

# Health Service Journal

## Médecins Sans Frontières?

Published: 17 March 2008 09:00

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### **There are conflicting approaches to providing NHS care to those not entitled to it, and the charity Médecins du Monde is at the front line of the battle. Mark Gould reports**

For the past two years the international aid organisation Médecins du Monde has cared for hundreds of asylum seekers who would otherwise go untreated. But this is not in Ethiopia or Sudan.

Médecins du Monde's relief centre is in a nondescript church extension in the East End of London, behind an undertaker's briefly famous for the Hollywood-style funeral of Reggie Kray. The church's location has historical resonance: over 20 years ago it provided refuge for hundreds of Bangladeshi asylum seekers fleeing political unrest.

The organisation set up the scheme Project London in 2006 because it felt there was a need to provide immediate basic medical care via a team of volunteer GPs and nurses, and to help illegal immigrants, asylum seekers or others whose residency status is uncertain to get access to mainstream NHS care.

The work is a political minefield. Some pundits accuse the organisation of aiding and abetting "health tourism" by those who simply want to plunder the NHS.

The Home Office says there are 310,000-530,000 "irregular migrants" (people without the legal right to stay in the UK) in England. Since a change in the law in 2004, they have only been eligible for NHS care in the forms of emergency hospital care, family planning, sexual health services and treatment for notifiable diseases such as HIV and tuberculosis. Access to primary care is at the discretion of GPs.

Any other treatment must be paid for and most trusts have dedicated teams who bill overseas visitors and chase payment - with varying degrees of success.

At present GPs can decide whether they accept irregular migrants onto their patient lists. But Médecins du Monde and others have told *HSJ* they expect this discretionary clause to be scrapped in favour of a ban on all but emergency care for anyone who cannot prove they are "ordinarily resident" in the UK.

Charities including Médecins du Monde are planning a UK and European legal fight against any changes. They say the plans will backfire, flooding accident and emergency and walk-in centres with people unable to get medical help elsewhere. And Médecins du Monde says it has evidence that "irregular migrants" are not currently sucking the NHS dry.

An analysis of the charity's work in 2006, its first full year in the UK, concludes that all these patients want is basic GP services and that providing them would have positive results in terms of fewer hospital admissions and a reduction in infectious diseases such as TB and HIV.

### **Abused at every level**

Project London saw 246 patients during 2006. While psychological illness was more common, the health problems seen were "broadly reflective" of a mainstream GP caseload. Just 44 patients were given prescriptions for medications. The charity's UK director Susan Wright is emphatic about the message this sends to policy makers.

"Our report totally refutes the idea of health tourism. Our clients didn't have any conditions that were not run of the mill in the general population. Our message to the NHS and GPs is that accepting this group will not overwhelm you if you have a good system in place and give it a bit of thought."

She says Project London's clients are people who are "abused at every level".

"They work in the cash-only world of childminding, babysitting and cleaning; they have no work rights or guarantees of basic working conditions. Many are slaves of the people they work for."

Ms Wright says current regulations encourage people to shy away from getting help. "Many people with TB may also have HIV. The NHS offers screening for both conditions yet it will only pay for medication to treat TB. What sort of incentive is that to come forward for screening?"

The charity says the government approach is wrong-headed when the World Health Organisation is calling for concerted Europe-wide policies on treating the most infectious conditions such as HIV and TB.

The number of Project London patients needing further help is small. Only 64 needed help to access hospital care. Of the 64, 25 were pregnant and needed support to access antenatal care, nine wanted a termination and six were referred to a TB clinic. But eight turned away when told they would be charged and six did not have a GP so could not get a referral. A further six were referred to a debt advice agency for help in dealing with NHS hospital charges.

Ms Wright describes some genuinely tragic cases, such as a Turkish man with cancer who needed urgent surgery to prevent it spreading. As his request for asylum had been refused, he was told he would not get any more NHS treatment unless he could pay a £6,000 deposit.

"More than a year later, he was admitted to hospital for emergency surgery. By that time, his mental health had deteriorated so much that he was admitted to an NHS psychiatric ward for several weeks and that cost far exceeded the cost of the surgery that had been initially refused," she says.

Another man, also an asylum seeker who had been refused, came to the project suffering from leukaemia. Because of his status, he was refused drug treatment which could have prevented the condition from worsening.

He told the project: "When I first went to hospital in June 2006, the doctors treated me well but they released me suddenly. I couldn't understand this. This country respects human rights, but they chased me out.

"They found out I was a refused asylum seeker, but I didn't know this because I never received the letter. I am scared of going back to my country because they could send me to prison for several months. I am not sure I would get medical treatment."

A year later, the man had to be admitted to hospital for emergency radiotherapy. Since it was too late to reverse the course of the cancer, the treatment options were very limited. He was given palliative pain relief, stabilised sufficiently to be safe to travel and given an airline ticket home.

Project London medical director Isabelle Raymond says nobody has abused it. "Patients seen so far came for one or two consultations and then we contacted them by phone to see if they needed more support.

"We sometimes negotiate with GPs who may need proof of address or some other ID. Proof of address is so difficult for people in temporary accommodation. There are no bills or tenancy agreements; no proof of address. ID is a direct barrier, as more and more surgeries are asking for passports. Sometimes GPs say go to the primary care trust and the PCT says no, go to the GP, and the patient keeps bouncing back and forth."

