

PAFRAS



Refused sanctuary then deprived of their health

**A report on the health and healthcare needs of
destitute asylum seekers in Leeds and their access to
health services.**

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July 2010

foreword

Of all of the attacks on the rights of asylum seekers that have been put in place in recent years—and there have been many—perhaps one of the most insidious is the decision to render those whose claims have been refused destitute. It is estimated that hundreds of thousands of refused asylum seekers have been forced into a twilight existence: with mainstream support withdrawn; with no right to work; and often with no immediate prospects of being able to salvage something from their situation. It is a cruel irony that whilst asylum seekers are demonised as seeking to benefit from a supposedly generous welfare system the reality, for many people, is that the denial of welfare is used as a tool to try and make them leave.

Destitute asylum seekers are vulnerable to exploitation by unscrupulous employers who offer dangerous undocumented work. They are vulnerable to unscrupulous lawyers who offer what is often substandard legal work at a cost. They are vulnerable to racist violence and the cold and the dark as, frequently, they are forced to find shelter wherever they can. Many have fled from torture, violence, and war and have lost contact with friends and family as a result of their journey to the UK. It is little wonder then that many refused asylum seekers are both physically and psychologically damaged by the treatment meted out by the British asylum system. And this, perhaps, is what makes the decision to withdraw particular forms of free healthcare from refused asylum seekers especially vicious.

Laurie Ray tackles these issues head-on in this report. As he makes clear, the withdrawal of some forms of free healthcare must be read alongside the harm that is both caused and exacerbated by the asylum system. He does this by enabling interviewees to explain exactly in their own words how their health has been affected since arriving in the UK. The answers that are provided indicate a series of harms including malnutrition, depression, and injuries sustained by racist violence. At the same time, as well as suffering from formal barriers to accessing certain forms of healthcare, the very fact of being destitute renders it more difficult to access those services that do remain.

This report should provoke anger. The denial of healthcare to some of those most in need should be regarded as the denial of dignity and basic rights. At the same time, it may well represent a betrayal of the principles upon which the NHS was founded.

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introduction

PAFRAS (Positive Action for Refugees & Asylum Seekers) is a not-for-profit organisation established in response to the policies of the UK government that force individuals seeking asylum here into destitution. PAFRAS seeks to promote social justice through a combination of direct assistance, individual casework and mental health support, research and analysis and campaigning. By working directly with asylum seekers and refugees PAFRAS has consistently adapted in response to the needs of this marginalised and often vilified group.

In 2005, in recognition of the growing severity of destitution policies, PAFRAS opened its drop-in at which food parcels, hot meals, clothes and toiletries are provided to those who need them and a number of other services are also offered. These include casework, referral and signposting services relating to individuals' asylum support needs and asylum claims; counselling and group therapy sessions and mental and physical health referrals; massage delivered in partnership with Leeds Wellbeing Project and English language classes delivered in partnership with St Aiden's Church. We work closely with the British Red Cross, which provides a part-time caseworker to deliver advice sessions alongside our own caseworkers.

Since 2006 there has been a 190% percent increase in the overall number of people accessing our services. As has been observed elsewhere, while a portion of these visits are made by first time visitors to the service the majority of them indicate people accessing the service on a regular basis. As such they represent individuals who have become forced to rely on the organisation for their basic survival (Burnett, 2009: 4). In 2009 PAFRAS received an average of sixty-two people per drop-in session. For the period January to April 2010 that average is 75, an increase of 21%.

	Service User Visits		Hot Meals		Food Parcels	
2006	2,230	-	1,847	-	774	-
2007	4,465	100.2%	4,266	130.97%	2,108	172.35%
2008	6,112	36.8%	5,610	31.50%	2,840	34.72%
2009	6,466	5.8%	5,557	-0.95%	3,849	35.53%

TABLE 1: PAFRAS SERVICES FIGURES 2006-09

who are destitute asylum seekers?

An asylum applicant's support is withdrawn 21 days after their asylum claim is refused,¹ and along with it entitlement to access many other forms of statutory support. In the unlikely event that the individual had permission to work prior to being refused, this permission is now withdrawn. Denied the right to work and refused access to benefits, they are forced into homelessness and destitution. Refused asylum seekers are some of the most vulnerable people in Britain today: forced to choose between passively accepting their circumstances and trying to survive on handouts from friends, churches and organisations like PAFRAS or struggling to survive by working in the black labour market where they are highly vulnerable to exploitation and becoming criminalised in the process. This destitution policy represents a deliberate strategy on the part of the UK government both to force refused asylum seekers to leave the United Kingdom and deter potential future asylum applicants from entering the UK. Nevertheless substantial research exists that shows that many refused asylum seekers are forced into destitution while unable to return home for bureaucratic (and financial) reasons, still more come from countries to which it is too dangerous to return (Hickey, 2009: 5; Williams, 2005: 732).

For a small minority of refused asylum seekers² limited support in the form of £35 per week in food vouchers and UKBA accommodation (so called Section 4 Support³) is provided. This includes refused asylum seekers who are (amongst other things) 'taking all reasonable steps to leave the United Kingdom' or placing themselves in a position where they can do so⁴ (UKBA, 2009: 3). Everyone else is expected to leave.

The story of refused asylum seekers' access to healthcare in many ways mirrors that of their access to other social goods. Prior to 2004 asylum seekers, refused and otherwise, were in principle entitled to access primary and secondary healthcare; although the reality of access remained far from perfect. From the late 1990s onwards however the New Labour govern-

¹ The only exception to this is an asylum seeker who has dependent children in their household before their asylum claims are finally determined. In this case they continue to be entitled to support until they are either removed from the UK or they leave voluntarily.

² The DH estimated that around 9,600 individuals were receiving Section 4 support in 2009 (DH 2010a:11)

³ Called so because the discretion to grant it is given to the Secretary of State for Home Affairs in Section 4 of the Asylum and Immigration Act 1999, numbers of individuals in receipt of Section 4 support fluctuate frequently but there are believed to be approximately the thousand recipients.

⁴ Other criteria include inability to travel due to a physical or medical impediment; lack of viable route of return (in the view of the Secretary of State); awaiting the outcome of an application for Judicial Review (Scotland only); granted permission to proceed with a Judicial Review (England and Wales); and in order to avoid a breach of an individual's human rights (under the Human Rights Act of 1998) (UKBA, 2009: 3-4). The latter criterion applies to individuals who have made further submissions for a fresh claim of asylum that have not yet been considered.

ment issued a steady stream of amendments to primary and secondary legislation (and consultations for further changes) which sought to limit the access of refused asylum seekers to most medical services. Overall, Labour's reforms of health access have met with mixed success; although it is hard to deny their pernicious influence on the lives of tens of thousands of refused asylum seekers. This report turns first to look at the political history of exclusion from health-care before taking in the realities on the ground in Leeds.

this research

This research, commissioned by Leeds Community Foundation, investigates the healthcare needs of destitute asylum seekers and their experiences of the healthcare system in Leeds while taking a critical look at health policy nationally and the delivery of health services in Leeds. Healthcare needs are identified by reviewing the available literature and in primary research conducted with PAFRAS service users and health professionals in Leeds and are situated in context of the location within the asylum system of the majority of PAFRAS's client group.⁵ The research will look at the restrictions upon access to healthcare instituted at the level of national policy, but also at both formal and informal barriers to access at the local level.

The key aims of the research are:

- To set out workable recommendations for reform of health policy at national level,
- To make proposals for the improvement of the quality and availability of care for refused asylum seekers, and
- To help to empower refused asylum seekers to access the health services that they are entitled to.

The research has three main outputs, (i) this report, (ii) a brief guide to the healthcare entitlements of refused asylum seekers for their use and (iii) a seminar for health professionals working with refused asylum seekers in Leeds that will aim to share knowledge and help forge and deepen links between service providers

This report is divided into three main sections, an initial part which taken an historical/political view at the origins and development of changing for NHS services and a particular focus on recent years. Then, after a short section on methodology we outline the findings of our research followed by conclusions and our recommendations.

⁵ That is, asylum seekers who have been refused asylum and no support from the state and those who receive Section 4 Support.

1. the denial of healthcare: a historical and political overview

Since 2009 a series of legislative measures have been introduced with the specific aim of curtailing the access of refused asylum seekers to National Health Service services. These arrangements are complex but, whilst not claiming to be an exhaustive history of policy and legislative changes, this section makes clear particular key moments, as they are relevant to this research and, at the same time, emphasises the ideological developments embodied by these policy developments. Simultaneously, attention will be given to the manner in which restricting healthcare services has been resisted both within and beyond the institutional structures of the NHS. This parallel story, of resistance and occasional revolt, has been vital in slowing the denial of fundamental healthcare provisions.

a universal health service? from healthcare to immigration control

According to former Secretary of State for Health Patricia Hewitt MP the NHS is ‘the product of a controversy, a bare-knuckle political brawl, and some extremely fancy political footwork’ (Hewitt 2006). In the vision of Aneurin Bevan, founder of the National Health Service, ‘[t]he essence of a satisfactory health service is that the rich and the poor are treated alike, that poverty is not a disability, and wealth is not advantaged’ (Bevan, 1952: 104). But Bevan, was instinctively an internationalist made clear in a well quoted passage that:

‘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... 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.’ (Bevan, 1952: 104)

Bevan however, combined this socialism with an instinctive libertarianism (sadly lacking in his New Labour decedents) which he also brought to bear on the argument noting that:

[...] 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. (Ibid: 105)

Although Bevan was able to establish the NHS as a universal health service, the brawl referred to by Hewitt was hard fought and not wholly won. Charges for certain prescriptions were introduced to the NHS in 1949 and plans for their wider implementation, outlined in the 1951 budget, were a central factor leading to Bevan's resignation from the Labour government (O. Morgan, 2000). Charging has since burgeoned to include a range of services and forms of care (House of Commons Health Committee, 2006) but it wasn't until the National Health Service Act of 1977 that the focus shifted from chargeable services to chargeable people. Section 121 of that Act granted the Health Secretary powers to introduce charging regulations for people who were not 'ordinarily resident' in the UK for NHS treatment and to set out these charges on a commercial basis. In doing so the act brought medical care and immigration together for the first time.

While the common-law concept of being 'ordinarily resident' consequently emerged as a key aspect of this interweaving of immigration and medical policy it was not defined by the National Health Service Act 1977. Rather, a case brought before the House of Lords in 1982, which dealt primarily with access to education, set out a definition of the term as referring to a person:

[L]iving lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, whether they have an identifiable purpose for their residence here and whether that purpose has a sufficient degree of continuity to be properly described as 'settled.' (cited in Department of Health, 2004a: 17-18).

One implication of this, not explicit at the time, was that it gave rise to the potential to reorient the considerable resources of the NHS towards the enforcement immigration policy. 1989 saw introduction of new charging regulations *obliging* NHS bodies to identify and charge individuals who were not classed as 'ordinarily resident' (individuals who were therefore 'overseas visitors') (see Department of Health, 1989; and 2004b: 22).⁶

⁶ It should also be noted that the 1989 regulations did also set out cases where exemptions from charging applied.

consolidating control: New Labour and the politics of health-care denial

In government, New Labour implemented reforms in asylum legislation and policy at a historically unprecedented rate (see for example Burnett, 2008; and Schuster and Solomos, 2004). No fewer than nine new pieces of legislation relating to asylum and immigration were introduced in the twelve years between 1997 and 2009. Simultaneous and ostensibly fuelled by concern over increasing numbers of people entering the UK primarily in order to access the NHS—so-called health tourism—there was an increasing emphasis on denying access of access to healthcare provision for people not ‘ordinarily resident’ in the UK. Both the government and national media used the spectre of undeserving ‘illegals’ intent on coming to the UK to claim benefits to try galvanise public discontent and legitimise governmental policy; against whom policy changes have been explicitly targeted. These developments, and the press-work that accompanied them, have had a pronounced effect in shaping public discourse. In her forward to the Department of Health’s most recent consultation of foreign nationals’ access to NHS services Ann Keen, Parliamentary Under-Secretary of State for Health, makes explicit the link between health access and immigration control, noting that ‘the regulations and guidance on NHS access and charging have to support ... wider government strategy on migration’ (DH, 2010: 3).

A Health Circular in 1999 emphasised the discretionary power of GPs to refuse non-emergency treatment of overseas visitors, and recommended that they register them privately and charge them for their care (DH, 1999).⁷ Regulations introduced in 2002 established that the charging of overseas visitors should be performance managed by Strategic Health Authorities (Home Office, 2002). The following year the government followed announced plans to ‘tighten up’ the regulations on identifying and charging overseas visitors for certain forms of hospital care (Hargreaves *et al*, 2006: 6); within months guidance was put in place setting out how this was to be achieved. This guidance (DH, 2004) explicitly (re)defined refused asylum seekers as not being ordinarily resident, consequently stating that they must be charged for any course of treatment started after their asylum claim was finally refused (Ibid: 26-7). Then Minister of State for Health, John Hutton MP stated that a charging regime for secondary healthcare was necessary in order to combat ‘abuse’ of health services. He also indicated that changes were to be implemented at the behest of the NHS (Hutton, 2004a: 1).⁸ This

⁷ This Health Circular was made obsolete in October 2008, to be replaced when a consultation by the Home Office and the Department of Health (discussed below) is finalised, and put in place. In the interim period, GP’s were advised to consult their local Primary Care Trust if they needed advice about whether they could refuse to register a patient.

⁸ Hutton said: ‘These changes, which come into effect on 1 April 2004, are the Government’s response to the concerns and abuses which the NHS have brought to our attention.’ (DH, 2004:1)

guidance reaffirmed that hospitals *did not* have discretion, but were obliged to charge those who were not entitled to free healthcare, as Hutton explained:

[t]he Regulations place a clear legal duty on the NHS to implement the charging regime, and I expect trusts to make enforcement of the Regulations part of their core business. (Hutton, 2004a: 1)⁹

Within a matter of weeks another consultation was launched proposing to exclude overseas visitors from primary healthcare. Refused asylum seekers were identified as one group to be denied such services and Hutton asserted that '[w]e wish to see closer links established between free use of the NHS and UK citizenship or residency' (op.cit, 2004b: iii). The proposals also made clear that access to healthcare was to be further asserted as a means through which to 'police' immigration. Only days previously the Home Office had announced draft legislation to create a national identity card system, and the Department of Health explained that the denial of health access would 'dovetail' with the proposed new identity documents (DH, 2004b: 3).

