Policies on Health Care for Undocumented Migrants in EU27

Country Report

United Kingdom

Carin Björngren Cuadra

April 2010
# Table of Contents

Preface .................................................................................................................................................. 3  
Introduction........................................................................................................................................ 4  
The General Migration Context ........................................................................................................... 5  
  Total Population and Migrant Population ......................................................................................... 6  
  Estimated Number of Undocumented Migrants ............................................................................. 6  
  Categories of Undocumented Migrants ............................................................................................. 7  
Policies Regarding Undocumented Migrants ...................................................................................... 7  
  Regularization Practice, its Logic and Target Groups ................................................................... 7  
  Internal Control: Accommodation, Labour, Social Security and Education .................................. 7  
Main Characteristics of the Health System ......................................................................................... 8  
  Financing, Services and Providers ................................................................................................... 8  
  Basis of Entitlement .......................................................................................................................... 10  
  Special Requirements for Migrants .................................................................................................. 11  
  Difference Sensitivity ...................................................................................................................... 11  
Health Care for Undocumented Migrants ........................................................................................... 12  
  Relevant Laws and Regulations ....................................................................................................... 12  
  Access to Different Types of Health Care ....................................................................................... 13  
  Specific Entitlements ....................................................................................................................... 14  
  Regional and Local Variations ......................................................................................................... 15  
  Obstacles to Implementation ........................................................................................................... 15  
  Obligation to Report ........................................................................................................................ 15  
  Providers and Actors ......................................................................................................................... 15  
    Providers of Health Care ................................................................................................................ 15  
    Advocacy Groups and Campaigns on Rights ............................................................................. 16  
    Political Agenda ............................................................................................................................ 16  
    International Contacts .................................................................................................................. 16  
Bibliography ....................................................................................................................................... 17
Preface

Undocumented migrants gain increasing attention in the EU as a vulnerable group that is exposed to high health risks and challenges public health. In general, undocumented migrants face considerable barriers in accessing services. Health of undocumented migrants is highly at risk due to difficult living and working conditions often characterised by uncertainty, exploitation, and dependency. In a state-control logic, national regulations often severely restrict access to health care for undocumented migrants. At the same time, right to health care has been recognized as human right by various international instruments ratified by European Countries (PICUM 2007; Pace 2007). This opens a paradox for health care providers: if they give care, they may act against legal and financial regulations, if they don’t give care they violate human rights and exclude the most vulnerable. This paradox cannot be resolved on a practice level but has to be managed in a way neither human rights nor national regulations are violated.

The EU Project “Health Care in NowHereland” works on the issue of improving health care services for undocumented migrants. Experts from research and practice identify and assess contextualised models of good practice of health care for undocumented migrants. It builds upon compilations of

- policies in EU 27 on national level
- practices of health care for undocumented migrants on regional and local level
- experiences from NGOs and other advocacy groups from their work with undocumented migrants

With its title, the project introduces the image of an invisible territory of Nowhere-land that is part of the European presence “here and now”. How health care is organised in NowHereland, what are policy frameworks that influence health care provision and who are the people that live and act in this NowHereland are central question raised.

**Health Care in NowHereland:**
**Improving Services for Undocumented Migrants in the EU**

*Project funded by* DG Sanco, Austrian Federal Ministry of Science and Research, Fonds Gesundes Österreich

*Running time*: January 2008 – December 2010

*Partners*: Center for Health and Migration at the Danube University Krems (AT) (main coordinator), Platform for International Cooperation on Undocumented Migrants (BE), Azienda Unità Sanitaria Locale di Reggio Emilia (IT), Centre for Research and Studies in Sociology (PT), Malmö Institute for Studies of Migration, Diversity and Welfare (SE), University of Brighton (UK)
Introduction