Think tank the Institute for Public Policy Research is also opposed to restrictions on access to primary care. "We would be concerned purely from a human rights point of view," says senior research fellow Jill Rutter. "Primary healthcare is a basic human right. There is also a danger that denying relatively cheap primary healthcare will result in more costly emergency admissions."

The Refugee Council says it is worried about "a relatively small number of people" who need NHS help after their claim for asylum is rejected, only to discover they are ineligible.

"These are the most needy: some are destitute and some may have suffered torture or been raped and sexually abused. If they are denied access to GP services as well as non-urgent secondary care, all you are

going to see is more people clogging up A&E when they become very unwell and there has got to be a simple economic argument against that," says a spokeswoman.

She adds that in the drive to generate income, the NHS is using tactics that are pushing the most needy people away. "One woman we know of went for her first pregnancy scan and was later charged something like £1,000 and bailiffs harassed her for it."

### **Soft touch**

Although restrictions on numbers of people claiming asylum, additional taxes for migrants and the idea of "earned citizenship" all point to a tougher line on illegal immigrants, there have long been concerns that the envied universality of the NHS could leave it open to being seen as a soft touch. The latest policy rethink dates back to 2004, following media concerns generated by some right-of-centre think tanks and politicians that waves of health tourists could swamp the NHS.

Back then the Home Office pressured the Department of Health into a consultation examining proposals to exclude illegal migrants from access to anything but emergency care.

The findings of the consultation have never been made public, despite several Freedom of Information Act requests. HSJ understands that the DH resisted pressure to ban access to primary care and there was also leeway on allowing treatment for notifiable diseases such as HIV and TB, family planning and sexual health, given their public health implications.

The DH admits that the consultation response was "divided" and highlighted links between a range of complex and sensitive issues, including asylum, migration, citizenship, public health, identity cards and equality.

In March 2007, the Home Office published *Enforcing the Rules*, a strategy to ensure compliance with immigration laws across security, housing, health, employment and education.

The strategy revealed that since 2005, three NHS trusts have been involved in a project that allows managers instant access to an individual's immigration status. Ineligible patients are told they must pay for treatment up front or be stabilised and discharged (see box below).

The DH and Home Office have just completed another review of foreign nationals' access to NHS care. One insider says the review was nothing but cursory: "It consisted of phoning up a few key doctors, a debate among ministers and civil servants writing a briefing paper."

A DH spokeswoman says that the review hopes to set clear rules for primary care that it is hoped will be consistent with the rules for secondary care. It will be completed shortly and a public consultation will follow. The review will take into account the responses to the 2004 consultation and is committed to ensuring that any new rules are fair to both UK citizens and foreign nationals, offer value for money and can be implemented effectively in primary care settings," she said. "In relation to secondary care, the review will focus on specific issues which have arisen since the NHS (Charges to Overseas Visitors) Regulations 1989 were amended in 2004, including the position of failed asylum seekers, asylum-seeking children and the UK's obligations under international law."

Without commenting on whether a primary care ban would follow, she added that a programme of communication and good practice to help the NHS implement any new rules flowing from this review would be completed by September. "Any new rules will take into account the key preventive and public health role of NHS primary medical care as well as international law and humanitarian principles," she said.

### **Stabilise and Discharge: no-nonsense policy**

Many people from India, Pakistan, Afghanistan and Iraq know that they are not very welcome at West Middlesex University Hospital trust, says income generation manager Andy Finlay. The trust is one of three operating an immigration and nationality directorate pilot scheme, which gives an instant verdict on those whose eligibility for the NHS is uncertain.

A PowerPoint presentation used by Mr Finlay makes clear what he feels is the motivation behind the scheme.

"Many patients identified as overseas visitors are under the impression their treatment is free if they go to accident and emergency. Many are in the UK expressly for 'free' treatment, many are coached by their relatives to lie about their real status to admin staff, but many will not lie to the treating clinician, as it may affect their care."

The trust works on the basis that if an overseas patient is discharged before they pay for treatment, it is very hard to get the money they are deemed to owe.

Given its proximity to Heathrow and as a result of new partnerships being developed under the cross-government Securing Our Borders initiative, the trust developed Stabilise and Discharge, a scheme in which three consultants decide whether a non-NHS patient is well enough to leave.

In practice, this means that where their status is illegal, if they can be stabilised, they will then be given two days in which to leave or be presented with a bill. However, where patients literally cannot move, they are allowed to stay.

The trust has even gone to the High Court to defend its action when challenged. The two-day threshold by which such patients can leave without payment is vital in terms of NHS finance. Mr Finlay says that under payment by results, it means the trust is owed just 20 per cent of the national tariff.

"Some patients walk straight back in via A&E, but if they do, it generates income for us so long as we have the medical director's say-so that the patient was stabilised when we discharged them and they don't require further treatment in A&E."

Mr Finlay deals with six or seven cases a week and does not pull any punches: "People say to me: 'This is the NHS, you are a rich country, it's all free.' I explain it like this: 'Do you have a mobile phone? Is it pay as you go? Well, for you the NHS is the same: if you don't pay, you can't use it. We have all paid in taxes.'"

The trust has a secure fax line to the Home Office that gives a verdict on a patient within a day.

"In extreme cases we have had security escort people off the premises, but it's usually a whole-system approach. Nurses say, 'You are going to be discharged, get dressed' and people go."

He is angry with the present de facto system, which he feels wastes a lot of money. "A lot of people have a lawyer funded by the public purse fighting us, who are also funded by the public purse. The only people who win are the lawyers."

He does not think free access to primary care will ease the burden on hospitals. "A lot of people simply want to come to hospital anyway."

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