Within some sections of the NHS though, proposals to deny access to free primary care were roundly condemned. Some voices opposed being used as instruments of immigration control (GHAP 2008: 12-13), while others argued that the withholding of primary care from refused asylum seekers and irregular migrants posed a threat to public health more broadly (GHAP, 2008: 5, 16-18). Still more objections were raised regarding the practicality of clinical or administrative staff determining immigration status and the cost effectiveness of forcing people not otherwise entitled to use expensive Accident & Emergency services (GHAP, 2008: 5). When, nearly five years after the deadline for submissions, the Department of Health finally published responses to the consultation they were obliged to explain that, with regard to refused asylum seekers, there was 'strong support' for exemption from any restrictions on primary care services (DH, 2009b: 11).¹⁰

In the meantime, organisations had begun to explore the impact of withdrawing secondary care and catalogued examples of physical and psychological deterioration. For example, in 2006, the Refugee Council reported that:

'Since the introduction of the regulations, [they had] worked with hundreds of refugees and asylum seekers experiencing serious problems accessing healthcare, but a smaller

⁹ The details of these restrictions are set out in Department of Health (2004c).

¹⁰ According to the Global Health Advocacy Project: 'the majority of respondents felt *refused asylum seekers, settled in the UK, were not 'overseas visitors'*, rather they were a vulnerable group who should not fall within the scope of the proposals.' (Global Health Advocacy Project, 2008: 5 *emphasis in original*).

number of cases where refused asylum seekers have been completely denied secondary care that they desperately need' (Kelley and Stevenson, 2006: 11).

Undeterred, the government continued to push for changes in healthcare access and in March 2007 the Home Office published an enforcement strategy that explicitly sought to deny benefits or basic provisions from those who did not have permission to be in the UK. This strategy simultaneously committed the Home Office and the Department of Health to yet another review of health provision. Stating their intentions, the strategy maintained:

'We will step up our work with service providers and those who control access to benefits to enable them to check the entitlement of all migrants quickly and easily, so we can identify those that fall into the illegal category. Where the checks show non-entitlement they will inform [the UKBA] and, in most circumstances, they will deny access to the service. There may be circumstances where a service would still be provided, but on a different basis—for example, some types of medical treatment might go ahead but the cost of the treatment would be recovered from the individual' (Home Office, 2007: 17).

Only months later the Joint Committee on Human Rights (JCHR) delivered a damning report on the treatment of asylum seekers within the UK, of which healthcare provisions (or indeed a lack of) were one part (JCHR, 2007). This report admonished the government for not publishing the responses to its 2004 consultation on primary care, and recommended that a Race Equality Impact Assessment be carried out on the impact of the existing charging regime. Describing particular aspects of the asylum process as inhumane, and raising concerns that the New Labour government may breach human rights conventions in its treatment of asylum seekers, the review prompted a rapid response from the then Minister of State for Borders and Immigration Liam Byrne MP (Byrne, 2007) in which he stated that the ongoing review on healthcare, ordered in March 2007, would take into account the issues raised by the JCHR.

legal challenges and reversals

This concerted critique of the government was not confined to the third sector or Parliament however, as battles over healthcare provisions spilled over into the courts. In 2008 the High Court found in favour of a refused asylum seeker's right of access to hospital treatment, on the ground that he was ordinarily resident in the UK (Medact, 2008). The ruling effectively conferred the same status to all refused asylum seekers who had been granted temporary leave to enter the UK, had been resident for at least one year prior to the refusal of their asylum claim and could demonstrate that they are living here 'for settled purpose as part of the regular order of their life'. (Medact, 2008; British Medical Association, 2008: 2). This situation lasted less

than a year though and, in March 2009 following an appeal by the Department of Health, the Court of Appeal ruled that:

‘...since the purpose of the NHS, according to legislation, was to improve the health of the 'people of England' and not 'people in England', this suggested the need for patients to have a legitimate connection with the country. Failed asylum seekers had authority to be 'at large' as an alternative to being detained, but this was an indulgence, not a right' (Webber, 2009).

At the same time however the court also ruled that the existing guidance was unlawful as it “did not make it clear enough that hospitals must consider providing treatment where a patient cannot return home and cannot pay for the treatment in advance” (Pierce Glyn Solicitors, 2009).

Between 2004 and 2007 John Hutton’s talk of linking free access to the NHS with citizenship or residency had given way to the draconian discourse of then Home Secretary John Reid, who spoke of “making life in this country ever more uncomfortable and constrained” for those without a regular immigration status (Reid, 2007: 3, also see Medact, 2008). These discursive developments signalled the converging priorities of the Home and Health Departments. The Health Department’s most recent consultation on health access makes this plain; arguing that:

‘automatic entitlement to full, free secondary healthcare, including both urgent and non-urgent treatment, would not be consistent with the denial of leave to remain and may act both as a deterrent to leaving the UK on a voluntary basis and an incentive to others to travel here illegally.’ (DH, 2010a: 11)

Thus, by the second decade of the twenty-first century the right to deny healthcare had become a weapon to be wielded against both irregular migrants and refused asylum seekers. There is much obfuscation—intentional or otherwise—in governmental discourse with political and officials using phrases like ‘failed asylum seekers who continue to be supported by the UKBA because there is a barrier to their immediate return’ (Ibid: 4) to demarcate asylum seekers supported under Section 4 seemingly interchangeably with ‘those co-operating with their eventual removal’ (Ibid: 3). Concern about such casual uses of language is not merely pedantic. These types of discursive practices both reveal a considerable amount about the last government’s view of asylum seekers and expose the ways in which un- and partial truths are used to shape public perceptions and create binaries of compliant/rebellious, worthy/unworthy even within officially unloved populations such as refused asylum seekers. The reality is much more complex, with, for example, considerable numbers of individuals accessing Section 4

support as an exercise of their human rights while they await Home Office responses to their further representations for fresh claims of asylum.

the 2010 Charging Regulations and guidance

On February 26 2010 the Department of Health launched a consultation on new (draft) charging regulations and guidance. These are declared to be ‘consolidated set of Regulations’ in that ‘they do not change the intent of the existing regulations, but clarify them to ensure they are applied properly’ (DH, 2010a: 7). Despite this, analysis of the new (draft) *National Health Service (Charges to Overseas Visitors) Regulations 2010* and (draft) *Guidance on implementing the overseas visitors hospital charging regulations* by Medact concludes that the Department of Health’s proposals amount to a significant change in policy (2010: 1).

This is achieved in part by dispersing responsibility for the charging regime across the NHS; the guidance is quite clear that it is ‘for staff in all relevant NHS bodies¹¹, including clinicians, senior managers and *clerks*’ (DH, 2010b: 5 *emphasis added*) and that ‘[a]ll staff, including clinicians and managers, have a responsibility to ensure that the charging regime works effectively’ (Ibid: 13). Key to this is the fact that all staff will have responsibility for asking ‘baseline questions’ to quickly identify those patients who may be overseas visitors’ (Ibid: 39).

Furthermore it is ironic, given the Court of Appeal’s ruling that the previous guidance was illegal due to its lack of clarity, that there is much confusion in the present document with regard to implementing the charging regime. Having established on page 12 that ‘patients who, after baseline questioning ... appear not to have lived lawfully in the UK for the previous 12 months ... should be interviewed by an OVM [Overseas Visitors Manager] to establish this definitively’ (Ibid: 12) page 40 of the document considerably widens the circle of people potentially involved in conducting interviews to establish chargeability. Paragraph 5.8 suggestively notes that ‘[s]ome relevant NHS bodies ensure that each specialty has at least one person trained to carry out the primary interview with a potential overseas visitor’ (Ibid: 40) a vague reference to present practice that muddies the picture considerably.

Secondly, the guidance also generates confusion over which services are chargeable. Paragraph 1.8 states: ‘This guidance does not concern treatment provided by a general practitioner (GP), dentist or optician’ (DH, 2010b: 6) – but makes no reference to *primary care* being exempt from charging whilst, on page 72, the guidance states: ‘[t]he Charging Regulations place a legal obligation on *all* secondary care providers to establish whether a person is entitled to NHS hospital treatment free of charge and, if not, apply a charge. (DH, 2010b: 72, emphasis in original)

¹¹ These include: NHS Foundation Trusts, NHS Trusts, Primary Care Trusts, Strategic Health Authorities and Special Health Authorities (DH, 2010c: 3).

The guidance also makes clear that relevant NHS bodies must make and recover charges where they provide overseas visitors with treatment (DH, 2010c: 4) – and explicitly *includes* primary care trusts in the definition of *relevant* NHS bodies (Ibid: 3; DH, 2010b: 72). As Medact observe this is ‘likely to be interpreted as a change of policy because – in the absence of a clear definition of what ‘primary medical services’ are – it leaves a lot to interpretation’ (Medact 2010a: 7). They note for example that Community Mental Health Teams provide an example which, under the new guidance, may fall outside of the exemption (Ibid: 7)

According to Medact, the guidance distorts the reality of what secondary medical care involves by focusing on ‘treatment’ and ignoring diagnosis and investigation. The draft statutory instrument does note that ‘treatment’ includes ‘diagnosis of symptoms or signs occurring for the first time after the visitor’s arrival in the United Kingdom’ (DH, 2010c: 3). Medact argue however that while the investigative work to generate an accurate diagnosis may not in itself appear immediately necessary or even urgent, the health problems uncovered by such work could be; this has important implications for the ability of chargeable individuals to access *potentially* urgent or immediately necessary medical attention. Taking the example of cancer, Medact note:

[L]ike the Charging Regulations, NICE [*the National Institute for Clinical Excellence*] has developed a hierarchy of urgency guidelines regarding referral for investigation and treatment for suspected cancer. They are ranked as i) immediate: an acute admission or referral occurring within a few hours, or even more quickly if necessary, ii) urgent: the patient is seen within the national target for urgent referrals (currently 2 weeks), and iii) non-urgent: all other referrals.’ (Medact, 2010b: 2)

They go on to observe that:

‘NICE exhorts GPs to refer patients urgently for conditions that defy diagnosis in primary care but could possibly be due to malignancy - highlighting the uncertainty inherent in primary care of the significance of symptoms before a patient is investigated.’ (Ibid: 2)

This is something that Jo Dr Newell of Leeds Health Access Team also highlighted, noting that on one occasion in the past staff of Leeds Teaching Hospitals NHS Trust had refused to conduct exploratory tests on the child of a refused asylum seeker on the grounds that they were not eligible and their symptoms (such as they were) did not indicate immediately necessary treatment. It was only through the intervention of a clinician in Public Health that ensured the necessary tests were undertaken (Newell, 2010).

To the confusion that the new Guidance introduces (or perpetuates) around the question of who is chargeable or not, must be added the strange and unnecessary way in which it raises the spectre of a two-tier system of healthcare being introduced by advising that:

‘In many cases, a patient undergoing immediately necessary treatment may be able to be stabilised, allowing them to be safely discharged and giving them time to return home for further treatment rather than incurring further avoidable NHS charges.’ (DH, 2010b: 12)

On the following page the Guidance notes that:

‘where it is medically safe to do so, the financial consequences should play a role in the choice of treatment provided to chargeable overseas visitors who cannot pay or the limits imposed on their treatment.’ (Ibid: 13)

This raises fears that the guidance implies the creation of a two-tier system of medical care and while the latter statement is followed by the point that such limits should be observed ‘...to the same extent that these considerations are taken into account for ordinarily resident NHS patients’, this only serves to add to the confusion such suggestions create. What are staff being told to do here: minimise treatment given to chargeable individuals within medically safe limits, or to provide them with the same level of care that non-chargeable individuals have a right to? Why make the former point specifically in relation to chargeable individuals if it applies to everyone treated by the NHS? It is arguable that this muddies the situation and creates a situation in which NHS employees are more likely to make mistakes about individuals’ entitlement whilst the prejudiced few are given (some) licence to exercise their prejudices. This is all the more concerning given historic evidence that hospitals are ‘inconsistent and aggressive [in the] application of charging’ at times ‘in direct contravention of government policy’ (Medecins du Monde UK in JCHR, 2007: 48).

conclusion

The past decade has seen rapid changes in the healthcare entitlements of one of the most vulnerable groups in society. Concern over the changes to healthcare entitlement of irregular migrants and refused asylum seekers has been widespread amongst health professionals, human rights organisations and advocacy groups as has criticism of government policy making. In 2005 the changes themselves appear to have been driven fundamentally by an immigration agenda and at the expense of considerations of human rights, public health or even cost effectiveness. The House of Commons Health Select Committee was highly critical of the government’s singular failure to conduct a cost-benefit analysis of the changes it introduced

(HCHSC, 2005 also see JCHR, 2007:50, 53).¹² Two years later the Joint Committee on Human Rights said the government's plans to deny people primary care could be in breach of its commitments under the European Convention on Human Rights by subjecting them to cruel and degrading treatment (JCHR, 2007: 53). At the same time the New Labour government was criticised for failing to conduct any investigation into the extent of the phenomenon of health tourism, a cost/benefit analysis or a Race Equality Impact Assessment prior to introducing the 2004 Charging Regulations (Ibid: 55-56). Notably it made no efforts to do so.

The NHS has been given some responsibility for the implementation of aspects of New Labour's immigration policy; withdrawing healthcare is seen as a means to discourage sick individuals from remaining in the UK. While the capacity of these measures to encourage irregular migrants—let alone refused asylum seekers who fear for their lives should they do so—to return home is questionable, it is quite clear that these measures will impact on people's health by discouraging them from accessing services, potentially including when they are urgently required (Ibid: 48). There is likely to be a knock-on effect on the health service more widely as more and more individuals present late and in need to more urgent, complex and expensive treatment (Ibid: 53, 56).

¹² In 2005 the Commons Health Select Committee wrote: "The [Health] Department's consultation on changes to the charging rules for overseas visitors suggested that cost saving was a key reason for reviewing the regulations. We were therefore astonished that by the Department's own admission these changes have been introduced without any attempt at cost-benefit analysis, and without the Department having even a rough idea of the numbers of individuals that are likely to be affected.' (HCHSC, 2005: 45)

2. methodology

The research presented in this report has been informed by the use of a variety of research strategies. Primary amongst these were a series of eleven semi-structured interviews with PAFRAS service-users and four with healthcare professionals. Information was also gathered via a brief questionnaire administered to services users at the PAFRAS drop-in while additional information has been extracted from a random sample of PAFRAS's records of its new clients for the calendar year 2009. A detailed literature review, the findings of which are discussed both here and in PAFRAS's briefing papers 5 and 11, was conducted by the researchers.

ethics

Research with refused asylum seekers poses a number of ethical problems. The project followed the Social Research Association Ethical Guidelines (see www.the-sra.org.uk/documents/pdfs/ethics03.pdf) and particular attention was paid to the following sections: 4.1 Avoiding undue intrusion; 4.2 Obtaining informed consent; 4.4 Protecting the interests of subjects; 4.6 Maintaining confidentiality of records; and 4.7 Preventing disclosure of identities.

