

ACCESS DENIED – OR PAYING WHEN YOU SHOULDN'T

**Access to publicly funded medical care: residency,
visitors and non-British/Irish citizens**

Research Paper



**NORTHERN
IRELAND
HUMAN
RIGHTS
COMMISSION**

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1: INTRODUCTION

Scope and limitations of this paper

This paper deals with human rights compliance and the current circumstances of access to publicly funded medical care based on residency status in Northern Ireland. It will examine if migrants (or perceived migrants) and visitors are being denied access, treated as private patients, or otherwise charged for medical services when this should not be the case.

The paper focuses on formal equality of access to medical care which covers both primary (GP) care and secondary (hospital) care, but not social protection provided by social workers or other social care workers, nor aftercare of sick persons. Neither does it cover entitlement to benefits or housing assistance from the Housing Executive or Social Security Agency – matters addressed in *No Home from Home*, an investigation report published by the Human Rights Commission in 2009 into homelessness for people with no or limited recourse to public funds.¹

This paper does not deal with other substantive equality issues in relation to differentials in health outcomes or barriers to accessing health services in practice, for example, linguistic or cultural barriers that may be faced by service users. Before making recommendations to the Department of Health, Social Services and Public Safety (DHSSPS) and subordinate Health and Social Care organisations, the substantive chapters of this research paper will cover the international human rights framework (Chapter 2); legislation and policy developments at UK level (Chapter 3) and the Northern Ireland legislative and policy framework (Chapter 4).

Background

Preliminary research for the *No Home from Home* investigation uncovered problems that migrants experienced in accessing entitlements to publicly funded medical care. Examples included a woman billed for £800 for giving birth in a local hospital (revoked when challenged by community organisation) and an EU national told by a GP practice that she needed to produce a work permit to

¹ Devlin R and McKenna S (2009) *No Home from Home: Homelessness for People with No or Limited Access to Public Funds*, NIHRC, Belfast.

register. This evidence was complemented by the findings of other research projects.²

The evidence base was further developed in October 2009 through a dedicated workshop, led by the Commission, at the annual conference of the Northern Ireland Health and Social Services Interpreting Service. Participants included health service practitioners, social workers, health service interpreters and minority ethnic organisations. Health service interpreters operating the advocacy approach to interpreting are particularly well placed to recount the everyday experiences of minority ethnic service users. The issues raised at the workshop included:

- **GP registration:** GP practice staff were generally showing better awareness of whom to contact in the health service Business Services Organisation (BSO)³ for advice regarding entitlements; there was still concern that advice given by BSO was not always consistent.
- **A2 EU Nationals:**⁴ Particular issues were reported in relation to ethnically-Roma Romanian nationals accessing GP services. These related to the criteria for residence with the A2 Worker Authorisation Card usually being the only document accepted, with EU visitor rights or other residence criteria (e.g. self-employment) not being fully explored.
- **GP Gateway:** Non-registration with a GP (for reasons of entitlement or otherwise) had a number of knock-on effects for other medical services to which there was free entitlement,⁵ including children's vaccinations, referrals to free services by accident and emergency (A&E), obtaining medicines following A&E treatment, and referrals for mental health treatment.
- **GP temporary patients:** Persons were refused full registration because they were deemed by BSO to be non-permanent residents (not ordinarily resident) were not being admitted as temporary patients on the grounds that they *were* deemed to be 'resident' by the GP practice.

² See, for example: Holder D (2007) *Issues Facing Migrant Workers in Northern Ireland: A Research Compendium of Animate and Partner Research*, Dungannon and South Tyrone Borough Council and South Tyrone Empowerment Programme, Dungannon; National Consultative Committee on Racism and Interculturalism (2007) *Fifth-North South Intercultural Forum, Access to Health and Social Services North and South*, NCCRI, Dublin; Sobieraj O (2005) *Migrant Workers in Cookstown: A Health Impact Assessment Focus Group*, Animate, Dungannon.

³ Formerly, the Central Services Agency (CSA).

⁴ A2 refers to two countries, Romania and Bulgaria, which acceded to the European Union in 2007.

⁵ 'Free' here and elsewhere refers to services free at the point of use and funded from general taxation, although in some circumstances these may be chargeable.

- **Asylum:** There was a generally good awareness of entitlements among GP practice and other health staff when a patient presented with asylum or refugee status letter.
- **Irregular migrants:** There was confusion over entitlements to temporary GP care and other services; fear of deportation if accessing health services (despite no obligation on health care staff to inform on patients); confusion over regular or irregular status as a concept; confusion over entitlements of irregular persons.
- **Maternity:** There were cases of migrant women being billed for deliveries; for example, a Chinese woman who had no ante-natal care and whose first contact with the health service was to go to A&E to give birth; there was a further case reported of a South American woman who was refused care.

A number of recurring themes have therefore emerged; in particular, difficulties and ambiguities in relation to entitlements for:

- accessing primary care and maternity services, and the knock-on effects of this, and
- persons who are from Romania or are irregular migrants.

As these matters fell outside the final scope of the *No Home from Home* investigation, the Commission decided to conduct further analysis which is the basis for this research paper.

Methodology

The aim of the research was to address the following questions from a human rights-based approach:

- Are the restrictions on medical entitlements as they presently stand compliant with international human rights standards?
- Is there sufficient legal certainty in practice around who is entitled to free medical treatment?

The second question, in addition to seeking clarity in the legislative and policy frameworks, also asks whether there are clear administrative arrangements in place to facilitate service users' access to the entitlements that they have. The research involved a literature review, detailed analysis of the legislative and policy frameworks, and discussions with officials and community organisations. The Commission is grateful for comments provided by the DHSSPS on a draft of this research paper.

2. HUMAN RIGHTS AND RESTRICTIONS TO ENTITLEMENTS

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

*Constitution of the World Health Organization*⁶

Conforming with legislation that denies access to health care goes against the instincts of many doctors, affronts common decency, and infringes international and domestic ethical codes. But it is in its violation of international law that the [the NHS charging] regulations offend us most.

*Doctors for Human Rights, evidence to Parliament*⁷

Substantive right to health

The right to health is asserted as a human right in a number of instruments to which the UK is a party, including the International Covenant on Economic, Social and Cultural Rights (ICESCR). Under Article 12, the UK has recognised the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The nature of the obligations to which this commits the UK are further elaborated in General Comments produced by the UN committee that oversees implementation of ICESCR.⁸ This includes, at the very least, the state satisfying core minimum essential levels in relation to each of the obligations under ICESCR. Provision of essential primary health care is singled out as a minimum obligation under the right to health.⁹ 'Primary health care' refers to the work of health care providers who are based in the community rather than in hospitals, and are generally the first point of contact with the health system.¹⁰

⁶ Adopted and opened for signature by the International Health Conference, held in New York from 19 June to 22 July 1946, entered into force on 7 April 1948. Preamble, para 2.

⁷ Joint Committee on Human Rights, *The Treatment of Asylum Seekers, Tenth Report of Session 2006-7*, HL 81-II/HC 60-II, EV196.

⁸ General Comments and other treaty body observations are not, strictly, binding on states, but are acknowledged as authoritative interpretations of the substance of the treaty.

⁹ Committee on Economic, Social and Cultural Rights (CESCR) (2000) General Comment No 14: The right to the highest attainable standard of health, UN Doc E/C 12/2000/4, para 43.

