mrn migrants' rights network
working for the rights of all migrants

DOCTORS OF THE WORLD

pierce glynn

Access to Primary Health Care for migrants is a right worth defending

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- The rules on eligibility to primary and secondary health care are fundamentally different
- Nobody can lawfully be prevented from accessing GP services because of their immigration status
- Some migrants can be charged for some hospital treatments

JANE'S STORY

> *"You're an illegal, so you are not entitled to NHS treatment. If you need treatment you'll have to pay for it privately or go to Urgent Care Centre or A&E, and your details will be passed to our Counter-Fraud team and the Home Office."*

It was the third time that Jane, 26 weeks pregnant and feeling unwell, had received this response when she tried to register with a local GP[1].

Jane returned to her sister's flat, and her brother-in-law contacted the local Primary Care Trust (PCT). They said the GP surgery were right, Jane could not access primary care unless she had 'leave to remain' in the UK for more than 6 months. He explained to Jane that they could not afford to pay for private treatment during her pregnancy, but would try to secure a loan in order to pay for the delivery. Jane decided that she could not risk enforced removal from the UK to her war-torn country of origin, so she decided to avoid further contact with the authorities and give birth to her baby at home.

Will Jane end up in the A&E department suffering from complications that her GP could have identified during routine antenatal screening? Will her baby be born with a low birth weight, and therefore likely to suffer poor health later in life? **Sadly, the answers may depend on whether Jane seeks legal advice, because the GP and PCT are acting unlawfully.**

ELIGIBILITY FOR NHS CARE

The NHS is not a "public fund" as defined by the "recourse to public funds rules". No law or regulation exists that restricts a patients' right to access primary health care services because of their immigration status. Jane could therefore consider suing because any policy that links residency status

with eligibility for primary care would be in breach of the Secretary of State's fundamental duty to provide NHS services free of charge unless otherwise legislated[2].

Secondary Care Regulations

The law on eligibility to primary and secondary care are different. Section 175 NHS Act 2006 empowers the Secretary of State for Health to make Regulations to charge some people who are not ordinarily resident in the UK for some hospital treatments. The rules on '6 or 12 months residence', 'lawful residence', 'settled status' etc. follow from section 175 and only apply to secondary care. Eligibility for free primary care is unaffected by these regulations.

Primary Care Regulations

There is no law excluding anyone from primary care, and therefore immigration status and 'ordinary residence' are irrelevant when registering with a GP. There is no legislation, statutory guidance, or case law suggesting that people must be 'resident' for any length of time, or have a visa etc. The only relevant pieces of legislation are the GMS Contracts and PMS Services Regulations[3], which govern the delivery of NHS primary medical services.

Any attempt by the PCT to interfere with a GPs' discretion to register Jane as a patient, would be a breach of the GMS/PMS Regulations. The PCT's policy that GPs should refuse to register people because of their immigration status, is unlawful. Their advice to the public that eligibility depends on immigration status is also unlawful, and places the PCT in breach of its statutory duty to procure primary care services to all people in its area[4].

Unfortunately, Jane's PCT is not the only one providing delinquent advice to GPs. Over two thirds of PCT's in London[5] have issued guidance to GPs that is incompatible with their legal obligations. Many PCT's advise GP's they should only register people living legally in the UK for more than six months', but this is wrong as the 'ordinarily resident' test applies only to hospital services.

The rules are simple. GPs have complete discretion to register whomever they wish. The GMS\PMS regulations do allow GPs to refuse to register someone on reasonable grounds (e.g. the patient is not living in the GPs catchment area, or their list is closed). However, they must not discriminate by refusing to register on grounds of health status, race, gender, sexual orientation, social class etc.

Upholding the Law

Based on poor guidance from their PCT's many GP practices demand proof of immigration status along with proof of residence before they will register some patients. As immigration status does not affect eligibility to primary care, GPs have no reason to establish immigration status.

By refusing to register Jane as a patient because of her immigration status, the GP imposed arbitrary criteria that are unlawful, unethical, and probably in breach of the GMS/PMS Regulations. Moreover, by linking eligibility with immigration status, the GP is utilising administrative arrangements that probably breach the Equalities Act 2010 provisions on indirect discrimination. Jane could therefore seek redress, including compensation for any adverse impact the refusal of treatment has on her and her baby's health, through the courts. She could also refer her GP to the General Medical Council (GMC), which regulates Doctor's in the UK.

