



UKBA Consultation: Refusing entry or stay to NHS debtors

NAT (National AIDS Trust) welcomes the opportunity to respond to the UK Border Agency (UKBA) consultation on refusing entry or stay to NHS debtors.

NAT is the UK's leading independent policy and campaigning charity on HIV. We develop policies and campaign to halt the spread of HIV and improve the quality of life of people living with HIV. Policy and advocacy related to the needs of vulnerable and socially disadvantaged communities in the UK, including migrants living with HIV, forms an important element of our work.

NAT has worked closely with the Home Office and UKBA on key migration issues over the past several years, most notably around the dispersal, detention and removal of asylum seekers living with HIV.

For certain infections, a major burden of disease falls upon particular groups of people who were not born in the UK - HIV is one such case. According to data from the Health Protection Agency (HPA), around 40% of new HIV cases in England, Wales and Northern Ireland in 2009 resulted from heterosexual contact outside the UK. 87% of heterosexual Black Africans diagnosed with HIV in the UK probably acquired their infection abroad. It is important to stress that nearly all migrants in the UK who were infected overseas only learned of their infection when diagnosed in the UK, often at a late stage of infection when very ill. They did not come to the UK knowing they had HIV.

In addition, a growing number of migrants to the UK are being infected with HIV after their arrival here.

1. Should non-payment of NHS charges be sufficient grounds for refusing entry or extension of stay to a foreign national?

No.

NAT opposes non-payment of NHS charges as a sufficient basis for refusal of entry because -

- **it is a disproportionate and misdirected response to the perceived 'problem' of health tourism**
- **it is discriminatory**
- **it will deter from urgent and from immediately necessary treatment many migrants currently living in the UK.**

A disproportionate and misdirected response

It is striking that the three case studies used in the UKBA consultation document are all of individuals entering the UK for the express purpose of accessing NHS care free of charge. It is also very misleading. Most people would accept such abuse should be addressed. But there is no robust evidence as to how common such actions are. What there is strong evidence for in the HIV sector is that many people currently living in the UK - who have come here for very different reasons but who do not now enjoy ordinary resident status - fall ill unexpectedly, need secondary care, are liable for charges and are simply unable to pay the substantial bills (often for thousands of pounds). In most cases this is because they are destitute, and have already been acknowledged by the UKBA to be so.

NAT has shown conclusively that in relation to HIV, health tourism is a myth, and should not be the basis of any policy in relation to access to treatment.¹

Were HIV treatment a 'pull factor' for migration to the UK we would expect HIV infection to be disproportionately high amongst migrants to the UK compared with those staying in their country of origin. But the HIV prevalence amongst migrants from sub-Saharan African countries is invariably lower than in their country of origin. Furthermore, HPA data show that the average length of time between a migrant's arrival and an HIV diagnosis is almost five years – hardly evidence of intent to access antiretroviral (ARV) treatment on arrival. This conclusion is confirmed by surveys² and by the Home Office's own research on motivations for migration and destination choice.³

In summary, the proposal to deny entry to those with unpaid NHS bills will have no impact on the decisions of these chargeable individuals to come to the UK in the first place, who do not migrate with the express aim of accessing free NHS care and who the evidence suggests to be the vast majority of those affected. It penalises a much larger group of people for the actions of a minority. It is therefore disproportionate and misdirected.

We also note that from the perspective of Government immigration policy this proposal could well be counterproductive. The majority of those chargeable are visa overstayers, migrants who have entered the UK unlawfully, and refused asylum

¹ NAT. (2008). *The Myth of HIV Tourism*. www.nat.org.uk

² THT and George House Trust (2003) *Recent Migrants Using HIV Services in England*, www.tht.org.uk.

³ Home Office (2002) *Understanding the decision-making of asylum seekers*, www.homeoffice.gov.uk.

seekers. As it is, there is no evidence that charging for NHS treatment has any impact on willingness to leave the UK. What is probable, however, is that knowing one has incurred an unpayable bill (often unavoidably) and that this prevents return to the UK at any point, will deter individuals from leaving the UK and encourage ongoing undocumented residence.

A discriminatory response

The proposal discriminates against those who become ill and in many instances (including for those with HIV) would be disability discrimination and open to legal challenge. It also discriminates against those who are poor.

Again, the UKBA consultation document fails to address the actual situation of most of those affected by NHS charges, who do not travel here with the specific intention of accessing free treatment. Foreign nationals travel for a host of reasons but sometimes fall ill whilst here, and because of immigration status and/or nationality, some will not have entitlement to free NHS care. For those who need 'urgent' or 'immediately necessary' treatment there is little choice as to whether or not to access NHS services, and inability to pay means an unavoidable and unpayable bill. To refuse further application for entry on these grounds is effectively to discriminate against those who fall ill.