This report is written within the framework of the research project, *NowHereland - Health Care in NowHereland – Improving Services for Undocumented Migrants in the EU*, and one of its work packages. The focus of this work package – *policy compilation* – was to collect data on policy approaches regarding access to health care for undocumented migrants in the EU member states, to deliver 27 Country Reports and to offer a clustering of the states. A descriptive approach has been applied. In order to contextualise health care access, certain other themes are covered, such as the main characteristics of the various health systems, aspects of policies regarding undocumented migrants and the general context of migration.¹

The term used in this project is thus, “undocumented migrants”, which may be defined as third-country nationals without a required permit authorising them to regularly stay in the EU member states. The type of entry (e.g. legal or illegal border crossing) is thus not considered to be relevant. There are many routes to becoming undocumented; the category includes those who have been unsuccessful in the asylum procedures or violated the terms of their visas. The group does not include EU citizens from new member states, nor migrants who are within the asylum seeking process, unless they have exhausted the asylum process and are thus considered to be rejected asylum seekers.

All the reports draw upon various sources, including research reports, official reports and reports from non-governmental organisations. Statistical information was obtained from official websites and from secondary sources identified in the reports. As regards legislation, primary sources were consulted, together with the previously mentioned reports. One salient source of this project was information obtained via a questionnaire sent to recognised experts in the member states.²

¹ Information regarding the project and all 27 Country Reports can be found at [http://www.nowhereland.info/](http://www.nowhereland.info/). Here, an *Introduction* can also be found which outlines the theoretical framework and method as well as a clustering of the states.

² For the report at hand, the persons to acknowledge are: Nasir Warfa, Senior Lecturer & Deputy Director of Mental Health Studies, Wolfson Institute of Preventive Medicine, The London School of Medicine and Dentistry, Queen Mary University of London and researcher for mighealth.net in UK, Milena Chimienti, Department of Sociology, City University of London. Michael Swaffield, Craig Keenan and Sarah Burrow, Department of Health.
The General Migration Context

The UK joined the EU in 1973 and is situated on the border of the Schengen Area.

The United Kingdom received immigrants for centuries, and yet remained a net exporter of people. Only from the mid-1980s did the United Kingdom become a country of immigration, with increased immigration generated in large part by sustained economic growth over a period of 15 years (Somerville et al. 2009). Historically, after World War II two contrasting trends changed the nature of UK immigration. The first trend relates to the free movement and settlement rights of Irish nationals and the countries comprising the United Kingdom, as well as the free movement of workers within the EU. The second trend relates to the fact that nationals of other countries, particularly former British colonies, like India and Jamaica, have experienced diminishing access to the United Kingdom. Up until the 1960s, Commonwealth citizens were guaranteed the right of entry, and in the 1950s and early 1960s workers from the Commonwealth migrated to the UK. From 1971 people from former British colonies, notably India, Pakistan, and the Caribbean, became subject to immigration controls (ibid.).

Since 2004, and following the enlargement of the EU, immigration levels have been boosted by a wave of mobility, with persons from Eastern European countries, particularly Poland, granted free movement and improved labour rights (Somerville et al. 2009). In 2007, the United Kingdom received a gross flow of 577,000 persons and a net flow of about 237,000 persons. Between 1997 and 2007 the net immigration contributed 1.8 million people to the UK population, and the net immigration exceeded 100,000 people per year. The migrants consisted of growing numbers of workers, international students, asylum seekers and family members. The UK immigrant population has been found to be transient. About 40 percent of male immigrants and 55 percent of female immigrants who arrived in the early 1990s and stayed for at least a year returned home within five years. These percentages have likely increased since the start of large-scale immigration from Eastern Europe (ibid.).

The number of asylum seekers differed over the years, reflecting the global situation, and had a significant peak in 2002. A combination of measures, such as tougher visa regimes, financial penalties on air and truck carriers, juxtaposed controls at various European ports, and a worldwide decrease in asylum claims, reduced the number of people claiming asylum. Applications totalled 30,545 (including dependents) in 2008, and originated mainly from those fleeing Afghanistan (14 percent), Zimbabwe (12 percent), Eritrea (9 percent), Iran (9 percent), Iraq (7 percent), and Sri Lanka (6 percent) (ibid.). In 2008, 33,525 decisions were issued (in the first and second instance) and the rate of recognition was 30% (7,080 in the first instance) (Eurostat 175/2009).

