Dismantling and Reassembling Health Policy for Undocumented Migrants and Failed Asylum Seekers in the UK

David Flood
dcflood@umich.edu

MSc International Health Policy Dissertation
Department of Social Policy
London School of Economics

1 September 2008

THE LONDON SCHOOL
OF ECONOMICS AND
POLITICAL SCIENCE

The world has to be dismantled and re-assembled in order to be able to grasp, however clumsily, the experience of another.

John Berger and Jean Mohr, *A Seventh Man*[1]

TABLE OF CONTENTS

INTRODUCTION 1
Framework for analysis..... 2
1. MIGRATION AND HEALTH IN THE UK 2
Defining relevant migrant groups 2
Migrant characteristics..... 4
The NHS 5
2. POLICY OVERVIEW..... 6
Policy before 2003 6
Secondary care 7
Primary care 8
Latest developments..... 9
Policy vs. practicality..... 10
3. DISMANTLING: A POLICY THAT DOESN'T MAKE SENSE..... 11
Lack of evidence on cost impact..... 11
Lack of evidence on public health impact 15
Inconsistencies between global health and domestic health policy 15
Inconsistencies in state support..... 16
Inconsistencies in human rights interpretations 17
4. REASSEMBLING: MAKING SENSE OF A POLICY THAT DOESN'T MAKE SENSE. 18
The multiple streams approach 18
Multiple streams and charging regulations 20
CONCLUSION..... 23
APPENDICES 25
Appendix 1: Diseases exempt from charges..... 25
Appendix 2: Informal interviews conducted during the course of research 25
REFERENCES 27

INTRODUCTION

The debate over who is eligible to receive free health care under the UK's National Health Service (NHS) dates back to the system's founding. In his 1952 book *In Place of Fear*, published just four years after the NHS was established, the NHS's chief architect Aneurin Bevan wrote that the free treatment of foreign visitors had already lead to considerable criticism of the health service. Bevan was strongly in favor of an NHS that was universal and free at the point of delivery, but he posed the following question as devil's advocate: "Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues?"[2]

Bevan offered two answers to his own question. He first emphasized that visitors *do* contribute to national revenues when they consume certain commodities and pay expenditure taxes. In this essay, however, we are more interested in Bevan's second answer, which we will return to later. For now, it is enough to note that the UK witnessed wide transformations in the areas of immigration and health policy in the fifty years following the publication of Bevan's book. The UK's borders were opened, closed, and gradually opened again. The NHS underwent innumerable reforms, shifts in strategy, and structural reorganizations. Yet, through all of this, Bevan's vision of universality remained entrenched: Foreigners, especially those making a life in the UK, were allowed relatively unfettered access to the NHS.

In 2003, however, the historical position of free NHS care for foreign visitors abruptly changed, and certain groups began to be fully charged for NHS serices. Was this change reasonable and coherent? Why did a 55-year-old government stance shift almost overnight?

This essay will address the first question by arguing that the implementation of recent Department of Health (DH) policies charging undocumented migrants and failed asylum seekers

for NHS care does not reflect consistent, evidence-based policymaking. This is not to argue these policies themselves are *per se* “bad” or “good.” Rather, it is to say (1) it is unclear whether the policies alleviate or aggravate the problems they intend to address, and (2) the policies conflict with broader Department of Health and government positions. In short, as one stakeholder reflected to the author, regardless of one’s ideological stance on immigration and health, taking health care access away from undocumented migrants and failed asylum seekers is a policy that “just doesn’t make sense.”

The essay will address the second question by offering a theoretical model known as the “multiple-streams” approach to explain DH decision making. The overriding thesis is that examination of the policymaking process can reveal the root of inconsistent, unproven solutions. In essence, this task is “making sense of a policy that doesn’t make sense.”

Framework for analysis

This essay is structured in four sections. Sections 1 and 2 provide basic information on the issue of migration and health in the UK and give a review of domestic health policy for undocumented migrants and failed asylum seekers, respectively. Section 3 offers a policy critique. Section 4 applies the “multiple-streams” approach to this policy.

1. MIGRATION AND HEALTH IN THE UK

Defining relevant migrant groups

The three migrant groups this essay will examine are asylum-related individuals, undocumented migrants, and health tourists.

Asylum refers to the idea a foreign country can serve as an enclave of protection for people fleeing persecution in their home country. Individuals who flee their country to seek asylum may choose the UK as a destination for several key reasons, but there is very little

evidence they have detailed knowledge of entitlement to state benefits before arrival.[3] "Asylum seeker" refers to a person who has applied for asylum under the 1951 Geneva Refugee Convention but whose application has not been resolved. The term "refugee" denotes an individual whose asylum case has been accepted. Under the 1951 Convention, refugee status is conferred when there exists a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion."[4] The term "failed asylum seeker," or "refused asylum seeker," describes an asylum applicant whose claim is rejected and all appeals exhausted.

Most asylum seekers are not permitted to work in the UK. However, Section 95 of the 1999 Immigration and Asylum Act allows the state to provide support to destitute asylum seekers in the form of accommodation and cash disbursements set at 70% of the income support level for adults.[5] Government assistance for failed asylum seekers ceases 21 days after a final asylum decision is reached, at which point individuals are expected to return to their country of origin. In reality, many remain in the country, and the Home Office may wait months or even years to carry out the removal process.[6] There is thus a sizeable period of time in which failed asylum seekers live in the country yet are not entitled access to free NHS services.

Undocumented migrants, also referred to in the popular press and academic literature as "illegal," "irregular," or "unauthorized" immigrants, refer to those without legal status in the country. This situation arises when a person enters the country by evading border control, uses false documents upon arrival, overstays a visa, or remains in the UK as a failed asylum seeker.[7] (Therefore, all failed asylum seekers are usually considered undocumented migrants, but not all undocumented migrants are failed asylum seekers.) Undocumented migrants come to the UK for a multitude of economic, political, and social motivations.[7] In particular, economic difficulties in

developing countries make higher wages paid in the UK more attractive, and UK's demand for cheap workers helps fuel its hidden economy.[8,9]

Health tourists are individuals who come to the UK to exploit free NHS medical care. Unlike asylum-related individuals or undocumented migrants, "health tourists" does not describe an easily identifiable group, and the term has come to suggest a hodgepodge of cases ranging from the wealthy Egyptian businessman receiving free heart surgery[10] to the HIV-positive Sudanese refugee treated with free antiretroviral drugs.[11] As will be discussed later, many critics question the true extent of health tourism in the UK.