Data Protection

If the GP or PCT did pass Jane's information to the home office, they would be in breach of the NHS Constitution and may have committed a criminal offence.

The UK Border Agency (UKBA) has contacted PCT's and GPs to inform them, incorrectly, that a specific patient is 'not entitled to NHS treatment'. Some GPs have acted on this false information, wrongly removed people from their lists, and then had to reinstate them.

In recent times, there have been a number of incidents where the UKBA have asked for patients' details, citing an exemption to Data Protection Act that authorizes disclosure where it is necessary to prevent crime or apprehend offenders. A GP or PCT would have to be satisfied that the requested information was necessary for the prevention of a specified (and sufficiently serious) crime to justify disclosure. They are unlikely to be able to disclose information lawfully without seeing legal documents to support the UKBA request. Even then, they would need to consider the competing public interest of maintaining trust in the confidentiality of medical records and personal data, as specified in the NHS Constitution. Therefore, if the GP or PCT did pass on her personal details to the UKBA, Jane could probably sue them for breach of the Data Protection Act.

EXCLUSION IS A BAD IDEA

Like Jane, thousands of migrants across the UK are facing unlawful restrictions on their access to primary care. As the NHS faces up to the realities of having to find £20 billion efficiency savings, calls to further restrict migrants' access to free NHS services, are growing. We can reduce costs to the taxpayer and improve services if we stop "illegal immigrants abusing our NHS", is the claim.

Demands to exclude migrants from the NHS are not simply the result of the financial crisis; they have been around as long as the NHS has existed. As Nye Bevan explained when he created the NHS - "*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… The whole agitation has a nasty taste. Instead of rejoicing at the*

opportunity to practice a civilized principle, Conservatives have tried to exploit the most disreputable emotions in this among many other attempts to discredit socialized medicine[6]."

Moreover, the evidence suggests that excluding migrants will increase costs, leave all of us at greater risk of ill health, and undermine the integrity of the NHS[7].

Economics

Current estimates suggest there are up to 725,000 undocumented migrants in the UK[8], or just over 1% of the total population. If these migrants consume NHS resources like the rest of the population, then they would consume a little over £1% of the total NHS Budget of £120 Billion, or just over a £1 billion per year. However, we know that undocumented migrants do not consume NHS resources in same way as the rest of the population.

On average, over a quarter of all the health care someone consumes in their lifetime they will consume in the last year of their life[9]. Most migrants are young, have good health[10], tend to make less use of NHS services[11], and have little impact on demand for health care[12]. Moreover, all migrants face particular problems accessing health care due to language barriers, lack of knowledge of the NHS, institutional racism, and the lack of cultural competence of NHS systems and staff[13]. These barriers are often insurmountable for undocumented migrants. Therefore, it is likely that the actual cost of treating undocumented migrants' will be significantly less than the cost of missed NHS appointments[14].

There are also additional costs associated with clinicians' spending time explaining and assessing eligibility, and administrative costs of checking documents etc. The evidence shows that even in a very high migrant area, the numbers of undocumented migrants using primary care is low and the costs of administration will probably exceed the income derived from charges[15].

Whatever the cost of treating undocumented migrants, the cost of not treating them may be higher as there is a strong economic foundation to the medical adage that prevention is better than cure. The cost of treating a neglected condition in an emergency setting will usually exceed the cost of preventative or maintenance treatment. Poor access results in late presentation for many conditions, including cancer, that then require more expensive and often less effective treatments, resulting in increased costs and unnecessary deaths. A visit to A&E costs three times more than a visit to a GP. One admission to intensive care for a patient with HIV-related pneumonia costs as much as two years of antiretroviral treatment[16].

Public Health

By refusing to register Jane as a patient, the GP and PCT are preventing her from accessing a range of screening, immunization, and health promotion services, which will probably have severe consequences for Jane and her baby. They are also putting the wider community at risk, because public health surveillance and protection in the UK depends on the NHS to manage infectious and communicable diseases.

The MMR vaccine helps to protect our children, in part, by establishing herd immunity. The decline in the take-up of MMR following ill-founded concerns about possible links with autism resulted in a measles epidemic. An epidemic that illustrates the risks to everyone if there is a break down in universal health care.

How can there be an effective emergency plan to combat a flu-pandemic, if we exclude hundreds of thousands of people from the arrangements? Excluding migrants from the NHS might satisfy prejudice, but as viruses do not discriminate, it will leave all of us at greater risk when the next measles epidemic or flu-pandemic strikes.

