Accessing healthcare for migrants in Northern Ireland: problems and solutions

Access to primary healthcare in Northern Ireland is much more restricted than in other UK jurisdictions, resulting in some migrants being unable to register with a GP.

This restriction puts patients' health at risk. It also causes difficulties for medical and social work staff as well as for support organisations, puts pressure on hospital and emergency services and threatens public health. In addition, a number of migrant categories cannot access secondary care. Again, this causes difficulties.

This paper is arranged in four parts. It sets out the Northern Ireland healthcare context, highlights current difficulties through a series of case studies, and offers pragmatic recommendations for change. A summary of recommendations can be found on page 14.

Key recommendations

We recommend that:

- The Department of Health, Social Services and Public Safety (DHSSPS) removes the 'ordinarily resident' test for primary care, thus bringing Northern Ireland in line with other jurisdictions.

- DHSSPS makes healthcare freely available for a number of categories of migrants.

- DHSSPS replicates the approach taken by Scotland and Wales by providing free healthcare to all asylum seekers.
Part 1. Accessing healthcare

A GP referral is essential for accessing secondary healthcare services: effectively, GPs are a gateway to healthcare.

GP access is required for services including:
- vaccinations;
- prescriptions for medicines;
- advice on health problems including nutrition, etc;
- simple surgical operations;
- health education;
- referral to a specialist doctor such as paediatrician, gynaecologist, cardiologist, ophthalmologist, dermatologist, chiropodist, neurologist, etc;
- referral to surgery; cancer treatment;
- rehabilitation services such as speech therapy or physiotherapy;
- mental health support such as psychiatrists or psychologists;
- referral to drug substitution medication;
- referral to social care services;
- access to NHS dental care.

1. General principles

The Department has a general duty to promote an integrated system of healthcare in Northern Ireland to secure improvement in the physical and mental health of people in Northern Ireland and to prevent, diagnose and treat illness. This is a wide duty and would appear to apply to any person in Northern Ireland without exception.

Generally, any person can access healthcare services in Northern Ireland. However, access to free healthcare depends on whether the patient is ordinarily resident in Northern Ireland. A person is regarded as ordinarily resident if:

S/he is lawfully living in Northern Ireland voluntarily and for a settled purpose as part of the regular order of her/his life for the time being. A person must have an identifiable purpose for her/his residence and that purpose must have a sufficient degree of continuity to be properly described as settled.

British/Irish nationals living in Northern Ireland should normally meet this definition as should any EEA national who is exercising a Treaty right (i.e. working, studying, self employed, etc). Migrants who have work visas or settlement also meet the definition.

If a person is not considered ordinarily resident then s/he is classified as a visitor for the purposes of the health regulations. Visitors can be charged for both primary and secondary healthcare. However, current regulations provide a number of exemptions from charges.

The exemptions apply to categories of visitors, such as cross border workers, refugees, diplomatic staff, certain international students, members of the armed forces, etc, as well as to specific services such as treatment at Accident and Emergency Departments (A&E), family planning services and treatment for particular contagious diseases.

Therefore, if a person falls within one of the visitor exemption categories or requires a particular exempted service then the treatment is free. This applies regardless of the person’s immigration status.

As a general rule, if a person is entitled to receive free healthcare, this entitlement also applies to her/his dependent family members. Cross border workers are an exception to this rule.
2. Accessing primary healthcare in Northern Ireland

Primary care is usually community based care provided by GPs, NHS-walk-in centres, district nurses, pharmacists, optometrists, etc. It includes preventative care (e.g. health screening and health promotion) as well as diagnosis and treatment.

To access free primary healthcare, a person must first register with a GP.

In Britain, prospective patients register directly with a GP practice. GPs have discretion as to whether to register patients. A GP must have reasonable grounds to refuse to register a patient and any decision must not be discriminatory. 7

The situation is different in Northern Ireland. From a policy perspective, there is a considerable lack of legal clarity about entitlement to primary care.8 Specifically, it is unclear whether the ‘ordinarily resident’ test applies to primary care.9 In practice, however, it is clear that the ‘ordinarily resident’ test is applied for GP registration.10 Therefore, when a prospective patient seeks to register with a GP in Northern Ireland, the registration form is sent to the Business Services Organisation (BSO) for approval. BSO considers the ‘ordinarily resident’ test and decides whether the person is entitled to be registered as a full NHS patient. BSO makes its decision based on the information provided by the patient on the form and, if necessary, accompanying documentation such as evidence of immigration status.

If the person is entitled to be registered as a full NHS patient, BSO registers her/him and issues a medical card. If the person is not entitled, BSO notifies her/him in writing. In such cases, the prospective patient may still access primary care but as a privately paying patient. Payments are a matter between the patient and the GP.

In cases where the prospective patient does not have settled status, then BSO automatically reviews the case after a specific time period. If the patient cannot demonstrate continued eligibility then s/he will be de-registered. When BSO is considering de-registering a patient, it should first write to the patient and provide an opportunity for her/him to submit any additional evidence of entitlement.