¹⁰ International experts at a World Health Organization meeting adopted the definition that primary care "refers to a span or an assembly of first-contact

The UN Committee on Economic, Social and Cultural Rights has emphasised that there is a level of state discretion as to how effect is given to the rights contained in ICESCR, but has emphasised that such arrangements must be effective.¹¹ The ICESCR also contains specific obligations in relation to the right to maternal, child and reproductive health which “may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre, and post-natal care... [and] emergency obstetric services”.¹²

There are also obligations elsewhere in ICESCR in relation to the widest possible protection and assistance being afforded to the family, and for special protection being accorded to mothers during a reasonable period before and after childbirth.¹³

At regional (Council of Europe) level, the UK is party to the 1961 European Social Charter, and has agreed to be bound by Article 13 on the right to social and medical assistance.¹⁴ This provides that persons lawfully in the UK, who are nationals of other Council of Europe states that have ratified the provision, and are without adequate resources, will be provided with the medical care necessitated by their condition. This is to be conducted in accordance with obligations under the earlier European Convention on Social and Medical Assistance, which the UK and 17 other states have ratified.¹⁵

health care services directly accessible to the public” (WHO Regional Office for Europe, Meeting on Primary Care, Family Medicine/General Practice Definition and Links to Other Levels of Care, Barcelona, Spain, 1–2 November 2002). An internationally agreed definition is also provided by the Alma-Ata Declaration on primary health care which describes primary care as essential health care “made universally accessible to individuals and families in the community... It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” (Article VI, Alma-Ata Declaration, *Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978*, in World Health Organization, “Health for All” Series, No 1, Geneva, 1978).

¹¹ CESCR (1998) General Comment No 9: The Domestic Application of the Covenant, UN Doc E/C12/1998/24, para 7; see also: “Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest standard of physical and mental health” (31 January 2008) UN Doc A/HRC/7/11, p2.

¹² CESCR General Comment No 14 (as above) para 14. The terms ‘pre- and post natal’ are intended to cover prenatal, perinatal, neonatal and postnatal care.

¹³ ICESCR Article 10(1) and (2).

¹⁴ Council of Europe, European Social Charter (CETS No 35) 1961. The UK has not ratified the 1996 Revised European Social Charter, but the medical assistance provisions do not differ between the original and revised Charters.

¹⁵ Council of Europe, European Convention on Social and Medical Assistance (CETS No 14) 1953. With the exception of Turkey and Iceland, all other state parties are also European Union member states, including Ireland.

Non-discrimination

The principle of non-discrimination is central to the specific legal obligations under ICESCR (see Article 2 (2) and (3)). In terms of the right to health protection against discrimination is an especially important concept, with state parties under an explicit obligation not to limit equal access to migrants, including irregular migrants:

In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services...¹⁶

This is echoed in the Committee's recent General Comment on non-discrimination which explicitly singles out nationality as a recognised ground, and clarifies that:

The Covenant rights apply to everyone including non-nationals, such as refugees, asylum-seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation.¹⁷

Differential treatment under the ICESCR relating to a prohibited ground such as nationality will be discriminatory unless it can be shown to be objectively and reasonably justified. The test for this includes:

...an assessment as to whether the aim and effects of the measures or omissions are legitimate, compatible with the nature of the Covenant rights and solely for the purpose of promoting the general welfare in a democratic society. In addition, there must be a clear and reasonable relationship of proportionality between the aim sought to be realised and the measures or omissions and their effects.¹⁸

A similar formulation is found in relation to racial discrimination in the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). ICERD allows for distinctions between citizens and non-citizens, but the authoritative interpretation of ICERD clarifies that any differential treatment based on citizenship or immigration status *will* constitute

¹⁶ CESCR General Comment No 14 (as above) para 34.

¹⁷ CESCR (2009), General Comment No 20: Non-Discrimination in Economic, Social and Cultural Rights, UN Doc E/C12/GC/20.

¹⁸ As above, para 13.

discrimination if it is not proportional or pursuant to a legitimate aim defined under the Convention.¹⁹

This can be interpreted as indicating that no barriers should exist in receiving emergency treatment and other core minimum obligations, and any other restriction must be justified and proportionate if it is not to constitute discrimination. In addition, stigmatising service users by subjecting them to means testing on questionable grounds of cost containment is capable of being discriminatory, as is putting doctors in a position of having to decide whether to treat a patient on non-medical grounds, such as whether they possess the right papers.

If it is at any point necessary to check papers or otherwise verify the nationality and/or migration status of a patient, this must be done in a manner that avoids 'racial profiling'. Racial profiling (also termed 'ethnic profiling') relates to a form of racial discrimination where ethnic stereotypes drive subjective decision-making. In this instance, it relates to persons being perceived as not having entitlements due to factors such as their skin colour, and hence being questioned or expected to furnish evidence to a standard higher than others.

Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the scope of which is elaborated in the Committee's General Recommendation No 24,²⁰ explicitly provides for non-discrimination in health care for women, and, in particular, gender-specific pre-, post- and antenatal care:

States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.²¹

¹⁹ Committee on the Elimination of Racial Discrimination (CERD) General Recommendation No 30: Discrimination against non-citizens, Office of the High Commissioner for Human Rights, 1 October 2004.

²⁰ Committee on the Elimination of Discrimination against Women (CEDAW) General Recommendation No 24: Article 12 of the Convention (Women and Health) 1999, A/54/38/Rev 1.

²¹ Convention on the Elimination of All Forms of Discrimination against Women, Article 12.

The Convention on the Rights of the Child also upholds the rights of children to the highest attainable standard of health. Article 24 provides that states should act to take appropriate measures:

- (a) To diminish infant and child mortality;
- (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- (c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- (d) To ensure appropriate pre-natal and post-natal health care for mothers;
- (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
- (f) To develop preventive health care, guidance for parents and family planning education and services.²²

European Convention on Human Rights

While the aforementioned instruments are legally binding on the UK in international law, they are not directly actionable in the domestic courts. However, most of the substantive rights set out in the European Convention on Human Rights (ECHR) were incorporated in domestic legislation by the Human Rights Act 1998 (HRA), and so are justiciable.

The main limitation of the ECHR/HRA in relation to the present subject matter is the absence of a substantive right to health. The prohibition on discrimination contained in Article 14 of the ECHR can only be exercised in relation to another substantive ECHR right, rather than in relation to any right set out by law.²³ The Commission has recommended that a justiciable right to health and that a freestanding right against discrimination be incorporated in a Bill of Rights for Northern Ireland.²⁴

²² Convention on the Rights of the Child, Article 24(2).

²³ Protocol 12 of the Convention does contain a freestanding non-discrimination provision. However, the UK has not ratified this Protocol.

²⁴ Further to the Belfast (Good Friday) Agreement, the Commission gave advice to government on the scope for a Bill of Rights for Northern Ireland providing for additional rights supplementary to the ECHR. See: NIHRC (2008) *A Bill of Rights for Northern Ireland: Advice to the Secretary of State for Northern Ireland*, 10 December 2008, NIHRC, Belfast.

Despite this, there are a number of other substantive provisions in the ECHR that provide obligations that relate closely to the right to health. Most notably, these are Article 2 (right to life), Article 3 (freedom from inhuman and degrading treatment) and Article 8 (right to private and family life), all of which can be read with the Article 14 prohibition on discrimination in relation to other ECHR rights. In certain exceptional circumstances, the European Court of Human Rights has recognised a right to health, in the form of a right which imposes positive obligations on the State, as opposed to an obligation on the State not to interfere with physical or mental health. Examples include: an obligation not to put an individual's life at risk by denying health care which has been made available to the population generally;²⁵ a positive obligation to take steps to safeguard the lives of everyone within the jurisdiction;²⁶ a duty pursuant to Article 3 to provide adequate medical treatment for detainees;²⁷ and a limited obligation not to deport an individual if to do so would deprive the person of medical treatment and result in inhuman or degrading treatment.²⁸

There are a number of domestic Human Rights Act 1998 cases which have shed light in relation to the interconnection with the 'right to health'. The landmark decision in *Limbuela* held that asylum seekers should not be left destitute by denial of access to

²⁵ *Cyprus v Turkey* (2002) 35 EHRR 30, para 219.