Migrant characteristics

Immigration to Britain since 1990 has been described by some commentators as the "emergence of super-diversity," reflecting not only expansions in the net number of people coming to the UK but also a dramatic diversification in the country of origin of these immigrants, their manner of UK entry, their reason for immigration, and their settlement patterns in Britain.[12,13] European Union (EU) enlargement has further opened labor markets and amplified migration flows: The wave of workers entering the country following 2004 EU expansion was the largest single immigration inflow on record to the British Isles.[14]

Ascertaining the numbers of undocumented migrants and failed asylum seekers living in the UK is difficult. Despite improved statistical techniques, little data is available, and illegal immigration by nature is impossible to quantify accurately.[15] The Home Office used the 2001 Census to extrapolate a central estimate of 430,000 undocumented migrants in the UK (range: 310,000 to 570,000).[16] Migration Watch calculate 205,000 people have become failed asylum seekers since the 2001 Census was conducted and provide a median estimate of 670,000 total undocumented migrants.[17]

Undocumented migrants and failed asylum seekers are a diverse population, and thus attempting to generalize a single health profile for them is a difficult. However, as Hargreaves succinctly concludes,

> There is a growing consensus internationally that both migration status, defined as people being born abroad, and low social position, are independent risk factors associated with poor health across all migrant groups.[18]

One literature review shows many migrants are particularly susceptible to hypertension, chronic conditions, and obesity.[19] Another review suggests undocumented migrants and asylum seekers have higher prevalence rates of infectious diseases.[18] In Britain, ethnic groups as a whole experience higher mortality rates, although the specific role of structural and biological factors is poorly understood.[18] Among asylum seekers and refugees, social isolation, poverty, and vulnerability exacerbate poor physical health.[18] Symptoms of psychological distress in these groups are common,[20] and two-thirds experience significant anxiety or depression.[21]

The interaction of migrants with the health-care system is complex, but there is agreement that individual characteristics, systemic barriers to access, and overall utilization of services account for many illness patterns.[18] Personal factors such as age, ethnicity, socioeconomic status, education, health beliefs, and proximity to health services influence health-seeking behavior.[18] Barriers to access, including language difficulties, fragmented care pathways, and health worker misapplication of policy, can be present even under the most equitable of access policies.[22,23]

The NHS

The National Health Service (NHS) is an umbrella term used to describe the government-operated health-care systems of the four constituent countries of the United Kingdom. Although funded centrally, the systems are managed and governed independently.[24] This essay will

primarily examine policies of the English NHS, whose access restrictions are most pertinent since over 90% of all UK migrants live in England. (40% of migrants live in London alone.)[25] Separate charging regulations govern access in Wales and Scotland. There are presently no such policies in Northern Ireland.[26]

2. POLICY OVERVIEW

Policy before 2003

A core objective of the NHS at its inception was to provide comprehensive health services free at the point of delivery.[27] In truth, however, charging arrangements (i.e., user charges) have existed almost as long as the NHS.[28] The impetus for user charges was substantial overspending during the NHS's first two years.[29] Legislation was quickly passed enabling patients to be charged for certain services, and in 1952 user fees were instituted for pharmaceuticals, dental services, and eyeglasses.[28]

Charging foreign visitors NHS care did not occur until well after these service-specific user fees were enacted. The 1977 National Health Service Act, later amended by the Health and Medicines Act 1988, gave the DH authority to establish regulations recovering charges from NHS services provided to those not "ordinarily resident" in the country. "Ordinary resident" is a common-law term defined by the DH as:

> Living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life.[30]

"Overseas Visitors" is a legal term referring to all individuals not classified as ordinarily resident. The term encompasses not only undocumented migrants and failed asylum seekers but also tourists, international business travelers, private patients from abroad, certain UK citizens working overseas, and other groups.[30] Regulations charging Overseas Visitors for NHS care

were enacted in 1982 and revised in 1989. These 1989 Regulations contained a number of exemptions precluding charges under certain circumstances, including Regulation 4(b), which exempted from charges all individuals who had lived in the UK for at least 12 months.[30] There were no specified limitations on the application of this exemption.[30] In practice, however, many undocumented migrants and failed asylum seekers had resided in the UK for longer than a year, and, as a result, most who needed medical care had a legal right to freely access the NHS.[31] Not until 2004 did the DH implement more comprehensive charging regulations.

Secondary care

The genesis for these 2004 Regulations was the July 2003 DH consultation "Proposed Amendments to the National Health Service (Charges to Overseas Visitors) Regulations 1989." The consultation intended to address a number of what is referred to as "loopholes" in the 1989 Regulations—most notably Regulation 4(b)—by revising the exemption to exclude all individuals not lawfully in the UK.[30] The amendments embodied in the consultation related only to the provision of secondary care (i.e., treatment delivered in a hospital) and came into force on April 1, 2004. Legally, these Regulations placed an obligation on trusts to identify ineligible patients and recoup the cost of their treatment. Entitlement remains based on the common-law concept of "ordinarily residence"—not British citizenship, tax contribution, or possession of a British passport.[26]

Trusts are also obligated by human-rights law to provide "immediately necessary" treatment, defined by the DH as care that "must not be delayed or withheld while the patient's chargeable status is being established." Failure to provide treatment in these circumstances may be a violation of the Human Rights Act of 1998, which enshrined the rights and freedoms of the European Convention on Human Rights into UK domestic law.[26] The term "immediately

necessary" has no established legal or medical definition. Rather, the DH makes it the responsibility of clinicians to determine when a treatment is immediately necessary and when it is not.[26,32] This uncertainty can be problematic as some treatments may be considered "appropriate" or even "urgent" from a clinician's perspective but not sufficiently severe to warrant classification as immediately necessary. Further, immediately necessary treatment is available under the new charging regime but is not free unless provided in an A&E department. For example, maternity services are always rendered as immediately necessary due to the medical risks associated with pregnancy, but women are still liable for the charges they accrue.[26]

To safeguard wider public health, DH guidance exempts the treatment of certain communicable diseases from charges. Although HIV/AIDS testing and counseling are exempt, antiretroviral treatment is not.[26] Appendix 1 incorporates a full listing of exempt diseases.