In order to ensure that rights were upheld the research implemented a number of steps.

First, fully informed consent was sought before interviews took place. This included consent to the place and duration of the interview, consent for permission to store and use data in research outputs. The purposes of the research in terms of the outputs and possible audiences were specified to participants as part of this process. Steps were taken to protect the privacy and anonymity of respondents by anonymising details from the interviews as and when they were transcribed (including details of respondents' names). Respondents were informed that they could withdraw any information that they provided at any point of the research process.

Second, Interviews were recorded in electronic format and transcribed by the interviewer to ensure that the transcriptions reflected the meaning and sense of the interview as far as possible. In most cases interviews were conducted in English. In two cases an interpreter was used.

Third, interviews were conducted within a setting that is close to the proximity of trained PAFRAS case workers, the qualified Mental Health worker, or both. As such, trained staff were on hand to respond directly to the needs of interviewees if they request support.

Fourth, where accessing data from the internal monitoring system of PAFRAS, steps were again taken to ensure the anonymity of clients.

Fifth, respondents for the research have been identified through full co-operation of case workers and the PAFRAS mental health worker. The researchers obtained advice regarding

who to interview and engage with, and other PAFRAS staff have helped to guide sample identification so as to ensure that people who in particularly vulnerable positions are not approached.

semi-structured interviews

Two sets of semi-structured interviews were conducted for the project. The first consisted of interviews with PAFRAS service users. Here interviewees were purposively selected (Denscombe 1998: 15-6) for in-depth interviews based on their having had experience of primary and secondary healthcare services in the UK. Interviewees were identified with the help of PAFRAS's project manager, caseworkers and mental health worker. These interviews lasted for between thirty and sixty minutes and were conducted with assistance from an interpreter where possible. The purpose and aims of the research were explained to participants and their anonymity was guaranteed. The general characteristics of those interviewed are outlined in the table below:

	Sex	Age	Origin	Asylum Status	Support	Housing	Employment
<i>A</i>	M	43	Sub-Saharan Africa	Refused	None	Hidden homeless	Barred
<i>B</i>	M	32	Sub-Saharan Africa	Refused	None	Hidden homeless	Barred
<i>C</i>	M	40+	Sub-Saharan Africa	Refused	None	Rough sleeper	Barred
<i>D</i>	F	33	Sub-Saharan Africa	Refused	None	Hidden homeless	Barred
<i>E</i>	M	35	Middle East	Legacy	Social Services	Social Services	Barred
<i>F</i>	M	41	Former USSR	Refused	None	Hidden homeless	Barred
<i>G</i>	M	44	Middle East	ILR	Section 4	UKBA	Permitted
<i>H</i>	M	54	Sub-Saharan Africa	Refused	Section 4	UKBA	Barred
<i>I</i>	M	c.35	Sub-Saharan Africa	Refused	None	Hidden Homeless	Barred
<i>J</i>	M	28	Sub-Saharan Africa	Refused	Section 4	UKBA	Barred
<i>K</i>	M	33	Middle East	Legacy	Section 4	UKBA	Barred

TABLE 2: SERVICE USERS INTERVIEWED

Topics included in the interviews were derived from a review of the relevant research literature. They included contextual information about the individual's length of residency in the UK and the status of their asylum claim as well as pre-existing health conditions and conditions that emerged after their arrival in the UK, and questions about experiences of accessing primary and secondary health care services. While a schedule of questions was drafted in preparation for the interviews, a fluid approach was taken to questioning with the aim of avoiding imposing the researchers' own agenda on interviewees and instead allowing them to bring information to the table that might have lain outside of the scope of questions prepared.

While the researchers aim to interview a balanced sample of individuals who represented the general characteristics of PAFRAS service users (see section 3 for further information) it was

more difficult than had initially been hoped to access some individuals, particularly women, to discuss these highly personal matters. There is a distinct gender imbalance with only one woman agreeing to interview. Therefore while the interviewees are representative of PAFRAS service users in terms of their nationalities and present form of destitution they tended to be older than average. This reflects the fact that older asylum seekers, particularly those who'd been destitute for some time, were more likely to have health problems and therefore more contact or need for contact with the health service.

Semi-structured interviews were also undertaken with four health professionals working with refugees and asylum seekers. These included two individuals from the state sector (both from the Health Access Team) and two from the Voluntary Sector (from Solace and PAFRAS itself). Ideally more individuals from both the state and voluntary sector could have been interviewed but resource limitations meant that this was not practical. A thorough literature review has hopefully offset this to some extent although speaking to more local professionals may have enriched the understanding of local need and barriers developed through the research.

survey

An anonymous questionnaire (see appendix 1) was administered to sixty-three individuals at the PAFRAS drop-in by PAFRAS volunteers. The purpose and aims of the research was clearly explained to respondents and their anonymity was guaranteed. The advantage of having a volunteer help in the completion of the questionnaire was that these volunteers spoke Lingala, French and Swahili as well as English and were able to explain the questions to many of our service users.

One potential disadvantage of this method was that it denied respondents an element of anonymity. In future research it may be worth considering using translation and/or questionnaires with many more closed questions (check boxes, scales, etc) to enable individuals to complete the survey anonymously. However, given the exploratory nature of this research, there would still be a requirement to give respondents the opportunity to introduce elements that the researcher is unable to predict.

3. findings

a general picture of PAFRAS service users

In 2009 PAFRAS received 6,466 client visits and saw 315 new service users. Data from a randomly selected sample of 152 new service users are discussed below. Of this sample the majority (67%, $n=102$) were men with 33% ($n=50$) being women. A little over 75% of all new

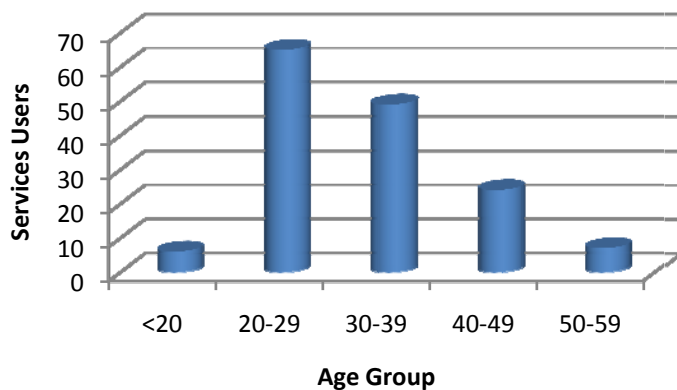


FIGURE 1: SERVICE USERS' AGES

service users in the sample were born between 1970 and 1989 with 32% being in their thirties and 43% in their twenties.

Service users came from a wide range of countries with the vast majority being Sub-Saharan Afri-

cans (73%, $n=111$). 22% ($n=34$) were from the Middle East, Central and Western Asia.

The largest single number of service users were Eritreans ($n=30$) followed by Zimbabweans ($n=17$), Iranians ($n=16$), Congolese (Democratic Republic) ($n=14$) and Afghani ($n=11$).

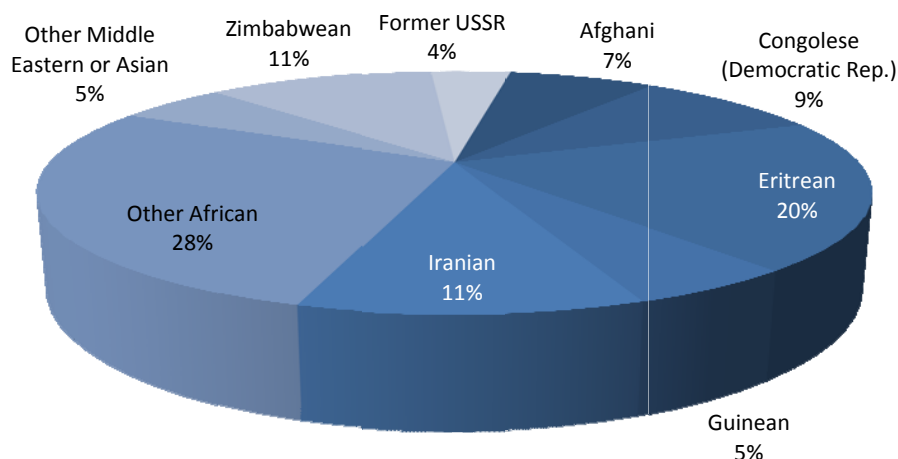
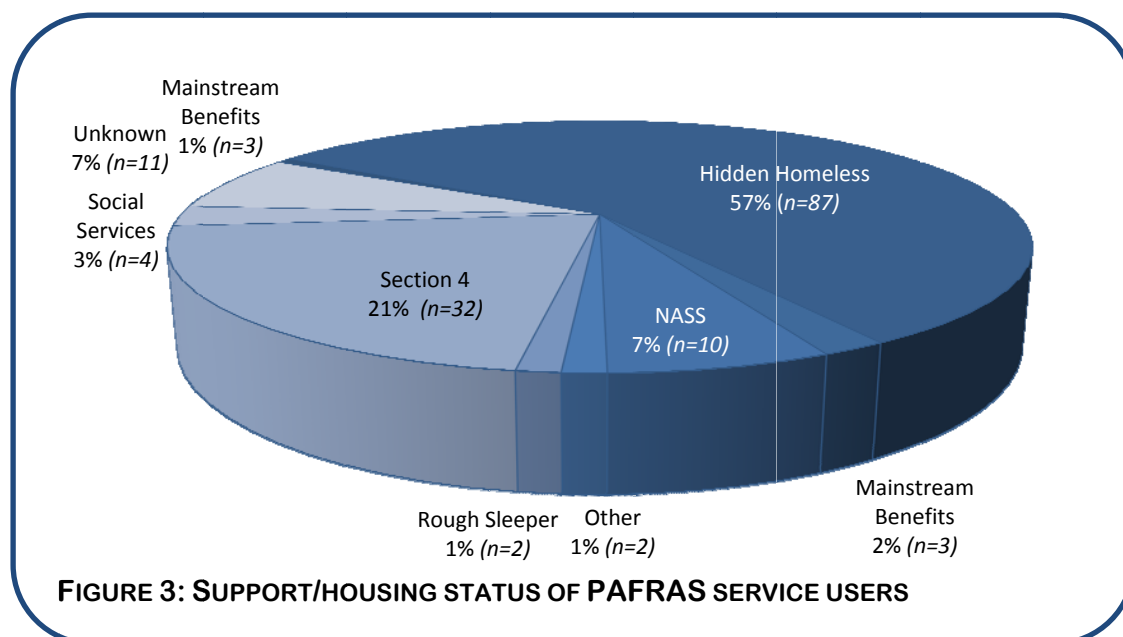


FIGURE 2: BREAKDOWN OF SERVICE USERS' NATIONALITIES

A total of 112 (74%) had been refused asylum of whom 32 (29% of refused asylum seekers, 21% of the total sample) were in receipt of Section 4 support when they first visited PAFRAS. Seventy-nine (57%) were 'hidden homeless' – surviving on the support of friends, community and organisations such as PAFRAS – and one person was receiving support from Leeds Social Services. Thirteen individuals (8%) did not provide details of their immigration status at that time.

In total 65% ($n=99$) of the sample reported that they already had a GP at the time when they



first came to PAFRAS while 22% ($n=33$) did not. We do not have data for the remaining 13% ($n=20$). Data recording for whether first time visitors had a dentist was poor with 113 (76% of the sample) being unknown. Of the remainder 23 (15%) did not have a dentist and 13 (9%) did.

survey of PAFRAS service users

As part of the project a short questionnaire was administered to PAFRAS service users. Sixty-three completed the survey questionnaire in total. The general characteristics of individuals surveyed match the picture above fairly well.

respondents' gender and age

In total there were 19 (30%) women and 43 (68%) men (one person did not answer this question). Respondents ranged from 20 to 59 years of age with the largest number ($n=26$ or 41%) coming from the 30-39 age bracket while 24 (38%) were between 20 and 29 years of age. Eighteen percent ($n=11$) were aged 40-49 and 3% ($n=2$) 50-59 (see figure 4).

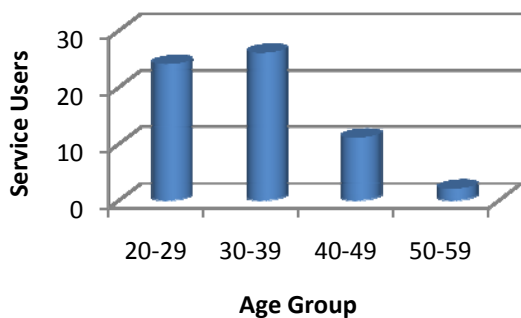


FIGURE 4: AGES OF SERVICE USERS SURVEYED

The length of time in the UK ranged from 3 months to 16 years with the majority having been in the country for between three to seven years while the average length of time in the UK was five years.

respondents' immigration and support status

In all 68% ($n= 43$) of respondents exist without support, while 22% ($n= 14$) were receiving Section 4; this latter figure approximates that for new service users in 2009, while the larger number of respondents is roughly equal to the sum of hidden homeless, rough sleepers and 'unknown' amongst the sample of new service users in 2009 (66%).

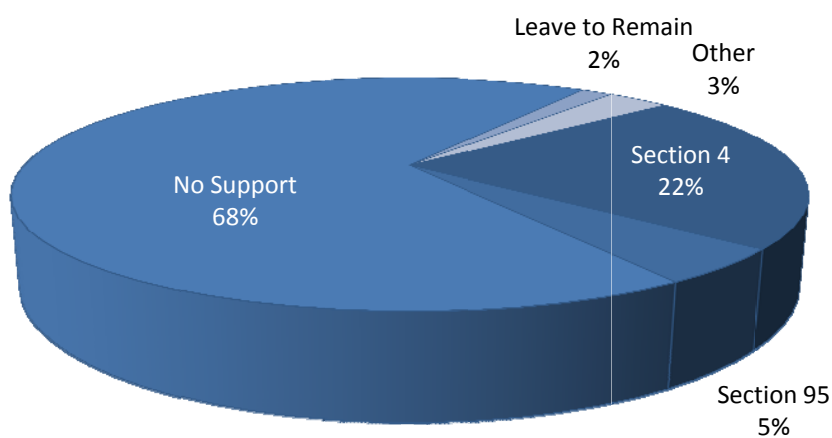


FIGURE 5: RESPONDENTS' IMMIGRATION/SUPPORT STATUS

3.1 health needs

Asylum seekers are not a homogenous group. They come from a variety of ethnic, national, cultural, religious and social backgrounds and can present a variety of complex physical, psychological and social needs (Cheal & Fine, 2005: 24) not all of which are necessarily specific to their identities as refugees or asylum seekers. These might include problems of pre-existing chronic health conditions and conditions in their country of origin, including prevalence of infectious diseases such as tuberculosis, hepatitis A, B or C and HIV/AIDS (Haroon, 2008: 4, Fisher, 2004: 4, Audit Commission, 2000: 61).

