantitative findings suggest widespread concern about introducing a charging regime in primary care, respondents to the consultation were a self-selecting group and, as such, may not represent public opinion or the opinions of the various professions. Furthermore, it would be inappropriate to give equal weight to individual members of the public and established organisations with expertise in health and migrant welfare.

This chapter outlines arguments made by key stakeholders, namely, the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), the Royal College of Midwives (RCM), the Royal Society for the Promotion of Health (RSPH) (now the Royal Society of Health), and the Community Practitioners' and Health Visitors' Association (CPHVA). Full copies of these submissions can be found on our website at www.wherestheconsultation.org. In this chapter we outline the main arguments made in these documents. A recent (2009) position statement from the RCGP can be found in an appendix to this report.

Whilst concerns about clarity did not feature prominently in submissions to the consultation as a whole, three submissions from key stakeholders recognised a need for greater clarity in the regulations governing access to NHS services for 'overseas visitors'.

'The Royal College of Midwives...welcomes the aim of these proposals to clarify, make more transparent and make fairer the rules relating to the eligibility of overseas visitors to receive free NHS primary medical services...'

Royal College of Midwives

'It is obviously extremely important that any such rules, however, are as transparent and uniform as possible, and attempting to bring the rules for eligibility to primary care in line with secondary care is sensible.'

British Medical Association

All submissions from key stakeholders were however concerned that the adverse consequences of the proposed regulations could outweigh any benefits gained from bringing greater clarity to current situation.

'We are quite prepared to accept that it will bring clarity. The question is whether clarity is a sufficiently important objective to warrant this change. The important questions for The Royal Society for the Promotion of Health are: i.) Will it save public money? and ii.) What effect might it have on public health? The first question cannot be answered since the Department of Health has provided no figures to support its case. The second cannot be answered definitively...it is entirely possible to improve clarity (and even save public money) while worsening public health.'

Royal Society for the Promotion of Health

It was also clear that many of the key stakeholders had doubts about the details of Department of Health proposals, with four of the five submissions containing requests for clarification.

All the submissions from key stakeholders were concerned that insufficient evidence had been presented to demonstrate the need for, or likely impact of, a charging regime in primary healthcare.

'We urge the Department, therefore, to undertake research to provide evidence of the extent of the problem that the proposals are designed to solve and to estimate the current costs of providing primary medical services to ineligible' patients. There is a danger that the new scheme will cost more to implement and police than the current situation and that much distress will be caused in the process.'

Royal College of General Practitioners

'[W]e are very concerned that once again Government is inviting us to comment on a proposal which will have serious health implications for people without offering even a general indication of the scale of the problem we are being asked to address. If Government considers the costs to the NHS of health tourism to be serious then an estimate of these costs must exist. If the costs are not considered to be great then we are concerned that this consultation may serve broader political purposes than those indicated in the rubric...we are anxious that health policy and immigration policy should not become entangled with each other.'

Royal Society for the Promotion of Health

Whilst the RCM and RCGP recommend policy change be placed on hold until the Government presents evidence of a need for a charging regime and evidence of its likely impact upon public health and NHS finances, the remainder either rejected the proposals entirely or stated that they should not apply to refused asylum seekers or undocumented migrants.

Three of the five submissions from key stakeholders argued that there was a need to consider vulnerable groups, such as refused asylum seekers, separately from tourists and other 'overseas visitors'.

'How will access to care be ensured for those who have passed through all stages of the asylum process, and have not been granted refugee status, but who cannot return immediately to their country of origin and do not have means of support sufficient to meet the costs of healthcare?'

Royal College of Midwives

'It is important...that 'health tourists' i.e. those who come to the UK with the sole purpose of receiving treatment which they would have to have paid for in their country of origin, are viewed separately to failed asylum seekers, who are unlikely to be able to pay for treatment and whose country of origin frequently lacks any substantive health infrastructure. These proposals could result in asylum seekers being effectively abandoned by the health care system. The BMA opposes any proposal which could effectively marginalise asylum seekers or restrict the access of this vulnerable group to health care.'

British Medical Association

Additionally three submissions from key stakeholders expressed concern that those entitled to care, but with limited understanding or ability to communicate their rights, might come to harm if the proposals were implemented.