Primary care

Primary care refers to community-based health services functioning as a patient's first point of contact with the NHS. Access to primary care for undocumented migrants and failed asylum seekers was not affected by the above changes to hospital care. However, a DH consultation released on May 14, 2004, less than two months after new rules for hospital care came into force, aimed to place GP access in line with secondary care.[33] Adopting charging mechanisms at the primary care level is a more technically difficult task as it requires new legal instruments—beyond merely removing exemptions in existing laws—and also a physical infrastructure for charging and collecting fees that many GP surgeries do not possess. To date, results of the consultation have not been officially published. DH correspondence shows responses evinced "particular support for allowing failed asylum seekers (and dependants) to

have access to primary medical services," [34] a finding corroborated by a sample of 38 consultation responses published by the advocacy group Medsin.[35]

Presently, the status of DH policies restricting GP access is still in the air, contributing to confusion and uncertainty within migrant groups about the future of free primary care in the UK.[32] In March 2007, a Home Office report stated a review of policies governing access to primary care for foreign nationals would be delivered by December 2007.[36] The UK Border Agency reported on June 19, 2008, that the review had been completed and that another public consultation was to be published shortly.[37]

Latest developments

Any new charging policies proposed by the DH must be considered alongside the April 12, 2008, High Court ruling *R (A) v Secretary of State for Health and West Middlesex University Hospital NHS Trust*, which broadened the scope of "ordinarily residence" in the UK. The case was brought by a 32-year-old Palestinian failed asylum seeker who had been denied hospital treatment for chronic liver disease. The judgment established that under certain circumstances failed asylum seekers *can* be considered ordinarily resident in the UK and thus entitled to free NHS care. The judgment also found that determining which asylum seekers were ordinarily resident and which were not was complex and not workable for practicing clinicians. Accordingly, at the moment, all failed asylum seekers can receive free NHS care if they can show "voluntary wish to settle, coupled with residence for a significant period."[38] In practice, this standard is not difficult to meet as most failed asylum seekers have lived in the country for months or even years.[39] Other undocumented migrants, however, can still be charged for hospital treatment.

It is too early to ascertain how the judgment will affect the future provision of primary and secondary care for undocumented migrants and failed asylum seekers. The DH has already filed an appeal, scheduled to be heard in the Court of Appeals in November 2008, and a judgment is expected at the end of the year. It is possible—perhaps likely—the case will later be appealed to the House of Lords, whereby a decision might not be rendered until the end of 2009.

It is interesting to note that the judgment in effect creates an exception to the exception: the NHS was created to provide free care; by statute an exception exists such that Overseas Visitors can be charged; by common law an "exception to the exception" exists such that not all failed asylum seekers are Overseas Visitors.

Figure 2.1: Policy summary

- In April 2004, the DH eliminated free access to hospital care in the UK for individuals not "ordinarily resident," a common-law term which at the time included all undocumented migrants and failed asylum seekers.
- A DH consultation released in May 2004 aimed to bring primary care access in line with hospital care. These regulations are still pending, and a new consultation is due shortly.
- By human rights law, the NHS still must provide "immediately necessary" treatment. "Immediately necessary" is a higher standard than clinical appropriateness.
- An April 2008 High Court decision found that some failed asylum seekers can be considered "ordinarily resident" and thus entitled to free NHS care. Other undocumented migrants were unaffected. The DH has appealed the judgment.

Policy vs. practicality

Legal entitlements to health care for undocumented migrants and failed asylum seekers can differ considerably from the situation in practice.[40] Two issues are most relevant. First, are DH charging regulations for hospital care widely enforced by the NHS? The answer here appears

to be "yes." An internal DH survey of 12 NHS Trusts in 2005 details that charging regulations are operational, although the extent of implementation varies considerably.[41] A number of NGOs have documented instances of individuals charged for NHS care *ex ante* (care withheld if the individual cannot pay) or *ex post* (billing patients after care is delivered).[32,42,43]

Second, are DH charging regulations being enforced *correctly*? There is evidence that incorrect applications of policy are frequent.[5] With primary care, administrators in GP practices are sometimes confused and wrongly believe primary care charging proposals have been enacted.[23] With maternity care, the DH has received regular reports of women who have been erroneously refused access to maternity services if they are unable to pay in advance, and even pregnant women exempt from charges (e.g., asylum seekers) have been charged.[5] Estimating the numbers of undocumented migrants and failed asylum seekers impacted by incorrect NHS enforcement is difficult, just as it is difficult to reliably quantify their total population in the UK.

3. DISMANTLING: A POLICY THAT DOESN'T MAKE SENSE

This section outlines five reasons the DH policy of charging undocumented migrants and failed asylum seekers for access to NHS care "doesn't make sense." Saving public money is the most obvious rationale for charging regulations, and, therefore, the lack of evidence regarding cost-effectiveness is discussed first and requires the most detail.

Lack of evidence on cost impact

Current DH policy relating to Overseas Visitors was formulated in an environment almost completely devoid of data. This absence of data is important because it is not altogether intuitive current Regulations properly address intended policy aims: (1) to deter abuse or (2) to

collect money and withhold care on the ground level.[41] Though they differ in scope, both aims are in essence cost-effectiveness arguments.[a]

The deterrence argument rests upon the premise that health tourists are specifically targeting the NHS and that implementing charging regulations would save money by dissuading sick foreigners from coming to the UK. Two points are salient here. First, there is a cost to deterrence. It requires building systems, paying Overseas Payment Officers, and training NHS ground staff. Institutional characteristics may also exacerbate costs. Full implementation of guidance is "potentially onerous" as it requires all patients to be screened.[41] The DH itself notes other difficulties:

> The main basis for determining chargeable status is the concept of residence which is not easily defined or proved … Coupled with that, we have an NHS which is geared towards being free at the point of delivery and does not have the charging infrastructure unlike the private sector or insurance based services.[41]

Second, deterrence presumes the existence of extensive "health tourism," a notion that has been strongly contested. In her review, Hargreaves concludes there has not been a single published research study suggesting health tourism is widespread in the UK.[18] A host of other critics have questioned its scope including NGOs,[42,43] the Mayor of London,[44] and at least two Parliamentary committees.[5,45] One committee in particular noted the DH did not produce "any evidence" supporting extensive health tourism in the UK.[5] The government responded to this report by referencing evidence on health tourism collected from Overseas Visitors Managers.[46] Notably, however, this information has not been made public.

The collection-of-money argument is more related to cost-effectiveness within the hospital. The costs outlined above (infrastructure, training, salaries, etc.) apply here as well.