The majority of eligible patients are registered as full NHS patients. However, patients who intend to stay in a place for more than 24 hours but less than three months can be registered as temporarily resident patients.11 Finally, where a person is not registered, a GP is nevertheless required to provide ‘immediately necessary’ treatment for a maximum of fourteen days.12

3. Accessing secondary healthcare in Northern Ireland

Secondary care is usually hospital based care. It includes specialist medical treatment or surgery.

To access free secondary healthcare, a patient must either satisfy the ‘ordinarily resident’ test or fall within one of the exemption categories. Ineligible patients must be charged for secondary health services. Each Trust has a Paying Patients Officer who assesses patients’ eligibility.

In November 2012, the five Trusts implemented a ‘UKBA/NHS Charging Pilot’. The pilot is currently focussed on particular hospital wards but it is anticipated that it will be extended to all hospital wards and clinics in due course.13 The pilot reflects similar initiatives that have been imple-
mented in England, Wales and Scotland. Its purpose is to identify patients who are not eligible for free healthcare so that charges can be applied accordingly. Where a patient accrues a debt of more than £1,000 that remains unpaid after three months, the NHS forwards this information to the UKBA. As of 31 October 2011, the UKBA has powers to refuse an application to enter or remain in the UK where a person has an unpaid debt.¹⁴

There has been a lot of criticism of this policy in Great Britain, including by the British Medical Association which has raised concerns about the detrimental impact it may have on the engagement of vulnerable groups with health services.¹⁵

4. Northern Ireland - policy intent for restriction

As outlined, the crucial distinction between Northern Ireland and Britain is that the ‘ordinarily resident’ test effectively applies to primary as well as secondary care. This means that it is much more difficult to register with a GP here.

The policy intent underpinning this restriction is to discourage persons residing in the Republic of Ireland who are not exercising Treaty rights in the UK from crossing into Northern Ireland for the purpose of availing of publicly funded health services.¹⁶ However, the current framework has the effect of excluding a number of migrant groups who do not satisfy the ‘ordinarily resident’ test. We believe it should be possible for the DHSSPS to differentiate between migrant communities living in Northern Ireland and people who reside in the Republic of Ireland (see Part 3).

5. Categories of migrants without entitlement

Difficulties arise when a person does not meet the ‘ordinarily resident’ test, does not fall within one of the listed exemption categories and does not require an exempted treatment. The following groups often encounter difficulties when seeking to register with a GP.

Some categories of Accession 2 (Bulgarian and Romanian) nationals. For A2 nationals, the question hinges on whether the person meets the right to reside test. This can be difficult for A2 nationals who are not exempt from the Worker Authorisation scheme, not self employed, and not registered with the UKBA or HMRC.

Refused asylum seekers. The position for refused asylum seekers in Northern Ireland is unclear. Specifically, the courts in Northern Ireland have not yet considered whether Temporary Admission, which is granted by UKBA to asylum seekers who are liable to detention, amounts to ‘lawful residence’ or whether other exemption categories apply.¹⁷

Irregular migrants. There is no provision in law for irregular migrants to access primary healthcare. This category of migrants includes persons who entered the UK lawfully but who have overstayed their visas and persons who have entered the UK unlawfully and are working without authorisation.

Children of all the above categories.
The Law Centre has experience of BSO refusing registration to prospective child patients in all these categories.
Part 2: Current difficulties

The fact that some migrants cannot register with a GP gives rise to a number of practical difficulties that, in addition to risking the individual’s health, also affect a range of agencies and practitioners. This section details some of the problems experienced by different stakeholders and is illustrated by recent case studies drawn from Law Centre (NI) and other voluntary sector groups.18

1. Patient health

A decision to refuse GP registration poses a serious risk to the individual’s health. Without GP access, a person is effectively denied access to a whole host of services and treatments ranging from obtaining a prescription to accessing mental health services.

Mahmood is an asylum seeker from an African country that has experienced decades of civil war. Mahmood suffers from serious depression. He was receiving specialist trauma treatment and was advised that a course of anti-depressants would complement his treatment. However, by this time, his asylum application had been refused and he had been de-registered from his GP. Mahmood’s mental health deteriorated rapidly and he began to have suicidal thoughts. He urgently needed medication but could not obtain a prescription. By then, Mahmood had lost his NASS accommodation and was completely destitute.

Neeraj, an Asian man, was unable to manage his Type 2 diabetes without GP assistance, which led to serious ill health and an amputation.

2. Pressure on emergency services and hospital resources

Many health conditions can be effectively managed through regular access to a GP and repeat prescriptions. Without GP access, conditions can deteriorate until such a point that an urgent medical intervention becomes necessary.

Melody suffers from asthma and was de-registered from her GP when she became a refused asylum seeker. Without access to her regular inhaler, she became so ill that she had to be admitted into the Intensive Care unit at a Belfast hospital in November 2012. She spent five days in hospital before being discharged.

Patients who do not have a GP have no option but to seek treatment elsewhere - often through A&E or in a hospital setting. This places pressure on these specialist services.