²⁶ *LCB v United Kingdom* [1999] 27 EHRR 212, para 36.

²⁷ *L v Lithuania* (2008) 46 EHRR 22, para 59 (in the particular circumstances, there was a violation of Article 8 in not regulating for transgender surgery, which meant that the State could be required to fund operative treatment abroad).

²⁸ A number of cases have involved the implications of deporting non-EEA nationals with critical health issues to another state with substandard health care systems, and whether this constitutes a violation of Article 3 (see *D v UK* (1997) 24 EHRR 423; *LCB v UK* (1998) 27 EHRR 212; *N v UK* (application no 26565/05) judgment of 27 May 2008; *Bensaid v UK* (2001) 33 EHRR 10). From the jurisprudence, it appears that the dividing line is rather porous. In the case of *N v UK*, the European Court held that an HIV-positive Ugandan national could not claim entitlement to stay in the UK in order to continue to benefit from state medical assistance. Article 3 would only be breached in very exceptional circumstances, where "humanitarian grounds against removal were compelling". As such, it could be concluded there is no obligation on states to alleviate disparities in other states' health care through provision of free and unlimited care to non-nationals without a right to stay in their jurisdictions. This case, however, can be contrasted with that of *D v UK*. The applicant, a national of St Kitts, was receiving treatment for AIDS in the UK and receiving accommodation from a national charity. It was held that withdrawal of this care would have serious consequences for him and, while the standards in St Kitts did not themselves breach those demanded by Article 3, D's specific removal there would. It seems the exceptional grounds were highly influenced by the fact that D was at the critical stages of a fatal illness and lacked a social network or other means of support in his home state.

welfare provisions.²⁹ As such, the state is obliged by Article 3 ECHR to prevent such destitution, even when an asylum claim was not made as soon as reasonably practical. However, as in the 'N' case,³⁰ the House of Lords' decision to refuse an HIV-positive Ugandan national residence and access to health care, upheld by the European Court of Human Rights, illustrates the high threshold that is required to engage the *Limbuela* safeguard. Further domestic case law has addressed the issue of whether a failed asylum seeker can be 'ordinarily resident'. In England, in 2004, government introduced charges for refused asylum seekers for most hospital care, by issuing guidance stating that refused asylum seekers were not ordinarily resident. In the 'A' case, this faced a successful legal challenge in the High Court in 2008.³¹ However, government appealed to the Court of Appeal and in the 'YA' case, this element of the judgment was overturned.³²

European Union

Article 35 of the Charter of Fundamental Rights of the European Union explicitly recognises a right to health, subject to the conditions and limits applicable to the EU law on which they are based.³³ Of greater significance are the treaty rights to freedom of movement of European Union citizens and their family members. By agreement, such rights generally extend also to members of the European Economic Area (EEA)³⁴ and Swiss nationals.

Persons coming from EEA member states to live (rather than visit) can exercise European treaty rights in five main categories: employment, self-employment, job seeker, student or self-sufficient person. Under EU Regulations, persons exercising treaty rights are residents and gain rights to non-discrimination and co-ordination in social security matters, including health care. While there are significant differences between EU states in terms of health care, EU nationals resident in another EU state exercising treaty rights

²⁹ *Secretary of State for the Home Department v Limbuela & Ors* [2005] UKHL 6638.

³⁰ *N v Secretary of State for Health* [2005] UKHL 31.

³¹ *A v West Middlesex NHS Trust* [2008] EWHC 885.

³² *R (YA) v Secretary of State for Health* [2009] EWCA Civ 255.

³³ The government has sought to limit the application of the Charter in the UK by means of a protocol to the Lisbon treaty: this seeks to limit application of the Charter by indicating it is non-justiciable in any UK court or tribunal or in the European Court of Justice, and more generally making the Charter subordinate to UK law and practice (Protocol on the Application of the Charter of Fundamental Rights of the European Union to Poland and the United Kingdom OJ C 306/156-7).

³⁴ The European Economic Area countries are the 27 EU member states plus Iceland, Liechtenstein and Norway.

should be afforded equal treatment on the same terms as nationals of the host state.

There are a number of EU regulations relevant to this matter. Regulation (EEC) No 1408/71 (as amended) relates to the application of social security schemes to employed persons, to self-employed persons (who are EU nationals, refugees or stateless persons) and to members of their families (irrespective of nationality) moving within the EU. Article 3 provides for those persons to enjoy the same obligations and benefits in any member state as nationals of that state.³⁵ This Regulation was consolidated and amended by regulation (EC) no 883/2004 which entered into force on 1 May 2010. Earlier, the regulation had also been extended to 'third country' (that is, non-EEA) nationals and their family members and survivors legally resident in an EU member state in situations which involve another member state.³⁶ This provision is particularly relevant to persons resident in the Republic of Ireland who engage in employment or study in Northern Ireland.

Regulation (EEC) No 1612/68 covers freedom of movement for workers within the EU.³⁷ This is amended by directive 2004/38/EC on the right of member state citizens and their family members to move and reside freely within the territory of the member states.³⁸ This concerns rights of residence, including equal treatment. Notably, under the regulation the verification of whether an EEA national retains a right of residence through exercising treaty rights should not be carried out systematically but only where there is 'reasonable doubt' as to whether the conditions are fulfilled.³⁹ This regulation has been transposed into domestic law by the UK.⁴⁰ The 2006 regulations include the introduction of an initial qualified right of residence of up to three months for member state nationals and their family members without exercising treaty rights.⁴¹ Persons exercising treaty rights can reside in the UK for as long as they retain that status and a permanent right of residence is introduced after five years. Persons exercising treaty rights are referred to as 'qualified persons'; the definition of a worker includes a person who is temporarily unable to work due to illness or accident, or has involuntarily become unemployed, having been employed for a

³⁵ Consolidated version 2006: OJ L 28 30 January 1997, p1/ OJ L 149, 5 July 1971, p2.

³⁶ Council Regulation (EC) No 859/2003 of 14 May 2003, entered into force on 1 June 2003.

³⁷ OJ L 257 of 19 October 1968.

³⁸ OJ L 158 of 30 April 2004.

³⁹ Regulation 2004/38, Article 14(2).

⁴⁰ Immigration (European Economic Area) Regulations 2006 SI 2006/1003.

⁴¹ Regulation 13.

stipulated period.⁴² There are time-limited exceptions to the definition of a qualified person in relation to workers and jobseekers from EU accession countries.⁴³

Further to regulations 1408/71 and 574/72, a decision was taken to introduce a European Health Insurance Card (EHIC) to allow individuals covered by one EEA state's health care scheme to access health care during a temporary stay in another EEA state.⁴⁴ The EHIC, issued since 2006, covers treatments "which become necessary on medical grounds during a stay in the territory of another Member State, taking into account the nature of the benefits and the expected length of the stay".⁴⁵ The arrangements cover visitors with the exception of those who specifically travel for the express purpose of medical care.⁴⁶ The matter of formal referral and travel for medical care is also provided for under the same regulations and, with some exceptions determined by case law; this usually requires formal approval from the respective institution of the member state via a referral form EEA 112.

