Refugee Council

First do no harm: denying healthcare to people whose asylum claims have failed

Oxfam

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REFUGEE COUNCIL

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"Not even the apparently enlightened principle of the 'greatest good for the greatest number' can excuse indifference to individual suffering."

Aneurin Bevan, founder of the NHS, In Place of Fear, *1952*

"There will always be, as there has been in the past, a proportion of overseas visitors who are … taken ill while they are here and receive healthcare to meet their needs and our international obligations. These people are visitors in need, not health tourists."

Lord Warner, Parliamentary Under Secretary of State, Department of Health, Hansard, 05 March 2004, col. 967

Note on terminology

Throughout this report the term 'refused' has been used to refer to asylum seekers whose asylum applications and any subsequent appeals have been finally rejected.

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Introduction

The Refugee Council is the largest refugee-supporting agency in the UK. In 2005, we worked directly with more than 60,000 asylum seekers, refugees and unsuccessful asylum applicants. We not only give help and support to asylum seekers and refugees, but also work with them to ensure that their needs and concerns are addressed by decision-makers. We are a membership organisation, and our members range from small refugee led community organisations to international NGOs such as Christian Aid, Save the Children and Oxfam.

At our London office we have a Specialist Team, established to help meet the health and mental health needs of vulnerable refugees and asylum seekers. The Specialist Team is made up of a health access worker, whose role is to enable clients to access care, bi-lingual support workers, who provide counselling and advocacy for refugees and asylum seekers with mental health support needs, and a women's worker, whose role is to provide gender sentisitive support to vulnerable women. The Specialist Team works closely with our health policy adviser, who provides advice to health practitioners from the voluntary and statutory sector who are working with refugees and asylum seekers.

Over the last two years, since the Government introduced restrictions on free healthcare for asylum seekers whose claims are unsuccessful, we have become increasingly concerned at the devastating impact this denial of healthcare is having on individuals and families. This report is based on our experience of working with refused asylum seekers denied access to secondary healthcare since the introduction of tighter charging regulations in April 2004.

NHS charging and 'health tourism'

The first charging system for overseas visitors using the NHS was introduced in 1982, then revised in 1989[1], but it was not until 2004 and the introduction of the NHS (Charges to Overseas Visitors) (Amendment) Regulation that charging was extended to refused[2] asylum seekers.

The rationale given for introducing the 2004 regulation was "to protect finite NHS resources by closing up loopholes where it has been identified that certain regulations may be open to abuse":[3] a response to "health tourism".

Health tourism is a term used to describe situations where foreign nationals travel to the UK for the express purpose of benefiting from free NHS healthcare. It is important to note that whilst individual instances of health tourism are commonly cited, and there is anecdotal evidence of its impact on the finances of some NHS trusts, no robust data on health tourism exists, a fact noted by the Health Select Committee in its 2004 Report on HIV/AIDS Policy:

> Despite John Hutton MP's conviction that "there is a significant amount of abuse going on", no evidence exists to objectively quantify the scale of abuse, either in relation to HIV or more generally. The Department's original consultation provided illustrations of "abuses" that should be stopped, but these only relate to people coming to the UK for a short period to use the NHS, for example during pregnancies to access maternity services, rather than people who are staying in the UK long term "without proper authority". The consultation document gives no specific examples of people migrating to the UK as "health tourists" to use NHS services for HIV or for any other chronic condition. The Department's consultation on changes to charging rules for overseas visitors suggested that cost saving was a key reason for reviewing the regulations. We were therefore astonished that, by the Department's own admission, these changes have been introduced without any attempt at a cost-benefit analysis, and without the Department having even a rough idea of the numbers of individuals that are likely to be affected.
>
> *Health Select Committee's Third Report of the Session 2004/5 on New Developments in Sexual Health and HIV/AIDS Policy*

Moreover, whatever the validity of the Government's claim that "health tourism" represents a significant challenge for the NHS budget, characterising asylum seekers whose claims have been refused as health tourists is clearly inappropriate. The regulation was aimed at stopping:

- Free hospital care for dependants of someone who is exempt from charges who visits the UK briefly just to obtain free hospital treatment, including giving birth.

- Free hospital care for those whose employment is based outside the UK but who fall ill or are injured during a business trip to the UK – or for any dependants who have travelled with them.