---

3 According to Eurostat, data on the number of applicants in the United Kingdom under Regulation (EC) 862/2007 are not available (Eurostat 66/2009).
The policy on illegal migration has developed incrementally since 2002, and both external (visa regime, biometric identification data) and internal measures have been developed. The latter involves employer and public service compliance and regularisation (Somerville et al. 2009).

**Total Population and Migrant Population**

By 1 January 2010 the population in the UK was 62 041 708 (Eurostat). The United Kingdom had about 6.9 million foreign born citizens in 2008, representing 11 percent of its population, and 4.4 million foreign citizens, or approximately 7 percent of the population. The five largest foreign-born populations were from India (639 000), Poland (526 000), Pakistan (436 000), Ireland (424 000), and Germany (293 000), whilst the Polish are the United Kingdom’s largest foreign-national group. According to the Labour Force Survey (LFS), in the fourth quarter of 2008 522 000 Polish nationals were living in the country. The next largest groups were from Ireland (355 000), India (307 000), Pakistan (202 000), France (133 000), and the United States (127 000) (Somerville et al. 2009).

According to statistics from Eurostat, the total non-national population in 2008 was 4 021 000, which equalled 7% of the country’s population (Eurostat 94/2009). The main countries of origin were Poland (392 800), Ireland (347 900) and India (296 500) (ibid.).

There is an increasing diversity of immigrants, with many originating from European countries and former settler colonies, such as Canada, Australia, and New Zealand, whilst immigration from India, Pakistan, Bangladesh, the Caribbean, and African countries including Ghana, Kenya, Nigeria, and Uganda have continued (Somerville et al. 2009).

**Estimated Number of Undocumented Migrants**

There are comparatively high numbers of undocumented migrants in the UK. Estimates range between 430 000 and 110 000 persons, corresponding to 1.2% of the population (Baldwin-Edwards & Kraler 2009:41). A study based on census data from 2007, estimates 618 000 undocumented migrants, with a range of between 417 000 and 863 000. It is interesting to note that approximately 70% of undocumented migrants are to be found in London (Somerville et al. 2009).

As regards the proportions of nationalities, there is only tentative data from detention centres in this respect, which suggests the following “ranking”, in hierarchical order: Jamaica, Nigeria, Pakistan, China, Turkey and India (Vollmer 2009:20).

---

4 Eurostat.

Categories of Undocumented Migrants

In terms of pathways into irregularity and categories of undocumented migrants, it has been concluded that persons overstaying and violating the conditions of employment restrictions constitute the largest proportion of undocumented migrants (Vollmer 2009:20). A majority enters legally and subsequently obtain an irregular status. Also, failed asylum seekers form a substantial group, even if their exact numbers are unknown (Lenoel 2009:105), with estimates from 2005 suggesting their numbers to be between 155 000 (number of persons due to be removed according to the Home Office database) and 283 500 (79 500 reported removals subtracted from the approximately 363 000 unsuccessful applications between 1994 and 2004) (ibid.). Based on this, it can be said that the asylum system has a role in “producing” undocumented migrants (Baldwin-Edwards & Kraler 2009:41). The smallest group of undocumented migrants may be assumed to be persons involved in clandestine border crossings or persons travelling with false documents (Vollmer 2009:20).