The European Court of Justice (ECJ) has dealt with numerous cases surrounding health care provisions within the EU. In *Kohll*, the Court held that the fundamental principle of freedom of movement still applies to services of a special nature, and healthcare can constitute such.⁴⁷ A barrier to free movement, therefore, can only be justified if there is a risk of seriously undermining the financial balance of the social security system. *Vanbraekel* extended this principle of non-restriction further, holding it applies both to hospital and non-hospital care.⁴⁸ *Müller-Fauré & Van Riet* also held that removing prior authorisation requirements for non-hospital care would not seriously risk weakening a social security system's financial balance.⁴⁹ In *Watts*, however, Article 49 was interpreted as meaning that persons ordinarily resident in member states operating state health systems are entitled to receive hospital

⁴² See: Regulation 6.

⁴³ See: Accession (Immigration and Worker Registration) Regulations 2004, as amended.

⁴⁴ Decision No 189 of 18 June 2003, OJ L 276/1 27 October 2003.

⁴⁵ Regulation 1408/71, Art 22(1)(a).

⁴⁶ There are, however, some practical discrimination issues as groups such as Roma may be unaware of access to EHICs, may be denied an EHIC because of insufficient social security contributions in their home country and may be unable to benefit from health coverage in the host state where registration of residence is a prerequisite. See: EU Fundamental Rights Agency, *The situation of Roma EU citizens moving to and settling in other EU Member States*; Available: http://fra.europa.eu/fraWebsite/attachments/ROMA-Movement-Comparative-report_en.pdf.

⁴⁷ C-158/96 *Kohll v Union des Caisses de Maladie* [1998] ECR I-1931.

⁴⁸ C-368/98 *Vanbraekel*, [2001] ECR I-5363.

⁴⁹ C-385/99 *Müller-Fauré and Van Riet* [2003] ECR I-4509.

treatment at the expense of their own health services, in *principle*.⁵⁰ This does not mean that all residents of such member states have unrestricted rights to travel to obtain treatment paid for by their home state, as such treatment may be subject to prior authorisation. This relates to persons travelling for medical care rather than migrant or cross-border workers. In 2008, a proposal for a directive on the application of patients' rights in cross-border health care was drawn up.⁵¹ This initiative intended to codify the case law of the ECJ and provide a transparent framework for the provision of cross-border health care. It states that patients have the right to access healthcare in another member state if they are entitled to the same care in their home state, and are to be reimbursed by their government for care provided by another state up to the cost of home state treatment.

Other international agreements

In addition to EEA provisions, there are also a number of reciprocal bilateral healthcare agreements between the UK and other states and territories. The majority of such arrangements provide for immediately necessary treatment where the need arises during a temporary visit; some also provide for formal treatment referrals. There are also arrangements in place for treatment of NATO personnel under the Status of Forces Agreement of 1955.

Legal certainty

A further relevant human rights principle is that of legal certainty. Legal uncertainty in relation to an entitlement can constitute a breach of rights. In *Tysiac v Poland*, a case in relation to abortion legislation, the European Court of Human Rights stated that when the legislature had decided on conditions for provision there must be an effective mechanism to determine if those conditions had been met.⁵² In the 'YA' case, the Court of Appeal in England and Wales (in addition to considering whether refused asylum seekers could be ordinarily resident) did find that the English entitlements guidance was deficient in not providing for legal certainty and hence

⁵⁰ C-372/04 *Watts* [2006] ECR I-4325.

⁵¹ Proposal for a Directive of the European Parliament & Council on the application of patients' rights in cross-border healthcare, EC Draft 11307/2008 (COM(2008)414 final). The proposal is still in the legislative process with the Council of the European Union having adopted its first reading position on 13 September 2010.

⁵² App No 5410/2003. More recently, the same conclusion was reached in *A, B & C v Ireland* (app no 25579/05), judgment of 16 December 2010.

was unlawful.⁵³ The Department of Health (England) issued a circular in April 2009 on the back of the judgment which included addressing matters of legal certainty.⁵⁴ The necessity of legal certainty is also highlighted by the issue of access to abortion in Northern Ireland. The DHSSPS was successfully judicially reviewed for not providing guidance as to the legal position on abortion in Northern Ireland.⁵⁵ Consequently, the DHSSPS consulted on, and issued, guidance in 2009.⁵⁶ As if to demonstrate the need for precision, this guidance itself was successfully judicially reviewed for not providing sufficient clarity in two areas (counselling and conscientious objection).⁵⁷ Revised guidance was issued for consultation in summer 2010. It is therefore important that, where there are entitlements for medical care for non-residents, there is both clarity as to what these are and a viable route to access them in practice. Exclusion from medical entitlements of a person from a minority ethnic background due to *perceptions* of ineligibility that are incorrect will constitute racial discrimination.

Summary

The UK is party to human rights standards binding in international law, in which it is committed to guaranteeing the right to health of all persons within its jurisdiction. A right to health is provided by the ICESCR and international legal obligations have been set out in some detail. This includes non-discrimination: the state should refrain from limiting equal access to health care to migrants, including irregular migrants. While the right to health in the ICESCR is not absolute, and there is some margin of discretion afforded to states, any restrictions on a protected ground must be solely for the purpose of general welfare in a democratic society, and there must be a reasonable relationship of proportionality between the objective pursued and the impact of restrictions.

⁵³ *R (YA) v Secretary of State for Health* [2009] EWCA Civ 255

⁵⁴ David Flory, Director General NHS Finance, Performance & Operation, Circular to Chief Executives, Department of Health Gateway ref. 11628, 2 April 2009. The letter clarified that all immediately necessary, including maternity, treatment must never be withheld for any reason, and that Trusts when pursuing payment should not go beyond what is reasonable; for example, debts should be written off when it is known the person has no funds.

⁵⁵ *R (Family Planning Association of Northern Ireland) v Minister for Health, Social Services and Public Safety* [2004] NICA 37.

⁵⁶ DHSSPS, *Guidance on the Termination of Pregnancy: The Law and Clinical Practice in Northern Ireland*, March 2009.

⁵⁷ *Society for the Protection of the Unborn Children's Application v DHSSPS* [2009] NIQB 92.

A similar formulation is present in ICERD: any differential treatment based on citizenship or immigration status will constitute racial discrimination if it is not proportional or pursuant to a legitimate aim defined under the Convention. There are certain minimum obligations that should not be derogated from in ICESCR, including the provision of essential primary care. There are also particular obligations in ICESCR, CEDAW and CRC for women and children to ensure maternal, child and reproductive health, including pre- and post-natal care.

Other minimum obligations are directly protected in domestic courts by the Human Rights Act 1998, under which the state must not threaten the right to life of any individual, subject them to inhuman and degrading treatment, nor unduly interfere with the right to family life. The ECHR requirement of legal certainty requires states to have clear procedures and practices for persons to access the entitlements that they have. Further, procedures to check entitlements must not be themselves discriminatory.

Persons from the EEA residing in Northern Ireland exercising European Union treaty rights to freedom of movement also have rights in EU law to equal access to health care. There are also rights under EU law for visitors for treatment the need for which arises during the visit (that is, unless the person travelled for the purpose of medical care, when different rules apply). The UK also has other international agreements affording similar rights.

In summary:

- The UK has made international human rights commitments that bind it to affording equality of access to all without discrimination, including migrants of whatever status.
- While this right is not absolute, the onus is on the state to provide justification for any restrictions as proportionate, otherwise they will constitute racial discrimination.
- Core minimum obligations which should not be subject to any restriction include access to primary care, and other treatment when the life of any individual is at risk or where withholding treatment would be inhuman or degrading.
- Special obligations also exist to ensure provision for maternity services and services to children.
- Persons from EEA and other reciprocal agreement states also have particular treaty based provision afforded to them.
- Where entitlements exist there is a requirement for a clear non-discriminatory mechanism to access them.

