



**Response to the Department of Health
Consultation Paper on
Proposals to Exclude Overseas Visitors
from Eligibility to Free NHS Primary
Medical Services**

"HIV/AIDS is not only a health issue but has risen to become a human rights crisis," Nelson Mandela, December 2002

AHPN

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August 2004 Executive Summary

Areas of concern

- NHS staff are already 'confused' about entitlements of asylum seekers to free medical services. In some parts of the country this has led to the use of emergency treatment facilities for routine healthcare matters and in others inconsistent delivery of HIV antiretroviral treatment as 'emergency treatment'.
- These proposals would accentuate inequalities rather address them. Charging undocumented migrants, failed asylum seekers, or visitors with AIDS, Tuberculosis or Malaria runs counter to public health interests.
- Africans living in the UK tend to present later for HIV/AIDS testing and we feel that the proposed measures would further deter people from taking up testing services. This has evident repercussions for the spread of the epidemic which will have further and weightier social and economic cost implications.
- The current proposal to introduce user charges to communities who by the nature of their status in this country cannot work and thus pay for medical services is both inhumane and unethical contradicting international and national legislation on human rights and discrimination.
- We feel that the proposed measures run counter to international, regional and national commitments within the UNGASS report to combat HIV.

Recommendations

- A system of charging should not be introduced particularly with regard to diagnostic testing, counselling and treatment services for sexually transmitted infection and HIV/AIDS. HIV treatment and care should be added to the list of diseases exempt from charges.
- The majority of visitors to the UK, are tourists, students, employees and visitors from the developed world who currently access the NHS most regularly, with less serious conditions than HIV. This group should be the legitimate focus of the DoH effort since it is here that the DoH are most likely to succeed in securing reimbursements. The AHPN encourages the DoH to be more vigilant in obtaining reimbursement through visitors' medical insurance or underwriting care through inter-country agreements.
- Attempts to reform the NHS should ensure that people in asylum seeking and migrant communities are informed about their rights to healthcare, by fully engaging community based organizations in advocacy and translation.

1. Introduction

The African HIV Policy Network (AHPN) is an umbrella organisation which represents African community groups addressing HIV/AIDS and sexual health throughout the UK.

The AHPN is an independent charity, registered in England and Wales. It is the only nation wide African organisation operating at policy level. It is involved in developing national HIV strategies and policy. It promotes research and lobbies on behalf of African community-based organisations.

The AHPN gathers and analyses information from community organisations, health care providers, researchers, NGOs and government departments and distributes what is relevant, up-to-date and accurate among its member organisations. The organisation also delivers capacity-building/training programmes and has been appointed by the Department of Health to manage the National African HIV Prevention Programme.

2. Structure of paper

This paper is divided into two sections. The first section sets the context for the arguments presented in this paper. The AHPN feel that while it may be necessary to introduce user charges for primary medical care in the UK the legitimate focus should be those who come to the UK for tourism or education purposes.

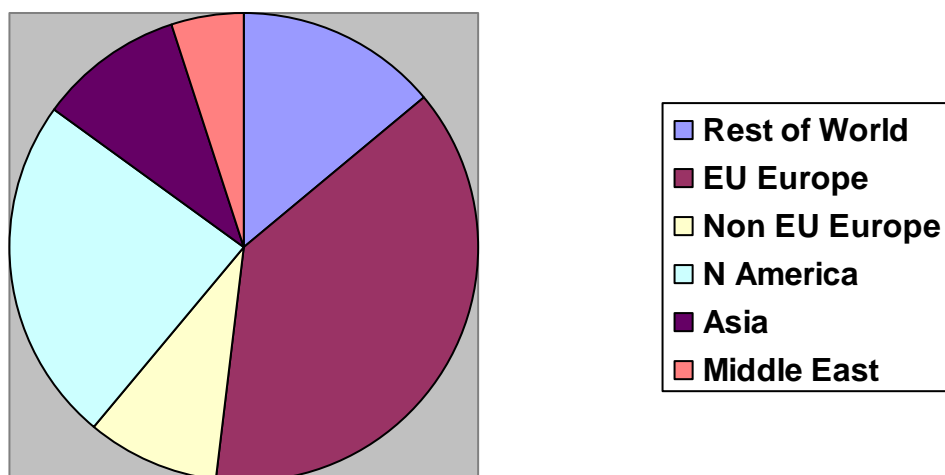
The first section provides a brief overview of statistics on overseas visitors, HIV/AIDS and Africans living in the UK, while the second section is structured according to the categories specified in the Department of Health document, 'Proposals to Exclude Overseas Visitors from Eligibility to free NHS Primary Medical Services. A Consultation Document', which was circulated in May 2004.