Restricting access to primary care will prevent the NHS from being able to diagnose and treat communicable diseases such as TB in a vulnerable section of the population. Limiting the availability of treatment to symptomatic patients in A&E departments, will mean that they will only receive treatment to stabilise rather than cure their condition. This will increase the probability of the evolution of drug resistant infections. In addition, it will help create backstreet health services outside the NHS regulatory framework, where unscrupulous practitioners will exploit a new market of vulnerable people. Unregulated health services will also help facilitate the evolution of drug resistant infections, and place additional demands on the NHS emergency services that will ultimately have to deal with the medical consequences when things go wrong.

Social Cohesion

Restricting migrant's access to health care, not only undermines the public health; it also undermines the social inclusion strategies needed to reduce health inequalities[17].

Our social environment is a powerful determinant of our health and on almost every index, there is a correlation between inequality and poor health and social problems, which is too strong to be attributable to chance. Relative poverty, low social status, and weak social affiliations explain most variations in health inequalities in industrialised countries and correlate with a range of social problems, from homicide to teenage pregnancy[18]. Therefore, condemning thousands of people to absolute poverty, and then excluding them from the one of the few national institution most Briton's still respect would be a folly of epic proportions.

PROTECTING THE NHS

Restricting migrants' access to primary health care is unlawful, uneconomic, and unhealthy. Moreover, it could undermine the foundations of our NHS.

Privatisation

If GP's have to identify and charge some patients for services, they will have an incentive and capacity to offer private treatments to other patients. GP Practices are businesses that want to maximise their income. If they have to invest in a system to charge some patients, why not use the system to offer additional services for patients able and willing to pay. Exclusion could prove to be yet another vehicle for the creeping privatisation of our NHS.

Increased Bureaucracy

If you want to separate the sheep from the goats both must be classified, and GP's will need to recruit new model army of bureaucrats to administer the system. The creation of a new bureaucracy to check eligibility for free care will make accessing GP's services a major inconvenience for everybody. The process for determining any individual's immigration status is complex and time consuming. Any GP that requests proof of immigration status will need to demonstrate that their actions are not discriminatory. They would therefore need to check the immigration status of every patient seeking to register with their practice and every patient attending for an appointment. An NHS number or previous GP registration would not be sufficient, because an individual's immigration status may change over time.

Institutional Racism

The new model bureaucracy will generate a culture of suspicion around eligibility that will inevitably focus on Mrs Patel rather than Mr Peters. There is substantial evidence that the poor health outcomes for established Black and Minority Ethnic (BME) communities are associated to the barriers to accessing health care they face, including institutional racism in the NHS[19]. Suspicion of eligibility will intensify these barriers, making BME communities access to the NHS a continuous struggle with 'institutional racism gone mad'.

Ethics

Excluding people because of their immigration status, establishes non-clinical criteria for rationing health care. Today we exclude the undocumented migrants, tomorrow the feckless welfare mother, or binge drinking child. The next day it is whomever else the Sun or Daily Mail decides is unworthy of

our generosity. Such an approach is ethically bankrupt. There is no crime in UK law that is punishable by the denial of health care. Every day we ask our Doctors and nurses to care for mass murderers, paedophiles, and rapists. Is having the wrong passport or visa such a heinous crime that doctors should treat its perpetrators worse than they would a mass murderer?

Many GP leaders have expressed concerns about the ethical implications of refusing to treat people because of their immigration status and argue that the extension of internal immigration controls into primary care would be incompatible with the GMC code of professional ethics[20]. It would certainly be incompatible with the World Medical Assembly Declaration on the Rights of the Patient, which states, "*Every person is entitled without discrimination to appropriate medical care… (and) physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them.*"

RESISTANCE

Before the politicians and bureaucrats start to change the current system let us remind them that Nye Bevan's civilised principle of universal health care free at the point of need remains the best prescription for a healthy society.

Up-Hold the Law

Migrant's rights campaigners and advocates need to make greater use of the law to ensure that GPs do not deny migrants access to primary care. The law is simple. Immigration status is not a criterion for eligibility to primary care. Any GP or PCT that suggests that it is, are acting unlawfully and unethically. Challenging them in the courts, and where possible suing for damages, will help GPs understand that costs of unlawful discrimination can be very high. Although undocumented migrants may be reluctant to seek redress through the courts, legal action by any migrant or asylum seeker refused the right to register with a GP, will help reinforce the principle of universal access and discourage unlawful discrimination against undocumented migrants.