In addition to placing pressures on emergency and specialist services, it is much more expensive to treat a person in a hospital rather than in a GP setting. Furthermore, this approach goes against the grain of the DHSSPS’s current focus of promoting community rather than hospital interventions.19
The average cost to the NHS of:

- An appointment with a GP £25
- Providing one prescription £12.87
- A visit to A&E £83
- Hospital bed per day £225
- An ambulance journey to A&E £300
- Intensive care bed per day £1,500

Costs also accrue where ‘delayed discharge’ occurs i.e. where hospital staff cannot discharge a patient because s/he is not registered with a GP.

Chen has lived in Northern Ireland for more than eleven years. His immigration status is unclear and he has no fixed address. He is not registered with a GP. He presented at a regional hospital with serious complications relating to Hepatitis B. He was transferred to a Belfast hospital for treatment. After almost a month in hospital, his medical team deemed him fit for discharge. However, the fact that he did not have a GP delayed his discharge by more than a week.

3. Difficulties for social work staff

When patients lose their entitlement to primary healthcare and become de-registered, they also lose a vital link with statutory services. This creates difficulties for social work staff who find it difficult to maintain contact, which can jeopardise the success of their interventions.

In limited instances, Trusts have duties to provide social care to patients who are being discharged under community care legislation. Where these duties do not apply, staff may have to discharge patients knowing that they face destitution and have no recourse to a GP. These cases are extremely time consuming for social services staff who are required to mediate solutions in often near impossible circumstances.

Pavel, an A2 national, was nearly blinded in an agricultural accident. He received extensive hospital care. As he was not entitled to access a GP he would not be able to access rehabilitation and follow-up services once discharged. The hospital consultant felt very strongly that the patient’s health would deteriorate rapidly if he were discharged without follow on treatment. The consultant maintained that this would render the whole medical intervention ineffective and that this would constitute a waste of public money. In the end, a social services team was able to access charitable support for this patient.

In other cases, social services have to provide assistance when people are refused GP access. This is another example of how the current policy creates costs that are borne by other statutory agencies or by the voluntary sector.

Luca is a Romanian man who was diagnosed with renal colics. He wanted to receive treatment in Romania but his health was too poor for him to travel. He attempted to register with a GP so he could obtain the prescriptions that would help him get well enough to complete the journey. He was refused registration. Eventually he ended up presenting at A&E with severe abdominal pains and was given the prescription he needed. Three weeks later he was fit enough to travel. However, during this period, he was unable to work or support his family. This resulted in a social services intervention.
4. Hindering early intervention

Research shows that early diagnosis and early intervention provide positive social and economic outcomes and significant long-term savings.22 Without regular access to a GP, conditions cannot be identified promptly. This is of particular concern in cases of infectious diseases which can be effectively managed if identified at early stages, enabling the risk of further transmission to be considerably reduced.

HIV: testing, treatment, late and non-diagnosis23

Diagnosing and treating HIV is the key to curbing onwards transmission. Effective treatment results in a 96 per cent reduction in transmission. Modelling by the Health Protection Agency shows that preventing one onwards transmission of HIV saves between £280,000 and £360,000 in treatment costs across a lifetime. Using statistics from 2008 as an example, the HPA noted that preventing UK transmissions diagnosed in one year alone would have saved £1.1 billion in future HIV-related costs. This does not take into account the additional social and economic costs of an HIV transmission, nor the additional people who may get HIV from those newly infected.

5. Difficulties for GPs

As outlined above, a GP is required to provide ‘immediately necessary treatment’ for a period of up to fourteen days even if the patient is not registered.24 In theory, a person can access urgent treatment despite not being registered with the practice. GPs can therefore find themselves providing treatment and prescriptions to persons who are not registered with their practice. A GP is responsible for any prescription s/he issues and yet, if the patient is unregistered, the GP is hindered from effectively monitoring patients and providing follow-up care.

In practical terms, however, it is extremely difficult for an unregistered person to convince reception staff to arrange an appointment with a GP. Thus this ‘safety net’ is rarely accessible.

The framework puts Northern Ireland GPs at odds with the position statement of the Royal College of General Practitioners which makes it clear that asylum seekers have a right to GP services:

*General practice should remain the main access to healthcare within the NHS. Based on the principle that General Practitioners have a duty of care to all people seeking healthcare, the Royal College of General Practitioners believes that General Practitioners should not be expected to police access to healthcare and turn people away when they are at their most vulnerable. Further, it is important to protect individual and public health. All vulnerable migrants, including refugees and asylum seekers, have a right to be fully registered with a NHS general practice [...]25*

In short, time-limited and partial entitlement to services is problematic.

6. Public health issues

The Department has a duty to support preventative healthcare and to promote public health.26 The Department must ensure that policies are in
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place for screening individuals entering the country, that it has resources available to offer appropriate medical services for treatment of such individuals and that it prevents further transmission of disease. These functions are delivered through the Public Health Agency.

