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Beyond the edges of healthcare provision: refused asylum seekers and access to healthcare

PAFRAS Briefing Paper Number 11

July 2009

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PAFRAS Briefing Papers

PAFRAS (Positive Action for Refugees and Asylum Seekers) is an independent organisation based in Leeds. By working directly with asylum seekers and refugees it has consistently adapted to best meet and respond to the needs of some of the most marginalised people in society. Consequently, recognising the growing severity of destitution policies, in 2005 PAFRAS opened a 'drop-in' providing food parcels, hot meals, clothes, and toiletries. Simultaneously experienced case workers offer one-to-one support and give free information and assistance; primarily to destitute asylum seekers. PAFRAS works to promote social justice through a combination of direct assistance, individual case work, and research based interventions and analysis.

Below an underclass, destitute asylum seekers exist not even on the periphery of society; denied access to the world around them and forced into a life of penury. To be a destitute asylum seeker is to live a life of indefinite limbo that is largely invisible, and often ignored. It is also a life of fear; fear of detention, exploitation, and deportation.

It is from the experiences of those who are forced into destitution that PAFRAS briefing papers are drawn. All of the individual cases referred to stem from interviews or conversations with people who use the PAFRAS drop-in, and are used with their consent. As such, insight is offered into a corner of society that exists beyond the reach of mainstream provision. Drawing from these perspectives, PAFRAS briefing papers provide concise analyses of key policies and concerns relating to those who are rendered destitute through the asylum process. In doing so, the human impacts of destitution policies are emphasised.

Introduction

Published by Positive Action for Refugees and Asylum Seekers (PAFRAS) © July 2009

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PAFRAS Briefing Paper 11 focuses on the provision of medical assistance available for refused asylum seekers. The level of medical care that refused asylum seekers are able to access has, for some years, been a source of contention. The present government has made clear that, where possible, access to medical support will be denied and the result has been ongoing; appearing before the courts on numerous occasions. At the same time, issues around access to medical support have caused debate, and in many cases protest, within the medical profession itself with many individuals calling for improved healthcare services.

Beyond the edges of healthcare provision has been written in the wake of a relatively recent court of appeal hearing in which it was decided that refused asylum seekers are not eligible for all free National Health Service (NHS) treatment;[1] and the outcome of a review by the Department of Health and the Home Office about access to NHS services for foreign nationals.[2] In essence, the former ruling articulated that refused asylum seekers are not obliged to be given secondary care (except in certain, limited, circumstances). Whilst the latter argued that refused asylum seekers with 'recognised barriers to their return home' should be entitled to receive secondary care. The review will be consulted on in autumn 2009, and as has been discussed elsewhere, one of the impacts of restricting secondary care to certain people may well be that increased numbers of people in this situation become reliant on General Practitioners (GPs) and other forms of primary care in order to attempt to access medical support.[3] GPs are unaffected by the Court of Appeal decision, and have discretion to 'register or refuse to register patients

[1] This case: 'R (YA) –v- Secretary of State for Health' ruled that refused asylum seekers, in many cases, will not be entitled to all forms of free medical care. There are exceptions and, for example, there should be no charges or restrictions on accident and emergency treatment. This will be discussed in more detail throughout this briefing paper.
[2] See Department of Health (2009) 'Access to NHS services for foreign nationals', *Department of Health News Stories,* 20 July, http://www.dh.gov.uk/en/News/Recentstories/DH_102993
[3] Newdick, C. (2009) 'Treating failed asylum seekers in the NHS', *British Medical Journal,* 338, pp. 1-2.

provided he or she does not discriminate in so doing'.[4] Consequently, what follows examines primary care access for refused asylum seekers by way of focusing on GP, and dental care.

When a claim for asylum is refused, so too is the claimants ability to access the most basic of requisites for existence in the UK.