1 NHS Charges to Overseas Visitors Regulations 1989.
2 The term 'refused asylum seekers' is used to refer to those whose asylum applications and any subsequent asylum appeals have been finally rejected.
3 Proposed Amendments to NHS Health Service (Charges to Overseas Visitors) Regulations 1989: A Consultation, 28/07/03 para 1.

• Free hospital care for someone who has come to the UK primarily to receive private medical treatment but stays for more than 12 months.

• Free hospital care for refused asylum seekers (i.e. those whose applications and appeals have been finally rejected, and others with no legal right to be in the country).

National Health Service (Charges to Overseas Visitors) Regulations 1989: A Consultation, Summary of Outcome (December 2003)
www.dh.gov.uk/PolicyAndGuidance/International/OverseasVisitors
[Accessed 31 May 2006]

Asylum seekers come to the UK in order to pursue the internationally recognised right of refuge. In a world where borders are ever more tightly controlled, many asylum seekers are smuggled or trafficked into the UK, unaware of their final destination. For those who can choose, available evidence suggests that the key factors affecting their choice are the languages they speak, family connections or historical connections between their country of origin and the UK.

The concept of health tourism implies not only deliberate fraud, but also the possibility of returning to one's country of origin for treatment. For many refused asylum seekers, this is simply not an option. In some cases, for those supported or entitled to support under Section 4 of the 1999 Act,[4] even the Government accepts they cannot return home. In other cases, people are terrified of returning to face persecution, to countries that are in the midst of upheaval and war.

Given the insecurity, distress and discrimination experienced by those who flee here seeking sanctuary, it is clearly not the case that asylum seekers are here to get free healthcare. They come here for our protection, and sometimes, whilst here, they also need our care.

4 Support available to those who cannot return to their country of origin for reasons outside of their control. See page 8 for detailed explanation.

The regulations

Since 01 April 2004, when this amendment came into force, the charging regulations require that all NHS trusts, foundation trusts and primary care trusts (the Trust) providing secondary care, have a legal obligation to:

• establish whether a patient is "ordinarily resident" in the UK;[5]

• if not, to assess whether they are liable to pay for their treatment, and

• charge those liable to pay.[6]

Department of Health (2004) Implementing the Overseas Visitors Hospital Charging Regulations: Guidance for NHS Trusts in England, HMSO, London, p8

In practice, this role is undertaken by trusts' overseas visitors managers, not doctors or nurses. The overseas visitors managers work with the trust finance departments and with external debt recovery agencies: in its guidance, the Department of Health "strongly advises the use of a debt recovery agency that is experienced in handling overseas debt".

Whilst asylum seekers' claims are being decided, they are entitled to free NHS care. Once they have exhausted their appeal rights, they remain entitled to continue any treatment they were already receiving, but all other secondary care is chargeable. In fact, the regulations encourage trusts to monitor patients' immigration status with care, to ensure that as soon as an asylum seeker exhausts their appeal rights, they can be billed for treatment. The Department of Health guidance states that "trusts should be prepared to check that the application is still ongoing at intervals if treatment is being provided over a long period".

Charges apply to all forms of secondary care, except treatment provided in Accident and Emergency (A&E) departments. "Emergency" treatment which is given in any other hospital department is still chargeable. Where treatment is considered "immediately necessary", the Trust is not obliged to check whether the patient can afford to pay before they provide treatment, but they must seek to recover the costs after the fact.

By contrast, where treatment is considered only "urgent", defined as "where the treatment is, in the clinical opinion, not immediately necessary, but cannot wait until the patient returns home", "trusts are strongly advised to seek deposits equivalent to the estimated full costs of treatment in advance of providing the treatment".

The charging system covers almost all health needs: the only types of treatment that remain free are family planning services, compulsory mental health care,[7] and treatment for a range of communicable diseases that might pose a public health

5 A common law concept: the regulations requires trusts to consider whether a person is "living lawfully in the UK voluntarily and for settled purposes as part of the regular order of their life for the time being whether they have an identifiable purpose for their residence here and whether that purpose has a sufficient degree of continuity to be reasonably described as 'settled" (DH:p43)

6 Nationals of EEA countries, and countries with which the UK has bilateral health agreements are either not liable for the costs of the care, or have limited liability. This includes countries such as Azerbaijan and Bosnia, which are refugee producing countries.