'We are not convinced that the implementation of these proposals will not lead to more racial discrimination, we believe those who will be asked to demonstrate/prove eligibility will more likely be from more visible minority groups.'

Community Practitioners' and Health Visitors' Association

All key stakeholders expressed concern about the likely impact of the proposals on public health.

'The public health risk of imported infections such as SARS or variant avian influenza from such visitors is increasingly recognised...Such infection is likely to present first to primary care or hospital accident and emergency departments. It is therefore very important that no barriers are raised to prevent early reporting and assessment of overseas visitors. Allowing and advertising free access to all visitors to primary and emergency care may be a key preventative strategy.'

Royal College of General Practitioners

The RSPH and RCGP argued that exempting certain communicable diseases from charging regulations could not mitigate the adverse consequences of denying a section of the community access to NHS primary care.

'[I]ndividuals cannot be neatly categorised into those with conditions which may have a public health implication and those with conditions which do not. It is of course the GP who normally undertakes to make this distinction, so it is difficult to see how there could possibly be no negative public health consequences of denying access to GPs. These of course would be over and above any negative health consequences for the individuals concerned. It should remain the responsibility of primary care practitioners to identify an individual's health needs and to decide on any further treatment. It is at this stage that possible payment for any future work might be determined – e.g. where a person has a longer term non-emergency problem which could be treated in their own country – to counter so-called health tourism.'

Royal Society for the Promotion of Health

All submissions from key stakeholders also expressed concern that the proposals might adversely affect NHS finances. There was concern not only about the administrative burden of implementing the regulations but that denial of access to primary care would lead to patients presenting later in their disease and therefore requiring more expensive treatments.

'Preventing individuals from needing emergency treatment can be extremely cost-effective. It is vastly more expensive, for example, to treat periodic diabetic comas than to provide maintenance doses of insulin.'

British Medical Association

'[W]e are aware that cost recovery by hospitals from overseas visitors remains problematic with high transaction costs. The transaction costs of any NHS system of charging in primary care may well exceed the costs recovered.'

Royal College of General Practitioners

Four of the five submissions from key stakeholders expressed concern that healthcare professionals be required to police access to NHS services.

'Health workers should not routinely be put in the position of mixing clinical imperatives with legal enforcement. Asking health workers to be both empathetic carers and arbiters of legal entitlements to care is inappropriate.'

British Medical Association

Finally, respondents raised concerns about denial of healthcare being used as a lever for immigration policy.

'The proposals particularly target failed asylum seekers and put general practice staff in the role of policing asylum status. Many of those seeking health care in this situation are children or old people or those suffering from serious chronic conditions. When seeking health care, they are likely to be extremely distressed and are also unlikely to be able to afford charges. This puts an intolerable burden on primary care staff and it is inappropriate to use access to health care as a device to police asylum status.'

Royal College of General Practitioners

In conclusion, key stakeholders expressed a wide range of concerns about the DH's proposals to charge 'overseas visitors' for NHS primary care. We felt that the submissions from three of the five key stakeholders were broadly opposed to the proposals. The remaining submissions were neither in favour of nor opposed to the proposals, yet stated definitively that vulnerable migrant groups should not be included in any charging regime. It is regrettable that this important body of information is only now entering the public domain.

Conclusion and Recommendations

Having consulted widely on proposals to charge overseas visitors for NHS services over four years ago, the Department of Health has had ample opportunity to formulate a clear, evidence-based policy in relation to the provision of healthcare services to failed asylum seekers. It has failed to do so.

Our report in August 2008³³ examined 34 submissions to the Department of Health consultation on proposals to exclude overseas visitors from eligibility to free NHS primary medical services. We found that healthcare providers and other key stakeholders had significant concerns about the proposals. With the benefit of the vast majority (274) of submissions to the consultation, it is now clear that these concerns are widely held.

The following recommendations to the Department of Health are made on the basis of those concerns.