PAFRAS is well placed, as an organisation, to both witness and respond to the effects of policy changes altering the level of medical support which refused asylum seekers and irregular migrants can access. This briefing paper then focuses on access to primary care, and analyses barriers to obtaining initial support. But in order to do so, it starts from the premise that difficulty in accessing primary care is farmed by wider denial, in certain cases, of secondary care. This briefing paper begins by exploring the context within which healthcare access has been curtailed, before utilising data from the internal monitoring systems that PAFRAS uses in order to gauge some idea of the extent to which medical care is available for refused asylum seekers. Correlating this data with immigration status, this paper explores the context within which access to health care is reduced before, finally, looking at some of the wider implications engendered.

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'Overseas visitors' and access to healthcare

Preventing refused asylum seekers from access to normal statutory services has become a staple facet of contemporary asylum policy. When a claim for asylum is refused, so too is the claimants ability to access the most basic of requisites for existence in the UK. Refused asylum seekers have no permission to take up employment; in many cases live on the streets or transiently at friends and in temporary accommodation; have no entitlement to most mainstream benefits unless they fulfil particular criteria; and, at the time of writing, have only limited access to healthcare.[5] Such punitive political choices embody a number of government objectives. The government seeks quite explicitly to ensure that those who they perceive as having no entitlement to reside in the UK will leave the country. The removal of services consequently occurs alongside concerted attempts to deport those who have fallen into 'irregular' immigration status. As we have documented elsewhere, there were an average of 22 early morning enforcement visits (or dawn raids) a day in 2007 and the physical removal of people from the UK is both pursued with zeal,[6] and shows no sign of abating.[7] At the same time, with regard to medical support, the government has put in place concerted strategies designed to reduce the scope for foreign residents accessing the NHS. There is little evidence to support the argument that increasing numbers of people enter the UK in order to access free health services. And according to Medecins du Monde UK, an organisation with a wealth of expertise and experience in this area, in 2008 they asserted that they 'saw no evidence of the so called "health tourist" who comes to the UK seeking expensive treatment'.[8] Nevertheless, it is such perceptions that have informed, and continue to inform, policy developments with regard to the medical care of refused asylum seekers.[9]

There is little evidence to support the argument that increasing numbers of people enter the UK in order to access free health services.

[4] Immigration Law Practitioners' Association (2009) 'Access to Healthcare 2', *Information Sheet,* 20 April, p. 1.
[5] See Burnett, J. (2009) 'What is destitution?', *PAFRAS Briefing Paper No. 9,* Leeds: PAFRAS.
[6] Burnett, J. (2008) 'Dawn raids', *PAFRAS Briefing Paper No. 4,* Leeds: PAFRAS.
[7] Home Office (2007) *Enforcing the Deal: Our Plans for Enforcing the Immigration Laws in the United Kingdom's Communities,* London: Home Office.
[8] Medecins du Monde UK (2008) *Project London, Report and recommendations,* London: Medecins du Monde UK.
[9] Whilst the New Labour government decries 'medical tourism' within the UK; there is no such indignation however with regard to British nationals travelling overseas to access healthcare. On the contrary, companies specialising in overseas medical assistance are allowed to prosper in the UK unhindered. In October 2010, the second health tourism conference for medical professionals will be hosted in London.

Primarily, the National Health Service (Charges to Overseas Visitors) Regulations 1989 set out the basis through which those not normally resident in the UK could be charged for care, and how these charges could be pursued.

The NHS was developed as an instrument of the nation state and, from its conception in 1948, has always been antagonistic with regard to the treatment of overseas visitors. At the same time as the NHS actively recruited medical professionals from the British colonies, immigration legislation ensured that the scope for accessing the NHS was restricted.[10] These restrictions have continued, and developed, most coherently through a series of amendments to 'Overseas Visitors Regulations'. Primarily, the National Health Service (Charges to Overseas Visitors) Regulations 1989 set out the basis through which those not normally resident in the UK could be charged for care, and how these charges could be pursued. And these regulations were amended in 1991, 1994, 2000, 2004, and 2008.[11] Statutory Instrument 2004 No614, in particular, ensured that the scope for refusing certain forms of healthcare was widened.[12] As a result, those who were deemed to be not normally resident in the UK would be charged for certain forms of secondary care.[13] Secondary care can include specialist services, as well as that which is designed to supplement the work of primary care services. Its withdrawal consequently had significant and well documented repercussions for those whose claims for asylum had been refused. Commenting on these provisions in 2007 for example, the Joint Committee on Human Rights stated that they:

> …caused confusion about entitlement, that interpretation of them appears to be inconsistent and that in some cases people who are entitled to free treatment have been charged in error. The threat of incurring high charges has resulted in some people with life-threatening illnesses or disturbing mental health conditions being denied, or failing to seek, treatment.[14]

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Similarly the Refugee Council noted cases where there had been misunderstanding, on the part of NHS staff, about who could access services; and examples of people being denied necessary treatment.[15]

Taking these measures further; that same year the government also announced proposals to withdraw primary healthcare from overseas visitors.[16] Almost immediately, an 'entitlement to health care' working group, made up of a range of key organisations working around healthcare and immigration and asylum policy, was set up. This group opposed such restrictions on the basis that they would be unjust; an abuse of people's human rights; and would lead to prejudice and discrimination.[17] As a result, primary care services have remained available. However, the debates over secondary care access have culminated in a number of test cases in the courts. In 2008, the High Court ruled that restrictions were unlawful and that refused asylum seekers who could not be returned home should

[10] On the 'recruitment' of medical professionals see for example Esmail, A. (2007) 'Asian doctors in the NHS: service and betrayal', *The British Journal of General Practice,* 57(543).
[11] See also National Health Service (1999) *Overseas Visitors' Eligibility to Receive Primary Health Care,* HSC 1999/018, London: National Health Service.
[12] For discussion see Medact (2007) *Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: impact on vulnerable migrant groups,* London: Medact.
[13] See Abergavenny, R. D. (2005) 'Ten out of 25 EU counties restrict health care for asylum seekers to emergencies only', *British Medical Journal,* 331(986).
[14] Joint Committee on Human Rights (2007) 'Tenth Report of Session 2006-07', *The Treatment of Asylum Seekers*, HL Paper 81-I, HC 60-I, para. 134.
[15] Refugee Council (2004) *The Refugee Council's Response to the Department of Health Consultation Paper: 'Proposal to Exclude Overseas Visitors from Eligibility to Free Primary Medical Care Services',* London: Refugee Council.
[16] Department of Health (2004) *Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services,* London: Department of Health.
[17] See Entitlement to Healthcare Working Group (Undated) *Presentation on the Entitlement to Healthcare Working Group,* London: Entitlement to Healthcare Working Group.

be allowed to access free treatment.[18] But in March 2009 the Department of Health appealed against this ruling, and it was ruled that refused asylum seekers are not entitled to all forms of free care, but Trusts have the discretion to treat people if they wish to.[19] The case was based on a Palestinian man, known as 'Mr A', who had been charged £9,000 for liver treatment. In effect, this returned the situation to one where certain forms of secondary care can be denied to refused asylum seekers.

The outcome of the joint review on healthcare and foreign visitors by the Department of Health and the Home Office, published a few months after the March 2009 ruling, has indicated that refused asylum seekers who cannot return home should be allowed access to secondary care. These findings have not yet been consulted upon, and look set to be implemented in 2010. Potentially though, they may not alleviate the problems of reduced NHS access in practice. The government has made clear that it takes an extremely stringent view of what constitutes as recognised barriers to return; and have placed clear emphasis on returning people to countries that are widely recognised as unstable, and dangerous.[20] Given the particular health needs of asylum seekers, reduced levels of care and treatment have particularly damaging repercussions. These were brought into stark reality in 2008 when Mohammed Ahmedi, a man with a heart condition, died whilst the NHS debated over his immigration status.[21] He is not the first person whose life has ended, rather than been saved, as a result of health policy.

It has been estimated that up to 30% of people seeking asylum have survived torture, and the campaigning organisation Black Women's Rape Action Project have estimated that roughly 50% of asylum seeking women in the UK are rape survivors.