7 Provided under the Mental Health Act 1983, or under a court probation order.

risk if not dealt with. Treatment provided in sexually transmitted diseases clinics is also free, except treatment for HIV/AIDS. HIV testing and counselling is free, but treatment is only provided to those who can afford to pay.[8]

The guidance requires trusts to "take all reasonable measures" to recover the debts incurred, with the only acceptable reason for not seeking payment being death: "where the patient has subsequently died, the Trust can decide to write the debt off'".[9] This means trusts are required to issue invoices, threatening letters or even refer to debt recovery agencies, debts owed by people they are fully aware are unable to pay.

The vast majority of asylum seekers whose claims have been refused are destitute, surviving on the charity of friends, family and community groups. A very small number of people qualify for support under Section 4 of the Immigration and Asylum Act 1999 on the grounds that they are:

• unable to leave the UK due to a physical impairment (serious illness or late stages of pregnancy; or

• unable to leave the UK due to there being no safe route of return to their country of origin; or

• they are complying with steps to facilitate return (applying for travel documents); or

• there are exceptional or compassionate circumstances for their remaining in the UK; or

• they have been given permission to judicially review their asylum refusal.

People on Section 4 support exist in a cashless economy: given either full board accommodation, or accommodation and vouchers.

Thus, no refused asylum seeker has access to any legal source of income, apart from borrowing from family and friends. They quite simply cannot pay the healthcare bills they are sent.

No patient is too vulnerable to escape charging: a refused asylum seeker involved in a near fatal car accident would receive free care in A&E, but once transferred to the intensive care unit would begin incurring charges that would ultimately amount to tens of thousands of pounds. Children are charged, people with acute mental health problems or learning disabilities are charged, and elderly patients with dementia are charged.

8 Department of Health: 2004:21

9 Department of Health: 2004:38

The health needs of asylum seekers and refugees

In addition to experiencing similar health problems as the rest of the UK population, refugees and asylum seekers also suffer from a range of physical and mental health problems as a consequence of experiences in their country of origin, sometimes made worse by poor access to healthcare and the dangerous and stressful journey to the UK.[10]

Often, problems are compounded by the conditions they face upon arrival: adapting to a new culture and language, the complexity of the asylum system, dispersal procedures[11] and lack of information about services (Kelly et al: 2005).

As many as 20 per cent of asylum seekers and refugees have severe physical health problems that make their day to day life difficult (Burnett and Peel: 2001). Many of these problems may have arisen as a result of conditions in their countries of origin, including poverty, lack of preventative healthcare, particularly immunisations, and the prevalence of particular diseases.[12] For example, tuberculosis (TB) can spread rapidly through cramped and squalid living conditions in refugee camps or during flight, or indeed in the inadequate housing many asylum seekers and refugees have in the UK (Woodhead; 2000). Some asylum seekers and refugees come from countries where the risk of exposure to HIV/AIDS is extremely high,[13] including those where poverty leaves no option open to mothers but to breastfeed, creating a significant risk of mother to child HIV infection (Woodhead; 2000).

Women are particularly vulnerable to deteriorating health, and maternal deaths in the UK are significantly higher among refugees and asylum seekers than the population at large.[14] Contributory factors include previous lack of access to antenatal care, poor nutrition, and highly traumatic instances of pregnancy caused by rape.[15]

Refugee and asylum seeking women may have experienced assault, sexual abuse and rape as forms of persecution,[16] which in addition to psychological trauma causes a range of physical health problems that are left untreated due to flight. Sexual health and childbirth can also be affected by female genital mutilation (FGM), and it is estimated that over 80,000 women and girls in the UK may have undergone this practice, with this number set to rise.[17, 18]

Like women, children are also at risk of ill health. Refugee children suffer more acutely from physical problems associated with their social deprivation before entering the UK, including malnutrition and disease, which is worsened by damp housing conditions in the UK and exposure to diseases they are not immunised against.[19]

Between 5 and 30 per cent of asylum seekers have been tortured.[20] The physical effects of torture include fractures and crushed bones, head injuries which may lead to epilepsy, deafness through ear damage and keloid scars from burns and cuts (Burnett and Peel; 2001). Both women and men suffer sexual violence, in particular rape (Peel: 2004). Violence of this nature triggers feelings of shame and grief, but also brings potential risk of infection with HIV and other sexually transmitted diseases. Torture survivors can also suffer from physical symptoms brought about by psychological stress, including abdominal, neck and back pain,

10 Burnett, A. Peel, M. (2001) "Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees", BMJ, 322, pp. 544-547.

11 Since the Immigration and Asylum Act 1999, asylum seekers wishing to access both cash support and accomodation have been dispersed outside of London on a no choice basis. For many this has meant isolation and social exclusion as a result of living in communities without a history of inward migration, and without established refugee or minority ethnic communities.