3. UK LEGISLATION, REFORM AND CHALLENGE

The 'National Health Service', termed the Health and Social Care (HSC) services in Northern Ireland, is founded on the principle of the human right to health care. Principles include:

- Medical services are funded through taxation and generally free at the point of use⁵⁸ (save exceptions such as some services that are charged for subject to means testing e.g. dental care and prescription medicines).
- The health and social care services are *not* categorised as a 'public fund'⁵⁹ in reference to immigration law (which restricts access to 'public funds', i.e. certain benefits and housing assistance in accordance with immigration status).

While the appropriate question for a human rights approach to eligibility for medical treatment is, 'who is sick' rather than, 'who is entitled', the health service does contain a number of restrictions to free access. Overall trends and developments in the UK are reviewed in this chapter with Northern Ireland legislation and policy covered in detail in the following chapter.

Primary care

There are no regulations restricting access to GP services in Great Britain in relation to migration status. GP practices have a level of discretion as regards who can become a registered patient. However, unless the practice is full and has formally closed its list, any refusal to register must be justified by reasonable grounds that cannot be discriminatory on grounds including ethnicity. If a patient is refused registration the GP must nevertheless provide free of charge any 'immediately necessary' treatment for up to 14 days.⁶⁰

⁵⁸ Although migrants are liable for full taxes, and studies demonstrate that they provide a considerable surplus to the public purse (see: Institute of Public Policy Research (2005), *Paying their Way: The fiscal contribution of immigrants in the UK*), this is not relevant to access to medical care as entitlements are not based on tax contributions.

⁵⁹ Under section 115, Asylum and Immigration Act 1999.

⁶⁰ What is 'immediately necessary' is a matter of professional clinical judgement.

Hospital care

In Great Britain eligibility for free full access to hospital services is based not based on nationality, nor on the payment of National Insurance contributions or taxes, but on residency, that is, if the person is living in rather than visiting the jurisdiction. The restrictions on eligibility therefore apply as much to British citizens as they do to others. The legal definition applied is that of 'ordinary residence'. An individual who is 'ordinarily resident' is entitled to full free access to hospital services. 'Ordinarily resident' is a common law concept largely deriving from a 1983 House of Lords ruling in *Shah*⁶¹ (although the term 'ordinarily resident' has featured in tax law since 1806). In *Shah*, Lord Scarman stated that unless it could be demonstrated that the legal context required a different meaning...

I unhesitatingly subscribe to the view that 'ordinarily resident' refers to a man's [sic] abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration.⁶²

Scarman further outlined that 'ordinary residence' should be lawful, voluntarily adopted and there must be a degree of settled purpose. Such purpose may be one or several and specific or general, for example, employment, study, or family purposes. The intention to reside does not need to be indefinite and can be for a limited period: 'all that is necessary is that the purpose of living where one has a sufficient degree of continuity to be properly described as settled'.⁶³ The Lords therefore held that the term should be given its ordinary and natural meaning, and rejected as wholly inconsistent the so-called 'real home' test, where migrants were only deemed ordinarily resident if their immigration status was of indefinite residence.⁶⁴ The appeal had been brought to the Lords in relation to ordinary residence stipulations in education legislation. In conclusion, the Lords held that:

The phrase 'ordinarily resident' in [the legislation] was to be construed in according to its natural and ordinary meaning without reference to immigration legislation... According to the natural and ordinary meaning of the phrase a person was 'ordinarily resident' in the United Kingdom if he habitually and normally resided lawfully in the United Kingdom from choice and for a settled purpose throughout the prescribed period, apart from temporary or

⁶¹ *Shah v Barnet London Borough Council and other Appeals* [1983] 1 All ER 226.

⁶² As above, p235(e-f).

⁶³ As above, p235(h-j).

⁶⁴ As above, 236(f); 238(d-e); 239(d).

occasional absences. Furthermore a specific and limited purpose, such as education, could be a settled purpose. It was irrelevant that the applicant's permanent residence or 'real home' might be outside the United Kingdom or that his further intention or expectation might be to live outside the United Kingdom.⁶⁵

It can be therefore concluded that, in lay terms, being 'ordinarily resident' means living in, rather than just visiting, the UK. *All* other persons who are not ordinarily resident are classified as 'overseas visitors', for whom there are restrictions on the types of hospital treatment that can be received free of charge.⁶⁶ This is set out in secondary legislation which provides for exemptions from charges in relation to certain services, certain medical conditions and certain sub-categories of 'overseas visitor'.⁶⁷ The regulations provide that no charge is to be made for most⁶⁸ overseas visitors for:

Services exempt from charges:

- Accident and Emergency departments, walk-in centres or non-hospital settings
- treatment for particular communicable diseases, family planning, sexually transmitted infections (except HIV where this is limited to diagnosis and counselling), and
- compulsory mental health treatment.

Sub-categories of exempt 'visitor':

- workers/self-employed persons whose principal place of business is in the UK; UK funded students/health service volunteers; persons taking up permanent residency
- persons with 12 months' lawful UK residence prior to treatment (unless in UK for private medical treatment)
- asylum seekers and refugees
- employees on UK-registered ships
- diplomats, Crown servants, UK or NATO armed forces, British Council or Commonwealth War Graves Commission employees
- war pensioners or UK state pensioners on long visits
- victims of human trafficking
- prisoners and detainees
- missionaries

⁶⁵ As above, 227(b-c).

⁶⁶ National Health Service (Charges to Overseas Visitor) Regulations 1989 (SI 1989/306), Regulation 1(2) (Interpretation).

⁶⁷ As above; this is the principal regulation in England which has been amended eight times, largely to add additional exemption categories. There are similar regulations in Scotland and Wales, with some differences since devolution.

⁶⁸ This is summary information only; qualifications apply to some categories.

- former long-term UK residents working overseas; private patients for whom there are exceptional humanitarian reasons
- EEA residents referred for medical treatment; or persons resident in other EEA countries (e.g. France) and paying National Insurance contributions in the UK
- non-EEA nationals not entitled to treatment under a reciprocal agreement, whose state is a European Social Charter signatory and who do not have the means to pay
- persons whose treatment is provided for in a bilateral agreement between the UK and another country, and
- particular family members of some of the above.

Treatment, the need for which arose during a visit:

These sub-categories of visitors are exempt from charges when the need for the treatment arises during the visit:⁶⁹

- EEA residents who are EEA nationals, refugees or stateless persons, and their family members
- persons (and spouse/civil partner/child) who at any time have had 10 years or more continuous lawful UK residence or Crown service and are in receipt of pension or resident in EEA or reciprocal agreement country
- residents in most reciprocal agreement countries, and
- nationals of states party to the European Convention on Social and Medical Assistance without sufficient resources to pay (whilst most are EEA states, this includes Turkey).

Therefore, a range of the above exemption categories relate directly to international treaty commitments entered into by the UK within the European Union and Council of Europe systems (European Social Charter, Convention Against Trafficking in Human Beings, European Convention on Social and Medical Assistance) and NATO. There are also a number of bilateral reciprocal agreements entered into by the UK with other countries (mainly states in the Commonwealth or the former USSR). Other exemption categories have been more broadly humanitarian, political or practical measures.

⁶⁹ Defined in the regulations as: "diagnosis of symptoms or signs occurring for the first time after the visitor's arrival in the United Kingdom and any other treatment which, in the opinion of a medical or dental practitioner employed by, or under contract with [the NHS], is required promptly for a condition which arose after the visitor's arrival in the United Kingdom, or became, or but for treatment would likely to become, acutely exacerbated after such arrival".