Policies Regarding Undocumented Migrants

Regularization Practice, its Logic and Target Groups

The UK (together with France) is categorised as a “reluctant regulariser” and has struggled to manage immigration over many decades, occasionally resorting to regularisation programs as a policy instrument (Baldwin-Edwards & Kraler 2009:42). The UK has never implemented large-scale regularisation. Nevertheless, the government has regularised between 60 000 and 100 000 people over the last decades by way of five small scale programs since 1997 (Somerville et al. 2009). The government has tended to consider regularisations on a case-by-case basis, or in terms of specific cohorts, in order to accommodate certain populations physically present in the state (and in particularly difficult situations), outside immigration rules. These regularisations generally applied to a finite number of people and cannot be regarded as general amnesties (Lenoel 2009:106). The legal framework allows individual regularisations, in the form of ‘concessions’ granted on compassionate grounds by the Secretary of State on behalf of the Home Office. In 2003, a discretionary ‘family amnesty’, as ordered by the Home Office, was granted to all asylum seekers who had a dependant minor, regardless of the pending or refused status of their cases. 16 870 families had benefited from this discretion by January 2006. In 2004, 4 080 settlements were granted on humanitarian and compassionate grounds (Vollmer 2009:25).

Internal Control: Accommodation, Labour, Social Security and Education

Accommodation and social security obtained by way of employment is not covered.

The UK prioritises external controls over internal controls (Düvell 2008:201). In the UK the right to education may be considered to be implicit, as there is no impediment to the
enrolment of children who do not have legal residence status in the country. (European Commission 2004:33).

**Main Characteristics of the Health System**

**Financing, Services and Providers**

In the United Kingdom the welfare system is mainly financed via the tax system. The responsibility for health care is devolved to the constituent countries of the United Kingdom, namely England, Wales, Scotland and Northern Ireland. In all counties, health care is predominantly funded through national taxation. Within each county, the responsibility for purchasing health services is being devolved to local bodies (Primary Care Trusts in England, Health Boards in Scotland, local health groups in Wales and Primary Care Partnerships in Northern Ireland) (Dixon and Mossialos 2002:104). Health care is organised through the National Health Service (NHS), which covers the entire population and is virtually free at the point of delivery (ibid.). In addition to general taxation, financing consists of a co-payment for prescriptions for pharmaceuticals prescribed outside hospital. However, many categories of patients are exempt (for example, children, people on low incomes, pregnant women, people aged 60 and over, and those with specific chronic conditions). Patients also contribute to the cost of NHS dental care (up to an annual limit) and optometry services. Approximately 12% of the population has supplementary private medical insurance (most common in higher income groups within professional and managerial occupations) (Dixon and Mossialos 2002:104).

The NHS provides access to a comprehensive range of services throughout primary and community healthcare, intermediate care and hospital-based care, as well as information services and support to individuals in relation to health promotion, disease prevention, self-care, rehabilitation and after-care. This is conducted according to three principles in relation to the patients: meet the needs of all, be free at the point of delivery, and be based on clinical need, not the ability to pay.\(^5\) The NHS does not specify an explicit list of services to be provided, but The National Health Service Act 1977 places a general responsibility on the Secretary of State to provide services “to such extent as he considers necessary to meet all reasonable requirements”, and this implies the provision of hospital and community

\(^5\) [http://www.nhs.uk/nhsengland/thenhs/about/pages/nhscoreprinciples.aspx](http://www.nhs.uk/nhsengland/thenhs/about/pages/nhscoreprinciples.aspx) (accessed January 2010). The NHS Constitution is legally binding. From January 2010, all providers and commissioners of NHS care will be under a new legal obligation to have regard to the NHS Constitution in all their decisions and actions. This means that the Constitution, its pledges, principles, values and responsibilities need to be fully embedded and ingrained into everything the NHS does. The State of Readiness Group (SoRG), convened at the request of the NHS Management Board, has produced a report containing recommendations and examples of good practice designed to help. See [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109417](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109417) (accessed January 2010).
health services. However, the duty to provide general medical practitioners (GPs), dental, ophthalmic and pharmaceutical services lies with health authorities, rather than the Secretary of State. Their duty is to arrange for practitioners in their areas to provide an acceptable level of service for the resident population. With this in mind, their national contracts state that they are obliged to provide patients registered with them ‘all necessary and appropriate personal medical services of the type usually provided by general medical practitioners’ (Robinson and Dixon 1999:35).