Advocacy Skills

To ensure you are able to represent migrants effectively when dealing with GP registrations, training and support are available from Doctors of the World UK[21] (http://bit.ly/gCGOkn).

Campaign for the NHS

There are campaigns in opposition to the Governments' proposals to restructure the NHS springing up across the UK. Migrant and refugee rights groups need to be active in support of these campaigns to ensure that the principle of universal access, including access for undocumented migrants, is part of the campaign agenda – www.nhscampaign.org

Build Alliances

Many GPs and other health care professionals are themselves migrants and the NHS could not function without them. Many more health professionals will try to maintain their ethical duty to their patients whatever the circumstances. Campaigners need to build alliances with these professionals. As a first step, campaigners could approach their local GPs and other clinicians to ask them to sign the European Declaration of Health Professionals – Towards non-discriminatory access to health care[22] (http://bit.ly/huma-petition).

Wayne Farah – Chair, Migrants' Rights Network
Adam Hundt - Pierce Glynn Solicitor
Fizza Qureshi - Doctors of the World UK

[1] Jane's story is based on a real case

[2] Regulation 3(7) NHS (Functions of Strategic Health Authorities & Primary Care Trusts & Administrative Arrangements) (England) Regulations 2002

[3] Paragraph 17, Schedule 6 NHS (GMS Contracts) Regulations 2004 & paragraph 16, Schedule 5 NHS (PMS Agreements) Regulations 2004

[4] Regulation 3(7) NHS (Functions of Strategic Health Authorities & Primary Care Trusts & Administrative Arrangements) England - Regulations 2002

[5] Miller-Sprafke, R and Qureshi, F (2010) Mystery Shopper Exercise for NHS London PCT's

[6] Aneurian Bevan (1952) In Place of Fear (p 80-81)1 Heinemann London

[7] Hargreaves S et al (2006) The identification and charging of Overseas Visitors at NHS services in Newham: a Consultation, Newham PCT, London

[8] Dr Ben Gidley and Dr Hiranthi Jayaweera (July 2010) An evidence base on migration and integration in London, ESRC University of Oxford

[9] http://tutor2u.net/economics/revision-notes/as-marketfailure-health-care.html

[10] M RD Johnson, 'Integration of new migrants: health' in S Spencer (ed.), Refugees and other new migrants: a review of the evidence on successful approaches to integration, COMPAS/Home Office, 2006, p 57

[11] http://www.bbc.co.uk/news/uk-england-norfolk-11994931

[12] Audit Commission, 2007, Crossing Borders: Responding to the local challenges of migrant workers, Public Services National report, London: Audit Commission

[13] Dr Ben Gidley and Dr Hiranthi Jayaweera (July 2010) An evidence base on migration and integration in London,

[14] In 2008, patients failed to turn up for over six million hospital appointments, 911,000 GP consultations and 264,000 practice nurse appointments, at a cost to the NHS of almost three quarters of a billion pounds http://www.medicalnewstoday.com/articles/12446.php & http://www.telegraph.co.uk/news/uknews/3322736/Missed-appointments-cost-NHS-575m-a-year.html . If we want a more efficient and accessible NHS, we do not need to leave Jane and her baby without health care, we just need to turn up for our appointments.

[15] Hargreaves S et al (2008) Charging Systems for Migrants in Primary Care: The Experiences of Family Doctors in a High-Migrant Area of London (p 13-18), Journal of Travel Medicine

[16] House of Commons Health Committee. 2005. New Developments in Sexual Health and HIV/AIDS Policy: Third Report of Session 2004-05: Volume 1, House of Commons London: The Stationery Office Limited

[17] Roman Romero-Ortuño, Access to health care for illegal immigrants in the EU: should we be concerned? European Journal of Health Law, September 2004, vol. 11, no. 3, pp. 245-272

[18] Richard Wilkinson and Kate Pickett (2009) 'The Spirit Level : Why More Equal Societies Almost Always Do Better Allen La

[19] John Reid and Trevor Phillips (2004) The Best Intentions? Race, equity, and delivering today's NHS. Fabian Ideas 611. London

[20] General Medical Council Good Medical Practice Code of Ethics (2006), paragraph 11.

[21] http://www.doctorsoftheworld.org.uk/lib/docs/131212-accesstohcworkshopflyer-13oct09.pdf

[22] http://www.huma-network.org/Petitions/European-Declaration-of-health-pro-fessionals-Towards-non-discriminatory-access-to-health-care