Note on access to treatment for undocumented migrants and those refused leave to remain

1. Introduction

The National AIDS Trust (NAT) and Terrence Higgins Trust (THT) welcome the opportunity on Thursday 9 February in Westminster Hall for Members to debate the Health Committee's Report 'New Developments in Sexual Health and HIV/AIDS Policy'. This note examines the Government response (Cm 6649) in relation to access to HIV treatment for certain categories of migrants. The Committee made a powerful case to exempt HIV treatment from NHS charges on grounds both of public health and cost-effectiveness. The Government response on this point has caused widespread disappointment, both for its refusal to change current policy and for its failure to address any of the Committee's arguments. NAT and THT aim in this note briefly to rebut the Government's arguments and re-emphasise the humanitarian distress and harm to public health resulting from these Government measures.

2. Are these charges new?

The Government rightly states that since the introduction of the charging regime HIV treatment has never been free to chargeable overseas visitors. But **what changed in 2004 was the definition of 'chargeable overseas visitor'**. It was no longer enough to prove 12 months residence – secondary legislation was introduced to add the word 'lawfully'. The new requirement of 12 months **lawful** residence suddenly removed (in all probability) many thousands from the right to access free NHS care. Putting aside the merits or otherwise of this decision, this meant charges were being applied where NHS treatment had previously been free. NAT and THT had not previously done much to argue for exemption of HIV treatment from charging, given that in practice there was no difficulty for people to access HIV treatment. The issue has become urgent because of the Government's actions in 2004 and the widespread distress they have caused.

3. No government answer to either the public health argument or the cost effectiveness argument

At the heart of the Committee's report, and of NAT and THT's submissions, was a simple contention – that **to allow serious communicable disease to go untreated in our community is to undermine public health**. Not only will the individuals' health deteriorate, but there is a substantially increased

infectiousness as a result of not being on treatment. Moreover the lack of access to clinical support removes a key opportunity to support safer sexual behaviours. The result of the Government's actions is an increased risk of HIV transmission for the wider public. The emergency bed days resulting from caring for someone with a failing immune system are far more costly to the NHS than providing anti-retroviral treatment.

The Government response makes no serious attempt to question either of these arguments. It falls back on making again the general case for there to be charges for overseas visitors. But this was never the issue in the Committee's report – the argument here is not against charging in general but against **charging for HIV treatment.** The Government has for good public health reasons a whole list of conditions and circumstances where NHS treatment remains free irrespective of residency status. Why is every other condition treatable in a GUM clinic exempt from NHS treatment charges, apart from HIV? The public health reasons why other STIs are exempt from charges apply equally to HIV. The fact that HIV is even more serious than other STIs treated in GUM, possibly life-threatening and at present incurable adds urgency to the argument to use treatment as a key intervention to reduce onward transmission. The case for it also to be the cheaper option has already been made. It is hard to see the Government's intransigence as anything other than HIV-related discrimination.

4. 'Immediately necessary care' and 'the easement clause'

Some confusion has arisen from the use of two phrases 'immediately necessary care' and 'the easement clause'. This section aims to clarify the meaning of these two terms and explain why they do not meet the concerns raised by the Committee.

'Immediately necessary treatment' refers to the fact that if, in the judgement of a clinician, treatment is immediately necessary either to save life or prevent a condition becoming life-threatening, treatment must be provided in advance of any investigation of entitlement to free treatment or ability to pay. We must stress that **it remains the case for chargeable overseas visitors that they have to pay for this treatment and will in all probability receive later on a significant bill**. Most of the people we are discussing are destitute and the mere prospect of a bill will be enough to deter them from accessing care. Maternity care may be classed as 'immediately necessary treatment'. But in THT's direct experience, this policy has led women to refuse needed treatment. It comes as a shock to many that we are charging pregnant women for the care within which many would have the first real opportunity to test for HIV, and charging for the drugs they might need if HIV positive to prevent transmission of HIV from mother to child.

The 'easement clause' allows those already being seen for HIV treatment and care before the failure of their asylum claim to continue on free treatment after a

claim has failed until they leave the country. Of course this is welcome (though not to have allowed this would in all probability have found the Government in breach of the Human Rights Act). It does not meet the needs of those who are diagnosed after the failure of their asylum claim (or those here permanently but without documentation).

5. 'HIV treatment tourism'

The Government restates, with increasing desperation and vagueness, their contention of the reality of HIV-related health tourism. Overseas Visitor Managers have apparently given 'many, many examples' of people 'who approach the NHS every day seeking to abuse its services'. None of this information has ever been made public or tested. Overseas visitor managers are not in a position to come to any sort of evidenced judgement on the reasons for someone's migration to the UK. We respectfully suggest that until the Government can give detailed evidence **in relation to HIV** that people are migrating or have ever migrated to the UK in significant numbers simply to access free HIV treatment, the Members should discount this argument.

The majority of those now being denied treatment are people who have overstayed their visas or failed in their asylum application, and who have only been diagnosed after the expiry of their visa or the failure of their claim. The Government seeks to cast doubt on the relevance of the THT/GHT[1] survey of migrants, pointing out that their residency status was not ascertained. This is to miss the point. The fact that people are accessing HIV treatment a considerable time after their arrival in the UK puts paid to the idea of people arriving simply to access HIV services. Were people migrating for such a purpose they would access treatment soon after arrival in this country, whilst they were still entitled to it. The idea of someone trying to enter the UK to access HIV treatment, making a claim for asylum, but only attempting to access care after the failure of their claim is preposterous.

The THT/GHT survey was cited as the only relevant research available. Further research would be welcome.

We might add, given the fact that HIV treatment is not subject to this charging regime in Scotland, it is surprising that these supposed HIV-treatment tourists have not travelled north of the border to access care.

6. Is there a problem?

At para.27 the Government quotes two London hospital consultants as stating that they have seen no evidence that the new charges have resulted in denial of treatment. Consultants are not best placed to make that judgement since those

[1] Terrence Higgins Trust and George House Trust 2003 - available from Terrence Higgins Trust

deemed ineligible for treatment are often intercepted before seeing a consultant (see the process as described by the Government at para.21).

NAT is currently gathering cases of denial of treatment from HIV organisations across the country. THT has already come across many cases through its own work. We can readily provide examples of denial of care. They include pregnant mothers deterred from maternity care, people co-infected with HIV and TB who discontinue their TB treatment for fear of their HIV-related bills, and people either without legal residency status or whose status is unclear being billed for many thousands of pounds. To give examples from just one service provider, the Leicester AIDS Support Services (LASS) recently contacted us with six new cases of charging for treatment. In one case the invoices resulted in the person 'disappearing' for three months, thus not adhering to his treatment for HIV. This obviously seriously endangers the person's health and can result in the development of drug resistant HIV. Another of the cases involves someone currently unable to afford to buy food, being billed for more than £10,000 and being pursued by a debt recovery agency, resulting in enormous mental anguish.

7. Conclusion

The answer to unfounded attempts to settle in the UK is an effective immigration and asylum system which deals with cases promptly and fairly, welcoming those whose claims are accepted and supporting the humane and efficient removal of those whose claims fail. The use of healthcare as an instrument of immigration policy is unacceptable. The withdrawal of accessible life-saving treatments does not speed up removals, it hastens deaths. We are simply arguing that while people are here they should be treated well – we do not think that is too much to ask.

National AIDS Trust
Terrence Higgins Trust

February 2006