As there is no defined list of benefits, the National Institute for Health and Clinical Excellence (NICE) issues binding guidelines as to whether the NHS should provide specific health services (ibid.).

The welfare system also covers unemployment and pensions. In the latter case, the benefits are less than half of a person’s active salary.  

The United Kingdom has a highly developed system of generalist primary care, delivered by general medical practitioners (GPs) and associated staff (e.g. practice nurses and community (district nurses), midwives and health visitors), as part of the NHS (Robinson and Dixon 1999:53). Over 99% of the population is registered with GPs, which is a prerequisite for gaining access to health care. Under Section 83 of the NHS Act 2006, the Primary Care Trust has a duty ‘to the extent that it considers necessary to meet all reasonable requirements, exercise its powers so as to provide primary medical services within its area, or secure their provision within its area’ (DoH 2010).  

Individuals seek registration with a primary medical care contractor by applying directly to the contractor (GPs). GPs are self-employed and have contracts with the local Primary Care Trust (PCT) to provide services on behalf of the National Health Service. Under the terms of those contracts, GPs have a measure of discretion in accepting applications to join their patient lists. However, they cannot refuse an applicant on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical conditions. They may only refuse an application if the PCT has agreed that they can close their list to new patients or if they have other reasonable grounds. When applying to become a patient of a particular contractor, there is no formal requirement to prove identity or immigration status (ibid.). Where a patient applies to register but is refused, the GP must nevertheless provide, free of charge, any immediately necessary treatment requested by the applicant, for a period of up to 14 days (this can vary according to circumstances). The Department of Health states that there is no formal definition of ‘immediately necessary treatment’ within the GP’s contract.

6 See [http://www.pitt.edu/~heinisch/ca_brit.html](http://www.pitt.edu/~heinisch/ca_brit.html)  

and doctors are thus required to exercise sensible professional judgement, on a case-by-case basis (ibid).

The GPs provide a range of preventative, diagnostic and curative primary care services. Patients may select a GP of their choice, although their choice is restricted within geographical areas. The GPs have a ‘gatekeeping’ role in relation to specialists and hospital care. Hospitals are only directly accessible at accident and emergency departments (walk-in-clinics). In addition, there is a small extent of privately financed primary care in the United Kingdom (ibid.).

Hospitals are mainly publicly owned, with independent trust status. Private hospitals mainly provide services to privately insured patients or persons willing to pay directly (Dixon and Mossialos 2002). The NHS hospital system is hierarchical, comprising three tiers, the first of which comprises district general hospitals are the basis of hospital provision. There are tertiary level hospitals offering highly specialised services in addition to secondary care (on referral), and these may operate at the regional or supra-regional level. The third tier consists of small-scale community hospitals, some of which are available to GPs to allow them to manage their patients directly (Robinson and Dixon 1999:63).

**Basis of Entitlement**

All persons who are “ordinarily resident”\(^8\) in the United Kingdom are entitled to secondary care cover under the UK National Health Service (NHS), thus the basis of entitlement is legal residency, but this is expressed from the provider’s perspective (as a responsibility to provide). From this follows that the right to care is not provided for in legislation. However, the NHS Constitution signals a move away from the language of targets, according to the government’s new publication, *Building Britain’s Future*, in which concepts such as responsibilities and rights are referred to (See NHS Constitution. State of Readiness Group, Final report, page 4).\(^9\)

As a substantial entitlement, from the patient’s perspective, requires registration with a GP, the question of how best to manage discriminatory practices is also relevant in relation to undocumented migrants. As previously stated, GPs have a measure of discretion in

---

8 "Ordinarily resident" is a common law concept interpreted by the House of Lords in 1982 as someone who is living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence which has a sufficient degree of continuity to be properly described as settled


9

accepting applications to join their patient lists. Paragraph 17 of the National Health Service (General Medical Services) (Contracts) Regulations 2004, prevents General Practices from refusing to admit patients to their lists on the basis of race, gender, social class, age, religion, sexual orientation, disability or medical condition (Hargreaves et al. 2006). A patient is entitled to join a practice list if they live in the practice area. However, there is no requirement to request official documentation (e.g. passport, immigration papers) and any General Practice requesting such documents in a discriminatory fashion could face prosecution under the Race Relations Amendment Act 2000. The Practice should instead ask that the patient provides documents such as gas or mobile phone accounts or Bank statements to prove residence (ibid.).