Section 4 specifically addresses the questions summarised in Chapter 3 of this document.

3. Key Facts about Overseas Visitors, HIV/AIDS and Africans living in the UK

Tourists

In 2003 Britain received 24.2 million overseas tourists with expenditure of £11,737 million, 4.4% of national GDP. The highest levels of expenditure included that from the US (£2,443 million), Middle East (£527 million) and Japan (£320 million). The pie chart below illustrates the origin of over seas visitors to the UK illustrating that the vast majority are form Europe and North Americas



Source: Review of Tourism Statistics Review July 2003. Department, Culture Media and Sport.

Overseas Students in the UK

Between 1999 and 2000 the total number of non-UK students on undergraduate programmes was 15,411 representing 15.5% of the total non-UK undergraduate student population. Between 1996/97 and 2002/03, much of the expansion in overseas students recruitment was in postgraduate studies 5,540 students came from other countries in the EU and 13,666 from the rest of the world. In 2000 the student population could be broken down as follows:

<u>Undergraduate:</u>	<u>Post graduate:</u>
Other EU: 49,700	Other EU: 40,880
Non EU: 85,400	Non EU: 99,285.
UK : 1,542,515	UK 35,7335
Total in the UK: 1677615	Total in the UK: 2296265

Source: HES Online Information Services
<http://www.hesa.ac.uk/holisdocs/pubinfo/student/quals0102.csv>

Overseas students play an important role in the UK HE sector, and their contribution to the UK is expected to continue to grow over the coming years. Reflecting patterns in tourism the majority of overseas visitors to the UK are from the developed world from the EU and North America. The British Council estimated that international education is currently worth up to £11 billion directly and a further £12 billion indirectly to the UK economy each year.

Asylum Seekers in the UK

In 2004 there were 8,940 applications for asylum in the UK in the first quarter of 2004 (January to March). This was 17 per cent less than the previous quarter and 44 per cent less than first quarter of 2003. 42,315 asylum applications were received in 2003/04, 48 per cent lower than the 80,880 applications received in 2002/03.

Between 2002 and 2004 The UK received application from 84,130 asylum seekers. The majority of these applications were from individual leaving conflict situations in the developing world. The majority of application are from Somalia, China, Zimbabwe, Iran, Turkey, Pakistan, India, Iraq Afghanistan and the Democratic Republic of Congo and by continent can be broken down as follows:

Asia 20,755
Africa 29,390
Europe 13,235
Americas 2,290
Middles East 18,315
Not known 145

Source: 5.11 Applications¹ received for asylum in the United Kingdom, excluding dependants, by nationality, 1994 to 2002

As all of the statistics above illustrate despite media depiction the majority of overseas visitors to the UK do not arrive through the asylum seeking process and are originate in the main from the developed world.

HIV/AIDS and African Communities

Since 1999 the number of new HIV diagnoses acquired heterosexually in the UK has been higher than the number of people diagnosed through sex between men. The majority of these cases, approximately 80 per cent are thought to have been acquired abroad, particularly in sub-Saharan Africa where 29.4 million people are currently living with HIV/AIDS and where 58% of HIV-positive adults are women.

The majority of migrants in the UK with HIV, or who are diagnosed here are currently people from African countries. Many originate from areas with high levels of HIV prevalence such as Zimbabwe with very little access to monitoring and treatment facilities. Some have arrived here as asylum seekers with little or no knowledge of the services available to them and others come to the UK on a short-term visa and fall ill and then become diagnosed with HIV here.

In 2002 it was estimated that there are 7,000 African people living with diagnosed HIV infection in the UK. (Sigma, NAT, NAM, AHPN, 2003)
Several thousand more may have undiagnosed infection. A survey

undertaken in 2002 indicated that 66% of African men and 70% of African women have never had an HIV test.