1. Refused asylum seekers are amongst the most vulnerable people in society. Many are unable to leave the UK and the vast majority lack the resources to pay for healthcare.³⁴ There is evidence that under the existing regulations, refused asylum seekers have come to harm.³⁵ Forty two per cent of respondents to this consultation expressed concerns about charging vulnerable migrant groups for NHS services. **We therefore recommend that refused asylum seekers be considered separately from other overseas visitors and be exempted from charges for healthcare services.**
2. Forty three per cent of respondents to the consultation had concerns about the impact of the proposals on public health. Whilst the treatment of many infectious diseases is exempt from NHS charging, it is not possible to diagnose conditions such as tuberculosis at an early stage if an entire section of our community is not routinely accessing NHS services for non-specific symptoms. Charging for healthcare will delay diagnosis and prevent the successful treatment of communicable diseases. Failure to vaccinate members of the community would contribute to a loss of herd immunity. This will create unnecessarily high risks for public health and necessitate financial outlay to treat avoidable infectious disease. **We recommend that the Department of Health commission an independent health impact assessment to evaluate the effects on public health of charging overseas visitors for health services.**

33 Global Health Advocacy Project (2008). Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services: A summary of submissions to a Department of Health consultation whose findings were never published. Available from <http://www.wherestheconsultation.org> (accessed 31 January 2009).

34 Refugee Action (2006). The Destitution Trap. Research into destitution among refused asylum seekers in the UK. Available from <http://www.refugee-action.org.uk/campaigns/destitution/intro.aspx#download> (accessed 12 April 2009).

35 Kelley N, Stevenson J (2006). First do no harm: denying healthcare to people whose asylum claims have failed. Available from <http://www.refugeecouncil.org.uk/policy/position/2006/healthcare.htm> (accessed 12 April 2009).

3. Fifty five per cent of the submissions expressed explicit concerns that the proposed charging regime would not be cost-effective or would not be practical to implement. The administrative and financial burdens entailed in the implementation of a charging regime are likely to be significant. There are notable practical concerns and, if this sample is representative, the proposals are likely to prove unpopular with NHS staff. The determination of an individual's immigration status and thereafter whether their medical condition constitutes a medical emergency are complex processes requiring specialist knowledge. The formulation and implementation of a payment recovery structure will involve significant transaction costs. Moreover, preventing overseas visitors from accessing primary care will place an unnecessary and preventable burden on emergency health services. **The cost of denying primary care services to migrant groups may well exceed the intended savings.**
4. Thirty one per cent of healthcare providers who responded to this consultation were concerned that, if implemented, the proposals could damage the doctor-patient relationship or place them in violation of professional codes of conduct. By imposing on medical professionals the duty to determine a patient's eligibility for care, ethical standards could be compromised. Furthermore, requiring primary care providers to determine immigration status and levy charges before providing care could damage the delicate relationship of trust that ought to exist between healthcare provider and patient. A doctor's first duty is to provide care to his or her patient. Nurses and other healthcare professionals have similar codes of conduct. **We recommend that full account is taken of the ethical concerns expressed by respondents to this consultation in this regard.**
5. The stated rationale for charging foreign nationals for NHS services has been concern about 'health tourism'. Despite this, only eighteen per cent of healthcare providers responding to this enquiry raised concerns about the number of foreign nationals attempting to access NHS services. Many expressed surprise that the DH had not sought evidence of the extent of health tourism to the UK prior to restricting access to NHS secondary care or consulting on proposals to restrict access to NHS primary care. Given the concerns described above, **we call upon the Department of Health to suspend the charging regime in secondary care (Statutory Instrument 614) and to abandon the proposals for charging in primary care until evidence can be presented that 'health tourism' is occurring at sufficiently high levels to warrant consideration of charging 'overseas visitors' for NHS services.**

We call upon the Home Office and the Department of Health to fulfil their duty under the Freedom of Information Act and release the Home Office submission to this consultation. This information belongs in the public domain. The policies being considered here are too important to be allowed to pass without adequate and informed public scrutiny.

Finally, in view of the damage done by Statutory Instrument 614, **we call upon the Government and all Members of Parliament to restore full access to NHS services for vulnerable migrant groups, such as refused asylum seekers.**

Appendix A – Our Freedom of Information Appeal

The Department of Health's consultation document was published on 14 May 2004. It indicated that a summary of the outcomes of the consultation would be published online by 12 November 2004. The Government did not fulfil that commitment and has not, as far as we know, done so since. Nor, apparently, did the Government decide upon or implement any policy changes following that consultation exercise.