The British Medical Association has identified health problems that are specific to asylum seekers or refugees as originating from “the physical or mental torture or other harsh conditions from which they have escaped” (2002: 5). Haroon, in a briefing paper on asylum seekers’ health needs written for the Commission for Public Health, notes that ‘the journey to the UK can have effects on individuals through extremes of temperatures, length of journey [and] overcrowded transport” (2008: 4). It is widely recorded that there are significant numbers of survivors of torture amongst asylum seekers (Fisher 2004: 5). Doctors Burnett and Peel of the Medical Foundation for the Care of Victims of Torture estimate the figure at between five and thirty percent (Burnett & Peel, 2001: 607, also see Aspinall 2006: 40 and Ashton & Moore, 2009: 12). Sexual violence and rape are used as a means of torture.

Dr Jo Newell of Leeds’ health access team reports that new arrivals quite frequently bear partially or poorly-healed injuries that are the results of physical trauma experienced in their home countries or during their journeys to the UK (Newell, 2010). The literature suggests that arrival in the UK does not mean a necessary improvement in health, with Fisher (2004: 5, 16) and the BMA (2002: 6) reporting that asylum seekers’ needs also reflect wider problems of poverty and social isolation of their circumstances once they have arrived here. A theme which Haroon expands upon, noting that

‘the health needs of asylum seekers can be significantly worsened (and even start to develop in the UK) because of loss of family and friends’ support, culture shock, uncertainty [about their claim for asylum], racism, hostility (e.g. from the local population), housing difficulties, poverty loss of choice and control.’ (2008: 4)¹³

¹³ Also see Audit Commission, 2000: 65.

TABLE 3: HEALTH PROBLEMS AND CONTRIBUTORY FACTORS

(adapted from BMA 2002 with additional material as cited)

Communicable diseases	Psychological health problems (symptoms)
<ul style="list-style-type: none"> • Tuberculosis • Hepatitis A, B, C. • HIV/Aids • Parasitic infections 	<ul style="list-style-type: none"> • <i>Anxiety</i> (hyper arousal intrusive thoughts, flashbacks, loss of appetite, sleep problems, panic attacks, shaking, involuntary movements) (Burghgraef, 2010b; Palmer & Ward 2006: 28; Burghgraef, 2010a; Newell, 2010; Karpuk, 2010)
Effects of war , torture and flight	
<ul style="list-style-type: none"> • <i>Trauma/Traumatic injuries</i> (muscular-skeletal injuries (Newell, 2010; landmine injuries; amputated limbs; soft tissue injuries (Aspinall, 2006: 40); head injuries ‘including epileptiform convulsions and post-concussion symptoms’ (Aspinall, 2006: 40) • <i>Lameness</i> • <i>Conditions secondary to torture</i>, such as shoulder or brachial plexus problems caused by being suspended by the arms (Cheal & Fine, 2005: 18) • <i>Partial loss of vision</i> • <i>Hearing difficulties</i>, traumatic drum perforation and scarring • <i>Injuries</i> arising from beatings and torture (including dental torture) • <i>Rape/sexual assault</i> • <i>Malnutrition</i> (could affect development in children)/diseases of malnutrition (Cheal & Fine, 2005: 18) 	<ul style="list-style-type: none"> • <i>Cognitive difficulties</i> (short term memory, recollection, concentration, inability to think) (Burghgraef, 2010b) • <i>Emotional issues</i> (grief & loss, depression, anxiety, numbness-feeling dead, self injury, suicidal, a range of different kind of fears, shame & guilt, passivity, lack of motivation) (Burghgraef, 2010b) • <i>Disorientation</i> (confusion, hearing voices, loss of sense of self/identity, fear of going crazy, disassociation, seeing people you think you know) • <i>Stress</i> • <i>Suicidal ideation</i> (Burghgraef, 2010a; Newell, 2010; Karpuk, 2010) • <i>PTSD</i> • <i>Stress-related physical ill health</i> (heart disease; cancer; increased susceptibility to infection, gastrointestinal disturbances; chronic headaches (Newell, 2010, Ashton & Moore, 2009: 13); stomach and bowel problems (Newell, 2010); pain in limbs (Newell, 2010).) • <i>‘Fear syndrome’</i> or fear of people in authority

Added to this is what the BMA refers to as the “detrimental impact of the asylum process on the health of asylum seekers”, an observation based on evidence that “the health status of new entrants may worsen in the two to three years after entry to the UK” (BMA 2002: 1, 6 also see BMA 2009). Health professionals in Leeds make similar comments, most specifically in relation to mental health (Newell, 2010; Raynor 2010), a subject to which we will return below. Table 3, adapted from *Asylum Seekers: Meeting their Health care Needs* (BMA 2002) and

TABLE 4: SOCIAL & OTHER CONTRIBUTORY FACTORS

(adapted from Burghgraef, 2010b)

Losses	
• Family	• Employment profession
• Friends religion	• Cultural competence
• Community political affiliation	• Cultural bereavement
• Language(s) personal identity	• Possessions
• Social networks social status	• Stability & certainty
Internal pressures	External pressures
• Coming to terms with multiple losses	• Limited financial resources
• Disorientation & confusion as you are confronted with too many changes at once	• Complex legal process
• Anxiety about the future and fear of return	• Asylum seekers not permitted to paid work
• Acute and chronic uncertainty	• Isolation
• Worry about family left behind	• Learning a new language
• Culturally displaced - no sense of belonging	• Cultural adaptation
• Deskilled as you need to learn the new 'rules' and ways of doing things through	• Little or no choice as to where you live
• Possible trauma related to experiences in the country of origin or during flight	• Hostility due to lack of understanding
• Early history, patterns of attachment	• Racism, stereotyping
• Aftermath of experiencing or witnessing violence including torture and rape	• Negative media images
• Disturbance of identity and worldview	• Poverty

incorporating additional information from other sources, summarises healthcare needs of asylum seekers and exacerbating factors. Table 4 shows factors pertaining to the poor mental health of asylum seekers.

destitute asylum seekers

While sharing the problems of other asylum seekers and refugees, destitute asylum seekers face 'an additional set of problems from being refused asylum' (Newell, 2010; Ashton & Moore, 2009). These problems relate to both mental and physical health and are the results of the refusal itself as well the destitution that almost invariably accompanied it. Newell notes that refusal is a blow to the mental health of most of those who experience it, a point with which Anne Burghgraef, senior therapist at Solace, concurs:

“When they get their refusal ... and if they lose their appeal, it really knocks people. Not only are they suffering, they’ve been branded a liar and they’re facing the threat of return. That triggers a downward spiral.” (Burghgraef, 2010a)

While refusal can have an immediate effect on an individual’s emotional and psychological wellbeing, being forced into destitution has longer term impacts on both physical and mental health (Ashton & Moore, 2009:16). As Alison Raynor, Lead Nurse for Leeds’ Health Access Team, observes:

‘If they didn’t have any mental health needs when they arrived then once they’re destitute for a while they will have.’ (Raynor, 2010)

The reasons behind this are multi-faceted, ranging from the impact of poor diet (Raynor suspects that malnutrition is endemic amongst destitute asylum seekers), to the effect of forced mobility on people’s ability to form stable attachments (Raynor, 2010).

Destitution is also a factor in decline in physical health, both as result of the lived experience of it (poverty, lack of food and nutritionally poor food, living in unsafe environments) and of ‘not having regular access to healthcare’ (Newell, 2010). This latter point is also taken up by Raynor who notes that dental health is a particular problem amongst refused asylum seekers ‘not because destitution causes dental health *per se* it’s just accessing regular dental care will be difficult so there will be acute dental healthcare need’ (2010). Certainly it is difficult to get onto a dentist’s list and (once on one) difficult to remain there if you are homeless and liable to miss appointment reminders. Healthcare professionals describe the experience of destitution as one of entering into a vicious cycle in which an individual’s circumstances impact on their mental health which again has knock-on effects on physical (and mental) health (Raynor, 2010; Newell, 2010). While indicating that destitution is not usually responsible for creating wholly new physical health problems, they suggest that it invariably impacts negatively on existing conditions, exacerbating for example chronic problems such as diabetes or arthritis. Table 5 summarises commonly identified health problems and risks for destitute asylum seekers.

J feels trapped by the asylum system. He has spent several months in the Becklin Centre for acute mental illness during his time in the UK, something he attributes to his status as a refused asylum seeker:

‘Since I have been here I deteriorated in terms of mental health ...caused by the asylum system, by the way I was treated. I have been destitute. There is no way to improve your health’

J takes six different types of medication which receives fortnightly on a repeat prescription. *J* self-harms and while he says the drugs ‘give a little bit of relief ...a bit of hope’ the ‘depression is still there’. He explains: ‘there is no medicine that can remove you from the asylum system. It breaks you’.

TABLE 5: HEALTH PROBLEMS AND RISKS FOR DESTITUTE ASYLUM SEEKERS

Source: author's interviews with Newell, Raynor and Karpuk unless otherwise indicated.

<p>Physical health</p> <ul style="list-style-type: none"> • Malnutrition • Skin problems, foot problems • Dental problems <hr/> <p>Chronic conditions/ diseases (exacerbated by destitution)</p> <ul style="list-style-type: none"> • Diabetes • Heart disease • Hypertension • Arthritis (Aspinall, 2006: 34) • HIV/AIDS • Hepatitis A, B, C 	<p>Mental health</p> <ul style="list-style-type: none"> • Depression • Anxiety • Sleeplessness • Self-harm (also see Dumper <i>et al</i>: 34) • Suicidal ideation • PTSD (often more vivid for those who've been refused and are facing deportation and retraumatisation). <hr/> <p>Risks</p> <ul style="list-style-type: none"> • Tuberculosis • Exploitation/sexual assault/rape
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survey results

In all 40 respondents reported suffering from 36 different symptoms or health problems, of which 12 relate to mental health or psychological wellbeing while 24 can be described as relating to physical health. There were a total of 104 occurrences of these problems or symptoms with each respondent averaging 2.6 health complaints (see table 6 on page 27).

Mental health problems made up 54% of all complaints with 23 respondents (22%) reporting depression. Due to the way in which the questionnaire was administered, and particularly in regard to mental health problems, it seems likely that this figure represents an under-reporting of problems, amongst asylum seekers as with other social group mental health problems carry with them a stigma. Dzmitry Karpuk, mental health worker with PAFRAS reports that around 50% of the clients he deals with engage in suicidal ideation. He also notes that 'all clients resist to even speak about mental health problems... they['re] afraid they'd be locked up or will fail to get asylum because of it' (Karpuk, 2010). As has previously been noted, mental health problems can have physical symptoms and impact on chronic physical health conditions such as high blood pressure or heart disease. (Cheal & Fine, 2005:18; Newell, 2010) Because of these factors the grouping of the symptoms above should be considered indicative only.

TABLE 6: RESPONDENTS' HEALTH PROBLEMS

Physical Symptom/ Health Problem	Instances	Psychological Symptom/ Health Problem	Instances
Dental	5	Depression	23
Headaches/migraine	5	Stress	13
High blood pressure	5	Sleeplessness/Insomnia	7
Muscular-skeletal/joint	5	Anxiety	5
Heart condition	3	Other mental disorder	2
Chest pain	2	Anger	1
Epilepsy	2	Fatigue	1
Gastritis	2	Forgetfulness	1
Pain	2	Lack of confidence/fear	1
Visual impairment	2	Nightmares	1
Asthma	1	Nervousness/inability to relax	1
Chest infection	1	Suicidal ideation	1
Cyst (eye)	1	<i>Total</i>	<i>57</i>
Diabetes	1		
Flu	1		
Gastric ulcers	1		
Hernia	1		
Liver problems	1		
Mobility problem	1		
Pregnant	1		
Respiratory problem	1		
Skin condition (Rashes)	1		
Stomach	1		
Stroke	1		
<i>Total</i>	<i>47</i>		

medication

Forty-seven percent ($n= 29$) of all respondents (73% of all respondents with any sort of health complaint) were on medication of some sort and most (22 of those on medication, and 4 of those currently not on medication) said they did not have trouble accessing medication, as one respondent put it: 'I'm only scared with the amount of medication I get' (Survey Respondent 15).