Parliamentary scrutiny

...our evidence clearly showed that existing restrictions on access to health services have led to confusion and, in some cases, to civil disobedience by medical professionals...⁷⁰

These conclusions, in 2009, from the House of Commons Home Affairs Committee highlight that the lack of legal certainty over existing restrictions has led to medical professionals respecting the primacy of human rights and providing treatment outside of present policy restrictions. Regulations in England, Wales and Scotland in 1989 introduced exemptions from free access to secondary (hospital) care services for 'overseas visitors' (that is, persons not deemed 'ordinarily resident' in the UK) subject to a number of exceptions. It is important to note that regulations in Great Britain do not restrict access to primary care (GPs, etc). Regulations which mirror exemption categories for hospital care, but differ in other ways, were not introduced in Northern Ireland until 2005.

The Home Affairs Committee conclusion was in response to "extensive evidence" received from medical professionals and organisations who were concerned at government proposals to further restrict access to health care. The Committee concluded that the evidence it received "cautioned against any future restrictions to primary health services for those subject to immigration control" citing "persuasive arguments" made by medical professionals "on the damaging effects of such restrictions". The evidence heard by the Committee related both to the impact on individual health, and to the "counter-productivity" of such restrictions on public health and finances.⁷¹ Two years earlier, in 2007, the parliamentary Joint Committee on Human Rights had examined the issue of access to secondary care in relation to asylum seekers. Among the conclusions were:

- The Committee had heard evidence that the [hospital charging regulations] caused confusion about entitlement, their interpretation had been inconsistent, entitled persons had been charged in error and the threat of high charges had resulted in some persons with life-threatening or otherwise serious conditions, including "extremely shocking examples", being denied or deterred from seeking treatment.
- Specific concerns were raised relating to maternity treatment with the charging arrangements having led to the denial of antenatal care to vulnerable women inconsistent with Articles 2,

⁷⁰ Home Affairs Select Committee, *Borders, Citizenship and Immigration Bill [HL]* Fifth Report of Session 2008–09, HC 425, 21 April 2009, para 20.

⁷¹ As above, paras 20-27.

3 & 8 of the ECHR. The Committee recommended all charges are suspended for antenatal, maternity and perinatal care.

- It recommended that HIV/AIDS treatment should be provided to refused asylum seekers in UK, and that persons in the final stages of terminal illness who would be without access to medical care should not be deported.
- The Committee had seen evidence that arrangements for GP access had resulted in denial of primary health care for refused asylum seekers and their children, which also increased costs by over-reliance on Accident and Emergency. In some cases, this was in breach of ECHR Articles 3, 8 and 14 or even article 2.⁷²

Government has established a number of reviews in relation to entitlements, the most recent of which is covered below. The motivation for reviews does not appear to have been human rights concerns but rather a response to sections of the London press who have regularly queried the rights of migrants to health care. The pejorative term 'health tourism' has been often used with allegations that large numbers of persons have been travelling to the UK deliberately for costly medical care or otherwise to overuse services.⁷³ Pressures from this type of discourse have influenced government in relation to its reviews of entitlements. Bodies such as the Joint Committee of Human Rights have been critical of government in this regard, the 2007 report concluding:

...the Government has not produced any evidence to demonstrate the extent of what it describes as "health tourism" in the UK.⁷⁴

Similarly the Home Affairs Select Committee, which cautioned against further restrictions on 'business case' as well as humanitarian grounds, took evidence that contradicted the assertion of widespread 'health tourism'.⁷⁵

⁷² Joint Committee on Human Rights, *The Treatment of Asylum Seekers, Tenth Report of Session 2006–07*, HL 81-I, HC 60-I, paras 134, 143, 152, 158.

⁷³ An article from the London *Evening Standard* provides one example, with a headline, 'Health tourists told to pay for treatment or go home' and accompanying editorial headed, 'The NHS must rein in the health tourists'. The article, which misrepresents the position as regards entitlements, has a rather inhumane tone, including lamenting that a hospital Trust had been unable to recover costs from "a man who died after spending 57 nights in intensive care". The editorial stated that individuals inspire sympathy but collectively are a considerable cost, alleging that 'health tourism is a particular problem in London and hospitals have been heavily burdened by the arrival of patients within hours of giving birth and those needing life-saving operations or dying of HIV/AIDS' (*Evening Standard*, 17 September 2009).

⁷⁴ Joint Committee on Human Rights, as above, para 129.

⁷⁵ The British Medical Association told the Committee that irregular migrants and asylum seekers do not access services very often, or did so too late having believed there was no right of access. The evidence of Médecins du Monde

Government review of entitlements

There have been a number of drawn-out reviews by the Home Office and Department of Health (England). In 2004, the Department of Health issued proposals to exclude overseas visitors from free primary care (GP, etc) services.⁷⁶ In 2007, the Joint Committee on Human Rights observed that while this consultation had concluded in August 2004 its results were still being considered and no analysis had been published which had exacerbated the confusion regarding entitlement. Government told the Joint Committee that the review was ongoing.

In March 2007, government launched another strategy which included a review, run jointly by the Home Office and Department of Health (England), into "rules governing access to the NHS by foreign nationals" which was to be concluded by October 2007. The objective of the strategy was for new sanctions to "ensure that living illegally becomes ever more uncomfortable and constrained until they leave or are removed".⁷⁷ Clearly, depriving humans who may have fallen into an irregular status of medical care in an effort to coerce their exit from the jurisdiction is not human rights compliant. The review was not concluded in this timescale but, in early 2008, the Home Office committed to consulting later in the year.⁷⁸ This did not happen, although another Home Office document in mid-2008 included an assurance that "Temporary residents will continue to have access to the NHS".⁷⁹

One explanation for delays in these review processes may be tensions between the different approaches taken by the Home Office (seeking to deny access) and health officials (seeking to

concluded, contrasting the 'public perception' of negative impact on the NHS with evidence that this is 'a client group not accessing the services they need' (Home Affairs Select Committee, 21 April 2009, para 23). The Royal College of General Practitioners has also taken the position that "GPs should not be expected to police access to healthcare and turn people away when they are at their most vulnerable", that vulnerable migrant groups should be entitled to free primary care and that there was "no evidence" of asylum seekers entering the UK to benefit from free health care (position statement, 'Failed Asylum Seekers/ Vulnerable Migrants and access to primary care'; Available: http://www.rcgp.org.uk/news_and_events/college_viewpoint/position_statements/failed_asylum_seekers.aspx [accessed 25 November 2009]).

⁷⁶ Department of Health, *Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Schemes*, 14 May 2004.

⁷⁷ Home Office (7 March 2007) *Enforcing the Rules: A strategy to ensure and enforce compliance with our immigration laws*, p24.

⁷⁸ Home Office, *The Path to Citizenship: Next Steps in Reforming the Immigration System*, section 5.3, para 199.