---

[a] In Section 4, the potential aim of removing undocumented migrants and failed asylum seekers from the UK will also be discussed.

Benefits accrue both from collecting money and from conserving resources by withholding care from ineligible patients. However, there is a paucity of data as to the extent of either of these benefits. The DH did not conduct a cost-benefit analysis or health-impact assessment before charging regulations were enacted,[45] and it does not collect data on the amount recovered through these charges, the amount of bad debt written off, the amount of bad debt outstanding, or the likelihood of debt recovery.[47]

Any estimates on the size of cost savings from the policy thus lack robust underlying data and, moreover, are methodologically dubious. An April 2005 internal DH report on Overseas Visitors estimates a chargeable amount of £62m. Issues regarding the representativeness of the sample, inconsistencies in data collection by NHS trusts, and differential pricing may bias this estimate.[41] Moreover, the report does not specify the proportion of the £62m specifically coming from undocumented migrants and failed asylum seekers—an important distinction as "Overseas Visitors" encompasses many other groups such as tourists, international business travelers, and private patients from abroad. Finally, of the estimated £62m *total* overseas debt in this report, only half is actually recovered by the NHS.

The collection-of-money argument must also consider the cost of postponing access or shifting use in the NHS system. Recall the DH can charge Overseas Visitors for NHS care, but it still must provide "immediately necessary" treatment. The postponement-of-care notion is sometimes referred to as the "squeezed-balloon effect," reflecting the idea that a lack of preventative measures early in the progression of a medical condition may exacerbate treatment costs at a later stage. An example of this is maternity care where, from a strictly economic perspective, a host of antenatal services have been considered cost-effective.[48] In this manner, a

policy that limits early access to medical services may result in higher costs over the entire cycle of care.

The shifting of use is another important issue. From a service perspective, immediately necessary care is often provided in an A&E department, where it generally costs more per patient to deliver than in a GP surgery. Minister of State for Health Services Rosie Winterton presented evidence that individuals not registered with a GP tend to use A&E services more often.[5] Thus, barriers to GP access, whether in practice or in policy, may increase costs over the long run as they shift use from primary care to emergency care.

A discussion on the true economic costs of the charging regulations must further consider any costs shifted outside the NHS system. International comparisons show a variety of safety nets have been instituted for those without regular status. In Belgium, undocumented migrants cannot work and are thus not entitled access to the state's social health insurance system. However, they are eligible for government-sponsored Emergency Medical Aid, which gives free access not only to A&E care but also to virtually all other services.[40,49] In France, although burdensome barriers still exist in practice, a specific state-financed insurance fund is in place for undocumented migrants.[43] The state also helps finance NGOs such as *Médecins du Monde* to provide medical care and to assist individuals accessing the public system. In the Netherlands, undocumented migrants are excluded from the state's obligatory health insurance scheme, but "medically necessary" care is theoretically available for free from a €5.5m special government fund.[49] The conclusion from these European cases is that even when access to medical care is restricted in some manner, governments often bear at least some of the cost of a safety net—in the form of government assistance, special funds, or the funding of NGOs. In the UK, where

very little medical care is available external to the national system, the societal cost-effectiveness of moving populations outside the scope of the NHS is uncertain.

Lack of evidence on public health impact

DH policy toward Overseas Visitors amplifies some public-health risks. The cases of HIV/AIDS and primary care are illustrative. First, although HIV/AIDS testing and counseling are free, charging for treatment serves as a disincentive for individuals to seek out testing. Less testing is problematic as evidence shows that an individual's knowledge of HIV-positive status reduces sexual risk behaviors.[50] Moreover, successful antiretroviral therapy decreases viral load, which is directly connected to infectivity.[51] The interaction between TB and HIV/AIDS is also a concern; under DH policy, individuals co-infected with both TB and HIV are only entitled to treatment for TB. As a result, cases have been reported where individuals have left the hospital before completion of TB treatment, endangering the larger community and risking the development of multi-drug resistant strains of TB.[45]

Second, research indicates certain migrant populations have higher prevalence rates of TB, hepatitis B, and other infectious diseases.[18] From a public-health perspective, it is a concern if these same populations face legal or practical barriers to primary-care access. Some evidence does suggest that barriers to GP care may be linked to more severe infections in overseas-born patients relative to UK-born patients.[52]

Inconsistencies between global health and domestic health policy

A number of inconsistencies exist between the DH's domestic health policy and the government's views on global health policy. Two comparisons with the UK's Department for International Development (DFID) are helpful. First, although seldom presented in this manner, DH Regulations removing free NHS access are technically equivalent to implementing a policy

of 100% user charges. Framing charging regulations as user charges is useful as it allows access to extensive literature examining the advantages and disadvantages of cost sharing. A full review is beyond the scope of this essay; however, it is enough to say that a number of prominent international organizations have advocated against them on both equity and efficiency grounds. One leading organization is DFID, which released a report in September 2004, just months after the DH consultation proposing primary-care charges was published, entitled "The Case for Abolition of User Fees for Primary Health Services."[53] DFID has remained faithful to this aim, and one of its key commitments in 2007 was "abolishing user charges for essential services."[54] Second, DFID's HIV/AIDS policy differs significantly from the DH's. DFID's goal is to achieve universal access to various services including treatment, and it declared in 2004 that "[t]here is now international consensus that treatment and care are essential parts of an effective and comprehensive response to AIDS."[55] As discussed, the DH does not fund HIV/AIDS treatment for Overseas Visitors.

Inconsistencies in state support

Some failed asylum seekers are unable to return to their country of origin. This can happen when a medical condition impedes the ability to travel, when a home country is unsafe for return, or when people simply cannot afford the cost of their return journey. Under Section 4 of the 1999 Immigration and Asylum Act, destitute individuals in these cases may qualify for government support in the form of accommodation and £35 per week in subsistence vouchers.[56] Children in families whose asylum claims have been declined are also always entitled to free school education in the UK.[57] The Home Office intended Section 4 assistance to be temporary, but in practice many people subsist on the benefits for many months.[5] Although they are unable to leave the UK, individuals who qualify for Section 4 support are not entitled to free NHS care.