**Special Requirements for Migrants**

For EU citizens, the European Health Insurance Card (EHIC) is required, and for visitors from the European Economic Area (EEA) and Switzerland, personal details are registered to allow for the reclaiming of costs.\(^\text{10}\) Entitlements for “overseas visitors” are regulated in Statutory Instrument 1989 No. 306The National Health Service (Charges to Overseas Visitors) Regulations 1989, which apply to anyone who is not ordinarily resident. These regulations place a responsibility on NHS trusts to establish whether a person is ordinarily resident or exempt from charges under one of a number of exemption categories. They also provide that certain treatments are exempt from charges in their own right, irrespective of the patient’s status. These include treatment given in accident and emergency (A&E) departments, treatment for certain specified communicable diseases (excluding HIV/AIDS treatment where only the initial diagnostic testing and associated counselling are without charge) and compulsory psychiatric treatment. Overseas visitors are advised to take out private healthcare insurance, as they can not purchase healthcare insurance from the NHS.\(^\text{11}\)

Asylum seekers are, according to Section 4 of the Immigration and Asylum Act 1999, entitled to access free health care on equal grounds as nationals, as they fall into one of the specified classes which in terms of the Regulations are exempt from charges. Furthermore, as persons on low income, asylum seekers may apply for an HC2 certificate providing exemption from statutory charges.\(^\text{12}\)

**Difference Sensitivity**

In the UK there are a wide range of adaptive structures to migrants in health care, integrated in the education of healthcare providers, and also involving


mediation/translation services, translated informational material, the promotion of multicultural staff in the health sector, health services adapted to migrant specificities (for example, meals in hospitals).  

**Health Care for Undocumented Migrants**

**Relevant Laws and Regulations**

In the UK, rules relating to the access to care are regulated by way of circulars from the Department of Health as well as by High Court Judges. There have been significant changes with respect to undocumented migrants over recent years which apply different interpretations with respect to whether failed asylum seekers (who constitute a large part of the undocumented migrants) are to be considered as being “ordinary residents” or whether they should be excluded and consequently fall into the group of “overseas visitors”. Prior to 2004 they were seen as ordinary residents and were entitled to free care (after one year of residence), as with anyone being in the country for at least 12 months (this also applies to secondary health care), regardless of their immigration status. In 2004 this was changed, and a requirement of lawful stay was introduced. In 2008, and contrary to this, a High Court Judgement ([2008] EWHC 855) provided that the failed asylum seekers are to be understood as being “ordinary residents”, and hence entitled to free care. In April 2009 the situation was again changed by the Court of Appeal. Guidance from the Department of Health (Gateway Reference number 11628) stated that failed asylum seekers cannot be said to be ordinary residents in the UK and are thus not entitled to free NHS hospital treatment (see below).

In the current situation, the relevant regulations are those which regulate access to primary care, namely Section 83 of the NHS Act 2006, which regulates both the Primary Care Trust’s duty to provide primary medical services and the subsequent procedures regarding registration with GPs (DoH 2010). As GPs can choose to register person regardless of their status, this system also applies to undocumented migrants.

Of similar relevance is the legislation from which the eligibility to emergency, maternity care and care for some communicable diseases follows, namely the Statutory Instrument

13 For examples, see http://mighealth.net/uk/index.php/Main_Page topic 5.

14 Subject: ADVICE FOR OVERSEAS VISITORS MANAGERS ON: 1a) FAILED ASYLUM SEEKERS & ORDINARY/LAWFUL RESIDENCE; 1b) WHEN TO PROVIDE TREATMENT FOR THOSE WHO ARE CHARGEABLE; 2) VICTIMS OF HUMAN TRAFFICKING. Gateway Reference Number 11628.