HIV infection is a disability in law under the Equality Act 2010. To refuse entry on the basis of an unpaid bill accrued through accessing 'immediately necessary' HIV treatment is to discriminate on the basis of disability. We would certainly look at challenging any such decision on legal grounds.

Of course some (but in our view a very small number) of those who fall ill and who are charged in the circumstances described above may have means to pay a bill. They will not be refused any future claim for entry because a bill is unpaid, and this will be simply because they have greater private means than others. This unacceptably privileges the well-off within the immigration system and discriminates against those in poverty.

A deterrent to testing and treatment

NAT is concerned that charging for HIV treatment has already acted as a serious deterrent to seeking healthcare for those who cannot afford to pay.⁴ Patients are lost to follow-up because of fear of billing. In some cases, they had TB, or were pregnant, putting others at ongoing risk as well as themselves.

Interruption of or withdrawal from HIV treatment carries extremely serious consequences. HIV drugs need to be taken daily without interruption - not to do so results not just in ill-health but in the development of drug resistance. Future treatment will as a result be more expensive. Moreover, when not on treatment the individual is much more infectious and more likely to pass HIV on to others. A misguided treatment access policy could therefore result in an increase in HIV infection in the UK.

In addition to acting as a deterrent to access treatment for those diagnosed, charging some foreign nationals for HIV treatment also acts as a deterrent to have an HIV test.

⁴ A number of cases can be downloaded online at:
<http://www.nat.org.uk/Media%20library/Files/PDF%20documents/NAT-Access-to-treatment-and-care-cases.pdf>.

There is already a serious problem of late diagnosis in African communities, which increases risk of death, serious illness and opportunities for transmission to others. In the UK in 2008, 66% of black Africans who were diagnosed with HIV were diagnosed late. This compares with 55% of late diagnoses in the community as a whole.⁵ If, on top of existing stigma around HIV, there is a perception that an HIV diagnosis will result in substantial and unpayable hospital bills, even more people will decide that they would prefer not to know their HIV status, and hope for the best.

Under the new proposals, in addition to fear of an unpayable bill, there will be knowledge that such a bill will undermine any future application for residence or entry to the UK, or delay to an application for citizenship. The HIV sector has for years been attempting to reassure those in migrant communities that accessing HIV testing and treatment will not have an impact on immigration processes - this has been a difficult task even when true.

Were this proposal to be agreed, we could no longer provide this assurance. NAT have no doubt that this will further deter many people living in the UK from accessing diagnosis and treatment both for HIV and other conditions, even when the condition is urgently in need of treatment or possibly life-threatening. Indeed, the stated goal of the new proposals is to deter from accessing care without payment. The Government needs explain how such a policy could be considered humane, consistent with human rights obligations, and with its duty to protect and promote public health.

Inconsistent application of rules and lack of review/appeal procedures

In practice, charging for NHS secondary care only takes place in England, not in Scotland, Wales or Northern Ireland. Scotland and Northern Ireland choose to ignore charging regulations. Wales has amended charging regulations to allow refused asylum seekers to access free secondary care including for HIV.⁶

It is clear that the proposed policy cannot be fairly introduced when there is inconsistent charging policy and/or practice across the four nations. NAT see no likelihood of the other three nations adopting in practice the approach pursued in England (and we would of course campaign strongly against any such moves).

Even within England, there is evidence that charges are applied inconsistently, which undermines the equity of the proposed UKBA system. There is widespread misunderstanding and misinterpretation of the current regulations, causing distress to patients who are incorrectly advised that they will be charged for thousands of pounds for HIV treatment.⁷ Some may have the necessary support from a doctor, lawyer or HIV support organisation to challenge these incorrect judgements. Others may choose not to access treatment that they cannot afford, with serious individual and public health consequences. Crucially, they have no recourse to appeal through any independent review mechanism, beyond the generic NHS complaints procedure.

If applications to enter or remain in the UK are to be refused based on evidence of personal NHS debt, the lack of formal review or appeal of decisions would have to be

⁵ Diagnosed when CD4 count was less than 350cells/mm³. HPA. 2009. *HIV in the United Kingdom: 2009 Report*.

⁶ Welsh Statutory Instruments (2009) No. 1512 (W.148).

⁷ Thomas F, et al. "If I cannot access services, then there is no reason for me to test": the impacts of health service charges on HIV testing and treatment amongst migrants in England. *AIDS Care* 22: 526-531, 2010.

addressed. The lack of such an appeal process would constitute a denial of fundamental human rights and due process. Immigration sanctions based on such charging decisions would be frequently challenged.