Currently on medication?	Problems accessing medication?		
	No	Yes	No Answer
No	4	1	28
Yes	22	5	2
<i>Total</i>	26	6	30

TABLE 7: ACCESS TO MEDICATION

changes in health whilst in the UK

When questioned 51% ($n=32$) of respondents said their health had declined since arriving in the

UK while 32% ($n=20$) said it had improved. Sixteen percent ($n=10$) said that they had seen no overall change in their health. Forty of the 52 respondents who stated that their health had either got worse or improved gave further details when asked what causes they attributed to these changes. Of these, nine indicated that their health had improved because they were either in receipt of medication or treatment from the NHS or their GP or, in two instances,

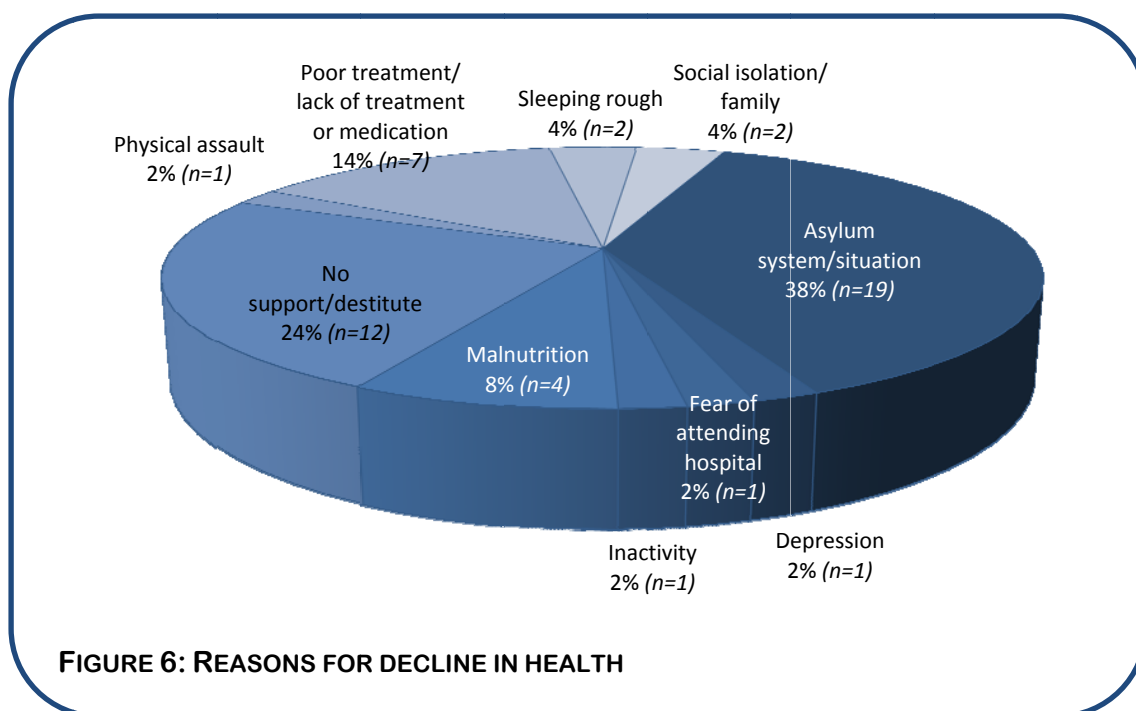
	Leave to Remain	No Support	Other	Section 4	Section 95	Totals
Asylum system/situation	-	13	-	4	2	19
Depression	-	1	-	0	-	1
Fear of attending hospital	-	1	-	0	-	1
Inactivity	-	1	-	0	-	1
Malnutrition	-	4	-	0	-	4
No support/destitute	-	10	-	2	-	12
Physical assault	-	1	-	0	-	1
Poor treatment/lack of treatment or medication	-	3	-	4	-	7
<i>Receiving or able to receive medication/treatment</i>	1	5	-	3	-	9
Sleeping rough	-	1	-	0	-	1
Social isolation	-	1	-	1	-	2
<i>Totals</i>	1	41	0	14	2	58

TABLE 8: REASONS FOR HEALTH CHANGES BY SUPPORT SITUATION

because they had access to the NHS or their GP. It should be noted that two individuals who said that their health had improved also indicated that 'without support my health cannot improve that much' (Survey Respondent 5) and that it was 'slowly improving' but that a lack of a dentist was a problem (Survey Respondent 14).

In all, 38% ($n=19$) of those who provided details of why they believed their health had got worse indicated that the asylum system and their current circumstances were to blame (see figure 6). Of these individuals 68% ($n=13$) had no support while 21% ($n=4$) were in receipt of Section 4 and 11% ($n=2$) of section 95 support respectively (see table 8 on the previous page).

Similar proportions of respondents with no support (51% $n=22$) and respondents with Section 4 support (50% $n=7$) felt that their health had got worse since arriving in the UK (and likewise for improvement: 30% and 36% respectively). The similarity in feelings about their



health (both positive and negative) between these two sets of respondents will, more than anything else, reflect the present confusion over who is entitled to what healthcare and under what circumstances. It further reflects the fact that Section 4 support is – for many people

Case Study

B arrived in the UK fleeing his home in 2003; his asylum claim was refused within the year. He says his health has deteriorated since arriving in the UK. Although he already had physical and mental health problems when he arrived in here, destitution, homelessness and sleeping rough on the streets from time to time have taken their toll.

‘...sometimes when I found some place, in a house maybe, to get to sleep, there will be people who ask me what I am doing, they will harass me. I will move maybe somewhere else...’

B has been prescribed anti-depressants which he says help him, but he’s under few illusions as to where the root of his problems lies:

‘To be honest the problem is the condition I live [in]. If you are not in a good condition and your mental health is not right you are not going to heal quickly or easily because your condition is not [getting] better.’

only short-term and most of those supported under Section 4 will have had spent significant periods of time unsupported.

That respondents place such emphasis on the ways in which their situation and the asylum system is making them ill is not particularly surprising; it is a phenomenon noted by the British Medical Association as long ago as 2002 (BMA, 2002; also see Refugee Action, 2006). The relationship particularly between mental health and enforced destitution is something that both health professionals and service users highlighted in interviews when talking about the difficulties of addressing these problems.

3.2 barriers to accessing healthcare

While all asylum seekers face significant barriers to accessing health care¹⁴, refused asylum seekers are made doubly vulnerable by their homelessness and the erosion of their rights by the government. Given this, the barriers that they face frequently reflect aspects of their status as foreigners in a strange country and of their homelessness (and thus bare similarities to the barriers faced by homeless people more generally) while also reflecting their status as a group of people whose rights have been curtailed.

This section of the report focuses on key barriers for *refused* asylum seekers identified by the research. Key amongst there are language and culture; bureaucracy; the physical and mental effects of homelessness; discrimination and resource limitations and the charging regime.

language

There is broad consensus in the literature on the significance of language as a barrier to accessing health services in the UK (BMA, 2002: 11; Fisher, 2004: 8, Aspinall, 2006: 49-50) with a number of different aspects of the problem being brought forward. Put broadly: language presents a potential barrier both to accessing healthcare (making appointments; communicating with reception staff) and to the quality of healthcare accessed (communication with medical professionals).

¹⁴ The table in appendix 3 presents factors identified in the literature, not all of which are always applicable in the same ways to refused asylum seekers.

In studies conducted in 1998 and 2002, 'lack of knowledge about languages spoken and the extent of need for interpreting services' were cited as significant barriers (Aspinall, 2006: 48-9). The main facility for interpretation open to clinicians is Language Line, a telephone interpretation service, which does have some draw backs and requires a period of familiarisation before it can be used easily. The literature suggests that, in the past, usage of Language Line by GPs (for example) has been limited for a number of reasons. In her survey of GPs' views in 2004, Fisher found that 'whilst some find interpreter facilities such as Language Line to be effective and invaluable, others criticise these facilities for being difficult to use, prohibitively expensive or inconvenient' (Fisher, 2004: 9).¹⁵ Dr Newell, herself a regular user of Language Line her in her capacity as GP for the Hillside Initial Accommodation Centre in

Case Study

D is a thirty-three year old refugee from southern Africa. She has been in the UK for six years having claimed asylum in mid-2004 and been refused early in 2005. *D* was diagnosed as suffering from degenerative fibroid (a benign, non-cancerous, muscle tumour of the uterus) after arriving in the UK. At the time still an asylum applicant; *D* was quickly referred to a specialist at King's College Hospital in London. She attends hospital every six months for what her doctors call 'ablation' though she says her condition has gradually deteriorated over the years; she experiences pain frequently.

While it is to be welcomed that she is receiving ongoing treatment for her condition she continues to experience pain and, worryingly, appears to not fully understand her medical condition, or the treatment she is receiving for it. *D* says her GP is 'quite good', but she speaks very little English and is never offered interpretation at consultations. She is not even aware that she might, potentially, be able to have interpretation at her consultations.

In light of this her capacity to offer her informed consent can be questioned. *D*, like the majority of asylum seekers, is very grateful to be offered treatment at all and has never requested interpretation. Ethical guidance nonetheless makes it clear that this sort of implied consent while 'not a lesser form of consent...*only has validity if the patient genuinely knows and understands what is being proposed.*' (BMA, 2009b: 7, emphasis added)

¹⁵ Fisher also found that a heavy reliance was placed by practices on so-called 'informal solutions' (having patients' friends and families interpret) with over 35% of respondents saying that they were used most or all of the time and over 55% using them some of the time (Fisher 2004:10). Fisher also notes that informal interpretation can lead to inaccurate and censored translation of what the patient is saying as well as withholding of information about sensitive issues such as sexual health, domestic violence or torture (Ibid: 14).

Leeds, argues that with a hands free telephone and a bit of practice Language Line is actually easy to use and ‘the instant access [to an interpreter] vastly makes up for not having a person in the room’ (Newell, 2010).

“When I was discharged from hospital an Indian doctor tried to talk to me and I couldn’t understand what it was all about. I didn’t ask for an interpreter, they were busy.”

– Interviewee F

According to Alison Raynor things have improved in Leeds since the early days of dispersal and there is a great deal more awareness of issues surrounding language and interpretation (2010). However, interviews with health professionals, advocacy workers and PAFRAS service users indicate that understanding or acknowledgement of the need for interpretation services is by no means universal and neither is its use. Interviewee *F* explains that interpretation

is provided occasionally but not consistently. He says: ‘It’s much better with an interpreter. Often I don’t know what’s going on, my vocabulary is very small so when I know a topic I’m okay, but outside of that I don’t understand.’ There is clearly a temptation to muddle through when dealing with patients who speak a little English and perhaps even say they can manage without interpretation – especially given the time constraints that GPs operate under. Like many others *F* compounds the problem himself by not always asking for interpretation. His motivations for this vary from worrying about wasting clinicians’ time to worrying that relying on interpreters slows his learning of English.

GPs’ willingness to be proactive in the use of facilities such as Language Line is however vitally important, particularly as not all destitute asylum seekers who need interpretation feel confident enough to request it. While there is no hard and fast rule to say they must provide *interpreters* for their patients, GPs also have an ethical responsibility to ensure that their patients can understand them.

‘I try to understand myself; I don’t want other people to be involved in the process. It’s okay to be creative, it helps to learn English. I really want to learn’

– Interviewee F

According to the General Medical Council, one of the core duties of a doctor is to ‘[g]ive patients the information they want or need in a way they can understand’ (GMC, 2008: unpaginated). Furthermore, the need for informed consent which is central to medical ethics and the ethical codes under which doctors and other health professionals operate frequently cannot be met without interpretation. The BMA explains:

Consent may be explicit or implied. Explicit or express consent is when a person actively agrees, either orally or in writing. Consent can also be implied, signalled by the behaviour of an informed patient. Implied consent is not a lesser form of consent but *it only has validity if the patient genuinely knows and understands what is being proposed*. The provision of sufficient accurate information is an essential part of seeking consent. *Acquiescence when a patient does not know what the intervention entails, or is unaware that he or she can refuse, is not 'consent'*. (BMA, 2009b: 7, emphasis added)

culture

Failings in cross-cultural communication and cultural misunderstandings, especially in conjunction with their other vulnerabilities, can function as barriers to access for refused asylum seekers. Health professionals spoken to, all highlighted the problems that asylum seekers have understanding waiting lists; as does the literature (see Home Office, 2010). This is often ascribed this to unfamiliarity with the ways in which the NHS works (and to its limitations), which offers half the explanation; there is another side to this however. Loss of control over one's own life combined with inability or reduced capacity to plan ahead creates what Alison Raynor refers to a sense of urgency or 'desperation that things have got to be sorted out now' (2010). This desperation may also reflect different cultural interpretations of what being told to wait means, as Karpuk explains:

'Imagine you have a difficulty and people say 'yes we can help you, however you need to wait' People cannot wait, *they think, they hear the message that nobody wants to take care of them when they hear someone say 'we will help you but can you come back in six months?'*

People say 'oh, no, no, no, no, I hear a message here. It's English politeness; you don't want me. Better tell me now you don't want me.' They think: 'don't lie to me; I know you're trying to be polite like everybody here, but it would better to say no'. (Karpuk, 2010)

Sensitivity to the vulnerability of destitute asylum seekers and awareness of the capacity for cross-cultural misunderstandings is important to ensuring that they continue to access health-care when they need it. Destitute asylum seekers exist on the very edge of our society. They have already experienced enormous loss in leaving their homes and rejection in the refusal of their asylum claims here in the UK. As with interpretation it is clear that many will not demand medical care, even when they need it (Fisher, 2004: 6)

Karpuk argues that those people who come from less individualist and right-based and more collective societies are especially vulnerable in this situation. He suggests that they both do not know their rights and are not culturally predisposed to demand them. He states,

‘These people find it difficult, they expect that someone will take care and they cannot demand. They will ask you, for example ‘I need a doctor’ and they’re rejected once, twice and they will get worse and worse, because they will not complain. [They believe that if] they’ve been rejected there is a reason for that; they’re not going to ask you a third or fourth time. (Karpuk, 2010)

Obviously people cannot be placed at the top of waiting lists; but this is not even necessary. In situations of cross-cultural understanding the most effective solution is to ensure the use of interpretation and thereby that communication between patient and clinician is free of harmful misunderstanding.

Furthermore differing cultural understandings of mental health problems can pose significant barriers to accessing and using mental health services. Karpuk and Burghgraef both report that in most cases an element of ‘psych-education’ must be provided to people to familiarise them with western ideas about mental health before they are able to engage. This is something that is also commented on extensively in the literature (see for example, Aspinall, 2006: 51).

homelessness and transience

In the UK, primary care services are the gateway to all statutory health services and as such serve an important function in the timely detection of personal health problems and public health risks, (GHAP, 2008: 27-8, 35). Most primary provision is made through GP Practices contracting with NHS Primary Care Trusts (PCTs).

PCTs also run (nurse-led) Walk-in Centres and specialist teams like midwifery. Dentistry services are also mostly commissioned by PCTs locally.¹⁶ The model of primary care organisation is predicated on a settled population who do not move about often, thus GP practices have geographical catchment areas within which an individual should live if they wish to register. Refused asylum seekers—the majority of whom are ‘hidden homeless’ and extremely transitory—do not fit into this model particularly well and consequently the fact of their homelessness becomes a barrier to accessing healthcare.

“I think failed asylum seekers miss out the most. Once you’re in the system then to some extent you’re alright; it’s the people who aren’t in the system at all...”

– Jo Newell

¹⁶ More specialised work such as oral surgery, specialist orthodontics or complicated root canal and bridge work delivered in a hospital setting is considered secondary care. (DH, 2010d)

PAFRAS's data show that most destitute asylum seekers are 'hidden homeless' living on the floors of friends, acquaintances or members of their community and constantly on the move.¹⁷ Many therefore are forced to leave the catchment area of their GP meaning that while—as Alison Raynor states—'there's no rule to say because you've 'failed' you can't have healthcare' (Raynor, 2010), the end of the asylum process regularly entails losing access to a GP. And although GPs may be acting properly in removing individuals from their lists in such circumstances, doing so leaves open the question of whether they can get onto another (Newell, 2010).