Asylum seekers and health care needs

The particular healthcare needs of all asylum seekers have been well documented. By virtue of having sought refuge, asylum seekers have had to leave friends, loved-ones, and their homes behind; and experienced and had to flee from persecution. It has been estimated that up to 30% of people seeking asylum have survived torture,[22] and the campaigning organisation Black Women's Rape Action Project have estimated that roughly 50% of asylum seeking women in the UK are rape survivors.[23] Health needs can further, as the Faculty of Public Health has discussed:

> …be significantly worsened (and even start to develop in the UK) because of the loss of family and friends' support, social isolation, loss of status, culture shock, uncertainty, racism, hostility (eg. from the local population), housing difficulties, poverty and loss of choice and control. [24]

Research published by PAFRAS earlier this year, based on interviews with 56 refused asylum seekers, emphasised that just over a third of females interviewees

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[18] See Ford, R. (2008) 'Ruling gives failed asylum-seekers free healthcare', *The Times,* 12 April, http://www.timesonline.co.uk/tol/news/politics/article3732002.ece

[19] For a brief overview of this case see the press release by Pierce Glyn solicitors, who represented 'Mr A': Pierce Glyn Solicitors (2009) 'Appeal Court: Unlawful for hospitals to refuse urgent treatment to migrants', *Press Release,* 30 March. For further discussion see also Webber, F. (2009) 'Important legal ruling for refused asylum seekers', *Institute of Race Relations News,* 2 April, http://www.irr.org.uk/2009/april/ha000008.html

[20] See the discussions in Burnett, J. (2009) 'No direction home: the politics of return for refused asylum seekers', *Briefing Paper No. 8,* Leeds: PAFRAS.

[21] Moriss, S. and Allison, E. (2008) 'Hospital defends treatment in asylum seeker death', *The Guardian,* 13 February, http://www.guardian.co.uk/society/2008/feb/13/nhs.immigrationandpublicservices

[22] Burnett, A. (2006) *Tackling Inequalities in the Health of Refugees in Host Countries: A Challenge for Researchers and Policy Makers,* Paper presented to the LSE and LSHTM, June 2006.

[23] See their Asylum from Rape petition at http://www.petitiononline.com/afrsep08/petition.html

[24] Faculty of Public Health (2008) 'The Health Needs of Asylum Seekers', *Briefing Statement,* London: Faculty of Public Health, p. 4.

who had been made to sleep outside in the UK had been sexually assaulted.[25] Many had been subjected to violent racist victimisation.[26] Moreover, as we have discussed elsewhere destitution and malnutrition are unequivocally linked and 'can lead to permanent harm, and in extreme cases death'.[27] It is in this wider context, of specific health needs in many ways caused and exacerbated by the asylum system, that many medical professionals have objected to reductions in levels of healthcare on the basis that refused asylum seekers should not be viewed as 'overseas visitors' but vulnerable people.[28] Reductions in healthcare only serve to compound this vulnerability further.

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Access to primary care

Given the above restrictions in healthcare services, it is especially important for those seeking asylum to be registered with a GP. Such frontline professionals act as a gateway to the NHS; improving access to care, providing personalised treatment, and generally improving public health.[29] As such, when a 'service user' works with a PAFRAS case worker basic details are taken about whether the individual in question has a GP, and a dentist. If people do not have medical support, or have physical or mental health concerns, they are referred to the Leeds Health Access Team; an NHS service which supports asylum seekers in accessing health care, or other appropriate services.

Using case details from service users coming to PAFRAS, it is consequently possible to ascertain some idea of the proportion of people who are registered with appropriate services within the NHS. In 2008, of the first 50 new service users who came to PAFRAS for support 28 stated that they were registered with a GP, and seven with a dentist. Of the first 50 new service users in 2009, 33 had a GP and five a dentist. As Table 1 (next page) shows, whilst 66 per cent of people or less were initially registered with a GP then, in both of those years, less than 15 per cent had dentists. Further, by correlating access to a GP or dentist with immigration status, a more detailed picture begins to emerge. Over the two years, the 100 service users in question were all either refused asylum seekers, waiting for a decision on their asylum claim, in receipt of 'Section 4' support,[30] or refugees. As Table 2 (next page) shows, immigration status had a clear impact upon the likelihood of having either a dentist or a GP. Those who were destitute, and without any support were much less likely to be registered with either than those who were receiving Section 4 support or those who had not yet received a decision on their asylum claim.[31] In short, when a claim for asylum is refused, access to GP's and dental care appears to diminish.