Access to Different Types of Health Care

Undocumented migrants should be provided care in an Accident & Emergency Department free of charge. Statutory Instrument 1989 No. 306 The National Health Service (Charges to Overseas Visitors) Regulations 1989 applies to anyone who is not ordinarily resident, and in terms of this legislation, treatment is to be provided free of charge in accident and emergency (A&E) departments, irrespective of the patient’s status or ability to pay the costs.

As regards secondary care, the patient may be liable for the costs of such, and this includes hospital treatment and all specialist care (in- as well as out-patient) as well as antenatal and postnatal care, medicines and HIV treatment. In the Guidance from the Department of Health (DH 2009), it is made clear that the providers have the discretion to withhold treatment whilst awaiting payment, as well as the discretion to provide treatment when there is no prospect of obtaining payment for such. In this context, the differentiation between ‘immediately necessary treatment’, ‘urgent treatment’ and ‘non-urgent treatment’ is relevant (detailed in the paper, Implementing the Overseas Visitors Hospital Charging Regulations), as this creates an increased requirement to charge the patient, whilst also requiring an assessment of when a patient is likely/able to “return home”.

The Guidance declares that immediately necessary treatment, which explicitly includes maternity treatment, should never be withheld for any reason. It also states that such treatment should be limited to that which is necessary to enable the patient to return to their own country, but that trusts should consider the likelihood of the person returning home when deciding which limits to place on the treatment (DH 2009). Urgent treatment (understood as less pressing than immediately necessary) implies treatment that cannot wait until the person can be reasonably expected to return home (e.g. cancer). In this case, the intervening period prior to treatment should be used to secure payment (without discouraging the patient or going beyond what is reasonable) (ibid.). It is said to be medically acceptable to wait until the patient has returned home before attempting to


17 Subject: ADVICE FOR OVERSEAS VISITORS MANAGERS ON: 1a) FAILED ASYLUM SEEKERS & ORDINARY/LAWFUL RESIDENCE; 1b) WHEN TO PROVIDE TREATMENT FOR THOSE WHO ARE CHARGEABLE; 2) VICTIMS OF HUMAN TRAFFICKING. Gateway Reference Number 11628.

18 [link](http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_0815_16.pdf)
obtain payment in respect of non-urgent, routine elective treatment. The patient is then charged the full cost (ibid., see also HUMA Network 2009).

In England, there is currently a consultation involving a review of the rules governing NHS access for foreign nationals. This process has led to a package of proposals (in July 2009) in respect of: failed asylum seekers who continue to be supported by the migration authorities because there is a barrier to their immediate return, and who should be exempt from charges for secondary healthcare, other failed asylum seekers who should remain subject to payment in terms of the current procedures, exempting all unaccompanied children from payment, and denying the right to enter the UK to overseas visitors with significant debts to the NHS. In addition, methods to make health insurance compulsory for visitors who do not qualify for reciprocal healthcare will be explored. It is also stated that there should be no change in current access rules for primary care, and that secondary care charges for maternity services should remain.

**Specific Entitlements**

Maternity services constitute secondary care, and thus as a rule are not exempt from charges. However, according to the Guidance, due to the severe health risks associated with complications during pregnancy, maternity services should not be withheld if the woman is unable to pay in advance. Subsequently however, the patient remains liable for the costs, and the debt should be pursued in the normal way (Hargreave et al. 2006). As the patients are chargeable, they will be liable for payment after receiving care. Furthermore, there is maternity care which is accessible at primary care level, and which is provided by midwives free of charge. Abortion is chargeable as it is interpreted as being secondary care (PICUM 2007).

