Version 1.0

# Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: impact on vulnerable migrant groups


## Summary

Department of Health, Statutory Instrument 2004 No614' (SI614) came into force in 2004. It made groups considered to be not 'lawfully resident' in the UK liable for National Health Service (NHS) hospital charges.

This was closely followed in May 2004 by a consultation that proposed to extend the charging regime introduced in SI614 to include primary care, including access to GP services. The legislation aimed to restrict access to NHS care for overseas visitors with the declared intention of reducing abuse of the NHS by "health tourists". There has been no published response to the May 2004 consultation.

There is no evidence that people seeking asylum do so because they wish to benefit from free health care, rather they are simply exercising a legal right to seek refuge from persecution. The current policy, however unintentionally, has been to leave some of the most vulnerable people in the UK without access to health care including failed asylum seekers, undocumented migrants and trafficked people.

This briefing is in response to a cross-Government enforcement strategy document "*Enforcing the Rules*" (Home Office, 2007). This suggests that primary care will be brought into line with existing secondary care regulations. A further and more detailed outline of the review process is set out in the government response to the report on asylum by the Joint Committee on Human Rights Joint Committee on Human Rights.

The purpose of the changes seems to have migrated over time from the protection of NHS resources in the 2004 changes to the more punitive language of deterrence for groups of people who are deemed to be living in the UK without legal residence, rather than visiting.

*To ensure that living illegally becomes ever more uncomfortable and constrained until they leave or are removed" (Home Office, Enforcing the Rules 2007)"*

The impact of the 2004 regulatory changes has been difficult and wide ranging and some of the data and reports outlining this are referenced in this briefing. It has meant people with cancer being turned away until they are able to pay in advance for treatment and mothers being left homeless and without medical care days after delivery. Health care workers are not lawyers, the definitions and processes involved are complex and beyond their remit so mistakes can and do happen.

Perhaps the most constant theme in this briefing is that there is much that we simply do not know. We don't know how many people in the UK fall - intentionally or not - into the groups that would be most affected by the proposed changes to primary care; nor do we know how many have already been refused secondary care and what has happened to this group. Perhaps more importantly it is not clear how we will provide alternative care for those who will be excluded from both secondary and primary care. It is perhaps not unreasonable to suggest that the Government answers these questions before taking such a drastic measure.


**Definitions**

**overseas visitor:** someone who is "not ordinarily resident in the United Kingdom"
**health tourist:** someone coming to the UK with the sole purpose of accessing free NHS treatment.
**failed asylum seeker:** an asylum seeker who has had their asylum application rejected and has also been refused on appeal
**undocumented migrant**: a foreign national worker who has not been granted permission to enter employment.

# Examples of the consequences of the 2004 changes in regulation

## Statutory Instrument 2004 No614 has a profound impact on individuals.

### *Case A*

Ms C was a visitor to the UK who subsequently submitted a claim for leave to remain on human rights grounds. The hospital refused to give her HIV treatment unless she paid. Ms C became seriously ill as a result of remaining untreated and was admitted into hospital where she was placed on antiretroviral therapy. After she was discharged, she started receiving hospital bills of several thousand pounds. Ms C was unable to pay as she had no income or savings. She was very ill and could not return to her home country. The outcome of this case is unknown as Ms C stopped attending the hospital for treatment and monitoring.

### *Case B*

A man who has been diagnosed as suffering from Pulmonary Carcinoma presented at XXXXX seeking treatment. He was unsure of his immigration status but the hospital contacted the Home Office for clarification to be told that he had two failed asylum claims.

He was refused treatment by the hospital and it was suggested he return to his own country to seek treatment. His GP has refused to a request that this is immediate and necessary care also suggesting he go home to seek care.