The majority of newcomers to Northern Ireland are young and healthy on arrival, with no greater health needs than the general population. Nonetheless, there is a clear public health argument for ensuring that migrants have access to primary healthcare. For example, rates for both TB and HIV are higher for non-UK born people. There is also evidence that, while the highest rates of TB among migrants occur among people who are recent arrivals in the UK, just under a quarter are diagnosed within two years of arrival. Such data emphasises the importance, from a public health perspective, of ensuring migrant communities have immediate access to primary care.

Indeed, the measles outbreak in a migrant community in Belfast during the festive period 2012/2013 illustrates this point. Measles is rare in Northern Ireland yet fifteen cases emerged in a short space of time among a migrant community – many of whom had no access to a GP and consequently had not been vaccinated. Unfortunately, a number of the cases required hospital admission, some for several days.

The statutory agencies delivered a swift response and set up ad-hoc vaccination clinics to try and boost immunity. This intervention (and hospital admissions) may have been avoided if the individuals had been able to access a GP.

In the long term, restricting access to primary care will prevent the NHS from being able to diagnose and treat communicable diseases.

7. Administrative costs

Determining a person’s health entitlement by assessing immigration status can be a difficult task requiring a comprehensive grasp of domestic and European immigration legislation.

One of the difficulties is that individuals may wait for months for a decision on their immigration application. As most individuals have to send their identity documents to the UKBA as part of their application, it can be extremely hard for them to provide BSO with the necessary evidence of their health entitlement. This is compounded by the fact that the UKBA does not always issue an acknowledgement of the application.

Nadia is a refugee from the Horn of Africa. She was granted five years leave to remain in the UK. Before her leave expired, she applied for an extension, which means her leave and entitlements continue while her application is pending. To date, however, Nadia has waited for fifteen months for the UKBA to determine her application. She has not received an acknowledgement status update letter. Consequently, she has been de-registered from her GP surgery despite having a clear entitlement.

Lidia is a Romanian national who applied to UKBA for a Registration Certificate, which demonstrates she is entitled to work, receive healthcare, etc. Although European law requires that such applications are processed immediately, Lidia waited for more than nine months. UKBA did not issue an acknowledgement letter despite her requests. She
was unable to demonstrate her eligibility to BSO, as she had sent all her identity documents to UKBA.

Until recently, the BSO practice was to require confirmation of a person’s immigration status every six months. This resulted in a number of patients struggling to demonstrate their entitlement and being deregistered. However, in Spring 2013, the BSO responded to concerns highlighted by the Law Centre and others, and agreed to extend the six month period to 24 months. The Law Centre welcomes this change as it will reduce the administrative burden around the process of registration, review, de-registration and re-registration of patients. More importantly, it will help ensure continuity of healthcare for patients.

8. Impact on migrant support organisations

Migrant support organisations report difficulties associated with helping ineligible migrants meet their health needs. Advice/support workers have at times accompanied migrants to chemists to help them obtain ‘over the counter’ medication. This presents serious challenges for support organisations.

Elena works for a migrant support organization and is often approached by migrants, who are not eligible for GP registration, requiring medication. Elena is aware that a number of individuals within the Roma community regularly buy medicines over the internet. Elena is deeply concerned about this practice, especially as many individuals have poor literacy skills and do not necessarily understand what they are taking. Nonetheless, Elena knows that these individuals have little other recourse.

9. Additional problems for individuals who do not have a GP

Refused asylum seekers without a GP face additional difficulties.

Asylum seekers are required to report regularly to the UKBA office in South Belfast. Failure to comply can result in detention. UKBA policy provides some scope for flexibility and allows it to reduce reporting events for asylum seekers with disabilities, or who are pregnant or in poor health. To qualify, the asylum seeker must provide appropriate medical evidence/confirmation. Clearly, an asylum seeker who does not have a GP is unable to satisfy this requirement.

Likewise, not being able to provide the necessary medical evidence may make it impossible for asylum seekers to apply for asylum support and accommodation in some circumstances. This may leave the individuals homeless and destitute.
Part 3. Proposed solutions

Our key proposal, which we believe would address the majority of problems outlined in Part 2, is for the Department to remove the ‘ordinarily resident’ test from primary care. This would bring Northern Ireland in line with current law in Britain and would ensure that all individuals who can demonstrate that they are living in Northern Ireland can access a GP.35 A legislative change would be necessary.

We believe it should be possible for DHSSPS to differentiate between migrant communities living in Northern Ireland and persons residing in the Republic of Ireland.

We propose that BSO should continue to manage GP registrations but that it assesses each case on its individual merits. Rather than apply the ‘ordinarily resident’ test, and get caught up in the complex legal question of whether a person’s residence is lawful or not, BSO should instead assess all the available evidence in the round. This would build a clear picture as to whether the patient does indeed live in Northern Ireland.

In addition, we suggest that DHSSPS expands the exemption categories to include individuals from the following categories who are living in Northern Ireland.36 This would enable these persons to access free secondary care:

a) those with protection needs including asylum seekers and victims of trafficking;
b) all EEA nationals living in Northern Ireland;
c) children of irregular migrants;
d) women requiring maternity services.