In short, when a claim for asylum is refused, access to GP's and dental care appears to diminish.

[25] Taylor, D. (2009) *Underground Lives: An investigation into the living conditions and survival strategies of destitute asylum seekers in the UK,* Leeds: PAFRAS.
[26] For further information on this subject see Burnett, J. (2008) 'Racism, destitution and asylum', *PAFRAS Briefing Paper No. 6,* Leeds: PAFRAS.
[27] Burnett, J. (2009) 'The political economy of malnutrition', *PAFRAS Briefing Paper No. 10,* Leeds: PAFRAS, p. 4.
[28] Global Health Advocacy Project (2008) *Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services: A Summary of Submissions to a Department of Health Consultation Whose Findings Were Never Published,* London: Global Health Advocacy Project, p. 5.
[29] Royal College of General Practitioners (2004) *The Future of General Practice: A Statement by the Royal College of General Practitioners,* London: Royal College of General Practitioners.
[30] For discussion see Burnett, J. (2007) 'Section 4 support', *PAFRAS Briefing Paper No. 1,* Leeds: PAFRAS.
[31] With only one person granted refugee status, it would be presumptuous to make any generalisations on the level of access to which they had.

Table 1 – Percentage of a selection of PAFRAS Users registered with GPs or dentists

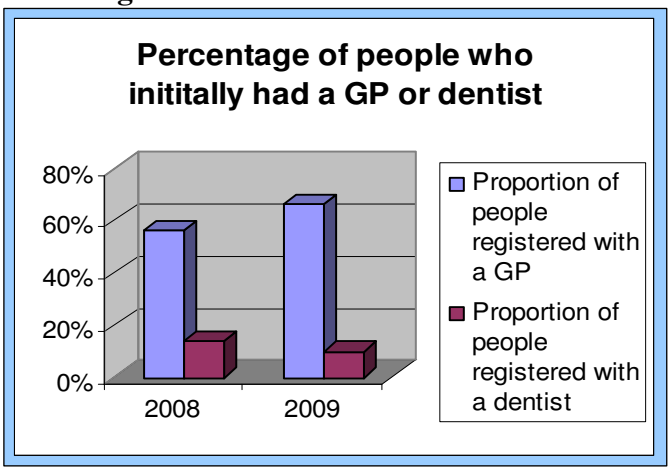

Table 2 – Registration and immigration status

	Number of people	Number of people with a GP	Number of people with a Dentist
Destitute	71	34 (48%)	4 (13%)
NASS	8	8 (100%)	4 (50%)
Section 4	20	19 (95%)	4 (25%)
Refugee	1	0 (0%)	0 (0%)

Many refused asylum seekers were reluctant to approach health facilities for fear of being 'picked up' detained and possibly deported by immigration authorities.

It is perhaps unreasonable to expect an individual who has moved to another country, and is traumatised and rendered homeless, to understand the complexities of the British welfare system and nuances of healthcare provisions.

As Fidelis Chebe, evaluating a PAFRAS project aimed at increasing the health and well-being of refused asylum seekers has noted, this reduction in primary care contact must be read alongside the wider impacts of the asylum process. Of the individuals who accessed this particular project he noted that:

> Many refused asylum seekers were reluctant to approach health facilities for fear of being 'picked up' detained and possibly deported by immigration authorities.[32]

In turn, the transience that characterises destitution ensures that appointments are harder to keep as people are often forced to constantly move from place to place. For others, reduced contact can well be a simple matter of misinformation, or lack of information. It is perhaps unreasonable to expect an individual who has moved to another country, and is traumatised and rendered homeless, to understand the complexities of the British welfare system and nuances of healthcare provisions. Rather, many people assume that all NHS care has been withdrawn from them along with the vast majority of mainstream services. And whilst it is important to highlight again that many GPs have led campaigns calling for full access to the NHS for refused asylum seekers; there have nevertheless been publicised cases of GPs refusing to treat asylum seekers.[33] A report published in 2001 noted that 20% of 36 asylum seeking interviewees had experienced racism from their GPs in London.[34]