Should the Government wish to deny entry to genuine 'health tourists' who come to the UK on tourist or multi-entry visas for the sole or main purpose of accessing free treatment on the NHS, without then paying bills, a system could possibly be considered that allows NHS Trusts to report to UKBA on a discretionary basis such individuals. But there would need to be careful consideration of the cost-effectiveness of such a system, the consistent criteria to be used in making such judgements and the rights of an individual to challenge the claim that s/he is a health tourist, though an independent review and appeal system.

2. Where it is subsequently established that a holder of a long-term or multiple entry visa has evaded payments of NHS charges, is it fair to curtail or cancel their permission to travel to the UK?

No, for the reasons set out in answer to question 1.

In addition, NAT questions the appropriateness of the use of 'evasion' to describe unpaid NHS charges, which implies unwillingness to pay. As made clear in answer to question 1, the main cause of NHS debt is inability, not unwillingness, to pay treatment charges. Many chargeable foreign nationals have no personal income at all, being unable to work because of Government policy and ineligible for Government support.

Whilst in theory debt can be written off by a Trust, there is no clarity as to whether or not someone with written-off debt would also be deemed as an 'evader' of charges for immigration purposes. Even if they were not, experience to date is that processes on the writing off of debt are either non-existent or haphazard and very inconsistent between Trusts. There is no Guidance for Trusts on how and when to write off debt beyond basic information on the fact that it is possible to do so. The effect will be that entry will be denied to individuals on an inconsistent basis, ignoring the key question of ability to pay.

3. Should non-payment of NHS charges be sufficient grounds for delaying someone's application to become a British citizen or permanent resident?

No.

This proposal will have a disproportionate impact upon the most vulnerable migrants, including those living in poverty, who happen to become ill and who are unable to pay their NHS charges. Delaying applications to become a British citizen or permanent resident will not alter their ability to pay NHS charges (and would certainly prolong the period in which they are unable to pay such charges) and will unnecessarily add to the hardship they are already experiencing. It could also be discriminatory under the Equality Act 2010, which provides protection against discrimination from the point of HIV diagnosis.

NAT is also concerned that any further source of delay to applications for residency or citizenship will simply extend the experience of insecure immigration status and prolong the stress already suffered by many migrants. This stress can have

significant impacts on the health of migrants living with HIV, and creates uncertainty in all areas of their lives.

The current Regulatory Impact Assessment is fundamentally flawed in its assumptions. It is striking, even were we to accept its estimates, how small are the amounts discussed in the context of the overall NHS budget. The NPV of unpaid debts over 5 years is merely £6.12 m. This figure is not the full story of the impact on NHS resources of charging, however. It does not take into account the additional health costs of those unwilling to leave because of fears of never being allowed back. Nor does it consider the increased costs of intensive or emergency treatment, which result from individuals delaying earlier access to healthcare because of fear of the consequences of unpaid bills.

But a more serious problem with the calculations is the assumption that all those with outstanding NHS debts are health tourists who could pay should they wish to. The opposite is the case - most chargeable people with HIV are not health tourists but living here and have no funds to pay bills. We believe this is probably the case for all chargeable patients. The proposal to link their unpaid bills to future immigration decisions will have no impact on their presence in the UK, their need for urgent or immediately treatment, the raising of a bill or their ability to pay. Were this group removed from the calculation it would become clear that the amount of likely recoverable debt, versus the resources used to pursue it, makes the proposals not cost-effective but a waste of taxpayers' money.

4. Should there be a minimum level of outstanding payments owing before the new sanction is enforced?

There should not be any sanctions enforced for outstanding payments.

5. Is it appropriate for the UK Border Agency to receive data on non-payers from the NHS in a more systematic manner across the UK?

No.

The sharing of data about unpaid treatment charges between the NHS and UKBA is an unacceptable breach of the confidentiality of migrants living with HIV.

NAT is concerned that regardless of the proposed safeguards, the sharing of data about NHS debts may result in the disclosure of a patient's HIV status to UKBA without their permission. This may well be simply a result of the lapses in confidentiality which we know afflict any administrative system (and of which there have been many well-publicised instances recently).

But additionally, given what has been stated above around unavoidable and unpayable debt and disability discrimination issues, the refusal process linked to unpaid NHS debt will inevitably prompt challenges to decisions where clinical detail has to be shared to make a case as to the unfairness of the process.

Thus the process will inevitable lead to unacceptable breaches of patients' medical confidentiality, despite promised safeguards. This is an issue of particular concern to many migrants living with HIV, who may fear any impact their HIV status may have on immigration applications. HIV is a particularly stigmatised condition.