### *Case C*

A woman who was a rejected asylum seeker sought maternity care when she was four months pregnant. She and her husband met with the Overseas Visitor Manager, who was so rude that the woman cried. The Overseas Visitor Manager rang the woman's GP during the meeting and said that the woman was not entitled to free treatment. The Overseas Visitor Manager told the woman that she had to pay or she would not receive maternity care. The woman received a bill for £2300 which she could not pay. The woman then received a call to say that the bill must be paid within five days or it would be passed onto debt collectors. The woman approached a voluntary organisation and was assisted to obtain antenatal care at that hospital. Each week during her pregnancy and after the birth, the woman received a call from the Overseas Visitor Manager asking for payment. These calls lasted up to an hour and sometimes left the woman in tears. Until the eighth month of her pregnancy, the woman and her husband were solely reliant on support from friends and community groups. In her eighth month, they obtained section 4 support which they supplemented with assistance from community and church groups. [Section 4 support consists of self-catering accommodation plus food vouchers or full board accommodation.] They are unable to raise the £2300 in charges.

## Current situation

Department of Health, Statutory Instrument 2004 No614' (SI614) came into force in 2004. It made groups considered to be not 'lawfully resident' in the UK liable for National Health Service (NHS) hospital charges. The power to make this statutory instrument comes from section 121 of the National Health Services Act, 1977, which authorises the Secretary of State for Health to impose charges in respect of persons not ordinarily resident in Great Britain.

Health Service Circular, HSC 1999/018 (DOH,1999) states that groups considered to be not 'lawfully resident' in the UK are not entitled to be registered with a GP. Despite this, the Department of Health Table of Entitlement to NHS Treatment (June, 2007) states that GPs have the discretion to register excluded groups as NHS patients.

Some forms of treatment are excluded from charging, this includes

- emergency care provided in Accident and Emergency
- treatment for communicable diseases including tuberculosis and sexually transmitted infections. HIV testing is free of charge but treatment is not.
- compulsory mental health treatment.

"Immediate and necessary" care is a term of convenience with no specific legal or medical definition. What constitutes "immediate and necessary" is a decision that can only be made by a clinician. "Immediate and necessary" care must be provided without delay or prepayment however it remains chargeable and an invoice will be issued on completion of treatment unless care is provided in an Accident and Emergency department when there would be no charge, Maternity care is always deemed to be "immediate and necessary" (DOH, Guidance, June 2007).

Currently no exemption has been made for children or babies for whom the same general conditions of entitlement as mentioned previously apply.

More detailed information on the current charging regulations can be found in "Guidance on the implementation of the NHS (Charges to Overseas Visitors) Charging Regulations 1989 and The NHS (Charges to Overseas Visitors) Charging (Amendment) Regulations 2004" (DOH, 2004).

## Proposed changes

In May 2004 a further consultation document was published: "Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services"(DOH 2004) The consultation proposed to extend the charging regime introduced in SI614 to include primary care including access to GP services. In the intervening three years there has been no published response to the submissions made in the consultation process. The result has been a continued sense of uncertainty adding to the existing confusion that has developed around access to both secondary and primary care.

There is an increasing sense of concern that in closing the consultation so long ago the Department of Health has seemed unwilling to listen to the experiences and impacts of the current regulations observed by those organisations involved in supporting vulnerable groups in accessing health care.

In 2006, the Home Office report, "Enforcing the Rules", announced yet a further review of the rules governing free NHS services for foreign nationals. The review is to be completed before October 2007. We are extremely concerned that the report suggests that further restrictions will be placed on access to free NHS care, including primary care, for all or many of the same groups excluded in Statutory Instrument 614.

In June 2007, the then Minister of State at the Home Office, Liam Byrne MP, outlined a joint Department of Health and Home Office review of access to the NHS by foreign nationals. This was part of the Government's response to the Joint Parliamentary Committee on Human Rights tenth report on the treatment of asylum seekers.