12 Heptinstall,T et al. (2004). "Asylum Seekers: a health professional perspective." Nursing Standard 18 (25), pp.44-53.

13 Loughna, S. Merheb, N. et al (2006). The State of the World's Refugees Human Displacement in the New Millennium. UNHCR Oxford University Press: Oxford.

weakness and headaches (BMA; 2001, Burnett and Peel; 2001). They are often unwilling or unable to discuss past traumas due to their magnitude, and many survivors prefer "active forgetting" to reliving these acutely distressing experiences.[21]

Refugees and asylum seekers commonly experience significant mental health problems. Past experiences of torture, rape, death of loved ones, social upheaval, detention and other forms of persecution give rise to intense "crisis emotions" such as fear, grief and shame (Medical Foundation; 2001) and these experiences can both cause mental health problems, or exacerbate pre-existing conditions.[22] Mental distress is a taboo subject in some refugee producing countries, so problems may have been left untreated, and are subsequently intensified with the further trauma of relocation (Burnett and Peel; 2001). Once in the UK, the stress caused by poverty, living in a hostile environment and attempting to adapt to a new society can themselves cause or contribute to significant mental health problems (Kelly et al; 2005, Burnett and Peel; 2001). Symptoms include: disturbed sleep, anxiety attacks, violent outbursts, self harm, erratic behaviour and extreme mood swings (BMA; 2001).[23] The despair people often feel can also trigger them to re-experience past trauma, which in the extreme can lead to Post-Traumatic Stress Disorder (PTSD). Sadly, asylum seekers and refugees are among the highest risk categories for suicide in the UK (Medical Foundation: 2001).

It is clear that refugees and asylum seekers have complex health needs, arising from trauma and deprivation in their countries of origin, compounded by trauma and deprivation in the UK. Meeting those care needs should be the sole focus of the NHS, not assessing immigration status and invoicing.[24]

14 Benjamin, A. (2005). "Forced to go it alone", The Guardian, 14 December.

15 British Medical Association. (2001). Asylum Seekers and health - A British Medical Association and Medical Foundation for the Care of the Victims of Torture dossier. [Internet] October 2001. Available at: www.bma.org.uk/ap.nsf/ Content/ Asylumseekers healthdossier [Accessed 09 May 2006]

16 Peel, Dr. M. (Ed.)(2004). Rape as a Method of Torture. The Medical Foundation for the Care of Victims of Torture: UK.

17 Burnett, A, Peel, M. 2001, "Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees", BMJ, 322, pp. 544-547.

18 Powell, R, 2002. Female Genital Mutilation, asylum seekers and refugees: the need for an integrated UK policy agenda. Forced Migration Review, 14, July 2002, pp.35.

19 British Medical Association. (2002). Asylum seekers: meeting their healthcare needs. BMA: London.

20 Burnett, A. Peel, M. (2001). "The health of survivors of torture and organised violence." BMJ, 322, pp.606-609.

21 Medical Foundation. (2001). Suicide in Asylum Seekers and Refugees – MF response to the Department of Health's consultation document National Suicide Prevention Strategy for England. [Internet] Medical Foundation July 2001. Available at: www.torturecare.org.uk/UserFiles/File/publications/brief29.rtf

22 Hill, M. Hopkins P. (2006). This is a good place to live and think about the future… the needs and experiences of asylum seeking children in Scotland. The Glasgow Centre for the Child and Society/ Scottish Refugee Council: Glasgow.

23 Cowen, T. (2003). Suffering Alone An examination of the mental health needs of asylum seekers and refugees in Barnet. Refugee Health Access Project: London.