More generally, data-sharing between the NHS and UKBA will undermine the trust that patients have in the NHS, and in their doctors. This could seriously compromise the effectiveness of HIV treatment for chargeable migrants, and may encourage them to go underground due to misunderstandings over entitlements, resulting in an increased 'pool' of infectiousness in society and raising the possibility of onward transmission.

**6. Are the proposed safeguards sufficient to protect the individual?
If no, what other safeguards should be put in place?**

NAT cannot suggest any such safeguards, as there is an inherent risk to confidentiality for the patient in the transfer of data.

7. How long should the NHS wait before it hands over data to the UK Border Agency on those who have failed to pay their NHS charges?

The NHS should not hand over any data to the UK Border Agency.

8. Would you agree that information should be provided to the UK Border Agency by NHS Scotland Counter Fraud Services on non-payers as soon as it is clear that the overseas visitor will not pay?

No.

NHS Scotland does not in practice charge for HIV treatment, so NAT is not currently concerned that this proposal will affect people living with HIV in the same way as outlined in response to questions 5-7. However, NAT still opposes the principle of information sharing between NHS Scotland Counter Fraud Services and UKBA.

If no, how long should NHS Scotland Counter Fraud Services wait before providing the information?

NHS Scotland Counter Fraud Services should not provide the information at any time.

9. Is it appropriate to keep a record of previous non payments in order to assist the UK Border Agency in making informed decisions on any future immigration application? (Previous behaviour, conduct and character are matters that are pertinent to immigration decisions.)

No, for the reasons outlined in answer to question 1.

In addition, non payment of NHS treatment charges should not be used as evidence of personal suitability in immigration applications. To make non-payment analogous to previous behaviour, conduct and character in immigration decisions adds a moral element which is not relevant or appropriate to the issue of NHS debt.

In the case of unpaid treatment charges, inability to pay is a far more relevant consideration than unwillingness or evasion on the part of foreign nationals. Many who have incurred debts for HIV treatment will have done so while in a precarious personal and financial position. Those who are chargeable for HIV treatment are very often refused asylum seekers, visa overstayers and people without documentation, who would have little or no personal income because they are unable to work legally in the UK.

10. In addition to the proposed safeguards, are further specific safeguards required to protect the interests of children or vulnerable individuals?

The treatment charging system as it stands already seriously harms the welfare of vulnerable individuals, and the proposal to make unpaid NHS debt a reason for entry refusal will only entrench further such harm. Children are also profoundly affected by the serious ill-health of their parents or guardians. A system which discourages people living here from accessing the treatment and care they need inevitably harms the children in the care of these adults. It is estimated that there are about 20,000 children in the UK living in households affected by HIV.

11. Do you believe that the proposed changes to the Immigration Rules will have a disproportionate impact upon any particular group(s)? (Please tick all that apply.)

HIV is a disability. As migrants living with HIV will be affected by these proposals, it is clear that they will disproportionately impact upon disabled people.

In addition, HIV disproportionately affects gay men and black African and Caribbean men and women. Many migrants living with HIV experience multiple discrimination (for example discrimination on the basis of HIV status, sexuality, race and residency status). Sanctions against migrants living with HIV who have unpaid NHS charges will have a particular impact on these groups.

The section in the Equality Impact Assessment on disability is woefully inadequate. It simply restates the NHS charging system in relation to urgent and immediately necessary treatment - but such treatment when arising from disability remains chargeable, will in most instances be unpayable, and will, should the proposal be agreed, result in refusal of entry. Individuals will be subject to negative immigration decisions, which, had the individual not had a disability, would have been positive - this is discrimination.

The claim that the treatment “may in most instances be covered by adequate travel insurance” is open to multiple interpretations. If what is meant is that most migrants currently chargeable have health insurance, we do not believe this to be true and would like to see any evidence to support this claim. If the meaning is that visitors should in the future be covered by health insurance, such as the compulsory health insurance scheme proposed by DH, we believe such measures would be ineffectual and discriminatory. It is highly unlikely that visitors who require chargeable treatment for HIV would have such insurance, either because the products aren't available for people with HIV or they are prohibitively expensive. We therefore find the claim disingenuous and untrue.

12. In order to avoid unlawful discrimination, it is proposed that all patients seeking secondary care are asked the same ‘baseline’ questions about residence. Are you satisfied that this safeguard will assist in avoiding unlawful discrimination?

No, refusing entry for an unpaid bill for HIV treatment is unlawful discrimination as outlined in the answer to question 1. In NAT's view charging migrants for HIV treatment is also discriminatory given the fact that treatment for every other serious infection and sexually transmitted infection is provided in all cases free of charge.