Incidence of HIV is several times higher among African communities in the UK than among the White British population. African people present later for testing and have significantly more advanced stages of HIV at the point of diagnosis than their white counterparts.

The past six years has seen an average increase in new diagnoses of 30% each year for men and 42 % each year for women. In 2001 there were two African women diagnosed for every African man diagnosed. Reasons to explain this include more widespread access to testing through antenatal HIV testing, social vulnerability and increased biological susceptibility. The increase in new diagnosis is driven by an increase access to treatment and improved prevention.

3. Consultation response

Who will be eligible for free NHS primary medical services?

3.1. Do you agree that strengthening the rules around access to free NHS primary medical services for overseas visitors, to better match those for hospital treatment will bring clarity to both the overseas visitor and frontline staff working in practices and PCTs?

3.2. If not please specify why.

No, the AHPN does not feel that this will increase clarity on either side. Frontline staff will experience increased pressure to enforce identity checks, and increased bureaucracy for the recovery of payment, which will detract from their roles as medical providers. The level of training and monitoring which will be required will be both labour and time consuming. The planned measures have also been proposed **without any attempt to cost the implementation**. There is as yet no evidence to substantiate the claim that these measures will save funds.

Although asylum seekers, refugees and those granted indefinite leave to remain are all eligible for free medical treatment under the NHS many are unaware of this eligibility. Health and social care workers are also unaware of their rights and responsibilities. This has already led to inconsistency in the levels of care provided across the country. This has been further compounded by the recent amendments to secondary care. In some parts of the country this has led to the use of emergency treatment facilities for routine healthcare matters and in others inconsistent delivery of HIV antiretroviral treatment as 'emergency treatment'. The proposed measures have the potential to exacerbate these inconsistencies leading to piecemeal healthcare provision, increased confusion and inappropriate and expensive use of emergency facilities.

The British Medical Council and British Council of Midwives have issued statements indicating that they do not wish to assume roles, which will involve 'policing' the immigration system. Asylum seekers generally have some form of Home Office identification. This is not automatically removed from them once they are refused. GPs therefore have no simple way of establishing entitlement - short of making a telephone call to NASS (National Asylum Support Service) or immigration every time a patient is seen. The proposed measures will involve a lot of policing and this will be expensive to resource. Although it has been suggested that all discussions for eligibility will be referred to Primary care Trusts the pressure on front line staff will be unavoidable.

Primary medical services for visitors ineligible for free NHS care.

Do you agree a system of charging should be introduced?

Not as articulated within the DoH document. As demonstrated in the preceding section the majority of visitors to the UK are tourists, students, employees and visitors from the developed world who access the NHS most regularly, for conditions less serious than HIV. We feel that these groups should be **the legitimate focus** of the DoH effort. They have access to the finances necessary to pay for health care and are treated most often for conditions other than HIV.

The current framework for proposed measures appears to be targeting those most vulnerable from the developing world. These proposals would accentuate inequalities rather address them. Charging undocumented migrants, failed asylum seekers, or visitors with AIDS, Tuberculosis or Malaria runs counter to public health interests. Seeking funds from those who are unlikely to possess them is neither cost effective nor productive. Such measures also run the risk of driving these diseases underground, and increase the burden on NHS A and E services.

3.5 If you have answered no what would be your reasons?

The proposed measures run counter to international commitments to combat HIV/AIDS.

The UK formally acknowledged the gravity of the global AIDS crisis during the G8 Summit and at the UN General Assembly Special Session on HIV/AIDS in 2001. Here it was agreed to set up and financially support the Global Fund for AIDS, TB and Malaria recognising the country's responsibility in the fight against communicable diseases. This together with WHO strategies offer the best hope of providing funds for treating HIV/AIDS and for preventing new infections, in order to ensure that 3 million people access combination therapy

by 2005. The proposed charges run counter to international policy and commitment made by the UK.

The proposed measures lead the AHPN to question the UK's commitment to the global consensus on HIV/AIDS under UNGASS 2001. We feel that the proposed measures run counter to international, regional and national commitments within the UNGASS report to combat HIV. Unless the UK government ensures free access to HIV/AIDS prevention and treatment facilities it will not be working towards,

'measures to eliminate all forms of discrimination against and to ensure the full enjoyment of human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information.' (UNGASS, 2001: 28)

The proposed measures inhumanely targets people from the developing world supporting current Home Office policy on asylum and immigration.