"*The aims of the review in relation to primary medical services will be to establish clear rules which are, wherever possible,* ***consistent with the rules relating to secondary care****. Any new rules will take into account the key preventative and public health role of NHS primary medical care as well as international laws and humanitarian principles*" **(*emphasis ours*)**
(*The full text of the Minister's response is attached to this briefing*)

## Rationale behind the proposed change in regulations

The intention of Statutory Instrument 614 was specifically to reduce abuse of the NHS by so called "health tourists". When asked by David Davis what health tourism had cost the NHS between 1997 and 2004 the then Minister of Health John Hutton responded.

"*Successive Governments have not required the National Health service to provide statistics on the number of overseas visitors treated under the provisions of the NHS (Charges to Overseas Visitors) Regulations 1989, as amended. It is therefore not possible to give a definitive assessment of the scale of health tourism*". (Commons Hansard, 1 March, 2005)

Health tourism was also the main target of the 2004 proposals, as is evident from the title: "Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services." However a fundamental shift of intent seems to have occurred since that time. Both *Enforcing the Rules* and the Government response to the *Joint Parliamentary Committee on Human Rights tenth report* on the treatment of asylum seekers focus on access to health care for migrants and asylum seekers. *Enforcing the rules* contains only a passing mention of "health tourism" in relation to maternity care.

## Charging

The two options for charging outlined in the 2004 consultation are:

**Option1**: GPs would hold a separate list for overseas visitors. The charges made would be NHS charges and would be considered to be NHS income. The practice would account for them as such.
**Option2**: Any services provided to Overseas Visitors would be provided on a private basis by GPs. In this case the practice would be responsible for agreeing and recovering charges from individuals.

It is expected that payment would be requested in advance except when treatment is deemed to be immediate and necessary in which case it would be requested after treatment.

## Who are Vulnerable Migrants?

Health tourists are defined as people coming to the UK specifically to avail themselves of free NHS treatment. We have almost no information on who makes up these groups and what numbers are involved. We can presume however that they include expatriates returning to the UK for health care in the mistaken belief that they are entitled to do so and family members of settled migrant communities (Hargreaves S, June 2006). There will also be some other people who can afford to make the trip specifically to obtain NHS care.

To date the Government has not provided any reliable data to show that this is an issue of significance. The following is a quote from evidence given by then Health Minister, Melanie Johnson, to the Health Select Committee:

"*It is very difficult to produce figures. Historically, figures have not been collected by the Health Service, over decades—never, basically—about levels of people using the service who are not resident or normally resident in the UK. That is partly because, obviously, some of the people who use those services are genuine tourists—and I am not just talking about HIV/AIDS here; I am talking more generally, because it is quite difficult, again, to make distinctions between this and a number of other things for which people need treatment. It is impossible therefore to disaggregate data as to whether a tourist came over and broke their foot and received treatment through an A&E department or whether somebody came in and received another service as a so-called health tourists*[1]" (Health Select Committee, February 2005).

Whether intentionally or not, the legislation has had the most profound impact on groups who are not health tourists but are instead the most vulnerable of migrants groups. These include failed asylum seekers, trafficked people, and undocumented migrants. Project London provides care to

undocumented migrants at its London clinic. Their first end of year report on this service found that the majority of their clients had lived in the UK for just under three years, on average, and presented with only routine minor complaints (Médecins du Monde, 2007).

Asylum seekers are entitled to full access to free NHS care during the period their asylum claim is being reviewed. If health care was a major consideration in coming to the UK they would seek treatment during this initial period and not wait until after their claim has been refused. Asylum claims even today take time to process and appeals will further extend this period. If, as John Reid claims in *Enforcing the Rules*, that 15 women a month enter the UK in the late stages of pregnancy solely with the intention of obtaining free NHS care, these women are not failed asylum seekers.

## Why don't we simply send people home?

The arrival of and removal of migrants from the UK is beyond the scope of this brief. We simply look to the responsibility of the state for the welfare of those who live in the UK no matter their legal status. We believe immigration should be managed at borders and not hospital doors.