24 During the consultation period, the BMA described their application to failed asylum seekers as 'utterly unacceptable' and the RCN voiced concers about 'endangering patient care' 'Health Tourism Rules Unveiled: BBC news http://news.bbc.co.uk/1/hi/health/3355751.stm

The impact of the regulations

Since the introduction of the regulations, the Refugee Council has worked with hundreds of refugees and asylum seekers experiencing serious problems accessing healthcare, but a smaller number of cases where refused asylum seekers have been completely denied secondary care that they desperately need. As distressing as these cases are, more distressing still is the thought of people who had no idea where to turn, and have been left to suffer.

The 37 cases explored below give us an indication of the serious impact the regulations are having on the lives of individuals and families, and some understanding of the wider potential impacts of limiting access to care.

Maternity care

Since the introduction of the regulations, we have worked with 17 women who have been denied access to maternity care. The women came from a range of countries including China, Democratic Republic of Congo, Vietnam and Somalia. They were all completely destitute, living on the charity of friends and community groups, and many were very young, including one 17 and one 15-year-old child.

> A is a young woman from China. When she came to us, she was eight months pregnant, destitute and homeless, sleeping on her friends' sofa. She was terrified about the safety of herself and her unborn child. Her local trust had told her that she would be charged nearly £3,000 for the care she needed, and that if she didn't pay, her debt would be passed on to a debt collection agency, and her information passed onto to Home Office, who would prevent her ever re-entering the UK.

> B is from Vietnam. She arrived in our office with a letter telling her that unless she paid the £2,300 cost of her maternity care within five days, her debt would be passed to a collection agency. She was 15 years old, and destitute.

The consequences of the charging process extend well beyond maternity care. There is a very real risk that having experienced the charging process, vulnerable people with acute health needs will not seek treatment, and will suffer terribly or even die. This is illustrated by the experience of one of the women who had been charged for her maternity care:

> C gave birth in hospital, and her baby was admitted to the special care unit after birth. C was invoiced for £3,024 in maternity costs, an amount she was wholly unable to pay. She then refused to attend follow up checks with her baby because of her fear of the debt collectors, and that the hospital would use the appointment as a way to deport her.

The guidance for implementing the regulations is clear:

> "Maternity services are not exempt from charges. However, because of the severe health risk associated with conditions such as eclampsia and pre-eclampsia maternity services should not be withheld if the woman is unable to pay in advance".[25]

Despite this guidance, eight of the women and girls we worked with had been told that unless they paid in advance, they

25 Department of Health: 2004:42

would not be provided with maternity care. This breach of the regulations had particularly damaging consequences:

> D, another young Chinese woman, was given an upfront payment schedule by the trust. She borrowed £800 for the first payment, then was unable to find the subsequent payments of £800 and £700. She gave birth at home, but was still billed by the Trust for the full amount.
>
> E, a young woman from China, was turned away several times by her local NHS trust, who told her that unless she could pay them several thousand pounds upfront, they would not support her through the birth of her baby. She gave birth at home, with no medical care, and then both she and her baby had to be admitted to hospital with serious health problems relating to the traumatic birth. Once discharged, the hospital continued to send E bills, which frightened her so much she fled her home. The whereabouts of her and her child are not known.

These are just a few examples of women who came to Refugee Council for help. There is no way of knowing how many more women are giving birth at home, unaided and alone. The risks associated with childbirth are significant, and without proper medical care, women may risk lifelong harm to themselves and their babies, or even death. These risks are particularly high for HIV positive mothers and their babies (Williams: 2005).

Clearly, there is also a risk that these mothers will be scared of seeking medical treatment for their babies. For babies who are born with conditions that need care, the potential impact is clear, but equally, failure to give children routine inoculations and care can cause life long health problems.

Acute / Chronic health needs

Over the last two years, we have worked with a smaller number of people with acute or chronic health needs, many of whom, left without treatment, would almost certainly die in unbearable pain.

Cancer

Four people came to see us who had been diagnosed with various forms of cancer, but denied treatment.

> F from Romania has stomach cancer. He was operated on, but then billed £1,085 and denied radiotherapy unless he was able to pay for it in advance. When he came to Refugee Council, he was so distressed he cried throughout his conversation with our health advice worker.
>
> G, is an Arab man whose nationality is disputed. He suffers from bowel cancer, and was admitted in an emergency because of uncontrolled bleeding. The clinicians in A&E scheduled him for an operation as soon as the bleeding stopped. However, once the hospital discovered G was a refused asylum seeker, he was given a bill for many thousands of pounds, and his operation was cancelled. He was discharged from hospital and told to come back "when his condition deteriorates".
>
> H is Rwandan, and when he came to Refugee Council was living on the street and destitute. He had bowel cancer and a colostomy bag from a previous operation. Not only had the Trust refused to provide care without advance payment, his local GP was refusing to register him.