Added to practical problems such as this are a number of mutually reinforcing problems which arise out of destitution itself. For example, memory and concentration are badly affected by a combination of malnutrition and depression, which has a knock-on impact on the capacity to organise and motivate oneself. At the other end of the scale the simple lack of a pen or anything to write on will also have a negative effect while modern technological solutions aren't universally helpful either. Most destitute asylum seekers have a mobile telephone but they're very unlikely to have credit and may not be able to charge it for lengthy periods of time. Destitute asylum seekers lack even the money to pay for fares to get to appointments (Raynor, 2010; Newell, 2010; Karpuk, 2010). As table 8 below shows, 22 of 63 PAFRAS service users surveyed said that they had problems keeping appointments with their GP, of

Transport (lack of money)	9
No GP	5
Fear	2
Forgetting	5
Language (making appointments)	1
Total	22

TABLE 9: DIFFICULTIES IN MAKING/ATTENDING APPOINTMENTS

whom nine identified transport—lack of money for bus tickets—as a problem and five forgetting their appointments.

Ultimately destitution is a barrier to health also because it forces those suffering it to prioritise other problems ahead of their health (Raynor, 2010) with dam-

aging long-term consequences. Karpuk explains:

'These people, they have to survive. They have to prioritise all the time, food is the first thing, second is a roof. Appointments are third after that. If someone is hungry or facing a night on the street they will take care of those things first.' (Karpuk, 2010)

Karpuk reports that a major problem for destitute asylum seekers, as patients of the NHS is the fact that 'the NHS doesn't want to accept this reality'. Instead he says 'I always hear 'well

¹⁷ The nature of the relationships to their hosts and, most probably, the prices paid – literally and otherwise – for hospitality vary widely.

we tried to', but actually they tried what they try for British people who have a roof and everything. It's not enough for these people.' He suggests that, when badly applied,

'...equal opportunities actually discriminate against asylum seekers, because if you offer them the same things you provide to British people you are offering them something they aren't able to access.' (Karpuk, 2010)

Ability and willingness to adapt to the needs and circumstances of destitute patients is more pronounced amongst those teams (for example the Health Access or No Fixed Abode Teams¹⁸) who deal with them on a daily basis. Dr Newell gives one example of this explaining that the No Fixed Abode Team (NFA) acts as a 'care of' address for some of its patients and also spend a lot of its time for reminding patients about their appointments (Newell, 2010).

resources and discrimination

It is apparent that discrimination—normally around the apportionment of resources—is a barrier to refused asylum seekers in accessing care. As discussed previously, clinical staff have an ethical duty to ensure that they understand and are understood by their patients and that patients have access to interpreting services where needed. While the failure to use an interpreter does not necessarily demonstrate discriminatory behaviour there is some evidence that clinical (and other) staff at GP practices use language as a means of excluding particular patients.

“Most people have a poor memory, it's one of the symptoms, so they cannot plan a few weeks ahead, it is terrible when the NHS doesn't understand that, when people who work with mental health difficulties still cannot understand that.”

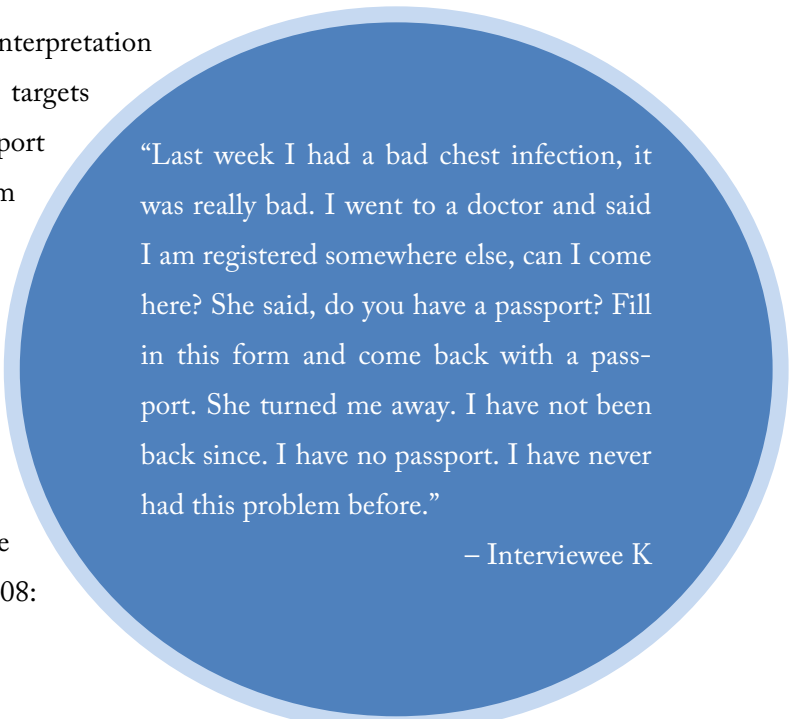
— Karpuk 2010

Kate Ferguson, Advocacy Support Worker at Solace, reports being asked by a number of their services users to help them arrange appointments with interpretation. They do this because they are refused interpretation if they approach their GP practice on their own. Ferguson explains that while most practices will agree to arrange an interpreter when she asks them, some categorically refuse to do so 'for money reasons, time reasons, because they'd need to allocate extra time for an appointment if they're going to use interpreters' (Ferguson, 2010). This is something which Jo Newell confirms, saying that 'there are a handful of practices in Leeds, *some that are in areas with a lot of asylum seekers*' (2010, emphasis added) who refuse to use interpreters. Given this latter fact it seems less and less likely that the reluctance to use Language Line stems from ignorance or misapprehensions about expense. Instead, Newell sug-

¹⁸ The No Fixed Abode Team is a specialist team providing primary care, mental health and drug treatment services to the homeless population of Leeds.

gests that refusing to use an interpreter may be a response to the complex needs of asylum seekers and to the additional workload that they are perceived to be: ‘a very useful barrier to stop people using up time that [GPs] haven’t got’—or do not believe they can spare (2010).¹⁹

Certainly there is evidence that using interpretation means longer consultations and targets missed. Jane Williams, in a scoping report on services for refugees and asylum seekers in Leeds, notes that three practices surveyed – all of whom stated they used Language Line—offered double appointments to clients who require interpretation which ‘in turn has a large impact on 24/28 hour access target[s] for the practice and the PCT’ (Williams, 2008: 13).



“Last week I had a bad chest infection, it was really bad. I went to a doctor and said I am registered somewhere else, can I come here? She said, do you have a passport? Fill in this form and come back with a passport. She turned me away. I have not been back since. I have no passport. I have never had this problem before.”

– Interviewee K

charging

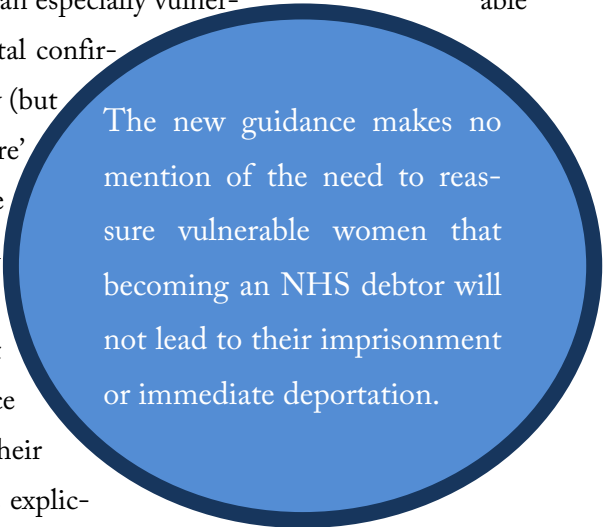
Aside from the interim period between the High Court’s ruling in *The Queen on the Application of ‘A’ -v- West Middlesex University Hospital NHS Trust* and its overturning by the Court of Appeal on 20 March 2009, refused asylum seekers have been chargeable for secondary health provision since 2004. At the same time, although there is no statutory duty to charge them for primary healthcare the government has sought to encourage GPs to register refused asylum seekers as private patients. In 2004, as discussed in chapter 1, the government consulted on the idea of making refused asylum seekers chargeable on a statutory basis but the idea was subsequently shelved. Launched immediately after the changes to the charging regulations on secondary care this consultation created a lot of confusion about the situation for refused asylum seekers which has subsequently has not completely abated.

Individuals who *are* chargeable for secondary care should be provided with urgent or immediately necessary treatment before any payment is received. Despite this an adequate literature exists to suggest that this frequently does not happen (Refugee Council, 2006; JCHR, 2007: 44-49) reinforcing the idea that the enforcement of the charging regulations has been poorly applied.

¹⁹ This reflects the findings of Tania Fisher’s who reported that ‘almost three-quarters (72%) of respondent GPs report that [having refugees and asylum seekers registered with their practice] does affect their ability to meet targets and a quarter state this has a big impact’ (2004: 10).

Charging presents a potentially dangerous barrier to accessing healthcare as individuals are deterred from accessing care they need, or in delaying it until their condition has deteriorated severely (JCHR, 2007: 45-6). Destitute asylum seekers have little access to accurate information about how the charging regime works and what is chargeable and they exist in an environment where rumours flourish. They also have no knowledge of what the implications of debt are and many, if not all, will come from countries with much harsher regimes than in the UK for debtors, including sanctions such as prison.

The literature suggests that pregnant women are an especially vulnerable group, of which Alison Raynor provides anecdotal confirmation; noting that in her experience ‘it is mainly (but not only) women being charged for maternity care’ that come to the attention of the HAT. While maternity care remains ‘immediately necessary’ in the new draft guidelines (DH, 2010b:10) research indicates that there is a risk of pregnant women and new mothers going into hiding once they discover that they will be charged for their treatment (JCHR, 2007: 45). The new guidance explicitly states while women ‘should not be discouraged from receiving the remainder of [their] maternity treatment’ and ‘OVMs²⁰ and clinicians should be especially careful to inform pregnant patients that further maternity care will not be withheld, regardless of their ability to pay’ chargeable pregnant women *should* nonetheless be informed that charges will apply (DH, 2010b:10). Perhaps not surprisingly given its purpose, the guidance makes no mention of the need to reassure them that becoming an NHS debtor will not lead to their imprisonment or immediate deportation.



The new guidance makes no mention of the need to reassure vulnerable women that becoming an NHS debtor will not lead to their imprisonment or immediate deportation.

Health professionals in Leeds point to a number of examples where the United Leeds Teaching Hospitals Trust have charged individuals for treatment provided; most commonly for maternity care, although other types of treatment have also been charged. The procedure of the Health Access Team is to advise all patients that if they require healthcare they should always seek it out and the HAT offers support to patients who have been charged – by writing to the relevant NHS body and explaining that the patient is unable to pay, as well as explaining any distress caused by debt collection attempts (Raynor, 2010).

²⁰ Over Seas Visitors Managers

In the survey of 63 PAFRAS service users, 30% ($n=19$) had been treated in hospital at some point since arriving in the UK²¹ while 19% ($n=12$) indicated that they had been charged for one form of NHS treatment or another. Of those charged most were charged for secondary or dental care (see table 10). Nine service users (14%) who were treated in hospital were not

Dental Care	4
Primary Care/Prescriptions	1
Secondary Health Care	4
Unknown	3
<i>Total</i>	<i>12</i>

TABLE 10: TYPES OF CARE CHARGED FOR

changed for their treatment.

Of eight service users who were treated in hospital *and* had their immigration status checked four were charged for treatment (two were invoiced by the hospital but could not pay; the other two did not provide details of what happened). One person was treated for high blood pressure; the remaining three did not give details what their treatment was for.

Survey results suggest quite strongly that *at present* the charging regime is not properly operational. Indeed, indications are that at the present there is a lack of clarity about the entitlement of refused asylum seekers to healthcare, both primary and secondary.

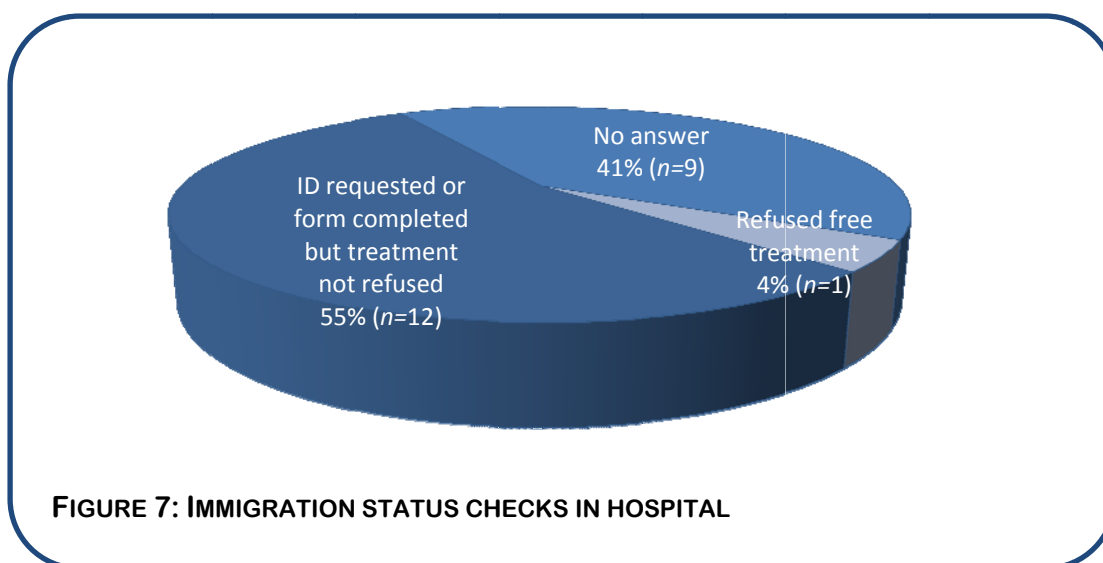
In relation to primary care, Newell suggests that many GP practices are unaware of the difference between an asylum seeker and a refused asylum seeker—and therefore do not exercise—their prerogative to refuse to register refused asylum seekers or follow Department of Health advice that they be registered only as private patients. Interviews with health professionals in Leeds and data gathered from PAFRAS service users also suggest that there is, at present, a certain amount of confusion over the implementation of charging regulations. While both Newell and

F, who was refused asylum in 2006, has recently had a haemorrhoids operation. This type of operation would most probably be considered to be urgent, but not immediately necessary. Under the present charging regulations therefore the Hospital should have sought a deposit equal to the full anticipated cost of the operation prior to the date of the operation (the 2010 draft guidance is clear that the operation should not be delayed while the hospital waits for payment to be made however).

Despite being liable to be charged, *F* reports that he cannot recall at any point being asked about his immigration status or the status of his asylum claim, although he says they did ask him a lot about his medical history.