The Immigration and Nationality Directorate (IND) recognizes that some failed asylum seekers are unable to return home due to factors beyond their control and for medical reasons. Short term support under section 4 of the immigration and asylum act,1999 (Home Office,1999) is in place to provide subsistence support. At the end of 2006, there were a total of 6,555 people in receipt of section 4 support (Home Office, Asylum Statistics, 4$^{TH}$ quarter 2006). These individuals do not have access to free secondary health services. Perversely, this includes those who are unable to return home for medical reasons, the proposed changes would also make this same group ineligible for primary care.

## The Health Impact of Current Policy

The 2004 regulations and ensuing confusion have resulted in desperate cases of people unable to access health care for serious or life threatening illness. This is sometimes because they are unable to find the funds required to pay for treatment or because they are so scared of the possibility of debt they choose to remain outside the health care system. Examples of this can be seen in the report *First do No Harm: denying health care to people whose asylum claims have failed* (Kelley N, Stevenson J. 2006). The impact of a potential debt of hundreds or thousands of pounds on people who have nothing cannot be overestimated.

The Department of Health guidance makes it clear that measures should always be taken to pursue debt, including when the individual leaves the country, and trusts are strongly recommended to use the services of debt recovery agencies to do so. The guidance also makes clear that it is unacceptable not to raise an invoice for treatment because the person is unable to pay (DOH, May 2004).

## Possible Health Impacts of the Primary Care Proposal

Primary care refers to services accessed directly by the individual and include; family doctors (GPs), pharmacists, dentists and midwives. This includes important public health measures such as vaccination. An estimated 86% of all UK health needs are met in primary care by GPs. It has been estimated that 90% of patients with the most common chronic diseases will never be referred to hospital but will instead be treated within a primary care setting (Pereira Gray D, 2006).

GP consultations are both cost effective and resource efficient, providing for early presentation and early intervention. Evidence shows that strong primary health care systems are more likely to produce better health outcomes at a lower overall cost (Starfield B, New York 1992).

The Health Care Commission have costed and compared provision of NHS services (Health Care Commission, London 2006):

- Consultation with a Nurse - £9
- Consultation with a GP - £20
- Attendance at Accident & Emergency - £110
- Ambulance Journey - £311
- One day in intensive care - £1,378

Some of the impacts of the proposed new charges would be:
- treatment for many routine and chronic conditions will, if left untreated, become either emergency or immediately necessary.

- cost effective treatment for conditions such as asthma, diabetes and respiratory infections will instead be replaced by highly technical and expensive care for life threatening illness.

Currently no charge is made for treatment of certain communicable diseases including but not limited to Tetanus, Tuberculosis, Rubella, Measles and Staphlococcal infection. Inability to access GP services will make it much more likely that many such illnesses will remain undiagnosed and untreated until the point at which treatment or intervention is more complex and may even pose a public health risk.

It has been estimated that there are up to 400 avoidable deaths from AIDS each year the majority of these due to late diagnosis (National Aids Trust, 2004). Already Africans present for HIV treatment significantly later than non-Africans in the UK, frequently with an AIDS defining illness (Winter M, 2006).

GPs provide an important source of support to women experiencing domestic abuse. These women may not be able to obtain funds to pay for a GP appointment. Women with no recourse to public funds already face significant barriers to escaping abusive relationships as they are not entitled to safe accommodation or welfare payments (Southall Black Sisters and Women's Resource Centre, 2006).

## Access to maternity care

Regulations state that all antenatal, birth and postnatal care is to be considered immediately necessary and is therefore to be provided irrespective of the ability to pay. This does not mean that maternity care is free but instead that women should not be denied care if they cannot pay the charges. There is evidence that the arrangements for levying charges has led to the denial of antenatal care to vulnerable women (Joint Committee on Human Rights, *The treatment of asylum seekers: tenth report of session 2006-7,* 2007).