One inconsistency is that these individuals are destitute, they cannot work, and they receive support in vouchers rather than cash; thus, they have no way to pay for NHS hospital care even if the need arises, and A&E departments might serve as the only viable conduit to health care. The more fundamental inconsistency is that one would expect a government either to fully *grant* benefits or to fully *not grant* benefits, depending on how it considers the issue. That is, there is no clear reason why Section 4 support should include should housing, food, and education but should exclude health care.

Inconsistencies in human rights interpretations

Inconsistencies exist in the way the DH considers human rights. This is not to claim, as some commentators have contended, that by implementing charging regulations the UK is in breach of its human rights obligations under the International Covenant on Economic, Social and Cultural Rights.[58,59] Nor is it to claim the DH is *not* in breach of its human rights obligations. Rather, it is to say DH charging regulations and broader DH policy on human rights do not reflect a consistent stance on human rights. Fundamentally, the 2000 NHS Plan, which revamped the health system's core values, declared health care under the NHS to be a human right:

> 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.[60]

Further, the 2007 DH publication "Human Rights in Healthcare – A Framework for Local Action" argues that the Human Rights Act of 1998 supports the incorporation of the principles of dignity, equality, and fairness into UK law and thereby into the provision of public services including health care.[61] The document further asserts the universality of these principles: "Anyone in the UK can be a victim – the Act is not limited to UK citizens."[61] The DH has also used a rights-based approach to health care in advocating for a number of populations, e.g., older

people,[62] adults with learning disabilities,[63] and mental health patients.[64] Taken as a whole, it is difficult to reconcile these generally supportive views on human rights with a policy designed to deny health care based on an individual's inability to pay.

4. REASSEMBLING: MAKING SENSE OF A POLICY THAT DOESN'T MAKE SENSE

This essay began by showing the implementation of charging regulations was in some sense an unexpected event. Section 3 then argued the Regulations do not reflect consistent, evidence-based policymaking toward undocumented migrants and failed asylum seekers. One question remains: Why would the DH implement a policy that is seemingly random, unproven, and inconsistent? This section will apply a popular theory in political science known as the "multiple-streams" model to suggest an answer. The overriding argument from this theory is that health politics and health policy can interact in a "predictably unpredictable" manner to produce divergent outcomes.[65]

The multiple streams approach

The multiple-streams model rests on work by Cohen et al., who proposed a theory to explain decision making in certain organizations deemed "organized anarchies," such as universities, that are characterized by ambiguous individual preferences, unclear internal processes, and shifting participation.[66] Kingdon adapted the model to politics at the U.S. federal level,[67] and Zahariadis later articulated its use in the UK government.[68] Much of this section will draw on Greer, who specifically applied the model to UK health policymaking.[65]

The multiple-streams model was created to help answer the simple question: "What makes people in and around government attend, at any given time, to some subjects and not to others?"[67] The model's answer begins with the recognition that national governments possess

similar characteristics to universities: People in government often must act without complete information (preferences); government actors do not necessarily understand the workings of their organization (processes); and turnover in government, even within bureaucracies, is high (participation).[67] Under these conditions, rational-choice theories of behavior do not apply.

An alternative theory resting on the three main ingredients, or "streams," of policymaking may provide better explanatory power. These three streams include (1) problems, (2) politics, and (3) policies. Problems are conditions that government wishes to act upon.[b] Politics refers to the ideology and interests of the governing party,[68] or "the extent to which a party sees reason to address a problem or proffer a solution."[65] Policies, the "solutions," consist of the wide array of ideas constantly furnished by think tanks, academics, Congressional staff members, and others in the policy arena.

The model postulates that these three streams flow largely independently of one another.[67] Policymakers focus on particular conditions not because of ideology or political strategy but because problems are presented to them in the form of media reports or feedback from existing programs. Changes in political views often reflect underlying shifts in the national consciousness rather than the appearance of a policy or problem. Policies are not created to address particular problems but float around in a "policy primeval soup" from which they are plucked. Occasionally, these streams will converge and open what Kingdon calls a "policy window."[67] During these fleeting opportunities for action, the political stars align such that a pre-formulated solution can be attached to an emerging problem:

> Plausible ideas ardently proposed (and a few implausible ones) couple with a problem, often media-generated or noticed because of a well-timed press release and the entry on to the stage of a politician who must make a mark to thrive and survive—and a policy is

---

[b] Kingdon highlights the difference between conditions and problems. Conditions are states of the world that are dealt with daily (think: illness) while problems are conditions necessitating a government response (think: flu epidemics)

> made. Policy emerges from this organised chaos … in a way that never necessarily suits anybody working in the health system.[65]

Greer's summary of the implications of a multiple-streams approach in UK domestic health policy is critical. He writes that, at minimum, the model indicates the practice of "evidenced-based policy" may be overpowered by the arbitrary convergence of problems, politics, and policies. Moreover, policy experts have a decided interest their ideas be implemented, and the solutions they proffer thus contain a fundamental bias. At maximum, the model suggests that the UK health-political system may be structurally susceptible to recurring political interventions that cannot easily be justified. In short, health policies may be generated that are incompatible with the broader goals of those working in the services.[65]

Greer further suggests that certain institutional features of the Department of Health and the Westminster system of parliamentary government may exacerbate the problem by making it easy to intervene when policy windows are open. In the UK, the party holding a majority of seats in Parliament dominates both the legislative and executive branches, reducing veto power and limiting checks and balances.[68] The large number of public providers in the NHS limit the amount of collective power providers wield in relation to the state. The structure of the NHS itself is akin to the Westminster system and centralizes authority in the Secretary of State, who additionally is a political figure concerned with re-election. Taken together, these factors suggest the NHS is more open to interventions from its political masters than other state-run health systems.[65]

Multiple streams and charging regulations

Fully applying the multiple streams model to DH charging regulations is beyond the scope of this essay. However, it is easy to conceptualize how the streams could converge in this case. Investigating the problem stream suggests the "condition requiring response" was not NHS

care for undocumented migrants and failed asylum seekers but the idea of pervasive health tourism. A LexisNexis News search of British national media shows the concept of "health tourism" had been scarcely written about in the previous 20 years before *The Sunday Times* published an article entitled "Medical tourists cheat NHS" on January 19, 2003.[69] The appearance of this article coincided with the rise of HealthWatch UK, a pressure group that ran advertisements in national newspapers promoting claims such as, "People are arriving from all over the world to treat themselves to our health services."[70] References to health tourism in the media then grew exponentially after Harriet Sergeant's Centre for Policy Studies report on the subject was published in mid-May 2003.[71] Even though she had conducted extensive interviews in NHS hospitals, Sergeant has stated she was unaware of any charging proposals being discussed by the NHS or DH by the time her report was published.[72] Approximately two months after Sergeant's report was published, the hospital charging consultation was released, which specifically mentioned feedback the DH had received regarding health tourism. It was also health tourism John Hutton first referenced in his press release formally announcing the Regulations in December 2003.