The AHPN questions whether or not the proposed measures are solely concerned with saving NHS funds rather than acting as support to the current Home Office clampdown on asylum and immigration.

Our fear is that the underlying target of these measures and those who will suffer the most from their implementation are people from the developing world. If these measures are aimed solely at reducing NHS costs the focus should be on visitors from America, Australia, New Zealand and Japan not visitors from war torn countries. Britain received 24.2 million overseas tourists in 2003 with expenditure of £11,737 million, 4.4% of national GDP. The highest levels of expenditure included that from the US (£2,443 million), Middle East (£527 million) and Japan (£320 million). The majority of visitors to the UK are tourists and students, and as such these are visitors from the developed world who access the NHS most regularly, for conditions less serious than HIV.

We feel that these groups should be **the legitimate focus** of the DoH effort. From the DoH perspective it is also more likely that there will be more success in securing reimbursements when targeting these groups. We accept that the DoH must be concerned with the allocation of finite resources and encourage increased vigilance in pursuing reimbursement through visitors' medical insurance or underwriting care through inter-country agreements.

Medical conditions such HIV, TB and Malaria (common in the Third World) should be underwritten by the NHS since many visitors from the developed world will have access to medical insurance and will be able to reimburse the NHS

The proposed measures will exacerbate poor health among asylum seekers

Asylum seekers are among the most vulnerable people in Britain. Displaced from their homes due to the threat of persecution, they are often subject to mental and physical violence seeking sanctuary in countries with more compassionate reputations. The UK Government's current system for the handling of asylum-seekers is not focused on helping, but rather on deterring them with present procedures such as the introduction of Section 55 as part of the Nationality and Immigration Act 2002 more punitive than compassionate in nature.

The AHPN feels that the proposed measures by the Department of Health are another example of this acting as support for changes to current Home Office and Immigration policy.

One in six refugees (17 per cent) have a physical health problem severe enough to affect their life, and two-thirds suffer significant anxiety or depression (Aldous et al, 1999). In addition, many experience act as barriers in accessing the right type of health care service, such as primary care

Evidence from research conducted by the British Medical Association (BMA, 2002) has clearly indicated that on arrival to the UK the health of asylum seekers although already precarious, often deteriorates. The health problems that many migrant populations encounter are linked to poverty and social exclusion. Their vulnerability is compounded by the fact that they may be poorly accommodated, and are quite likely to face racial and xenophobic harassment.

Common problems faced by asylum seekers and refugees are psychological and may be linked to trauma, or isolation from friends and community in the UK. They also experience the physical effects of war and torture such as rape/sexual assault, landmine injuries, beatings and malnutrition and social and psychological problems related to depression, stress and racial harassment. A significant number of asylum seekers are also prone to communicable diseases such as TB, Hepatitis and HIV/AIDS

The main reasons to explain the higher susceptibility to HIV include (Broring G et al, 2003):

1. Refugees and Asylum Seekers may have experienced situations of risk from High prevalence areas.
2. They maybe particularly vulnerable to contracting HIV because of the experiences that have led them to leave their countries of origin. e.g. rape, sexual assault torture
3. The experience of becoming an asylum seeker may mean people are exposed to malnutrition, poor living conditions and a lack of personal safety. Poor living conditions may contribute to sex work as a means of survival.
4. A lack of appropriate testing and treatment facilities in the developing world.

The United Nations Convention Relating to the Status of Refugees, which Britain signed in 1951, states that host countries must provide those fleeing tyranny and persecution with access to health, housing, education and employment services. Despite this recent migrants continue to face problems accessing health services in the UK due to unclear immigration status and ambiguities or fears about eligibility for health treatment.

The BMA study highlighted that from the point of entry not enough is being done to safeguard the health of asylum seekers. Basic medical testing is not routinely undertaken with communicable diseases such as HIV and tuberculosis (TB) often going undiagnosed. Those suffering from the psychological effects of torture are also not always referred to specialist centres. Equally concerning is that unaccompanied children are not given appropriate vaccinations and immunisations.

The current proposal to introduce user charges to communities who by the nature of their status in this country cannot work and thus pay for medical services is both inhumane and unethical contradicting international and national legislation on human rights and discrimination.