While policies promote direct access to midwives, the most common pathway into maternity care is through a GP appointment. In 2006, 86% of women having their first child made first contact with their GP, and this figure was higher amongst black and minority ethnic women (Redshaw M, Rowe R, et al, 2007). Excluding vulnerable migrants from free GP services is likely to prevent or delay access to maternity care. Late booking for maternity care is a major risk factor for maternal death (Royal College of Obstetricians and Gynaecologists, 2004) and is linked to infant mortality (DOH, *Review of the health inequalities infant mortality* 2007).

Vulnerable migrants are at particular risk of maternal deaths and infant mortality. Social disadvantage, living in poor communities and minority ethnic status are associated with significantly higher maternal mortality rates (Royal College of Obstetricians and Gynaecologists 2004). The maternal mortality rate for Black African women is seven times that of White women (Royal College of Obstetricians and Gynaecologists 2004). Infant mortality is closely associated with socio-economic status and babies born to the most socially disadvantaged group (NS-SEC Other) have infant mortality rates almost twice that of the population as a whole (Department of Health 2007).

## Wider public health impact

Infectious disease poses an increasing threat not just nationally but globally, something that requires international cooperation to be successful (Donaldson, 2007). While TB is currently exempt from charging, without access to primary care there is likely to be a delay in detection with resulting poor outcomes for individuals and increased risk of infection for others. Delays in detection have been shown to occur as a result of a lack of continuity of care in general practice (Metcalfe E, Davies J, Wood F et al, 2007).

While exemption is made for other sexually transmitted diseases HIV treatment remains chargeable, though testing and related counseling are free. Payment for treatment includes the provision of antiretroviral therapy to pregnant women despite the obvious long term benefit of doing so both for the individual concerned and the health system in whatever country they later reside. (Pollard A, 2004). There is no proof whatever that people in the groups discussed here come to the UK seeking treatment for HIV, on the contrary diagnosis is more often the result of an opportunistic infection with a resulting late diagnosis. Earlier presentation during an asylum claim or while a work visa is valid would have ensured treatment was available.

## Lack of alternate provision

The only free health care provision currently available outside the NHS are those services provided by the Refugee Council, Médecins du Monde UK and the Helen Bamber Foundation. Each of these organisations would want it made clear that any care they can offer is minimal. The primary purpose of each is to act as an advocate to facilitate entry into NHS care for clients unable to access care themselves. While neither the voluntary sector nor the Government have any idea of the numbers involved, they are likely to be significant enough to overwhelm the few resources currently available.

## Emergency care

Care provided in Accident and Emergency is currently not chargeable and as a result it is likely that it would provide an initial point of contact with NHS services for those otherwise excluded from free NHS care.
The implications of this might be:

- a significant increase in waiting times undoing the previous efforts in this area.
- people will delay or resist engaging with Accident and Emergency until illness has progressed to a point at which it can no longer be ignored.
- failed asylum seekers and undocumented migrants are likely to present in the greatest numbers in areas of existing deprivation
- poor language skills and understanding of the UK health system result in individual consultations taking longer in an ill-prepared setting

The voluntary sector organisations previously mentioned continually struggle to facilitate access to secondary care services and, perhaps more importantly, to GP registration. If access to primary care was no longer available the need could overwhelm available services.
A study of A&E attendance suggests have that poor rates of GP registration already equate with the high usage by this service by migrant groups only a small percentage of whom are refugees or asylum seekers. (Hargreaves S, Friedland JS, Gothard P et al, 2006).

## Human Rights

As Parliament's Joint Committee on Human Rights report makes clear - all asylum seekers including those whose claims have been refused and the Home Office intends to remove from the UK, are still 'within the jurisdiction' and therefore beneficiaries of the rights set out in the panoply of international human rights treaties that the UK has adopted (Joint Committee Human Rights, 2007).