²¹ Fourteen said that they had not, while 30 did not answer the question; indicating on balance that they had probably not had secondary care.

Raynor stress that Leeds Teaching Hospitals NHS Trust is very much ‘on the ball’ with regard to implementing charging regulations they also conceded that there is a great deal of variation in outcomes when referring to different departments (Newell, 2010; Raynor 2010). What is more, PAFRAS service users’ experiences—most recently the experiences of *F* discussed above—suggest that the situation remains fluid. By all accounts it remains unheard of for Leeds’ other secondary care trust—the Leeds Partnership Foundation Trust—to charge its patients for care.



the HC2

Presently refused asylum seekers qualify for support with some healthcare costs on ‘low income grounds’.²² These costs include prescriptions, dental care and sight tests amongst others. To access these benefits they must apply for a HC2 (NHS 2009: 29) using the form HC1. The form is available in English only, is twenty pages long and makes no reference to asylum seekers or refugees at any point. At least in the first instance, to complete it without support, even if you read and write English, would be challenging. Even so these are not the main obstacles that the HC2 places in the way of accessing healthcare for destitute asylum seekers.

HC2s must be renewed every six months and can take between six and eight weeks to arrive once applied for. The system is not geared toward individuals likely to have a long-term need,

²² They may also qualify on other grounds, for example they qualify for free prescriptions and dental if they are pregnant or have had a baby in the last twelve months. They must apply for a maternity exemption card using the form FW8. Proof of entitlement, in the form of a MatB1, birth certificate, doctor’s or midwife signature is required (NHS, 2009: 33).

nor is it sensitive to the needs of homeless people, in particular those suffering from a variety of mental health difficulties that impede memory and make organising extremely challenging. Many of the charges levied against PAFRAS clients for healthcare were for dental treatment – costs that could have easily been avoided had individuals had a HC2. While it is possible to claim back money paid on production of a valid receipt this is not much help if you have no money at all and it is unclear how many people are deterred from having dental check-up or seeking timely treatment by the requirement to produce a HC2.

All interviewees noted that when attempting to collect prescriptions from chemists they were routinely asked to show their HC2 certificate although some also indicated that they found that not having one did not necessarily mean that the chemist would refuse to dispense their medicine. *F*'s explains that normally he has a HC2 but he doesn't often show it; 'I just tick the box, normally they don't ask and they don't look at the pharmacy.' (Interviewee *F*, 2010). Asked if he remembers to renew his HC2 on time he replies that he does, and explains that it expires next week! Other interviewees have similar if different experiences. *D* says she has never had a HC2 but that although she is always asked for it when she collects her regular medication she has never been refused for not having one.

3.3 provision in Leeds

the Health Access Team

If across the UK primary healthcare services and GP practices are the gateway to the NHS then in Leeds the Health Access Team (HAT) is the gateway into primary care. The Home Office began dispersing asylum seekers to the Yorkshire and Humber region in 2002 and it was at that time and in response to 'pressure felt by general practitioner services' (Cartledge, 2006: 2) that the Primary Care Trust established the HAT. The HAT's central function is to support asylum seekers to access mainstream primary care services and especially GP services. We return to discussing the model adopted in the establishment of the later.

Initially the HAT delivered its services at drop-ins held on different days in differing segments of the city. More recently resources have been refocused somewhat. The HAT now runs a twice-weekly drop-in based at the Arch in central Leeds and an all-day nurse session, by appointment only, near the NFA building. They also run a session alongside PAFRAS's Thursday session to provide support with health issues as when they occur during the session. Changes were made at the behest of NHS Leeds, whose review of the HAT concluded that holding many smaller sessions around the city was less efficient than concentrating resources in one central location (Raynor, 2010; Newell, 2010). The HAT is presently undergoing an-

other review the outcomes of which may potentially have a wide-ranging impact the way in which its services are delivered.

services

The HAT offers a number of services to asylum seekers (including refused asylum seekers) from health assessments and referrals (to GP practices, the NFA Team, Community Mental Health Teams, secondary care providers and the voluntary sector), to help with completing HC1 forms, and signposting to other services that might impact on individuals' health such as ESOL classes, walking groups, gardening, swimming or befriending; as Alison Raynor puts it: 'we're not just about physical health; we do mean health in a very broad sense' (Raynor 2010).

training and informational services

A second key function of the HAT is to provide training and support to other healthcare providers in the city, including GP practice staff, nurses, health visitors, staff in A&E departments, etc. A rolling training programme is open to all health workers in Leeds as well as *ad hoc* provision being given if and when requested. There is no element of compulsion in having this training and Jo Newell notes that GPs, perhaps because of the sheer numbers of educational opportunities available to them, their limited time and their different priorities, are the hardest to get to training sessions (Newell, 2010; Raynor, 2010).

integration versus specialisation

The 'integrationist' model of the HAT was chosen over one of establishing a specialised GP practice to deliver healthcare for asylum seekers. According to Jo Newell, one of the advantages of the integrationist model is that it allows mainstream GPs to gain experience which they would not otherwise be able to develop (Newell, 2010). A criticism of the alternative (a specialist GP practice) is that it requires an 'exit strategy', a means of integrating asylum seekers once they become refugees, residents and citizens into mainstream care. While one immediate downside of the integrationist model is that this trade-off between long term development of mainstream GPs skills for this is paid for in a *potentially* lower quality of care for those asylum seekers registered at practices where the relevant skills have yet to be developed (Newell, 2010).

Newell concedes that with the faster pace of decision making by the Home Office under the New Asylum Model (NAM) the logic of the integrationist model has been partly undermined. Far fewer asylum seekers have time fully to settle in one place while they wait for their decision and most people move once they have a decision which militates towards specialist provision. Such a system could have other positive impacts. Chief amongst these would be the advantage of creating a team of clinical and non-clinical staff with deeper knowledge and

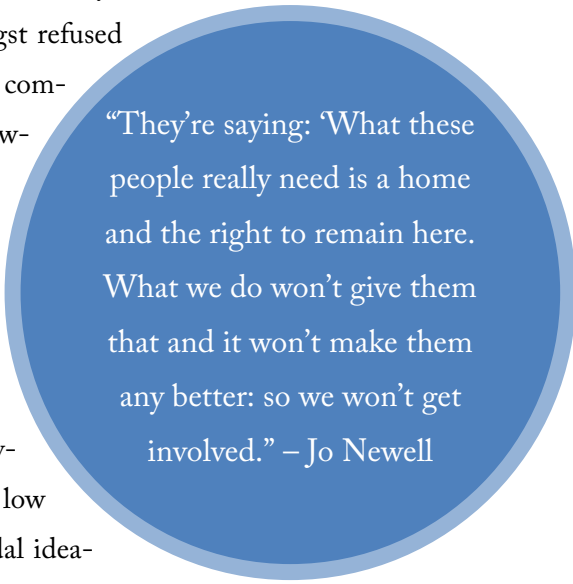
more extensive experience of providing primary care to asylum seekers. Such a service would in principle be more responsive to the needs of asylum seekers and more sensitive, for example, to the importance of interpretation. Being a specialist provision would also mean that service targets more properly reflected the complexity of asylum seekers' cases and the additional time requirements of interpretation.

Such a strategy is not without risks however. An element of ghettoisation is implied in concentrating provision in one place; and mainstream practices will have less early exposure to asylum seekers' particular needs; many of which will remain with them after status is granted. Another core concern about ghettoisation in the present climate has to be the danger of presenting government and NHS authorities with an easy target for 'savings' while at the same time potentially limiting their access to other sources of primary care (i.e. mainstream GPs). If the government were to introduce charging for primary care this sort of specialised service *could* present an additional risk to refused asylum seekers. A single specialised service employed perhaps directly by the local PCT is more easily disciplined than a multiplicity of independently contracting GP practices, and a more specialised and experienced staff, once disciplined, would be more effective at identifying who is chargeable.

mental health services

Mental health is an enormous problem amongst refugees and asylum seekers fleeing persecution, torture and war. This is not to say that all refugees and asylum seekers suffer from severe mental health problems or mental illness, rather it is that many will have some form of mental health problem (Ashton & Moore, 2009: 3). Amongst refused and destitute asylum seekers this is likely to be more common (Ibid:16; Raynor, 2010; Burghgraef, 2010a; Newell, 2010).

Interviews with both statutory sector health workers and third sector or voluntary workers suggest that there is a heavy reliance on voluntary and non-state provision in the area of mental health. Mental health problems are very widespread amongst destitute asylum seekers who experience problems ranging from low mood and clinical depression, to self-harming, suicidal ideation, PTSD and other serious and enduring mental illness. Statutory services are divided between the Primary Mental Health Teams (which come under NHS Leeds, PCT) and secondary and community mental health services such as the Crisis Resolution Team, Becklin Centre, and psychotherapy service run by Leeds Partnership NHS Foun-



“They’re saying: ‘What these people really need is a home and the right to remain here. What we do won’t give them that and it won’t make them any better: so we won’t get involved.’ – Jo Newell

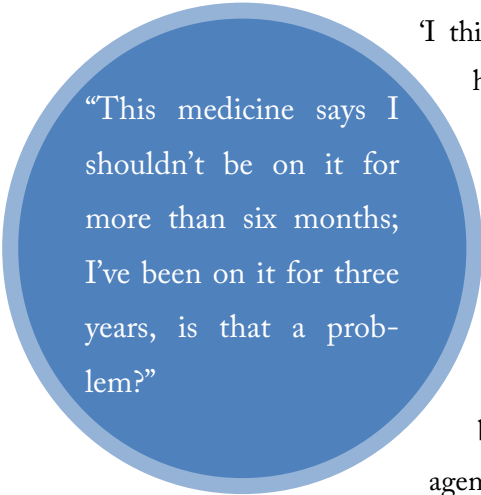
dation Trust. For those individuals with more severe mental health problems there are a number of difficulties in accessing appropriate statutory services. Aside from the exceptionally long waiting lists, secondary mental health services have very specific and often narrow criteria for referrals. Jo Newell explains “the problem of referring people to secondary mental health care is where people fit’. The PTSD Service for example,

‘is very much about pure PTSD and ... they have problems with working with people who are still in a lot of chaos. The work they do is very heavy-duty psychotherapy and you really have to be in quite a good state to be able concentrate on it and engage with it.’ (Newell, 2010)

Ann Burghgraef of Solace agrees that, in order to be able to recover, people suffering from PTSD ‘need to be post the trauma and while you’re living with the threat of destitution and the threat of return you’re not post’ (Burghgraef, 2010a). More generally secondary mental health services often reject referrals of destitute asylum because of the significant role their on-going destitution plays in their mental health problems, Newell again explains that destitute asylum seekers are often:

‘...people [who] are very distressed and possibly quite high risk self-harm-wise but they don’t fit the criteria of secondary care services. They don’t have severe and enduring mental illness; they have a terrible life instead. In those circumstances then secondary care will say ‘if their social situation was better they wouldn’t be like this; therefore it not a mental health problem it is social and we can’t deal with it.’ (Newell, 2010)

In less serious cases the primary statutory provision are the Primary Mental Health Teams, who have, according to Newell, improved greatly in recent years. She explains that



“This medicine says I shouldn’t be on it for more than six months; I’ve been on it for three years, is that a problem?”

lem.’ (Newell, 2010)

‘I think, when we first started a lot of the primary mental healthcare teams felt that people were too unwell; too complicated; if they had a whiff PTSD about them they thought that meant there was nothing they could do for them; it was a secondary care matter. But I think over the years they’ve become more confident and more skilled at knowing there are things that they actually can do; that they can work with somebody about sleep; or they can work about anxiety management even if they’re not touching the heart of the prob-

Nonetheless, the majority of Solace’s referrals come from the statutory sector including GPs, mental health workers, psychiatrists and with a waiting list of perhaps one hundred clients,

Solace's resources are seriously over stretched (Burghgraef, 2010a). Improvements in the confidence of the Primary Mental Health Teams notwithstanding, Burghgraef believes that 'whereas previously mental health workers might have done more [now] they assess and think: 'ah, an asylum seeker, Solace is the place to go'' (Burghgraef, 2010a) The explanation she offers for this is simple: 'Asylum seekers ... create a lot of anxiety amongst professionals because so many are close to the edge, suicidal, a lot of the time and we're constantly living with that.' (Ibid)

Whether it is in fact because of their ill ease in dealing with the particularly harrowing problems of destitute asylum seekers, out of despair at the intractable nature of the origins of these problems or simply because of their 'social' origins, a heavy burden of care for destitute asylum seekers with mental health problems is taken up by general practitioners and the voluntary sector. Burghgraef notes that perhaps eighty-percent of clients who come through Solace's doors are medicated for problems related to mental health by their GPs; be that with drugs for sleeping problems, depression, anxiety or analgesics for the somatised symptoms of mental distress. What is more often they are taking these drugs for prolonged periods of time whilst simultaneously not having enough to eat (Burghgraef, 2010a, Ashton & Moore, 2009: 2, 13).

According to Alison Raynor, the HAT makes a lot of referrals to voluntary sector organisations like the Feel Good Factor, Touchstone and LASSN for leisure, befriending and involvement activities to combat loneliness and isolation while low-level mental health problems such as depression caused by struggling to come to terms with separation from family might result in a referral to the community mental health teams.

Karpuk argues that in reality the state sector is dependent on voluntary sector organisations which play a vital role, providing a detection mechanism for people in crisis, fire fighting and carrying out preventative work. He suggests that the work of the voluntary sector in providing 'low-level' support, from befriending, women's or men's groups, and social activities *as well as* group and one-to-one therapy sessions serves to reduce the burden on the state sector considerably (Karpuk, 2010). He also notes that while the statutory sector can refer to the voluntary sector easily for voluntary sector organisations referring to mental health services directly is impossible, he can only work to keep individuals' GPs notified of their situations and request that they make onward referrals.

Case Study

G, arrived in the UK from the Middle East in 2000. Then aged 34 he claimed asylum immediately and was refused it a little under a year later. G arrived in the country physically fit, but suffering from depression and PTSD resulting from his experiences of being tortured in and fleeing from his country for which he was prescribed anti-depressants and also referred to a therapist. In 2004 he was also diagnosed with diabetes, for which he was prescribed insulin.

G's asylum claim was finally refused in 2004 but he was too scared to return home. In 2006 he came to live in Leeds. Initially he stayed on a friend's floor but ended up sleeping rough for weeks at a time. During this period he saw a rapid deterioration in his health and a marked loss of weight. In the winter of 2007; too ill to be able to attend the drop-in and access PAFRAS' support and having not eaten for three days, G collapsed into a diabetic coma.