Bowel cancer is the second most common form of cancer in the UK, and even with treatment, only 50 per cent of those diagnosed with bowel cancer survive for more than five years.[26] Although less common, stomach cancer has a lower survival rate: with treatment, less than 40 per cent of people with stomach cancer survive.[27]

Diabetes

We have also worked with two diabetic patients, both of whom are insulin dependent, one in renal failure.

> I is a diabetic in renal failure who was referred to Refugee Council by his

26 www.cancerscreening.nhs.uk/bowel/index.html#how [Accessed 05 June 2006]

27 Stomach Cancer Survival Statistics http://info.cancerresearchuk.org/cancerstats/types/stomach/survival/ [Accessed 05 June 2006]

own primary care trust, after they were unable to make any impact on the charging of the local trust. By the time he was referred to us, he had been charged more than £70,000 pounds for his care. He was destitute.

J is a Roma woman with diabetes and high blood pressure. She was referred to us after being turned away by every local GP in her area. When she went to her local Accident and Emergency department, they too turned her away, saying her condition wasn't life threatening or an emergency, that if she wanted healthcare, she would have to pay. J is destitute.

Left untreated, insulin dependent diabetes can lead to circulatory problems so severe that amputations become necessary. It can cause blindness, cataracts and retinopathy and miscarriage or stillbirth for pregnant women. Ultimately, untreated diabetes can cause renal failure and death.[28] With minimal care and treatment, diabetes can be controlled, and these devastating consequences avoided.

Trauma recovery

Six of the people we worked with needed treatment for injuries sustained both in the UK and in their country of origin.

K is a Zimbawean who sustained multiple leg and hip fractures in a recent car accident. He experiences acute pain, needs physiotherapy and may need bone grafts in the future. He was charged £4,572 for his emergency treatment, and told that if he wants physiotherapy or other treatments, he will need to pay. K is on Section 4 support on the grounds that the Government accepts he is too unwell to travel.

L is an Eritrean man and a survivor of torture. He was given poor quality treatment after a serious road accident 14 years ago. He is a wheelchair user, and experiences significant spasming and pain. He wants to be able to walk again. His GP tried to refer him to a specialist spinal injuries unit, who refused to treat him without payment. L is destitute.

M is a Ugandan woman. After being raped, she was experiencing serious abdominal pains and bleeding. She came to us after both her GP and her local trust had turned her away.

General operations

Four clients came to us who had had or needed operations for a range of conditions. One had been charged more than £66,000 for his care, another charged £145 for a consultation where he was told he needed an operation, but could only have it if he paid for it. Another man, from the former Yugoslavia, managed to raise the money for his operation from members of his community, but when the operation went wrong, and he needed aftercare, was told that he would have to wait until his condition deteriorated to the point he needed emergency care, or pay. Two of these four clients were living on Section 4 support on the grounds that the Government accepts that they are too unwell to travel.

Communicable diseases

Many communicable diseases are exempt from charging in order to protect public health. Thirty four communicable diseases are specifically listed in the regulations and in addition all treatment given in or on the basis of a referral from a sexually transmitted diseases clinic is also free of charge. One important exception to this rule is HIV/AIDs, where initial testing and counselling is free, but treatment is chargeable. Two people came to the Refugee Council:

N is an Eritrean man who tested positive for HIV after his appeal rights were exhausted. His trust have refused to prescribe him anti-retroviral therapies unless he is able to pay.

O is a Zimbabwean woman with cancer and possible HIV infection from her husband who died of AIDs. Her Trust denied her cancer care, and offered to test her but not treat her, for HIV.

28 www.nhsdirect.nhs.uk/articles/article.aspx?articleId=128&sectionId=15589

Not only is it inhumane to diagnose but not treat HIV, it also undermines the Government's commitment to managing the spread and effects of HIV worldwide.[29]

29 Ainsworth, Dr J. Anderson, Dr J. Gazzard, Prof. B. Wood, Dr. C. (2004). Treat with Respect HIV, Public Health and Immigration. [Internet] Available at: www.ukcoalition.org/migration/HIV-Treat_With_Respect1.pdf [Accessed 01 March 2006]

Implementing the regulations

During the consultation on the new regulations, they were strongly opposed by the medical profession partly on the basis that clinicians had an ethical duty to provide care, and therefore could not be involved in turning away sick patients who are too poor to pay. The Government's response was to make it clear that the clinicians' only responsibility would be to refer people they suspected of being liable to charging to the overseas visitor managers for assessment.