We also recommend that DHSSPS considers its duties in respect of:
e) irregular migrants.

We believe that, in addition to humanitarian arguments, extending healthcare to these categories would be beneficial to public health and ultimately better value for money. These categories are considered in turn below.

Evidence could include:

- a teacher’s letter confirming a child is in school;
- tenancy agreements;
- a letter from a solicitor, voluntary sector organisation or faith group confirming that the prospective patient is known to them and living in Northern Ireland;
- wage slips (where relevant);
- evidence of regular use of a UK mobile phone (+44);
- utility bills;
- driving license;
- store cards;
- library cards;
- travel tickets, etc.

a) Replicating the Scottish and Welsh approach to asylum seekers and victims of trafficking

We recommend that all asylum seekers and their dependants have access to free healthcare care until they leave Northern Ireland, regardless of the status of their asylum application. This should also extend to victims of trafficking. Both Wales and Scotland have taken this approach and serve as useful ‘tried and tested’ models for reform. We would especially commend the Welsh approach as its healthcare legislation is similar to legislation here. See Appendix 1 for details.

Barnardos NI is aware of a number of cases where children of refused asylum seekers have been de-registered from their GP. In
one case, the mother and her four year old son have been de-registered whereas her seven month old daughter continues to be registered and receives GP and health visiting services.

In a second case, a mother in receipt of s. 4 NASS support and her three year old daughter have been de-registered from their GP.

Many asylum seekers whose initial applications are refused go on to be granted refugee status and some refused asylum seekers cannot be returned to their country of origin for legal, political or practical reasons. It is difficult to understand why it is appropriate to withhold free healthcare in these circumstances.

The number of refused asylum seekers in Northern Ireland is extremely small. The cost of extending healthcare to this category would be relatively modest.

b) EEA nationals living in Northern Ireland

The large majority of EEA nationals are entitled to free healthcare by virtue of them exercising their European Treaty rights. However, there is a small category of EEA nationals who, despite living in Northern Ireland, cannot establish a right to reside and therefore cannot access healthcare. This category primarily consists of certain Romanian and Bulgarian nationals.

Although these individuals do not have a right to reside, they cannot be removed from the jurisdiction except in very exceptional circumstances. Consequently, it makes pragmatic sense to provide healthcare. At the moment, they have little alternative but to self medicate or seek treatment at accident and emergency units.

Ioana is a seven year old Romanian national whose parents are not considered to be ‘ordinarily resident’ in Northern Ireland, despite having lived here for several years. Ioana suffered kidney problems and was eventually diagnosed as having only one kidney. Ioana’s parents have no alternative but to take their daughter to A&E every time she needs a prescription for infections, colds, etc.

The current restrictions on Romanians and Bulgarians will cease on 31 December 2013. From 2014, these A2 nationals should be able to register with a GP. Given that full access is imminent, it makes no sense to continue to restrict access in the interim.

We estimate that the number of EEA nationals in this category is extremely small.

c) Children of irregular migrants

At the moment the regulations do not allow children of irregular migrants to access healthcare. We argue that this should change.

The Supreme Court has clearly articulated its view that children should not be penalized for the actions of their parents, or, for example, for their parents’ immigration status. Specifically, the Court held that the best interests of the child cannot be ‘devalued’ by reference to the parent’s wrongdoing:

*The importance of the child’s best interests is not to be devalued by something for which the child is in no way responsible.*

Barnardo’s NI is aware of a case where a six year old girl and a five year old boy are unable to access GP services. The chil-
dren’s mother is an irregular migrant and therefore unable to register. However, the children themselves have settled status and have a legal entitlement to be registered with a GP. This appears to have been overlooked by BSO which is focusing on the mother’s status.

Now that the UK has lifted its reservation to the UNCRC on children subject to immigration control, all the duties outlined in the Children’s Convention apply to all children in the UK, regardless of their status. Children must be treated first and foremost as children; only secondly can they be treated as subjects of immigration control. The Convention creates a specific duty of ensuring the provision of necessary medical assistance and healthcare to all children, with emphasis on the development of primary health care. It also calls on states to ensure that no child is deprived of his or her right of access to such healthcare services.41

The Committee on the Rights of the Child is clear that the Convention’s concepts of ‘health and development’ should be interpreted broadly.42 Even though the UNCRC has not been incorporated into UK domestic law, it is increasingly referred to in judgments of the UK domestic courts. Moreover, with the Treaty of Lisbon now in force, and with it the incorporation of the EU Charter of Fundamental Rights and Freedoms (which derives many rights from UNCRC), the UNCRC has increased status under domestic law.