By early October 2008 G's condition had deteriorated to the point where Leeds Social Services offered him support under the National Assistance Act 1948. After two months with support G's condition was improving. He was able to feed himself and to climb the stairs unaided. In late December 2008 support was withdrawn as G was considered to no longer qualify as 'destitute plus'. He found himself back on the streets and his health rapidly deteriorated.

After the introduction of the New Asylum Model in 2007 his case was one of approximately 450,000 placed into the case resolution process; meaning that he was essentially given another chance of gaining leave to remain in the UK. As with all other individuals with a case resolution or 'legacy' case G was not permitted to work, nor was he entitled to access mainstream benefits or any form of support from the Home Office. In 2008 he made further representations for a fresh claim of asylum and was subsequently entitled to apply for Section 4 support. In spring 2010, after nearly ten years in the UK, he was granted Indefinite Leave to Remain outside of the Immigration Rules.

Despite having had generally good experiences of the UK health system, G's health and particularly his diabetes have deteriorated severely over the years. This can be readily ascribed to his enforced destitution, poverty, poor diet, lack of choice whether or not to eat food, inability to cope with medication regimes and frequently lost prescriptions. G has recently had an operation to install a catheter in his leg and is in constant pain. He takes fourteen tablets a day for depression, diabetes and the pain (including pain killers and aspirin to thin his blood) and has been given a permanent sick note from his doctor; meaning that once his Section 4 support finishes he will, in theory, receive Income Support rather than receiving Jobseekers Allowance and having to look for work.

G's story exposes the inhumanity of the destitution regime and exemplifies the tragedy of lives permanently damaged by an asylum system that denies individuals the right to dignity, to health and to work.

conclusion

As with other asylum seekers and indeed refugees, refused asylum seekers have considerable and often complicated health problems. Some of their needs are inevitably related to their country of origin and the reasons for their flight to the UK, but they are greatly exacerbated by the refusal of asylum and crucially by enforced destitution. The enormous mental and physical strain that people are placed under by destitution is an intended result of a policy intended to force them to leave the country and return to their former homes. The UK government does not monitor the effectiveness of this policy, nor does it monitor its impact on individuals' health or on the National Health Services' resources.

Under New Labour the policy of enforced destitution was accompanied by concerted, if only partially successful, attempts to exclude asylum seekers from access to healthcare. Resistance from the medical profession and others, and perhaps common sense on the part of some in government, meant that the 2004 plans to deny refused asylum seekers free primary care were shelved. The new government has not indicated its views on refused asylum seekers' access to health care, or on the draft 2010 Charging Regulations and Guidance. It is therefore impossible to know whether it will seek to implement these changes either in full or in part.

Nonetheless it seems likely that even without reform of the charging regulations, new guidance will have to be introduced very soon. This is because, notwithstanding those clear examples of refused asylum seekers being charged for secondary care that do exist, the present lack of guidance on how the charging regulations are to be implemented appears to have created a space in which it is possible for clinicians and other staff to ignore the regulations (either out of altruism or for practical reasons) when they choose to.

This situation would be very likely to change if the new guidance and regulations (currently being consulted on) were to come into effect, or if, in a more limited scenario new guidance were implemented for the present regulations. Even given in the latter case, the fact of there being guidance to follow would be likely to restrict clinicians' room for manoeuvre by raising the profile of the charging regime in much the same way as the 2004 regulations did (JCHR, 2007: 44).

In clearly making it the responsibility of all NHS staff members to ensure that the charging regime works, the new guidance further reduces this space by putting more pressure on clinicians to conform to the policy. Under the new guidance, it may also be possible for Trusts to discipline their staff for failing to provide other NHS bodies with information they have regarding a patient's chargeable status. Concerted and coordinated efforts at resistance will be required to stop a significant worsening in the situation for refused asylums seekers in coming

years. Some hope can be found in the fact that NHS clinical staff and especially doctors are highly privileged and empowered sector of the workforce whose ethical code remains very much at odds with government policy. Efforts at resistance will prove especially difficult given the present dominance of the theme of austerity over public discourse and the revanchist stance of the present government towards public spending.

recommendations

to the Department of Health and the National Health Service Trusts

- That the 2004 exclusion of refused asylum seekers from secondary health care should be reversed *or* that legislation be brought forward to explicitly grant free secondary healthcare access to individuals whose asylum claims have been refused whilst they remain in the country.
- *Notwithstanding the above*, that the new draft guidance been reviewed and that it be made clear that only Overseas Visitors Managers who are properly trained should conduct interviews to determine chargeability of patients.
- That reference in the regulations and guidance to primary care services as being NHS bodies that must make and recover charges be removed.
- That the guidance should explicitly state that investigative treatment should be considered urgently necessary treatment at all times in relation to the charging regulations.
- That references to stabilising patients undergoing immediately necessary treatment are removed from the guidance and that it be made explicit that chargeable patients should be offered all necessary care in line with the care offered to non-chargeable patients.
- That references to financial consequences playing a role in the decisions of clinicians when determining a course of treatment are removed and that it be made explicit in the guidance that clinicians must base their decisions on the same criteria as for non-chargeable patients.
- That the guidance should indicate clearly that debts are unlikely to be recoverable from destitute asylum seekers and that NHS Trusts should prioritise conserving resources when considering whether or not to pursue them for payment.
- That the Department of Health and Trusts where appropriate ensure the creation of mechanisms to properly reflect in service targets the additional time required to provide high quality medical consultations to non-English speakers.
- That the Department of Health investigate the potential for replacing the HC1 certificate for refused asylums seekers with a mechanism for easily proving entitlement to free prescriptions, dental care, etc. that is more appropriate given their circumstances.
- That, given the importance of the voluntary sector's contributions to providing mental health services for asylums seekers, Trusts explore ways in which the statutory sector can

support the work of the voluntary sector; especially around areas such as funding out research work and supporting with the provision of interpretation.

- That GP practice staff be offered regular training on the nature, purpose and correct use of advocacy and interpretation on an annual basis. Training should be offered to administrative and clerical as well as clinical staff.

to medical associations and professional bodies

- That associations and other professional bodies amend their ethical guidelines to explicitly state that medical professionals *must* consider the potential need for interpretation for their patients.

to health professionals

- That health professionals take note of the importance of actively ensuring that patients fully understand the implications of their health situation and their care options and use interpretation where necessary.
- That if in any doubt health professionals should use an interpreter and maintain awareness of the potential for destitute (and other) asylum seekers to fail to request the provision of an interpreter or to be unduly optimistic about their ability to understand English.

to asylum-seeker support agencies and the voluntary sector

- That agencies and the voluntary sector remind doctor's practices and GPs that they have an ethical responsibility to ensure that they can understand their patient and their patients can understand them.
- That they campaign for recognition in NHS targets that providing services to patients who do not speak English takes more time than when they do.

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appendix 1: PAFRAS service user questionnaire

Questionnaire

PAFRAS is conducting a research project on access to healthcare, and experiences of healthcare. The aim of this project is to improve the quality of healthcare services. Please answer the questions on this questionnaire below. You do not need to leave your name, and this information will not be used to identify any particular person.



1. Are you male or female?

2. What form of asylum support are you currently receiving (if any)?

Asylum Seeker Section 95 (cash)

Refused Asylum Seeker with Section 4 (vouchers)

Refused Asylum Seeker with no support

Refused Asylum Seeker with other form of support (please specify)

Refugee with Leave to Remain in the UK

Other (please specify)

3. How long have you been in the UK?

4. How old are you? <19 20-29 30-39 40-49 50-59 60+

5. Do you have health problems at the moment?

If yes could you describe these problems?

6. Are you on any medication or receiving any treatment for these problems at the moment?

If yes, do you have any trouble accessing this?

7. Since you have been in the UK, has your general health improved, or got worse?

If yes can you explain *how* and *why*?

8. Do you have any problems keeping healthcare appointments?

If yes, what are these?

9. Have you ever had treatment in a hospital?

If yes, what was this for?

10. When in the hospital did they check your immigration status?

If *yes* have you ever been refused treatment? Can you explain what happened?

11. Have you ever been charged for treatment?

If *yes*, could you explain when this happened and what treatment you were charged for?

appendix 2: barriers to health access²³

Formal

COMMUNICATION: Language

- The non-availability of **interpreting** services outside working hours (Hicks and Hayes, 1991) and for acute consultations (Jones and Gill, 1998;Aspinall, 2006: 47-8)
- “...lack of **knowledge** about the **languages** spoken and the extent of need for **interpreting** services” (Jones and Gill, 1998; Ghebrehewet *et al.*, 2002;Aspinall, 2006: 47-8)
- “Whilst some find **interpreter** facilities such as Language Line to be effective and invaluable, others criticize these facilities for being difficult to use, prohibitively expensive or inconvenient.” (Fisher 2004: 9)
- **Receptionists** not using interpreters: e.g. “It became apparent that *only* those who were accompanied by a friend, relative or refugee staff member experienced a trouble-free registration process” (Bhatia & Wallace, 2007: 3 (*not for citation*) emphasis in original)
- “...**language** difficulties at reception and in the consultation”(Aspinall, 2006: 47-8)
- Problem of obtaining informed consent (Fisher 2004: 10)

Informal

DISCRIMINATION/RACISM/IGNORANCE/STIGMA

- Asylum seekers are “perceived as being demanding” (Fisher, 2004: 14)
- Institutional **racism** (HO, 2010)
- “Staff often feel **inadequate and ill-equipped** to deal with” the complex clinical and social problems of refugees (Fisher, 2004: 14)
- Lack of **awareness and understanding** amongst health professionals (Kibondo *et al.*, 2000;Aspinall, P. 2006: 47-8)
- “Due to the **stigma** of being classed a refugee, participants started to question how often they could reasonably access healthcare services with some stating that they were afraid to go to the doctor for **fear** of being thought of as using up too many resources” (Bhatia & Wallace, 2007: 5)
- “...many refugees and asylum seekers are in reality reluctant to make demands.” (Fisher, 2004: 14)
- Feeling unwilling to seek treatment for their own needs such as for anxiety, depression or other mental health problems if preoccupied with many other problems, such as finding employment, or when assailed by **guilt** at, for example, having left close family members and friends behind. (HO, 2010)
- “In some countries, healthcare is associated with hospital care and locally based primary care services may lack **credibility** or be seen to be second class.” (Fisher, 2004: 15)

²³ All emphasis added, except where otherwise noted.

RESOURCES [Time/Targets/Workload]

- **Language:** refusal to use Language Line, length of consultations (Fisher 2004)
- “Requirement of double appointments per individual asylum seekers as language line is used within the consultation” (Williams, 2008: 13)
- “some GPs advised the Audit Commission that asylum seekers’ consultations took on average **three to four times longer** than those for other patients” (Audit Commission, 2000: 62; Aspinall, 2006: 47-8)
- “reports (including those of GPs) of anxiety in dealing with refugee and asylum seeker patients and their **demands on time**” (Ramsey and Turner, 1993; Audit Commission, 2000;Aspinall, 2006: 47-8)
- GP concerns about increased **administrative workload** arising from asylum seekers’ mobility, e.g. following up child immunisations, vaccinations and cervical screening (Audit Commission, 2000;Aspinall, 2006: 47-8)
- Temporary rather than permanent registration (Jones and Gill, 1998; Audit Commission, 2000), perhaps to minimise the impact on their **targets** for immunisations, cervical smears, and related payments... (Aspinall, 2006: 47-8)

RESOURCES: [Time/Targets/Workload]

- **Complexity of need:**
- “...general lack of **resources**, time and local support needed to appropriately address the multiple health needs of refugees and asylum seekers.” (Fisher 2004: 9)
- “...respondents state that they did not have sufficient time within the limits of a standard consultation to provide full explanations to their patients about these issues and this further exacerbated the problem” (Fisher 2004: 10)
- Lack of knowledge about the **special needs** of asylum seekers, making GPs reluctant to accept them as patients (Audit Commission, 2000; Aspinall, 2006: 47-8)
- “...the lengthy, often **complex consultations** that refugees and asylum seekers need.”

COMMUNICATION: Cultural

- **Expressing distress in ways that are unfamiliar** to some health professionals (HO, 2010)
- Being **unfamiliar** with some types of therapeutic interventions, such as psychotherapy and counselling. Refugees may be more accustomed to discussing problems with their family or community, but not with strangers. (HO, 2010)
- Not attending therapy and counselling sessions through **lack of understanding** of what is going to happen and what is expected of them. (HO, 2010)
- low awareness amongst asylum seekers of what services GPs can provide and how they are delivered (Audit Commission, 2000;Aspinall, 2006: 47-8)
- **Appointments systems:** “Not understanding appointment or referral systems, waiting lists or letters from doctors, specialist clinics or hospitals” (HO, 2010)
- GPs’ discretion to register patients.

(Fisher 2004: 4)	
<p>RESOURCES: [Other]</p> <ul style="list-style-type: none"> • Three-quarters of GPs report that having asylum seekers registered on their list affects their ability to meet targets, and a quarter state[s] that this has a big impact on their ability to meet targets. The main reason given for this is non-attendance at some sessions, particularly for procedures such as immunisations. (Fisher 2004: 3 <i>emphasis added</i>) 	
<p>TRANSIENCE</p> <ul style="list-style-type: none"> • “because refugees and asylum seekers are moved around so frequently, consistency of care is difficult and diagnosing and treating conditions effectively is a problem” (Fisher 2004: 10) • Lack of information about previous medical history: “a central concern identified by GPs in this survey is the lack of previous medical history for refugee and asylum seekers patients.” (Fisher, 2004: 8, 15) 	
<ul style="list-style-type: none"> • “Others believed that [linguistic difficulties] difficulties meant that GP tend to rely heavily on medication and failed [to] just listen to them or provide appropriate advice” Bhatia & Wallace, 2007: 5) <i>However</i>: “This would be expected given that this is found to some extent in non-refugee patients also.” (Ibid: 6) 	
<p>RIGHTS AND ENTITLEMENTS</p> <ul style="list-style-type: none"> • Confusion amongst GPs about rights of registration (Jones and Gill, 1998; Refugee Health Consortium, 1998; Aspinall, 2006: 47-8) • Health professionals lack of awareness of refugee entitlements. (HO, 2010). 	
<p>FAILINGS OF THE ASYLUM SUPPORT SYSTEM</p> <ul style="list-style-type: none"> • Having insufficient funds to afford travel to appointments (HO, 2010) • Distance from health care and lack of money for transport (Kibondo <i>et al.</i>, 2000; Aspinall, 2006: 47-8) 	

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