African communities must receive appropriate testing and treatment

The first National Strategy for Sexual Health and HIV was produced by the Department of Health in 2001. It identified that asylum seekers are a group 'at special risk' for whom information and advice need to be provided. Targeted prevention work with African communities was also identified as a priority but no targets were set for improving provision for refugees or asylum despite the fact that the Department itself highlighted need by estimating that over 60% of HIV diagnoses in the UK was among this group with over 80% heterosexually acquired in Sub Saharan Africa. The current proposals ignore the deficit in health services which meet need.

Delayed diagnosis concerns.

If certain African communities and other migrants are denied access to treatment the end result is that they will delay attending to serious conditions such as HIV which need to be treated in their infancy. Although TB treatment will remain free diagnosis remains chargeable. Who will be responsible for the loss of life if such patients cannot access A&E or GP care? Equally concerning is that if people are unaware of HIV/AIDS status there is a risk that behaviour will remain unchanged leading to an increased public health risk.

The risk to public health through Increased spread of HIV/AIDS

The UK already has the worse rates of sexually transmitted infections since the start of the NHS. Rates have doubled in the last five years. Increased rates of STI are widely regarded as a sign of potential transmission of HIV. Preventing people from accessing appropriate treatment and care, be they citizens of the UK, students, those seeking asylum or those with indefinite

leave to remain is both inhumane, unjust and poses significant risks to wider public health. HIV needs to be placed at the forefront of the NHS agenda and we feel that this proposed measure will undermine efforts of agencies, like ourselves, working to prevent the spread of STIs and HIV.

A system of charging should not be introduced particularly with regard to diagnostic testing, counselling and treatment services for sexually transmitted infection and HIV/AIDS. Africans living in the UK tend to present later for HIV/AIDS testing and we feel that the proposed measures would further deter people from taking up testing services. This has evident repercussions for the spread of the epidemic which will have further and weightier social and economic cost implications.

Under the National Health Service (Charges to Overseas Visitors) Regulations 1989, anyone who has been resident in the UK for more than a year is not subject to charge for NHS treatment. Asylum seekers are exempt as are claimants under Article 3 of European Convention on Human Rights. The AHPN support these entitlements as vital to tackling HIV in the UK.

This current legislation already poses a problem for people who enter the UK on short-term visas or without a visa, who discover HIV positive status in these first twelve months. These people are currently only eligible for 'emergency treatment' regardless of ability to pay, pregnancy status or how long they wish to remain in the country. The consultation document outlines that this 'emergency treatment will still be made available, however reports received by sexual health agencies have stated that many hospitals consider emergency treatment as that only available in accident and emergency departments'.

There is a risk that people may be treated repeatedly for life threatening opportunistic infections e.g. pneumonia without accessing the underlying cause of HIV. Timely antiretroviral treatment decreases levels of virus in the body and is a more humane response. The result of the combined measures of introducing charges for primary and hospital care will be to treat fatally weakened immune systems, shorter life terms and greater economic cost as people revisit emergency services for treatment of opportunistic infection

Proposed measures as a violation of Human Rights and Equality

The Human Rights Act (HRA) brings into national law the majority of the rights and freedoms set out in the European Convention on Human Rights. Withholding proper medical care from someone with a serious illness could be held to contravene Article 2 (right to life) or 3 (freedom from torture). Those rights are actionable directly in the domestic courts and create an obligation for courts, and "public authorities" to interpret the provisions of all legislation in a way that is compatible with the Convention. The NHS, Trusts and health professionals working within the NHS are seen as "public authorities" and therefore need to be aware of the Act. Although many aspects of care remain unchanged, the HRA is likely to have a great impact on the public awareness of patients' rights in relation to medical care.