Policies are not formulated to address specific, emerging problems in the multiple-streams model. Rather, they are pre-fabricated solutions later attached to emerging problems. In Bevan's rhetorical question posed in the introduction, the rationale for limiting access to the NHS was based on the public purse; that is, public services should be reserved for those who fund them. However, access restrictions can also serve as an instrument to influence the behavior of migrants illegally living in the UK. Indeed, the concept of punitively withdrawing state benefits to pressure non-British individuals to leave the country has been around since at least 1996.[73] By 2003, actors such as Migration Watch brought public attention to the large number of

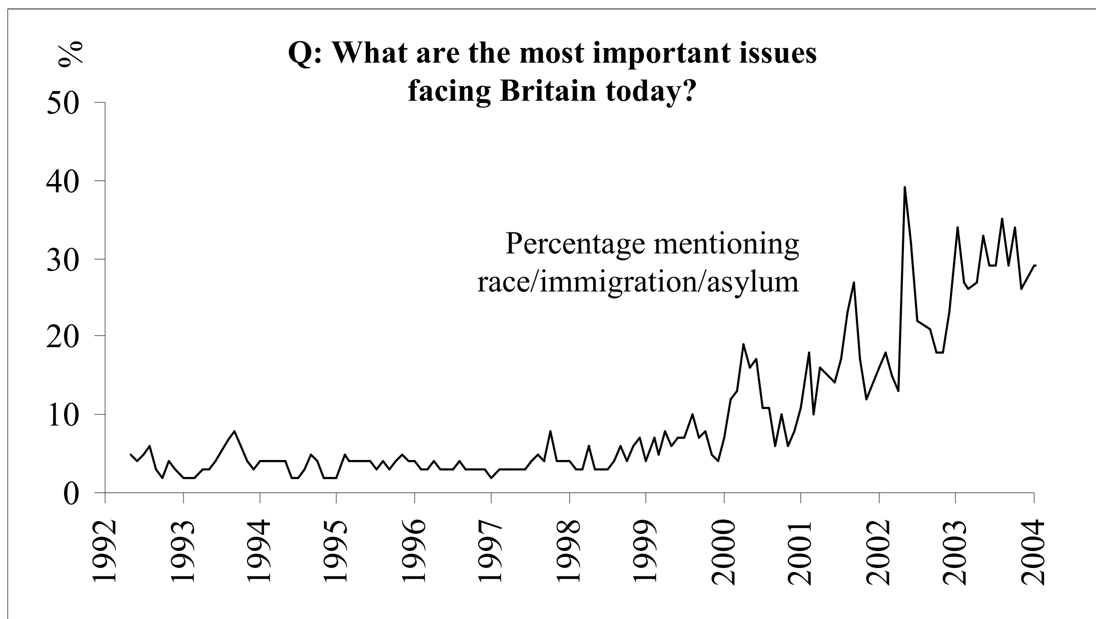
undocumented migrants and failed asylum seekers living in the UK.[74] The interaction between state benefits and immigration is reflected in written evidence provided by Beverley Hughes, Minister of State, in December 2003:

> While we will of course continue and intensify our programme of compulsory removals, if we rely solely on it we will not achieve the increase in the proportion of failed asylum seekers leaving the country which we are determined to bring about. Hence **the need to eradicate the perverse incentives which lead failed asylum seeking families to refuse opportunities to leave voluntarily** (emphasis mine).[75]

Whether seen as a public-purse issue or an immigration issue, it is not unreasonable to view charging regulations as a policy idea that existed long before the problem of health tourism arose. Thinking of the decision-making process in this manner explains the government's conflation of two very distinct issues: (1) health tourism and (2) health care for undocumented migrants and failed asylum seekers. That is, the DH responded to the problem of health tourism by implementing a policy not specifically tailored to this problem. As a result of this conflation, undocumented migrants and failed asylum seekers were disqualified from free NHS care.

In the political stream, there were certainly political benefits to be garnered from addressing immigration and health. A MORI poll in February 2003 showed that 64% of the British public believed that asylum seekers come to Britain because it is a "soft touch," and 85% disagreed that the government had asylum under control.[76] Tracking surveys also reveal in 2003 the public perceived the issues of NHS and immigration to be two of the most important issues facing Britain.[77] The rise in prominence of the issue of immigration is especially striking.

Figure 4.1: MORI survey of the British public, 1994-2004[76,77]



Kingdon emphasizes public surveys may not perfectly reflect national mood. Still, the strength of these polling results, coupled with the growth of pressure groups promoting strict immigration agendas since 2000,[70] suggests the political climate was opportune for intervention. It is also important to note the populations impacted by charging regulations—undocumented migrants and failed asylum seekers included—are not constituents. Advocacy groups may apply political pressure on behalf of these populations, but any political influence is nonetheless limited without the ability to vote.

CONCLUSION

The introduction of this essay presented Aneurin Bevan's rhetorical question as to why the NHS should offer universal access, irrespective of legal status. Bevan arrived at his second answer in support of universal access by estimating the number of visitors in the UK, approximating their use of NHS services, and calculating their total cost impact on the NHS. He found the impact amounted to a "negligible fraction" of the total cost of the NHS and then used

this finding to argue against access restrictions.[2] In short, Bevan justified his position with an appeal to evidence.

This essay contends that the Department of Health failed to adopt a similar approach before restricting free NHS health care for undocumented migrants and failed asylum seekers. It is entirely possible the modern equivalent to Bevan's methodology—a robust cost-benefit analysis and health-impact assessment—would indeed show charging regulations save sizeable sums of public money and reduces wider public-health risks. But it is irresponsible to restrict access to medical care for approximately 500,000 of society's most vulnerable people without providing even a cursory evidence-based review.

Section 4 argued that viewing the policymaking process through a "multiple-streams" framework shows how inconsistent, unproven solutions can prosper. Further research should be conducted in this area. Did the issue of health tourism drive the implementation of charging regulations? What was the political interaction between immigration policy and health policy? These questions must be addressed if health-care policies are to truly reflect underlying values.