Statutory Instrument 1989 No. 306 The National Health Service (Charges to Overseas Visitors) Regulations 1989 also relates to treatment for certain specified communicable diseases, however HIV/AIDS treatment is excluded and thus chargeable. Only the initial diagnostic testing and associated counselling are without charge. Compulsory psychiatric treatment is also accessible, irrespective of the patient’s status or ability to pay.

Children of undocumented migrants are entitled to health care in terms of the same regulations applicable to adults. They are required to register with a GP as adults and

---


access “immediately necessary” and “urgent” care subject to the same rules (i.e. they are chargeable). This is also the case for unaccompanied minors (Médecins du Monde 2009).

There is a proposal in the current consultation to exempt unaccompanied children from charges generally, although this will be a formality as almost all such children will currently not be charged.\textsuperscript{21}

**Regional and Local Variations**

There are variations within the UK between the constituent countries. For example, failed asylum seekers have access to free care in Wales.\textsuperscript{22} Another example is that HIV/AIDS treatment is still provided free of charge by the Scottish Health Service (PICUM 2007:99).

**Obstacles to Implementation**

The obstacles to implementation which have been identified involve difficulties in registering with a GP due to barriers which may include discrimination or a lack of knowledge amongst the reception staff with respect to whether an identity document is required (PICUM 2007:100).

**Obligation to Report**

There is no obligation for health care staff in the UK to denounce “overseas visitors”. Nevertheless, it does occur that GP practices and hospitals wrongly believe that their duty to check entitlement also constitutes a duty to report to immigration authorities, and there are increasing reports of staff contacting the Home Office to inform about the immigration status of current or potential patients (PICUM 2007:102).

**Providers and Actors**

**Providers of Health Care**

Providers of health care may be found among the hospitals’ accident and emergency units (A&E) and hospitals in general. Furthermore, amongst general practitioners within the NHS system, the same GP might also offer to register the patient as private, fee-paying patient. However, providers are also found in the civil society, such as non-profit religious organisations, nongovernmental international organisations, as well as among local nongovernmental organisations. Nongovernmental organisations and voluntary health providers offer medical treatment in alternative systems of care and also provide assistance to enable access to mainstream services (ibid.:104). A number of walk-in clinics have been


\textsuperscript{22} http://news.bbc.co.uk/2/hi/uk_news/wales/7409265.stm (2010-03-02).
established by Médecins du Monde which, in an effort to overcome administrative barriers, do not require identification or residency documents.²³

Providers outside the mainstream system can mostly be found in the main cities (Questionnaire UK).

**Advocacy Groups and Campaigns on Rights**

In the UK context there have been campaigns conducted, and there are advocacy groups to be found, in respect of the rights to health care. One example is Médecins du Monde, which runs Project: London and advocates on behalf of undocumented migrants to ensure their access to GPs. They contact individual surgeries, organise interpretation services and accompany patients on appointments. Support workers communicate with reception staff regarding NHS practices and inform them of the undocumented migrant’s right to access services. If registration still proves problematic, they may request the Primary Care Trust to allocate a GP directly. Another salient actor is the Medical Justice Network.²⁴

**Political Agenda**

Undocumented migrants are a topic on the political agenda, both in general and in relation to health care, and arguments oriented towards control of migration, the cost of care, the right to care, as well as public health arguments are involved. There is an ongoing national campaign, “Strangers into Citizens”, driven by nongovernmental religious organisations, calling for a one-off regularisation of long-term irregular migrants in the UK.²⁵

As regards health care, there is an ongoing discussion including official bodies such as the Home Office and the Department of Health. The discussions relate to restricting access to primary care.²⁶ In May 2004, the DoH issued a consultation which included proposals to exclude particular groups, including refused asylum seekers, from access to free NHS primary care services. As yet, the DoH has not published their findings from this consultation (from Master thesis with no name).

**International Contacts**

Actors in the field of health care for undocumented migrants in the UK have international contacts. Médecins du Monde and Médecins sans Frontières have local bodies and are active there.

Bibliography