### *European Convention on Human Rights (ECHR)*

Articles 2 (protection of life), 3 (protection from torture and degrading treatment) and 8 (protection of private and family life) of the ECHR are all applicable to the provision of healthcare (Joint Committee Human Rights, 2007).
Additionally, Article 14 requires that the rights and freedoms set forth in the ECHR be secured without discrimination.

### *International Covenant on Economic, Social and Cultural Rights (ICESCR)*

The Magna Carta of health rights is the ICESCR which, in recognising the right of everyone to the highest attainable standard of health, puts governments under a specific obligation not to limit equal access to health care. Any discrimination violates their rights, as guaranteed by Articles 2 and 12 of the ICESCR (United Nations.1976) . Although not yet justiciable (*liable to court trial or legal decision*) the ICESCR is binding on every government that has ratified it.
A great deal has recently been written about health and human rights in the UK, not least by the Department of Health (DOH , Human Rights in Health Care, 2007 ) and the BMA (Asher J, Hamm D, Sheather J, 2007) but there is a disconnect between what is published and what goes on in hospitals and the community.

## Professional Ethics

Health professionals have a duty to provide care for their patients without discrimination. The GMC requires doctors to protect and promote the health of patients and the public as a duty ranked second only to making the care of patients their first concern (General Medical council, 2006). Neglecting people's human rights is bad for their health (Department of Health. Human Rights in Healthcare, 2007).

## Will it be workable?

The simple answer is we don't know. Newham PCT is responsible for the only Health Impact Assessment (HIA) so far carried out on the identification and charging of Overseas Visitors (Hargreaves et al, 2006).The Newham research included the following:

"Our data indicates that proposals to bring GP charging procedures in line with hospital procedures are currently unworkable in Newham at this time. (Newham HIA)

and

84.8% of the doctors interviewed in Newham felt that better systems needed to be in place to address the issue of overseas visitors along with training for non clinical staff such as practice managers (Hargreaves S, Holmes A H, et al, 2007). The cost benefits of implementing a suitable system must also be viewed in the light of a study showing that, in a borough with a high migrant population, it was estimated that approximately 100 GP visits across the borough might be chargeable equating to perhaps £3,000 of income.

## The need for "Joined up government"

There has been a great deal of talk about joined up government in recent years. We believe the UK must be seen to align national with international policy if we are not to be viewed as applying double standards.

User charges don't work and cost lives, so why are we planning to introduce them to some of the most vulnerable people in the UK?

"*DFID's recent assessments are that official user fees contribute minimal amounts to the financing of public services. Additionally, fees are a significant barrier to poor people's access to basic health services*" (Benn H, 2005)

HIV testing and counseling are currently free but treatment is not. Restricting access to primary care services will make access to testing much more difficult.

"C*ommitments to reduce the global HIV and AIDS resource gap, make sure that costed, inclusive, sustainable, credible and evidence-based national HIV and AIDS plans are funded and implemented – and ensure that countries set ambitious national targets, including interim targets for 2008, to achieve universal access*". (DFID & G8, HIV and Aids, June 2007)

Universal access to health care is a right laid out in article 12(d) ICESCR: the creation of conditions which would assure access to all medical services and medical attention in the event of sickness.

"*Developing countries are now preparing national plans to try to achieve universal access by 2010. The UK has argued that no credible, sustainable country plan should go unfunded*" (Brown G, Benn H, 2006).

## Conclusions

- A full health and equality impact assessment should be carried out before any further changes in NHS regulations
- Who enters and who leaves or is removed as long as it is done legally and humanely is outside our remit however we believe that a duty of care exists for all who live within our borders without discrimination.
- Any change in regulation must ensure that no one is excluded from accessing health care simply because they are unable to pay.
- Health care workers must remain clearly and visibly separate from government immigration policy

We end with a quote from the founder of the NHS, Labour MP Aneurin Bevan addressing the very same concerns in 1952!