As a consequence of the way this issue was handled, professionals and organisations working with vulnerable failed asylum-seekers have become concerned about the Government's approach to policy-making in this area. Rightly or wrongly, a perception has developed in some quarters that, notwithstanding the Government's public commitment to evidence-based policy-making, its policy-making in this area is being guided by political concerns.

On 13 September 2007, we wrote to the DH requesting, under the Freedom of Information Act (2000), disclosure of the names of those who responded to the consultation exercise and copies of their responses.

The DH replied on 2 October 2007, providing the list of respondents. Regarding copies of the responses, it supplied generic section 35(1)(a) arguments that did not apply to our request.

The DH said that a new policy review was underway. It said that any policy changes would be in place by September 2008. The second of these statements proved not to be correct.

On internal review of Mr Yates' request the Department maintained its refusal. We complained to the Information Commissioner on 10 January 2008.

On 16 July 2008 the Department wrote to us, indicating that it would publish the responses in October 2008. This again proved not to be correct.

In that letter the Department claimed that it was unable to publish the responses until after the Parliamentary recess. A letter sent to the Department on 17 July 2008, we pointed out (a) the plan to publish implied that the public interest favoured disclosure and (b) that the disclosure obligation under the Act overrode any policy regarding non-publication during Parliamentary recess. That letter requested that it be treated as a fresh request under the Act.

On 11 September 2008 the Chief Medical Officer, Professor Sir Liam Donaldson, wrote to us. Sir Liam wrote 'As you have been advised on a number of occasions it has always been our intention to make public the views that were expressed to us in relation to the consultation'. The Department, so far as we know, still has not done so, which is why we are doing so in this report.

Obtaining a response to our letter of 17 July 2008 required chasing repeatedly by letter, email and telephone, finally with a request that it be treated as a formal complaint.

On 24 October 2008 the DH conceded that the section 35(1)(a) exemption was not engaged and that the responses would be disclosed. That change of position was accompanied by no apology for the unlawful non-disclosure of the responses for (at that time) a year following our original request. The DH confirmed, in terms, that section 35(1)(a) does not protect the responses made to the consultation exercise,

including the response from the Home Office, which remains undisclosed. The apparent acknowledgement that the responses should be disclosed was not accompanied, or followed, by disclosure. In the event, such disclosure did not begin for three months.

On 27 October 2008 we wrote to request immediate disclosure. On 7 November 2008 we telephoned to request immediate disclosure. In violation of either or both of sections 1(1) and 17(1) of the Act the Department expressly declined to indicate whether it considered that it was obliged to disclose the information requested.

Consequently, on 8 November 2008, we wrote to submit a fresh request under the Act. The Department never responded to that request.

In November the Department wrote, on its own initiative, to respondents to the consultation exercise, asking 'as a matter of courtesy' for consent to publication of their responses.

On 24 November 2008 Lord Avebury asked a question in the House of Lords about why the responses had not been disclosed. The explanation to Parliament of Lord Darzi, the Parliamentary Under-Secretary of State for Health, was that the Department would first be contacting all of those who replied to ensure that they 'still have no objections to their comments being published'. He indicated that the responses would then be published.

As far as we are aware, the responses have still not been published. In making this statement to Parliament the Minister, and those advising him, were presumably aware that consent at this stage was irrelevant to the ongoing non-disclosure to Mr Yates of the responses.

The Information Commissioner's Office became involved in resolving this complaint in November 2008 and has, since then, been mediating most of the communication between the Global Health Advocacy Project and the DH. We understand that the Department has, at various times, indicated that:

- it would be relying on the section 40 exemption;
- it would be publishing some of the information on either 23 or 24 December 2008;
- it would not release any responses until it resolved 'issues' surrounding a minority, which it believed would make the majority 'misleading';

No responses were disclosed until 22 January 2008, over fourteen months after the original request. On that date a large majority of the responses were released. Of the rest, after advancing either no or spurious grounds for non-disclosure, the DH has been persuaded to disclose most of the information.

The remaining dispute is over one submission.

The DH initially indicated that this was from a Government department, but refused to disclose neither which department, nor which level of officer. It was only when we pointed out that the response was from Mike Mahony of the Home Office's Immigration Policy Directorate that the Department conceded that it was. The Department had apparently forgotten that it had previously disclosed to us a list of the respondents to the consultation exercise.