Article 2 of the European Convention on Human Rights is concerned with the 'right to life'. This policy refers to any life threatening condition not just HIV. Applications for Exceptional leave within the UK remain are often made (not always successfully) under this clause. The proposed measures will undermine access to treatment and therefore this article of the convention. It states that *'Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.'*

Article 3 states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 14 of the Act is related to the Prohibition of Discrimination. Stating that *'The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.'*

The UK is also bound legislatively by the UN Declaration on Human Rights. Article 25 of this declaration recognises the right to health by migrant communities. Stating that these rights and freedoms *'shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.'*

The 1969 International convention on the Elimination of all Forms of Racial Discrimination also accords minority ethnic communities the right to access public health, medical care, social security and social services. ***The proposed measures contradict all these forms of legislation.***

The tone of the proposals will exacerbate racial tensions and discrimination

The AHPN feels that the link made between HIV and migration in the last year has contributed to the proposed measure. It has been suggested that there are a large number of people entering the UK for reasons of 'health tourism' in order to benefit from free HIV treatment on the NHS. This flawed concept has been used to introduce a range of policies that limit access to the UK, to HIV treatments and much needed social support services. Additionally, the proposed measure runs the risk of exacerbating this. Health professionals must also be careful not to breach section 20 of the Race Relations Act by discriminating against asylum seekers (by refusing to provide them with health care services, for example, or by providing lower standards of care.) It is unethical to refuse to accept particular patients solely because they may require expensive treatment (so-called 'uneconomic' patients).

As an umbrella African organisation we are concerned that the tone with which the proposed measures are introduced, will serve to stigmatise African communities compounding existing experiences of racial discrimination and

social exclusion with that of stigmatisation as the 'bearers' of disease within the British public mind.

There is no vaccine or cure for AIDS, but provided HIV is diagnosed early enough new treatments can prolong life for many. Access to essential life-saving HIV treatments is a human right. Although the National Health Service currently makes HIV treatments widely available, a range of barriers exist to equitable treatment access for some, particularly for overseas visitors. These include limited availability of information about treatment options, lack of patient support services for adherence to complex treatments, the discriminatory attitudes of health care workers, and regulatory restrictions affecting groups such as asylum seekers. Research indicates that the most common form of discrimination experienced by people with HIV in the UK is discrimination by health care providers.

Charges of Health Tourism are unsubstantiated.

The existence of alleged 'health tourism' to which this measure is clearly a response has not been substantiated and has also been contradicted by a recent study conducted by the Terence Higgins Trust among predominantly African service users of HIV services in London, Manchester and the West Midlands. The study found that:

- Most people only test positive for HIV when already ill, pregnant or after the diagnosis or death of a partner. This does not suggest the actions of those who enter the country specifically for HIV treatment.
- People accessing HIV treatment enter the country for a number of reasons and no one category of migrants stands above the others.
- Late diagnosis is a serious problem amongst African migrant communities because most wait until they are palpably ill before using medical services.
- HIV infection among UK based African people takes longer to diagnose, because many African people are here in very difficult circumstances – already experiencing racial discrimination and there is a strong resistance to facing the additional stigma of HIV.
- Most HIV in African communities is transmitted heterosexually, and this has only become more apparent, because the NHS has diagnosed more women with HIV through antenatal screening programme over the last two years.

Access to antenatal care is vital to stemming the epidemic

As early as 1999 government guidelines have stated that 'all pregnant women should be offered an HIV test' (Health Service Circular 1999/183). To withdraw this option is to contribute to both heterosexual and mother to child transmission. THT Direct the National HIV/AIDS helpline has already had reports that many hospitals have diagnosed women as HIV positive, but denied access to treatment if they do not have the ability to pay or qualify for the twelve-month rule. The AHPN consider this inhumane and would not wish to see this as an outcome duplicated within primary medical services involved

in HIV testing. Most HIV among African communities is acquired heterosexually antenatal testing and referral is vital to stemming the epidemic.

The Impact upon unaccompanied children

The Department of Health document does not consider the impact on unaccompanied children and young people under the age of 18. The impact upon children's issues is of specific concern to African communities – because the majority of children currently affected by HIV, Tuberculosis and Malaria will, be African. The proposed policy contradicts other policy and legislation such as The Children Act 1989, Lord Laming's recommendations following the Victoria Climbié Inquiry and the current Children's Bill.

