

BACKGROUND BRIEFING

Access to HIV services for all migrants to the UK

This briefing seeks to explain

- the recent changes in entitlement to NHS services for migrants to the UK
- the impact these changes are already having on public and individual health
- the concerns expressed by many clinicians and other HIV experts
- practical proposals to counter these unintended but serious consequences

The situation up to April 2004

Prior to April 2004, NHS treatment of all kinds was available free of charge to anyone who could show that they had been in the UK for more than 12 months. It was also available free to anyone currently applying for asylum or for leave to remain. This situation, while not ideal, ensured that anyone who was clearly a long stay resident of the UK, no matter how they became so, would receive the health treatment they needed. The Regulations governing NHS charging, and a number of key exemptions to them, were enshrined in the NHS Act 1977 and the NHS (Charges to Overseas Visitors) Regulations 1989. The exemptions included universal free treatment for a range of conditions on public health grounds. These included TB and all sexually transmitted infections except for HIV. For HIV, you had to wait 12 months to access free NHS services.

However, in response to media and political agitation about "treatment tourism" and the cost to the NHS of people allegedly flying in to the UK for the sole or primary purpose of exploiting the UK health system, new restrictions were imposed on all hospital services from April 2004. These new regulations meant that treatment for HIV (or for anything else not specially mentioned in the 1989 Amendment) would never be provided without charge for certain categories of people. This was despite the lack of any research showing the existence or extent of "treatment tourism" in HIV. Although HIV was repeatedly named in the media as an example of treatment tourism, the only piece of extant research indicated that the reverse was true. Most migrants were unlikely to be aware of their status until they had been in the UK for more than nine months (THT/GHT 2003).

As of November 2004, we are also awaiting the outcome of a related consultation by the Government on reducing eligibility to primary care services. If the outcome of this consultation parallels that for the acute sector, anyone excluded from free NHS services will not even be able to access primary care for an initial assessment of their health needs to determine whether they are in emergency needs. We believe that this would damage individual and public health and lead to a reversal of the recent reduction of waiting times and improved conditions in Accident & Emergency Departments.

The situation from April 2004

New NHS charging regulations were introduced in April 2004 after consultation, but without any research or evidence base. Amongst other changes, some genuinely beneficial (students, for instance, can now access NHS services without charge provided their course is of at least six months duration) the twelve month rule was removed. This change means that long stay visitors, anyone in the UK without documentation, and anyone refused asylum or leave to remain, but not removed from the UK, are liable to be charged for any NHS services other than those provided in an

emergency (usually interpreted as those available at A&E departments) or those outlined in the 1989 exemptions.

It is clear (as of November 2004) that these changes to the regulations are already causing hardship. It is also beginning to be clear in the case of HIV that, while they may result in a small short term cost reduction to local NHS budgets, in the longer term they are highly likely to have a negative effect in all three major areas – the public purse, the public health and individual health. From cases already referred to the instigators of this campaign, the following concerns arise:

- Individuals coinfectd with TB and HIV (a relatively common combination for African people) have been told that, while their TB treatment is free, the HIV treatment necessary to ensure that their TB treatment is effective will be charged for. This has resulted in at least three cases where patients have left the hospital before the end of their course of TB treatment, risking the development of multi-drug resistant tuberculosis (which is transmissible) and returning to the community still able to transmit TB.
- At least two pregnant women (and anecdotally more) have been told they will be charged (and thus effectively refused) for temporary HIV treatment to prevent transmission of HIV to their unborn child.
- Patients taken to hospital as emergencies have not been informed of possible subsequent charges, usually several thousand pounds, until their discharge from hospital. In at least one case, they have subsequently been refused access to their medical records (needed to apply for leave to remain) unless they paid a large bill first.
- People within communities of high prevalence for HIV have begun to ask why they should bother to test for HIV if they cannot obtain treatment for it. While we believe there is almost always good reason to know one's diagnosis and thus be able to make informed decisions about both health and sexual behaviour, this view is gaining currency amongst migrant communities and is impacting on testing campaigns targeting them.
- There have already been several cases known to us of misinterpretation of the regulations to refuse treatment to those entitled, and other cases where manner of questioning has discouraged people entitled to services from reattending for them
- Although some NHS staff have said to us that "people may be charged but if they can't pay, we won't stop treating them", there have already been examples of debts being handed over to collection companies for pursuance. Where people have no legal means of employment and are effectively destitute, this is not only a waste of time and money but an enormous stress upon the already unwell individuals pursued.
- Health inequalities are already emerging between people accessing different clinics with differing interpretations of the new regulations.

In the longer term, the organisers of this campaign have the following concerns:

- It is unlikely that charging for treatment (and thus effectively refusal of it) will encourage people refused asylum to return to countries they have been determined to leave, many of which have even less health infrastructure and free treatment than they would receive on emergency grounds in the UK
- People with HIV unable to access antiretroviral treatment and associated services will remain in the community and be more infectious than if in treatment. They will also be less accessible to support services designed to support safer sexual behaviour and avoidance of onward transmission
- Community discussion of charging regulations will discourage people, including some entitled to free NHS services, from coming forward to any kind of support services

- People with progressive immune deterioration resulting from HIV will need to access emergency services multiple times, with increasing frequency and severity, resulting in many cases in far higher incident costs than a simple ongoing prescription for antiretrovirals. Annual cost of combination therapy is now under £10,000; one week's stay in intensive care can cost almost as much, and this could be repeated many times, given the high standard of emergency medical care in the UK.
- People coinfecting with HIV and other STIs will be able to access free treatment for gonorrhoea or chlamydia, but not for HIV, which is the more serious (and potentially fatal) condition transmissible by the same route.

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