The DH's reasons for arguing that this response is not subject to disclosure under the Act were communicated to us one year and seven months after our original request, on 28 April 2009. They are generic section 35(1)(a) arguments. It is only lawful to withhold information on these grounds if the public interest in non-disclosure outweighed the public interest in making this information available to the public. There is a presumption in favour of disclosure. In our view, the Government has identified no special reasons why the public interest particularly favours the non-disclosure of this policy-related information.

Our attempts to access this final document continue.

Appendix B – RCGP Position Statement, February 2009: Failed Asylum Seekers / Vulnerable Migrants and Access to Primary Care³⁶

Background

Regulations from the Department of Health (England), which came into force on 1 April 2004, identified groups who were not considered “lawfully resident” in the UK and made them liable for National Health Service hospital charges. Subsequently, a consultation in May 2004 proposed to extend the charging regime to Primary Care, including access to GP services. The aim of the draft legislation was to restrict access to NHS care for overseas visitors with the declared intention of reducing abuse of the NHS by what are termed “health tourists”. Although, to date, there has been no published Government response to the 2004 consultation, a recent cross-Government enforcement strategy has been published, “Enforcing the Rules”. This suggests that primary care be brought into line with the regulations that exist for secondary care. The Home Office document describes the purpose of the strategy as *“To ensure that living illegally becomes ever more uncomfortable and constrained until they leave or are removed.”*

RCGP Position

Based on the principle that General Practitioners have a duty of care to all people seeking healthcare, the RCGP believes that GPs should not be expected to police access to healthcare and turn people away when they are at their most vulnerable. **According to the Table of Entitlements to NHS Treatments (correct as of November 2008) GP practices have the discretion to accept Failed Asylum Seekers as registered NHS patients.** It should, however, be noted that the appeal against the April 2008 review is due to be published imminently and the current situation could change as a result. In addition to failed asylum seekers, we would urge the government to consider the health needs of other vulnerable migrant groups, who we feel should also be entitled to free primary care.

The College urges the Government:

- to commission independent and wide ranging social, race, health and impact assessments of the proposed changes before the current situation is changed. The assessments should include, but not exclusively cover, issues such as vaccination coverage, outbreaks of communicable diseases, antenatal, perinatal, infant and child health including mortality; maternal health and mortality; and the health and social wellbeing of women and men who are abused or exploited at home or elsewhere, sexually or in other ways. These assessments should also include effects on inequalities in health.
- to examine the compatibility of the proposals with the international human rights obligations of the UK, including those, but not exclusively, covering children.
- to re-examine the proposals in the light of the evidence generated by the above assessments.
- to commission independent, continuous, monitoring of access to health care and of the health needs of refugees and undocumented migrants.

³⁶ Available from http://www.rcgp.org.uk/news_and_events/college_viewpoint/position_statements/failed_asylum_seekers.aspx (Accessed 12/02/09).

- to explore and implement modes of mitigating or reversing adverse effects of excluding migrants from free access, such as non-compliance with necessary prevention and treatment for fear of being presented with bills that cannot be paid. Mitigating measures may include annulment or non-enforcement of payment requests and compensation for Hospitals, General Practices and other NHS organizations from central funds.
- to issue guidance to overseas visitor managers and similar officers in NHS organisations and general practices that they shall deal with vulnerable migrants in a sensitive way that will not undermine migrants' health.
- to monitor the approach of vulnerable migrants by health care professionals, other staff and overseas visitor managers and similar officers in NHS organisations and general practices
- to particularly commit itself to the protection of children and pregnant women.

The RCGP bases its position on the following:

- There is no evidence that asylum seekers enter the country because they wish to benefit from free health care.
- Asylum seekers are exercising a legal right to seek refuge from persecution.
- The Government's policy has had the effect of leaving some vulnerable people in the UK without any access to health care.
- There is an adverse effect on infant mortality and children's health in particular.
- Denying free access to primary care could increase the likelihood of serious communicable diseases not being detected.
- There could be deleterious effects on the health care and support for exploited women
- Health inequalities policies could be undermined.
- Additional stress would fall on A&E services if access to primary care is restricted
- Such a change in policy infringes the basic human rights obligations of the UK

Pending further legal clarification, the RCGP reminds all general practitioners that failed asylum seekers are entitled to unrestricted access to primary care services.