The largely invisible population of young people born overseas, who live in British cities without their biological parents will be significantly affected by restricting access to General practice. These maybe school age children who have sought asylum (usually without any knowledge of our legal system) without any adult, even a distant relative. These children have fled their homelands after civil war or state-sponsored genocide and few attend school or maintain a fixed address

The health needs of these children can be serious and complex (psychological and physical trauma, TB, substance use or pregnancy following rape), however health services will be inaccessible to them if the proposed measures are introduced. Local Government currently acts as the 'corporate parent' of these children. The AHPN feel that the proposed measures undermine the necessary role of primary medical providers for this group. These children maybe without parental support or guidance and can be exposed to commercial, sexual and servile exploitation. Access to a GP, for treatment of a minor injury, may be their first opportunity for contact with a responsible, law-abiding UK citizen. Removing this right will severely impact on their future life opportunities. It is also a violation of the right to health guaranteed under the UN Convention of the Rights of the Child.

How would the proposed new scheme operate?

3.6) Should the onus of proving eligibility for free NHS primary medical services be the responsibility for the overseas visitor?

3.7) If not please specify your reasons.

No. The proposed scheme should focus on the **presenting medical diagnosis**, without being the responsibility of the patient or NHS staff to operate.

If we look at the current situation with regard to HIV. The onus is on all positive people to access help from Social Services. Whereas this may be an appropriate measure for those familiar with language and the services

provided in the UK many Africans and other overseas visitors are new to the culture and consequently the services provided in the UK.

If we take the example of asylum seekers. The nature of entering a country through asylum means that many people arrive without documents. The clients that AHPN member organisations work with often experience administrative errors which delay the release of vital information such as their National Insurance number and or passport being with Home Office, while an application is being made, which can lead to them being denied access to benefits and accommodation. The proposed measures rely heavily upon proof of eligibility for primary medical services, if this proof is withheld due to bureaucratic error, which is all too likely this will have severe implications for those awaiting diagnosis and treatment for HIV.

3.8) What practical difficulties do you envisage that practices would have in operating the proposals outlined in this document?

The most apparent difficulty has already been articulated by both the British Medical Association and the British Council of Midwives. Placing a duty upon doctors and other medical professionals to assess eligibility for medical services will have the evident implication that treatment and care will no longer be based upon clinical judgement, but rather nationality. Once again we re-iterate that treatment should be dependent on presenting medical diagnosis.

General Medical Council guidelines clearly state that doctors should put the needs of patients before all other concerns. These measures will compromise both professional integrity and ethical doctor-patient relations placing professionals in the role of what the British Council of Midwives has termed as 'social police'.

As mentioned earlier Asylum seekers generally have some form of Home Office identification. This is not automatically removed from them once they are refused. GPs therefore have no simple way of establishing entitlement - short of making a telephone call to the National Asylum Support Service (NASS) or immigration every time a patient is seen. The proposed measures will involve a lot of policing and this will be expensive to resource.

The immigration system is also constantly changing and GPs may find it hard to ascertain when someone is no longer entitled. The simple solution for many practices will be to refuse to treat any overseas visitor, thereby including many who required and are still entitled to treatment.

The suggestion of GPs only offering refused asylum seekers treatment as private patients is a contradiction in terms. When NASS support is initially granted to an asylum seeker it is because they have no visible means of support. As asylum seekers are evicted from NASS property and lose financial support on refusal - but are not entitled to work, they lack the means to pay for treatment.

Current guidelines on providing 'emergency treatment' already lack clarity which has meant that patients have been receiving different levels of care around the country. These guidelines will need to be implemented with consistency in order to be effective and again this will be of significant economic cost.

3.9) What other measures do you think the Government should consider which would reduce the instances whereby persons who are not ordinarily resident in this country access and receive free NHS primary medical services?

3.10) Would you agree that a form of self – certification would help reduce the numbers of people who receive free NHS primary medical services to which they may not legitimately be entitled?

3.11) If not please specify your reasons.

No, the AHPN does not support the introduction of a national identity card scheme, which we feel will have worrying costs and few benefits. Such a scheme would undermine rights such as privacy and equality, and would be unlikely to yield any reduction to benefits or medical fraud.

Analyses of countries in Europe, where a variety of ID card schemes are in place, shows that there are no proven benefits in terms of cutting fraud, reducing crime or tackling terrorism. Identity cards have often been easily forged and have had negative effects on community relations, with those from minority ethnic groups being required to prove their identity most often. If people seeking GP and hospital treatment will have to present a card each time they visit a medical provider there is a significant risk that providers will discriminate with disproportionate use against African and other minority ethnic communities.