Many of the above points equally apply to the particularly low registration of refused asylum seekers with dentists. It should, of course, be noted that many people are unable to register with dentists regardless of their immigration status.[35] There is a shortage of dentists throughout the UK. There are particular issues with regard to refused asylum seekers though in that, by virtue of having been forced into homelessness, people frequently find it difficult to maintain oral health. As one individual has explained:

[32] Chebe, F. (2009) *Healthy Living Project Final Report,* Leeds: PAFRAS, p. 22.
[33] BBC (2002) 'Asylum seekers refused treatment', *BBC News Online,* 8 November, http://news.bbc.co.uk/1/low/england/2414423.stm
[34] Cowen, T. (2001) *Unequal treatment: findings from a refugee health survey in Barnet,* Barnet: Refugee Health Access Project.
[35] See BBC (2008) 'Dentist shortage hits "millions"', *BBC News,* 16 January, http://news.bbc.co.uk/1/hi/health/7189448.stm

> Sometimes I eat once a day, sometimes once every two days. I survive eating cheap custard cream biscuits from a supermarket that costs 27p per packet. Because of eating so much sugary food I've now got a problem with my teeth.[36]

In effect a policy framework which explicitly limits particular form of healthcare has the effect, intended or otherwise, of reducing access to general treatment.

Whilst refused asylum seekers should, ostensibly, be allowed to access free dental care the particularly low registration with dentists means that many people instead have to rely on emergency treatment as and when required. In order to access free treatment particular documentation is required,[37] which can take a long time to arrive after ordering; and if pain is acute this may be too late. PAFRAS has paid for emergency care for people on a number of occasions where they have been in such pain that they required immediate assistance. In effect a policy framework which explicitly limits particular forms of healthcare has the effect, intended or otherwise, of reducing access to general treatment. Notes by PAFRAS case workers (in Table 3), taken when making referrals to health practitioners, give some indication of the extent to which asylum policy both damages people and restricts their ability to seek care:

Table 3 – A selection of PAFRAS healthcare referral notes

1. Was due an operation last year but it was refused because he was made homeless. Has dental problems.
2. Severe internal pain.
3. Dental problems. Severe pain on arms and wrist
4. Problems with eyes and hand/thumb (inability to move joint). No GP, in a lot of pain and cannot sleep.
5. No money to travel for medical attention.
6. Needs doctor and dentist. Attacked by four or five people. Has received no medical attention.
7. Rough sleeping, has very painful jaw.
8. Skin problems. Problems with dental treatment.
9. No current GP and wants access to previous medical records.
10. Addiction problems. Torture victim. Been turned down from some medical agencies because of his addiction problems. Client says that his addiction problems stem from flashbacks he has about his experiences in prison and the torture he suffered.
11. Severe gastritis – suspected gastric ulcers. Recurrent headaches and pain in the head.
12. Needs to collect prescription. HC2 expired and urgently needs replacement

Conclusions

The healthcare needs of asylum seekers have been well documented. However, for many refused asylum seekers health services are beyond reach. Whilst primary care is available, in theory, for those whose asylum claim has been rejected a combination of factors underpin particularly low levels of access. In turn, this is buttressed by the denial (at the time of writing) of particular forms of secondary NHS care which formally confines refused asylum seekers to the periphery of healthcare provision. This situation does look set to potentially change, and a joint review by the Home Office and the Department of Health indicates that refused asylum seekers who cannot be returned home may be entitled to both primary and secondary care. Whether this will alleviate the lack of access to NHS services indicated here though remains to be seen. Much depends on how the government defines 'barriers to return'. Potentially, what may remain intact is what, at the moment, is in effect a two-tier system of healthcare.

[36] Taylor, D. (2009) *Underground Lives: An investigation into the living conditions and survival strategies of destitute asylum seekers in the UK,* Leeds: PAFRAS, p. 24.

[37] In order to receive free NHS primary care an individual normally must be able to produce a valid 'HC2' certificate. HC2 certificates are valid for 6 months, after which time the recipient will need to apply for a renewal. In order to obtain an HC2 form an 'HC1' form must be completed and processed; a procedure which can take weeks to complete.