APPENDICES

Appendix 1: Diseases exempt from charges

Acute encephalitis[26]	Leptospirosis	Rabies	Tuberculosis
Acute poliomyelitis	Malaria	Relapsing fever	Typhoid fever
Amoebic dysentery	Measles	Rubella	Typhus
Anthrax	Meningitis	Salmonella infection	Viral haemorrhagic fevers
Bacillary dysentery	Meningococcal septicaemia (without meningitis)	Severe Acute Respiratory Syndrome (SARS)	Viral hepatitis
Cholera	Mumps	Scarlet fever	Whooping cough
Diphtheria	Ophthalmia neonatorum	Smallpox	Yellow fever
Food poisoning	Paratyphoid fever	Staphylococcal infections	
Leprosy	Plague	Tetanus	

Appendix 2: Informal interviews conducted during the course of research

Person	Affiliation	Date
Susan Wright	Director, Médecins du Monde UK	In-person, 24 June 2008
Andy Finlay	Income Generation Manager, West Middlesex University Hospital	In-person, 26 June 2008
Julian Le Grand	Richard Titmuss Professor of Social Policy, London School of Economics; Senior Policy Adviser to the Prime Minister, 2003-2005	In-person, 27 June 2008
Iona Heath	General practitioner, Caversham Group Practice; BMJ Ethics Committee chair (2006)	In-person, 27 June 2008
Moyra Rushby	Medact	In-person, 27 June 2008
Adam Hundt	Solicitor at Pierce Glynn, London	Telephone, 8 July 2008
Harriet Sergeant	Research Fellow, Centre for Policy Studies	Telephone, 12 August 2008

Sally Hargreaves	Senior Editor, The Lancet Infectious Diseases	Telephone, 19 August 2008
Scott Greer	Assistant Professor, University of Michigan School of Public Health	Telephone, 22 August 2008

REFERENCES

1. Berger, John, et al. *A Seventh Man: A book of images and words about the experience of migrant workers in Europe*. 1975, Harmondsworth: Penguin.
2. Bevan, Aneurin. *In Place of Fear*. 1952, London: Heinemann.
3. Robinson, Vaughan, et al. Home Office Research Study 243: Understanding the decision-making of asylum seekers. 2002, Migration Unit, Department of Geography University of Wales, Swansea: London.
4. UN. Convention Relating to the Status of Refugees. 1951, United Nations: Geneva.
5. JCHR. The Treatment of Asylum Seekers: Tenth Report of Session 2006-07, House of Lords and House of Commons Joint Committee on Human Rights. 2007, The Stationery Office Limited: London.
6. International, Amnesty. Down and out in London: The road to destitution for rejected asylum seekers. 2006, Amnesty International UK: London.
7. IPPR. Irregular migration in the UK: An IPPR FactFile. 2006, Institute for Public Policy Research: London.
8. Evans, Yara, et al. Making the City Work: Low Paid Employment in London. 2005, Queen Mary, University of London: London.
9. Sergeant, Harriet. Welcome to the Asylum: Immigration and Asylum in the UK. 2001, Centre for Policy Studies: London.
10. BBC. Health 'tourist' pays NHS £30,000. *BBC News*. April 6, 2005.
11. Butler, Jo. Migrant health tourists jump NHS queue (and we foot the bill). *Daily Mail*. May 24, 2003.

12. Vertovec, Steven. The Emergence of Super-Diversity in Britain, Working Paper No. 25. 2006, Centre on Migration, Policy and Society, University of Oxford: Oxford.
13. Robinson, David, et al. Neighbourhood experiences of new immigration: Reflections from the evidence base. 2006, Sheffield Hallam University and the Joseph Rowntree Foundation: York.
14. Salt, John, et al. Foreign labour in the United Kingdom: current patterns and trends. *Office for National Statistics: Labour Market Trends*. 2006, Migration Research Unit, University College London: London.
15. ONS. Methodology used to estimate Total International Migration in 2006. *International Migration: Series MN No 33*. 2006, Office for National Statistics: Newport.
16. Woodbridge, Jo. Sizing the unauthorised (illegal) migrant population in the United Kingdom in 2001. 2005, Research, Development and Statistics Directorate, Home Office.
17. MW. Briefing Paper 9.15: The illegal Migrant Population in the UK. 2005, Migration Watch UK.
18. Hargreaves, Sally. The Impact and Use of the UK's National Health Service by New Migrants [PhD Thesis]. 2007, International Health Unit, Imperial College: London.
19. McKay, Laura, et al. Occasional Paper No 12, Migration and Health: A Review of the International Literature. 2003, MRC Social & Public Health Sciences Unit, University of Glasgow: Glasgow.
20. Burnett, Angela, et al. Health needs of asylum seekers and refugees. *BMJ*, 2001. 2001(322): p. 544-547.
21. BMA. Asylum seekers: meeting their healthcare needs. 2002, Board of science and education, British Medical Association.

22. Arai, Lisa. Migrants & public services in the UK: a review of the recent literature. 2005, Compas/University of Oxford: Oxford.

23. MdM. Project:London: Improving Access to Healthcare for the Community's Most Vulnerable (2007). 2008, Médecins du Monde UK: London.

24. NHS. About the NHS. Available at: [http://www.nhs.uk/aboutnhs/Pages/About.aspx].

25. GLA. DMAG Briefing 2008-05: A Profile of Londoners by Country of Birth: Estimates from the 2006 Annual Population Survey. 2008, Data Management and Analysis Group, Greater London Authority: London.

26. DH. Implementing the Overseas Visitors Hospital Charging Regulations: Guidance for NHS Trust Hospitals in England, Department of Health. 2007.

27. NHS. About the NHS, NHS core principles. Available at: [http://www.nhs.uk/aboutnhs/CorePrinciples/Pages/NHSCorePrinciples.aspx].

28. HSC. NHS Charges: Third Report of Session 2005–06, House of Commons Health Committee. 2006, The Stationery Office Limited: London.

29. Webster, Charles. *National Health Service: A political history*. 2002, Oxford: Oxford University Press.

30. DH. Proposed Amendments to the National Health Service (Charges to Overseas Visitors) Regulations 1989: A Consultation, Department of Health. 2003.

31. Harris, Robert. The Exclusion of Failed Asylum Seekers from Free NHS Care; A Policy Analysis and Impact Assessment [BSc Dissertation]. 2005, International Health and Medical Education Centre, University College London: London.