"*One of the consequences of the universality of the British Health Service is the free treatment of foreign visitors. This has given rise to a great deal of criticism, most of it ill-informed and some of it deliberately mischievous. Why should people come to Britain and enjoy the benefits of the free Health Service when they do not subscribe to the national revenues? So the argument goes. No doubt a little of this objection is still based on the confusion about contributions to which I have referred. The fact is, of course, that visitors to Britain subscribe to the national revenues as soon as they start consuming certain commodities, drink and tobacco for example, and entertainment. They make no direct contribution to the cost of the Health Service any more than does a British citizen. However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats both must be classified. What began as an attempt to keep the Health Service for ourselves would end by being a nuisance to everybody. Happily, this is one of those occasions when generosity and convenience march together.*" (Bevin A, 1952)

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Response to recommendations 16-20, 22-25

When Department of Health Minister, the Rt Hon Rosie Winterton, gave evidence to the Committee on February 5th she was not in a position to give a date by which a conclusion could be reached on the various issues relating to access to healthcare by overseas visitors.

Shortly afterwards, on March 7th, the Home Office published *Enforcing the rules: A strategy to ensure and enforce compliance with our immigration laws,* which commits Department of Health and the Home Office jointly to undertake a review of access to the NHS by foreign nationals. The review is due to be completed by October. A programme of communication and good practice to help the NHS to implement any new rules flowing from this review will be completed by September 2008. Rosie Winterton wrote to the committee on March 20th to draw their attention to this but it appears that this was too late for them to take account of in their report.

Subsequent work to determine the detailed scope of the review has taken into account the comments and recommendations of the JCHR, and the review will look at all the healthcare issues raised by the committee's report. The aims of the review in relation to primary medical services will be to establish clear rules which are, wherever possible, consistent with the rules relating to secondary care. Any new rules will take into account the key preventative and public health role of NHS primary medical care as well as international laws and humanitarian principles.

We acknowledge that the existing rules regarding eligibility for primary medical services are unclear and leave much to the individual discretion of GPs and practices. The response to the 2004 consultation was divided and highlighted the links between a range of complex and sensitive issues including asylum, migration, citizenship, public health, ID cards and equality.

The review will take into account the responses to the 2004 consultation and we are committed to ensuring that any new rules are both fair to UK citizens and to foreign nationals, offer value for money and can be implemented effectively in primary care settings.

In relation to secondary care, the review will focus on specific issues which have arisen since the *NHS (Charges to Overseas Visitors) Regulations 1989* were amended in 2004, including the position of failed asylum seekers, asylum seeking children, and the UK's obligations under international law. It will also look at public health issues, humanitarian issues and cost implications, as well as investigating ways in which the NHS can better protect its resources for those entitled to use them, and work more closely with the Border and Immigration Agency to identify those who are not.

As Rosie Winterton said during her evidence to the Committee, an equality impact assessment will also be carried out as part of this review process, in relation to both primary medical services and secondary care.

Additional response to recommendation 19

The Government's approach is in accordance with our obligations under the European Convention on Human Rights (ECHR), on which there is extensive case law both domestic and from the European Court of Human Rights. It can be a breach of Article 3 of the ECHR to remove someone from the UK if to do so would amount to inhuman or degrading treatment on account of the suffering caused as a result of their medical condition, but the threshold for inhuman and degrading treatment in such cases is very high. Persons who are in the final stages of a terminal illness and would not have access to medical care to prevent acute suffering while they are dying, or who would face imminent death without medical or other support if returned to their home country, would however be likely to meet that threshold, in which case they would be granted Discretionary Leave to remain in the UK.

The House of Lords case of *N* clearly establishes that states are under no obligation to allow those otherwise liable to removal to remain in their territories for the purpose of receiving medical treatment. It would be unfair to those suffering from other serious conditions to offer a special concession to those with a particular condition such as HIV/AIDS.