⁷⁹ Home Office (July 2008) *The Path to Citizenship: Next Steps in Reforming the Immigration System: Government Response to Consultation*, pp20-21.

prevent denial of access). Notably, in February 2009, the Health Secretary (then Alan Johnston MP) stated at a British Medical Association (BMA) conference that he was opposed to proposals to deny free GP treatment to failed asylum seekers. Citing the opposition of medical experts and clinicians, Mr Johnston reportedly attacked the “sheer inhumanity of refusing to treat people who are ill in primary care” that had been proposed in the plans. In remarks that one commentator described as a “U-turn after years of wrangling”, Mr Johnston said that while a final decision had not been made within government he was personally opposed to the restriction.⁸⁰ The backdrop to the discussion included a petition signed by over 500 GPs and 79 MPs denouncing the plans; campaigners had flagged up the proposals as being incompliant with human rights standards and the Hippocratic Oath of practitioners.⁸¹

Mr Johnston left the Department of Health to become Home Secretary in June 2009. The results of the joint review were made public the following month and the headline recommendations set out in a ministerial statement. This included dropping the plans to charge failed asylum seekers for GP care. The main recommendations of the review were to:

- maintain the position that A&E treatment and treatment for specified diseases be free and that immediately necessary and urgent medical treatment should never be withheld
- maintain GP discretion to determine registration to access NHS primary care services
- maintain the system of charges for non-residents for hospital care, but introduce new exemptions for unaccompanied minors or failed asylum seekers receiving UK Border Agency (UKBA) support
- amend the period of absence for residents that is disregarded for continued entitlement from three to six months
- maintain charges for non-residents for maternity treatment, but without ever delaying or denying treatment, and
- commission more research on current policy on HIV treatment.⁸²

The ministerial statement outlined that while the proposals applied to England, the devolved administrations would also be consulted. The Under-Secretary for Health, Ann Keen MP, also indicated that she was “urgently engaging” with stakeholders to ensure that

⁸⁰ Nowotny S (2009) ‘Alan Johnson: “Sheer inhumanity” of denying asylum seekers GP care’, *The Pulse*, 6 February 2009.

⁸¹ ‘GPs fight plans to deny NHS care to failed asylum seekers’, *The Pulse*, 25 February 2008.

⁸² Department of Health (20 July 2009) press release, ‘Access to NHS services for foreign nationals – Department of Health and Home Office publish joint review’.

guidance as to “immediately necessary and urgent” treatment was clear. She also indicated that government had not been persuaded to abolish non-resident charges for maternity care (despite conceding that only a “small number” of visitors had entered the UK to specifically use NHS maternity services). In relation to the “small minority” of visitors who had sought to enter the UK to access NHS treatment, the Minister proposed information sharing from the NHS to the UK Border Agency (UKBA) and amending the immigration rules to apply immigration sanctions on applications to remain and enter the UK until significant debts to the NHS were paid. A visa requirement for visitors from outside EEA and reciprocal agreement countries to have health insurance was also being examined.⁸³

A full consultation document was issued in February 2010, along with draft consolidated Regulations introducing the changes⁸⁴ and draft Guidance on implementing the hospital charging regulations. Annex 4 of the consultation document refers to primary care and defers to the provisions of the General Medical Services Contract regulations. The consultation ended in June 2010 but it does not appear that there has been subsequent movement and the amended 1989 Regulations remain.

A potential new policy obliging all non-EU migrant workers to have ‘health insurance’ was widely reported as being brought forward by the Home Secretary, Theresa May MP, when the new government announced a ‘cap’ on non-EEA immigration in June 2010.⁸⁵ However, no such proposal was set out in the Ministerial Statement outlining proposed reforms that day.⁸⁶ A different proposal, to give migrant workers more ‘points’ for having health insurance when seeking a migrant worker visa under the ‘points-based scheme’ was briefly alluded to in the accompanying consultation document.⁸⁷ This in itself would not amend entitlements to access to NHS care and to date no such changes have been made.

⁸³ Statement by Parliamentary Under-Secretary for State for Health (Ann Keen): NHS Access (Foreign Nationals), *Hansard* 20 July 2009, Column 97WS.

⁸⁴ Draft National Health Service (Charges to Overseas Visitors) Regulations 2010.

⁸⁵ For example, see: <http://www.dailymail.co.uk/news/article-1290288/Migrants-private-healthcare-insurance-pressure-NHS.html>; and <http://www.telegraph.co.uk/news/uknews/immigration/7858835/Immigrant-workers-need-private-health-insurance.html> [accessed 3 November 2010].

⁸⁶ Statement by Home Secretary (Theresa May): Limits on Non-EU Economic Migration, *Hansard* 28 June 2010, Col 585.

⁸⁷ Home Office UKBA (June 2010) *Limits on Non-EU Economic Migration: A Consultation*, p10. On the back of the Joint Review, the UKBA also conducted a consultation on changes to the Immigration Rules to refuse persons with NHS debts re-entry or continued residence in the UK (UKBA (February 2010) *Refusing entry or stay to NHS debtors*).

As part of the Home Office's 'earned citizenship' agenda in 2008, a review was also announced into the terminology used to determine residence. This included 'ordinarily resident' as well as 'habitually resident' (used in Social Security determinations) and 'lawfully present'. The objective was "to ensure that these terms operate and interact with each other as logically, simply, and effectively as possible; and in a way that meets our policy objective of ensuring that migrants can only access benefits and services where they have 'earned' the right to them."⁸⁸ However, no clauses to this effect were included in the November 2009 draft Immigration Bill, with the Home Office indicating that "there were still outstanding issues to be resolved."⁸⁹ This draft Bill, which proposed further restrictions on other public funds but did not reference medical care, was not introduced.⁹⁰

'Earned citizenship' reforms which were brought in under the earlier Borders, Citizenship and Immigration Act 2009 would have affected the length of time persons were excluded from access to social protection (particular welfare benefits, homelessness assistance, etc).⁹¹ While this would have been of serious concern, it would not have impacted on medical entitlements, although the Home Affairs Select Committee felt it necessary to caution against future restrictions on health entitlements in light of the plans.⁹²

In November 2010, the new government announced the abandonment of the 'earned citizenship' reforms.⁹³ It is still worth noting that any UKBA-led legislative redefinition of 'ordinarily resident' would have a major impact on entitlements to medical care. The drive to redefine 'ordinarily resident' appears to be connected to the earned citizenship and immigration control agendas, and legal challenges regarding the application of the definition to failed asylum seekers.⁹⁴

⁸⁸ Home Office UKBA (July 2008) *Making Change Stick: An Introduction to the Immigration and Citizenship Bill*, p8.

⁸⁹ Home Office UKBA (November 2009) *Simplifying Immigration Law: The Draft Bill*, Command Paper 7730 paras 4.6-4.7.

⁹⁰ As above.

⁹¹ For further details, see: NIHRC (October 2009), 'Response to the Home Office Consultation on "Earning the Right to Stay: A New Points Test for Citizenship"', paras 6-20.

⁹² Home Affairs Select Committee (21 April 2009) *Borders, Citizenship and Immigration Bill [HL], Fifth Report of Session 2008-09*, HC 425.

⁹³ Home Office UKBA (11 November 2010) Settlement and Citizenship policy written statement, Deputy Director Permanent Migration.

⁹⁴ The 2004 Regulations in England which introduced charges for refused asylum seekers for most hospital care, by issuing guidance indicating that refused asylum seekers were not ordinarily resident, faced a successful challenge in the High Court in 2008 (*A v West Middlesex NHS Trust* [2008] EWHC 885). However, this

Summary

The present situation in England, Wales and Scotland is that all persons ordinarily resident in Great Britain have full access to the NHS. Through the NHS (Charges to Overseas Visitors) Regulations 1989 (as amended), free access for 'overseas visitors' to hospital services is restricted. Charges can be made unless services or visitors fall into one of a number of exemption categories. Access to GP services is not restricted by these Regulations.

Parliamentary Committees examining this situation, and taking extensive evidence from the medical profession, have expressed concern at the restrictions, highlighting in particular:

- that the hospital charges regulations lack legal certainty and are too restrictive, including 'extremely shocking examples' which have engaged articles 2, 3, 8 and 14 of the ECHR. Maternity and HIV/AIDS treatment were particularly highlighted
- opposition to government extending the hospital charges regime to primary care, and
- criticism of the lack evidence base or business case for the existing restrictions, as government has not produced evidence of a substantial problem of 'health tourism'.