32. Medact. Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: Impact on vulnerable migrant groups. 2008, Medact: London.

33. DH. Proposals to exclude overseas visitors from eligibility to free NHS primary medical services: a consultation. 2004, Department of Health.
34. DH. Correspondence from the DH, in 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. 2007, Global Health Advocacy Project, Medsin.
35. Medsin. 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. 2008, Global Health Advocacy Project, Medsin: Cambridge.
36. HO. Enforcing the rules: A strategy to ensure and enforce compliance with our immigration laws, Home Office. 2007.
37. HO. Enforcing the Deal: Our Plans for Enforcing the Immigration Laws to the United Kingdom's Communities, Home Office UK Border Agency. 2008.
38. HC. R (A) v Secretary of State for Health and West Middlesex University Hospital NHS Trust (interested party). April 2008, High Court of Justice.
39. Hundt, Adam. Law & practice / public law case note: Entitlement to free hospital treatment for refused asylum-seekers. *Legal Action*, June 2008.
40. Chauvin, Pierre, et al. European survey on undocumented migrants' access to health care. 2007, Médecins du Monde: Paris.
41. DH. Overseas visitors: report, Department of Health. 2005.
42. Council/Oxfam, Refugee. First do no harm: denying healthcare to people whose asylum claims have failed. 2006: Oxfam and Refugee Council.

43. MdM. Project:London: Helping vulnerable people to access health care (2006). 2007, Médecins du Monde UK: London.
44. London, Mayor of. Department of Health consultation “Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services”: Response by the Mayor of London. 2005.
45. HSC. New Developments in Sexual Health and HIV/AIDS Policy: Third Report of Session 2004–05, House of Commons Health Committee. 2005, The Stationery Office Limited: London.
46. DH. Government response to the Health Select Committee’s Third Report of Session 2004–2005 on New Developments in Sexual Health and HIV/AIDS Policy. 2005: London.
47. JCHR. Testimony by Rosie Winterton, The Treatment of Asylum Seekers: Tenth Report of Session 2006-07, Volume II- Oral and written evidence, House of Lords House of Commons Joint Committee on Human Rights. 2007, The Stationery Office Limited: London.
48. Di Mario, Simona, et al. What is the effectiveness of antenatal care? (Supplement). 2005, Health Evidence Network, WHO Regional Office for Europe's: Copenhagen.
49. PICUM. Access to Health Care for Undocumented Migrants in Europe. 2007, Platform for International Cooperation on Undocumented Migrants: Brussels.
50. Weinhardt, Lance S., et al. Effects of HIV Counseling and Testing on Sexual Risk Behavior: A Meta-Analytic Review of Published Research, 1985-1997. *American Journal of Public Health*, 1999. 89(9): p. 1397-1405.

51. Porcoa, Travis C., et al. Decline in HIV infectivity following the introduction of highly active antiretroviral therapy. *AIDS*, 2004. 2004(18): p. 81-88.

52. Cooke, Graham, et al. Impact on and use of an inner-city London Infectious Diseases Department by international migrants: a questionnaire survey. *BMC Health Services Research*, 2007. 7(113).

53. Pearson, Scott. Issues Paper: The Case for Abolition of User Fees for Primary Health Services, DFID Health Systems Resource Centre. 2004: London.

54. DFID. Working together for better health, Department for International Development. 2007.

55. DFID. HIV and AIDS treatment and care policy, Department for International Development. 2004.

56. HO. Section 4 Support. UK Border Agency, Home Office. Available at: [http://www.ukba.homeoffice.gov.uk/asylum/support/apply/section4/].

57. Council, Refugee. Education to 18. 2007, Refugee Council.

58. Hall, Peter. Failed asylum seekers and health care. *BMJ*, 2006. 2006(333): p. 109-110.

59. Hunt, Paul. Foreward, in *Project:London: Helping vulnerable people to access health care (2006)*. 2007, Médecins du Monde UK: London.

60. NHS. The NHS Plan: A plan for investment, A plan for Reform, Department of Health. 2000, Department of Health.

61. DH. "Human Rights in Healthcare – A Framework for Local Action". 2007, Department of Health.

62. DH. A New Ambition for Old Age: Next Steps in Implementing the National Service Framework for Older People. 2006, Department of Health.

63. DH. Valuing People Now: From progress to transformation. 2007, Department of Health.

64. DH. Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett. 2005, Department of Health.

65. Greer, Scott. Why do Good Health Politics Make Bad Health Policy, in *Future Health Organisations and Systems*, Sandra Dawson and Charlotte Sausman, Editors. 2005, Palgrave MacMillan: New York.

66. Cohen, Michael D., et al. A Garbage Can Model of Organizational Choice. *Administrative Science Quarterly*, 1972. 17(1): p. 1-25.

67. Kingdon, John W. *Agendas, Alternatives, and Public Policies*. 1995, Boston: Little Brown.

68. Zahariadis, Nikolaos. *Markets, states, and public policy: Privatization in Britain and France*. 1995, Ann Arbor: University of Michigan Press.

69. Rogers, Lois. Medical tourists cheat NHS. *The Sunday Times*. January 19, 2003.

70. Hampshire, James. The Politics of Immigration and Public Health. *The Political Quarterly*, 2005. 76(2): p. 190-198.

71. Sergeant, Harriet. No System to Abuse: Immigration and health care in the UK. 2003, Centre for Policy Studies: London.

72. Sergeant, Harriet. August 12, 2008, Personal communication.

73. RA. The Destitution Trap: Research into destitution among refused asylum seekers in the UK. 2006, Refugee Action.

74. HAC. Asylum Removals: Fourth Report of Session 2003-04, House of Commons Home Affairs Committee. 2003, The Stationery Office Limited: London.

75. Hughes, Beverley. Supplementary memorandum submitted by the Home Office, in *First Report of Session 2003-04: Asylum and Immigration (Treatment of Claimants, etc.) Bill* House of Commons Home Affairs Committee, Editor. 2003, The Stationery Office Limited: London.

76. MORI. British Views On Immigration. MORI Social Research Institute, Ipsos Mori. 2003; Available at: [http://extranet.ipsos-mori.com/polls/2003/migration.shtml].

77. MORI. The most important issues facing britain today. Political Trends, Ipsos MORI. 2008; Available at: [http://www.ipsos-mori.com/content/turnout/the-most-important-issues-facing-britain-today.ashx].