Although it is easy to understand why doctors and nurses refused to participate in a practice which is in conflict with their own professional ethics, the practical effect of this system has been to allow clinicians to deny care. Overseas visitors mangers and trust finance departments are thus free to pursue debts without taking any account of the situation or vulnerability of the patients.

Common sense might dictate that where dealing with refused asylum seekers, who are almost certain to be living in poverty or are destitute, trusts might take a more lenient approach. However, evidence from our casework suggests that these clients are pursued with vigour, as the following extracts from charging letters indicate:

> "Failure to respond to this letter before (DATE) will result in this matter being transferred to (DEBT COLLECTION AGENCY) who will take all necessary steps including litigation to recover this debt".

> "Your account with us is now seriously overdue for payment and we now request immediate settlement of the stated amount … if we do not receive a response from you within 7 days, you will leave us with no other option than to begin legal proceedings to recover this debt".

> "If we do not hear from you by (date) invoices will be issued to you for the full amount chargeable for your confinement and subsequent care. Any unpaid invoices are registered with Debt Agencies, and this information is available to the Home Office, who can then prevent re-entry into the UK".

All of these letters were sent to people who are destitute with no source of income at all, or to people supported under Section 4, which provides voucher support and no cash. Many asylum seekers will be unable to understand either the letters or the implications of non-payment. Someone who has grown up in the UK with access to the NHS, and to a robust legal system protecting their human rights, might assume that no terrible consequences would flow from refusing to pay their healthcare bill. Someone who has grown up in Eritrea, or Zimbabwe, or China, might be very frightened indeed to receive threatening letters from state agencies: perhaps frightened enough to go underground, as some of our clients did.

Even with the support of organisations such as Refugee Council, it is extremely difficult to get trusts to use their discretion and treat patients who are desperate for care. In some cases, despite repeated calls from our specialist health worker to the Trust in question, and to the Department of Health, we were unable to get our clients treated without paying in advance.

A tiny minority of patients are able to find lawyers to take up their cases, as illustrated

by the following case studies, kindly provided to us by Pierce Glynn Solicitors:

P is a failed Somali asylum seeker in her 20's who was referred to us by the Red Cross in February of 2005. She had been refused maternity services including ante-natal care by the Barking, Havering & Redbridge Hospital NHS Trust. They had advised her that they would charge her for the delivery of her baby who was due in May 2005. P had been referred to the local hospital for ante-natal treatment and had a particular need for treatment due to complications in her first pregnancy (she has a 2-year-old son) because her son had to be induced 10 days after the expected date of confinement. We sent a letter threatening court action to the NHS Trust pointing out that since our client was now 6 months' pregnant and had received no ante-natal treatment, we considered that they were placing her and her child at risk violating Article 3 and 8 of the Human Rights Convention. We requested a scan and blood pressure checks. We later pointed out that the Department of Health Guidance on Charges for Overseas Visitors specifically states that maternity services should not be refused because of the risk of infant mortality due to pre-eclampsia. Although the Trust then agreed to provide maternity care and not to pursue our client's treatment, she continued to receive invoices for the delivery and maternity services of £2,100 at a time when she was 8 months pregnant and found this very distressing. As we had explained to the Trust in our letter before action, P was in receipt of NASS Section 4 support which is supermarket vouchers only of £70 per week for her and her son so she was not in any position to pay for maternity services.

Q was a Chinese refused asylum seeker in her 20s who was referred to us by the Refugee Council. She was informed by the same health trust that she must pay £2,300 to cover maternity treatment. In the late stages of her pregnancy, she became ill due to hepatitis and was afraid that she might lose the baby. As a result, the father of her child who was working on a low income borrowed two amounts of money, firstly £360 and then £800 in order to cover the delivery. The overseas visitors patient manager, threatened to contact the Home Office about her case and in fact contacted her GP as a result of which her GP refused to continue treating her. After the birth, she continued to receive invoices. It was only at this stage that she was referred to us and asked for our help because her child's father was under pressure from those who had lent him the money to repay it. She was also very frightened that the health trust might take action to enforce the outstanding debt. She had no income at all except for some food and rent payments made by the father of her child and was due to be evicted from her private rented accommodation.