Given the recent measles outbreak in Belfast, it is particularly relevant to note the opinion of the European Union Agency for Fundamental Rights:

Children who have an irregular migration status continue to face legal and practical obstacles to accessing healthcare. In light of Article 24 of the CRC, every child present on the Territory of an EU Member State is entitled to the same healthcare services as nationals. This should include immunizations, which are a major preventative healthcare measure. 43

Accordingly, we recommend that irregular migrant children are specifically exempted from the regulations. This approach would be consistent with immigration law. Immigration law currently restricts the access of certain migrant groups to some health and social services but does not exclude children44. Consequently, all children in Northern Ireland are entitled to the general health and social care services outlined in the 1972 Order.45 Specifically, children are entitled to access to preventative healthcare services, care and after care.46 Thus, granting access to irregular migrant children would be consistent with Northern Ireland’s commitment to an integrated health and social care system.

d) Women requiring maternity services

The UK has a very clear duty in international human rights law to diminish infant and child mortality47 and to ensure appropriate pre-natal and post-natal health care for mothers.48 Domestically, Northern Ireland has duties under the 1972 Order. We note that Northern Ireland’s Strategy for Maternity Care does not distinguish on the basis of immigration status but instead desires to give every baby and family the best start in life.49 The Strategy repeatedly highlights the importance of early contact for screening purposes and risk assessment.

All pregnant women and young mothers must have access to healthcare. Where the mother
cannot pay for the care, the healthcare should be provided free of charge.

The risk of HIV transmission from a mother to her baby can be significantly reduced to less than two per cent if she receives the appropriate treatment throughout her pregnancy. It is therefore essential that pregnant women are linked in with a GP.

National Aids Trust, ‘Guidelines for reporting HIV’ (June 2010)

e) Irregular migrants

Many of the arguments that we have advanced above in respect of other categories also apply to irregular migrants i.e. waiting for conditions to deteriorate to a point where A&E treatment is dangerous for patients and places pressure on hospital resources. The DHSSPS also has a general public health duty, which applies regardless of the immigration status of the person who is potentially a risk to public health. We therefore ask the Department to consider how it is discharging this duty in relation to irregular migrants.

It is impossible to know how many irregular migrants live in Northern Ireland. However, it is known that irregular migrants in the UK predominantly live in large metropolitan areas and in London in particular.\(^50\) Thus we surmise that the number of irregular migrants in Northern Ireland is relatively small and that the cost of providing free healthcare would also be relatively modest.

Irregular migrants tend to avoid contact with statutory agencies and services, including healthcare.

Fear of being detected based on real or perceived exchange of data between healthcare providers and immigration enforcement bodies means that migrants in an irregular situation delay seeking healthcare until an emergency arises. This has negative consequences for the health of the individual and results in more expensive interventions.\(^51\)

Accordingly, the EU Agency for Fundamental Rights calls on member states to ‘disconnect healthcare from immigration control policies’ and to avoid ‘imposing any duty to report migrants in an irregular situation upon healthcare providers or authorities in charge of healthcare administration’. Such information sharing mechanisms are, however, already in place between NHS and UKBA across the UK (see Part 1). It is unknown as yet what the impact of this pilot will be on individual or public health.

Nonetheless, the UKBA/NHS Charging Pilot makes it all the more important that irregular migrants can obtain healthcare in a confidential setting. For this reason, we commend Belfast Health and Social Care Trust for its Northern Ireland New Entrant Screening Service, which receives funding from the Public Health Agency. We would urge DHSSPS to consider ways in which it can lend support to this project so that its services can be expanded. For example, the New Entrant Service could provide a specialist doctor who could prescribe for emergency treatment on a short-term basis.
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Part 4. Conclusions and summary of recommendations

There is a clear disparity between access to healthcare in Northern Ireland and access to healthcare in Great Britain. This disparity is taking its toll on patients, healthcare professionals and indeed on the public purse.

Although the Law Centre recognizes the policy intention of restricting NHS care to those living in Northern Ireland, we believe the Department should distinguish between:

- individuals, such as Irish nationals, who are residing in the Republic of Ireland, who have access to an alternative healthcare system;
- individuals who are living in Northern Ireland and have no viable alternative.

The DHSSPS ‘Transforming Your Care’ (TYC) paper outlined a long term vision underpinned by twelve key principles including a focus on prevention and tackling inequalities. TYC is clear that ‘greater investment in preventative care and improving health and well-being is not just good for patients, service users and the public, but is highly cost-effective’. The Department sets out its vision of integrated care partnerships which will draw together primary, secondary and community care into a collaborative network. Such partnerships are designed to help individuals, for example to better manage and maintain their health and well-being, prevent the development of conditions that might later require hospitalization and facilitate earlier discharge from hospital.

The recent DHSSPS consultation offers a real and meaningful opportunity to tackle current inequalities and ensure that no categories of migrants are excluded from Northern Ireland’s vision of enhanced health and wellbeing. It also provides an opportunity to address the clear disparity between access to healthcare in Northern Ireland and access to healthcare in Great Britain.

Accordingly, we urge DHSSPS to:

1. remove the ‘ordinarily resident’ test for primary care;
2. replace the test with evidential requirements whereby prospective patients must demonstrate they are living in Northern Ireland;
3. for secondary care, extend the ‘ordinarily resident’ exemption categories for the following groups of people who can demonstrate that they are living in Northern Ireland:
   a. all asylum seekers and victims of trafficking, regardless of the status of their case;
   b. all EEA nationals;
   c. children of irregular migrants;
   d. women requiring maternity services.