As we have already mentioned Africans are already likely to use medical services later than other groups other than the UK we would not want to see a situation in which discrimination leads to a lower number taking up vital medical services.

3.12) Should members of EEA countries or 'insured' Swiss residents visiting the UK be required to carry a form E111 completed by their home country, or from 1 June 2004, the European Health Insurance card.

3.13) If not please specify your reasons.

How would eligibility be confirmed?

3.14) Are there any other options that the Government should consider for checking a persons eligibility, and if so, what are they?

Their medical condition and the types of treatment and referral required after accessing primary medical care.

Existing Overseas Visitors who currently receive free primary medical services.

3.15) Do you agree with this approach to existing overseas visitors who currently receive free services?

This paper argues that the

As mentioned earlier the majority of visitors to the UK, are tourists, students, employees and visitors from the developed world who currently access the NHS most regularly, with less serious conditions than HIV. This group should be **the legitimate focus** of the DoH effort since it is here that the DoH are most likely to succeed in securing reimbursements. The AHPN encourages the DoH to be more vigilant in obtaining reimbursement through visitors' medical insurance or underwriting care through inter-country agreements. Only a small proportion of UK visitors are from the Third World (and Africa particularly). This group **should not be the legitimate focus of the policy** since it would be less cost effective to pursue funds. Pragmatically, specific medical conditions (common in the Third World) can be underwritten by the NHS since few such visitors will have medical insurance.

The UK currently support and promotes the Global Fund for AIDS Tuberculosis and Malaria. The AHPN would like to emphasises that it would be controversial for domestic British policy to run counter to the efforts of international strategies such as those of the Global Fund and the World Health Organisation Strategy which aims to ensure 3 million people access combination drug therapy by the year 2005. As mentioned above the proposed measure also runs counter to the outcomes of the United Nations General Assembly Special Session on AIDS.

3.16) If not, please specify your reasons.

3.17) Are there any alternative options for handling existing overseas visitors who currently receive free NHS primary medical services that the Government could consider, and, if so, what are they?

As mentioned earlier the majority of overseas visitors to the UK are from the developed worlds that are likely to have medical insurance. We feel that it will be fairer and practically efficient to seek reimbursement for care from those who have access to medical insurance

Public Health

3.18) Are there any primary medical services which you consider should continue to be freely available on public health grounds?

Yes, this policy should promote greater free Access to health Care for all people with AIDS, Tuberculosis and Malaria.

Annex D of the consultation document highlights a number of exempt diseases for which no treatment charges can be made. This includes other sexually transmitted infections and communicable diseases such as Malaria and TB. These diseases still need diagnosis before they can be treated and the introduction of charges will reduce the numbers who are able to access treatment. A significant proportion of people access diagnostic testing for STIs and HIV through information received at GP services. We feel that the primary medical services such as GP and Midwives services should be freely available.

The AHPN would like to request that this issue is addressed and that provision is also made for testing and treatment related to HIV/AIDS, which is no more expensive to treat than other renal and hepatic conditions outlined in this appendix.

The AHPN would also recommend that the definition of 'emergency treatment' within the document is also revised to include pregnant women with HIV and people whose HIV status is severe enough to require combination treatment according to the British HIV Association's guidelines.

It is the responsibility of the Department of Health to act in favour of public health and we strongly feel that restricting access to primary medical care will impact upon the take up of testing and treatment facilities. The measures proposed in this document can be considered inhumane, a violation of human rights legislation at national and international level and as posing a considerable threat to public health in the UK.

Conclusion

The introduction of charges for primary care services as proposed in the consultation if implemented would exacerbate the health inequalities that exist in Black Minority Ethnic and migrant communities. Its implementation would further discriminate against those find themselves vulnerable and unable to navigate an already complex healthcare system, namely failed asylum seekers, undocumented migrants, and overstayers. These provisions would counter the strides made in public health, and would serve to push people underground, especially people with special needs like HIV/AIDS, who desperately need life saving treatment and services. Far from saving money it would further burden the system as A & E services would become their source of primary care. Further, it would force people to turn up for care when their conditions have progressed beyond repair. Introducing charges for primary care would be a retrograde from the strides made towards a preventative model of care. The introduction of charges to the most vulnerable in our society counter the very raison d'être of the NHS.

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