We have made a formal complaint to the NHS trust in particular about the breach of confidentiality which resulted in her losing access to primary care even though the rules about primary care are different from those relating to hospital treatment and the GP had discretion to continue treating her. As a result of the Trust action, she lost her GP at a crucial time since her hepatitis status means that her child needs regular check-ups.

A more humane approach would be that healthcare providers would use their discretion when applying the charging regulations. Our experience suggests that trusts commonly apply the regulations without regard to the poverty or vulnerability of the patient, and that they will often defend this decision in the face of professional advocacy by NGOs, and even legal action.

Access to primary care

Finally, there is some evidence that the regulations are having unintended impacts on access to primary care services, making it even harder for failed asylum seekers to get even basic care.

Although refused asylum seekers are entitled to free primary healthcare, accessing that care in practice can be challenging in the extreme. Language barriers make it hard for people to get the care they need,[30] with this problem particularly acute for people with mental health problems (Woodhead: 2000).

Lack of interpreting services means family members are sometimes used, causing misinterpretation, embarrassment and lack of disclosure, particularly amongst women (Heptinstall; 2004).

Even registering with a GP can be difficult, because of closed lists and lack of entitlement knowledge by staff. Practices in some areas lack the resources to deal with time-consuming assessments with an added language barrier, so will refuse to provide services. This can be made worse by prejudice amongst frontline staff (Cowen: 2003).

From our health casework, there are indications that misinterpretation of the charging regulations is causing more and more surgeries to turn people away, as the examples below illustrate.

> R is a Somali woman with high blood pressure. She was turned away by her GP practice and told that as a refused asylum seeker, she would have to pay £45 for an appointment and her regular prescription.

> S is an Iranian woman with depression relating to the recent death of her husband. Although her asylum claim had been refused, her husband had been granted refugee status prior to his death. S's doctor refused to see her or prescribe her regular anti-depressants unless she paid.

Not only are the regulations preventing desperately ill people getting the help they need, it appears they are also preventing people getting the care they are entitled to.

30 Coker, N. (2001). Asylum Seekers' and refugees' health experience. [Internet] Health Care UK: London. Available at: www.kingsfund.org.uk/applications/site_search/search.rm?term=refugee+children&searchreferer_id=1 [Accessed 16 March 2006]

Conclusions and recommendations

The first core principle of the NHS is:

> **The NHS will provide a universal service for all based on clinical need, not ability to pay. Healthcare is a basic human right. Unlike private systems, the NHS will not exclude people because of their health status or ability to pay.**
>
> *NHS Core Principles*
> *www.nhs.uk/England/AboutTheNhs/CorePrinciples.cmsx*
> *(Accessed 05 June 2006)*

When the NHS was founded, universal access to free treatment was seen as the only way to make sure that the poor and disenfranchised got the care they needed. Today, we are turning away some of the most vulnerable and impoverished people in the UK to suffer and in some cases to die. We are violating that "basic human right" and we are excluding people because of their inability to pay.

Refugee Council calls on the Department of Health to:

• Amend the NHS Charges to Overseas Visitors Regulations 1989, and the NHS (Charges to Overseas Visitors) (Amendment) Regulation 2004 to specifically exclude asylum seekers whose claims have been refused from liability to pay.

• Issue guidance to all Primary Care Trusts, NHS Trusts and Foundation Trusts making it clear that asylum seekers whose claims have been refused are entitled to both primary and secondary healthcare.

• Issue guidance to all primary care trusts, NHS trusts and foundation trusts requiring them to monitor the outcomes of all charging decisions made by the overseas visitors managers.

• Support primary care trusts, NHS trusts and foundation trusts to make their services fully accessible to refugees, asylum seekers and asylum seekers whose claims have been refused.

We call on the Health Select Committee to:

• Conduct an enquiry into the impact that the NHS Charges to Overseas Visitors Regulations 1989, and the NHS (Charges to Overseas Visitors) (Amendment) Regulation 2004 are having on access to healthcare for asylum seekers whose claims have been refused and other vulnerable migrants.

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