In addition, we ask the Department to:

4. consider how it is discharging its duties with respect to healthcare of irregular migrants.

Finally, we recommend that the Department:

5. lends its support to the New Entrant Screening Service and consider ways to expand its services e.g. to write prescriptions.
Appendix 1: Access to healthcare for asylum seekers in GB

Healthcare in England

The NHS Regulations issued in 1989 introduced a number of exemption categories including anyone who has been accepted as a refugee or who has made a formal application for leave to stay as a refugee. Consequently, all asylum seekers were entitled to free healthcare in England until mid 2000s. In regulations subsequently issued in 2004, a further condition was adopted to ensure that the exemption only referred to those whose asylum applications had ‘not yet been determined’. The effect was that only asylum seekers with pending applications were now entitled; refused asylum seekers had no entitlement. In general, England has maintained this approach of restricting access to refused asylum seekers.

Healthcare in Scotland

Scotland’s approach to healthcare is also rooted in the NHS regulations 1989. Unlike elsewhere in the UK, Scotland never introduced subsequent regulations to restrict access for asylum seekers. Therefore the legislative position in Scotland is that any person who has lodged an application - whether the application is pending, refused or under appeal - can access free healthcare. This legislative position has been confirmed in guidance issued by the Scottish government which states:

Anyone who has made a formal application for asylum, whether pending or unsuccessful, is entitled to treatment on the same basis as a UK national who is ordinarily resident in Scotland while they remain in the country.

Healthcare in Wales

Prior to 2009, Wales took the same approach as England. Initially all asylum seekers were entitled to free healthcare but restrictions introduced in 2004 meant that only asylum seekers with pending applications could access free healthcare. However, in 2009, Wales issued new regulations which deleted the ‘not yet been determined’ criteria. Thus Wales reverted to its original position whereby all asylum seekers fall within this exemption category and therefore cannot be charged for healthcare.
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Law Centre (NI) Policy Briefing

Notes

1 Health & Social Care (Reform) Act (Northern Ireland) 2009 art 2
2 Circular HSS(PCD) 10/2000 para 2
3 Circular HSS(PCD) 10/2000 para 3
4 2005 Visitor Regulations Reg 2(1)
5 2005 Visitor Regulations Reg 3
6 2005 Visitor Regulations Reg 4
7 GMS Contract Regs Schedule 5 Reg 15
8 We hope this lack of clarity will be addressed through the DHSSPS consultation, ‘Proposed consolidation and updating of the provision of health services to persons not ordinarily resident regulations (Northern Ireland) 2005, including amendments to specific provisions and extension to primary care services’ (DHSSPS, 2013). A copy of the Law Centre’s response to the consultation is available at www.lawcentreni.org.
9 This uncertainty is described in NIHRC’s Access denied - or paying when you shouldn’t. Access to publicly funded medical care: residency, visitors and non British/Irish citizens (January 2011), pages 32-39. In short, the problem is: whether the HSS(PCD)10/2000 Circular still applies; whether the 2005 Visitor Regulations apply to primary healthcare and whether the ordinarily resident test can be ‘read into’ the GMS Regulations 2004. If the 2005 Visitor Regulations do apply it means that, for primary care, no charges can be made, the ordinarily resident test does not apply and registration falls to the discretion of the GP. If the Regulations do not apply then the ordinarily resident test applies to both primary and secondary care.
10 In theory, like their GB counterparts, GPs in Northern Ireland have discretion and therefore could register the patient without going through BSO. However, the GP would not receive payment for any services provided to the patient.
11 GMS Contract Regs Schedule 5 Reg 16
12 GMS Contract Regs 15 (8 – 10) See also paragraph 20, Circular HSS (PCD) 10/2000. Also note that BSO can specifically assign a patient to a GP practice in certain circumstances. Health Services (Choice of Practitioners) Regulations (NI) 1998 Regs 4 and 5
13 The Pilot currently applies to: Belfast HSCT - maternity, antenatal clinic, Regional Fertility outpatients and Ward 6d/6e/6f admission wards at the Royal Hospital; Cardiology patients, dermatology outpatients, Grove Wellbeing Centre and Regional Fertility Outpatients at City Hospital; Southern HSCT, maternity and gynaecology at all trust sites providing these services; Northern HSCT - the admission ward and weekly antenatal clinic at the Antrim hospital, the admission ward at the Causeway hospital; Western HSCT - gynaecology ward 4, orthopaedic outpatients, gynaecology outpatients at Altnagelvin Hospital; South Eastern HSCT - maternity, MAU, gynaec and plastics (included - OPD, trauma clinic and oral surgery) at Ulster Hospital.
14 Statement of changes in Immigration Rules [HC1511], presented to Parliament on 10 October 2011 (Session 2010-2012)
15 E.g. see BMA correspondence with Lord Goodlad dated 17 October 2011.
16 DHSSPS memo to NIHRC, 14 December 2010, as reported in Access Denied, page 37
17 2005 Visitor Regulations Reg 3 (c)
18 The Law Centre is grateful to a range of stakeholders who fed their experiences into this paper. This includes social workers, GPs, mental health practitioners, migrant support organisations, children’s organisations and legal practitioners as well as patients who have been refused GP registration.
20 Data from NHS Choices 2013
22 E.g. the National Audit Office Report by the Auditor General, ‘Early action landscape review’ (31 Jan 2013 HC 683 Session 2012-13)
23 Extract from National AIDS Trust, ‘Universal access to primary care: a gateway for HIV testing, treatment and prevention’ (November 2012). Note the Health Protection Agency is now part of Public Health England.
24 Health and Social Services (General Medical Services Contracts) Regulations (NI) 2004, Regulation 15
25 Royal College of General Practitioners Position Statement, ‘Failed asylum seekers/ vulnerable migrants and access to primary care’ (Jan 2013)
26 Health & Social Care (Reform) Act (Northern Ireland) 2009
27 Belfast Health Development Unit, ‘Barriers to health: migrant health and wellbeing in Belfast’, para 7.4
28 Belfast Health Development Unit, ‘Barriers to health: migrant health and wellbeing in Belfast’, para 7.0. This finding reflects the same situation across the UK as found in Johnson, M, ‘Integration of New Migrants’ in Refugees and


31 There have been other examples such as a small outbreak in Craigavon in December 2009 which resulted from the introduction of measles from outside Northern Ireland. See Public Health Agency, ‘Transmit: Health Protection Service Bulletin’ (August 2010).

32 Migrant Rights Network, ‘Access to primary health care for migrants is a right worth defending’ (January 2011)

33 UKBA’s backlog of undetermined asylum and immigration cases has attracted serious criticism from Chief Inspector John Vine, An inspection of applications to enter, remain and settle in the UK on the basis of marriage, civil partnerships (January 2013).

34 Asylum support for some refused asylum seekers (Section 4) can be issued for different reasons including where the applicant is unable to leave the UK due to a ‘physical impediment to travel or for some other medical reason’ e.g. where the applicant is in the late stages of pregnancy or has a baby under six weeks old; the applicant has a contagious disease and the airline refuses to carry her/him, etc. To rely on the ‘obstacle to travel’ condition in health cases, an applicant must provide a ‘medical declaration’ completed by a GP.

35 The eligibility framework in Britain is likely to change. The Queen’s Speech (2013-14 Session) outlined a proposal for a new Immigration Bill which it is thought will contain measures to restrict access to healthcare, especially for TemporarY Visitors. The Bill may be published in September 2013.

36 The Department is considering expanding the exemption categories – see proposal J of the consultation.

37 For example, the UK had a policy of not forcibly deporting refused Zimbabwean asylum seekers for many years.

38 Based on the limited data publically available we estimate that 63 individuals became refused asylum seekers in 2012 (79 including dependants).

39 The European Citizens Directive (2004/38/EC) contains provisions that restrict UKBA powers to exclude or expel EEA nationals. The only permissible grounds are on public policy, public security or public health. It is not permissible to exclude/expel in order to achieve an economic purpose. Exclusion/expulsion on public health grounds is only permitted in very limited circumstances relating to infectious or communicable disease and only then if the disease occurs within the first three months of arrival.

40 See ZH (Tanzania) v SSHD [2011] UKSC 4, para 44 per Lord Hope, para 33 per Lady Hale. See also HH v Deputy Prosecutor of the Italian Republic [2012] UKSC 25, para 15 per Baroness Hale


42 Committee on the Rights of the Child, General Comment No.4 (2003)


44 Schedule 3 to the Nationality, Immigration and Asylum Act 2002 states that the Act does not prevent the provision of support or assistance to children.

45 Health and Personal Social Services (Northern Ireland) Order 1972

46 Health and Personal Social Services (Northern Ireland) Order 1972, Art 7

47 UNCRC Art 24 (2)

48 UNCRC Art 24 (2)

49 First desired outcome in DHSSPS, ‘A Strategy for Maternity Care in Northern Ireland 2012 – 2018’ (July 2010), p 8

50 Dr Ben Gidley and Dr Hiranthi Jayaweera, ‘An evidence base on migration and integration in London’ (ESRC University of Oxford, 2010)

51 European Union Agency for Fundamental Rights, ‘Migrants in an irregular situation: access to healthcare in 10 European Union Member States’ (Luxemburg, 2011), p 12

52 DHSSPS, ‘Transforming your care: vision to action. A consultation document 9 Oct 2012 - 15 Jan 2013’. See also Law Centre’s response to the consultation document, which is available at www.lawcentreni.org

53 This is one of the twelve key principles underpinning the approach to TYC, p 10

54 TYC, p 18

55 TYC, p 19
Law Centre (NI) offers legal services to practitioners and policy development in community care, employment, immigration, mental health and social security. We also offer training courses for practitioners and information through our publications and website. We hold regular legal practitioner meetings where practitioners can exchange expertise and receive important updates.

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