Despite a lack of evidence base, against the backdrop of tabloid campaigns alleging 'health tourism', government has engaged in a number of review exercises looking at restrictions. These reviews have been drawn out and largely inconclusive as they have been strongly resisted by the health sector and medical profession. A review published in July 2009 did not propose any further restrictions but some limited additional exemptions from liability for charges.

element of the judgment was overturned on appeal (*R (YA) v Secretary of State for Health* [2009] EWCA Civ 255).

4. NORTHERN IRELAND LEGISLATIVE AND POLICY FRAMEWORK

The following section reviews the legislative and policy context regarding access to medical care in Northern Ireland. This includes relevant primary and secondary legislation and policy guidance.

The devolution context

Matters which have been transferred to the devolved Northern Ireland institutions under the Northern Ireland Act 1998 include health and social services, where legislation is within the competence of the Northern Ireland Assembly and policy falls to the Department of Health, Social Services and Public Safety (DHSSPS), part of the Northern Ireland Executive. Nationality, immigration (including asylum and the status and capacity of persons in the UK who are not British citizens) and the free movement of EEA nationals are excepted matters (schedule 2), and responsibility at UK-wide level rests with the Home Office.

The UK devolution context appears to have clarified that the issuing of regulations in relation to entitlements to health services is a matter for DHSSPS, not the Home Office. Wales has changed its regulations which, unlike in England, include failed asylum seekers as a category exempt from charges.⁹⁵ The DHSSPS has also been clear that the competence to provide the legislative framework for entitlements to publicly funded medical care rests with it by virtue of the Northern Ireland Act 1998.⁹⁶

The Northern Ireland authorities recently issued a policy document which notes that while immigration and asylum law are matters for UK government, immigration matters have substantial implications for government in Northern Ireland "as service deliverers, but also for people living here under immigration control. Consequently these issues are a legitimate concern of the Executive".⁹⁷

⁹⁵ National Health Service (Charges to Overseas Visitors) (Amendment) (Wales) Regulations 2009 WSI 2009/1512, art 2(a).

⁹⁶ DHSSPS response to NIHRC, 14 December 2010, para 8.

⁹⁷ Office of the First and deputy First Minister (2010) *Consultation on the Programme for Cohesion, Sharing and Integration*, para 1.12.

Principal legislation and 'ordinarily resident'

As in Great Britain, full free access to publicly funded medical services in Northern Ireland is afforded to all persons 'ordinarily resident.' All other persons are classified as 'visitors'.⁹⁸ The DHSSPS and its Business Services Organisation (BSO)⁹⁹ both confirmed to the Commission that the policy and legislation they used to assess 'visitor' entitlements were regulations from 2005 and DHSSPS primary care policy guidance issued in 2000, namely:

- The Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2005 (as amended)¹⁰⁰, and
- HSS(PCD)10/2000: Family Health Services for Persons not Ordinarily Resident in Northern Ireland (23 June 2000).

Also of relevance are the Health and Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004 (hereafter the 2004 GMS Regulations) which set out the framework for GP contracts. The principal legislation underpinning both sets of regulations is the Health and Personal Social Services (Northern Ireland) Order 1972, as amended (hereafter 'the 1972 Order'). Services provided under the 1972 Order are provided free of charge except when the Order expressly requires otherwise.¹⁰¹ Article 42 of the 1972 Order contains a power to make services available to persons who are not 'ordinarily resident', to levy charges for them and provide exemptions from such charges.

Under the 1972 Order the residential jurisdiction for being considered 'ordinarily resident' is Northern Ireland rather than the UK or the (UK-Ireland) Common Travel Area.¹⁰² 'Ordinary resident' is not defined in the legislation and, therefore, defers to the UK common law concept. The HSS(PCD)10/2000 policy circular does include a definition drawing on the *Shah* judgment:

⁹⁸ SR 2005/551 Regulation 2(1) (Interpretation).

⁹⁹ Then the Central Services Agency (CSA).

¹⁰⁰ Statutory Rule 2005/551. The Visitor Regulations have been amended twice to add additional exemptions by the Provision of Health Services to Persons not Ordinarily Resident (Amendment) Regulations (Northern Ireland) 2008 SR2008/337 and the Charges for Drugs and Appliances and Provision of Health Services to Persons not Ordinarily Resident (Amendment) Regulations (Northern Ireland) 2009 SR 2009/186.

¹⁰¹ Art 98.

¹⁰² Eligibility for persons resident in Great Britain is dealt with by such persons being visitors exempt from charges under the 2005 Visitor regulations. The visitor eligibility for residents of the Republic of Ireland is the same as for other EU states.

A person is regarded as ordinarily resident if he/she is lawfully living in Northern Ireland voluntarily for a settled purpose as part of the regular order of his/her life for the time being. A person must have an identifiable purpose for his/her residence here and that purpose must have a sufficient degree of continuity to be properly described as settled.¹⁰³

The policy circular elaborates that it regards anyone intending to stay in Northern Ireland for less than six months as unlikely to fulfil the criteria. Asylum seekers and refugees are considered ordinarily resident. The circular outlines that the decision on ordinary residence and visitor entitlement is taken by BSO as part of the process of issuing a medical card.

The Commission requested and received copies of all relevant policy documents used by BSO (then the Central Services Agency, CSA) which, on behalf of the Health and Social Care services, is responsible for processing applications for inclusion in a GP Practice list, the issuance of medical cards and HSC registration numbers. A CSA circular was issued in February 2007 to draw attention to the good practice measure of the translation of application forms into a range of minority languages. The application form¹⁰⁴ among other details seeks information on:

- country of birth
- previous medical cards in Northern Ireland or Great Britain
- National Insurance contributions
- whether the person is a registered Job Seeker with the Social Security Agency
- whether the person has not continuously resided in the UK since birth: the most recent dates of departure and arrival; the last permanent address before moving to the UK; reason for coming to UK; details of place of study or hospital worked at
- whether the applicant intends to reside permanently in the UK, and if not how many months/years they intend to stay, and
- whether the applicant retains an address outside the UK, and why.

The form also requests (confusingly) applicants 'from non-European countries' for a copy of a 'visa' or 'UK passport' and 'work permit' where applicable.

¹⁰³ Para 3.

¹⁰⁴ HS22X (11/2006) WCA716.

The Guidance Notes accompanying the form outline that its purpose is for Primary Care registration. There are attempts on the form to ascertain information regarding ordinary residence. Some of the questions, however, relating to country of birth and retention of residence outside the UK, seem to relate more to a 'real home' rather than the definition of ordinary residence established by law.

Primary care

The Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2005 ('the 2005 Visitor Regulations') have been in force since 10 January 2006 and replaced earlier more restrictive regulations passed by the Stormont Parliament in 1970.¹⁰⁵ The 1970 Stormont regulations, uniquely in the UK, restricted access to primary care as well as to hospital services. The exemption for charges under these 1970 regulations was largely restricted to sub-categories of visitors for whom there were international agreements with the UK. The 2005 Visitor Regulations largely follow the much broader exemption categories that have been implemented in Great Britain (see previous chapter), with some differences that are explored later.

Significant problems are immediately apparent with the HSS(PCD)10/2000 policy circular still being in force. This policy circular relates only to primary care¹⁰⁶ and is based on legislation that has been repealed for over five years, namely the 1997 GMS Regulations and the 1970 Visitor Regulations both of which were more restrictive.¹⁰⁷ Equivalent guidance issued shortly before this in England has been withdrawn as obsolete.¹⁰⁸ If the law held that the 2005 Regulations applied to primary care (or that no restrictions applied), the extent to which the policy circular restricted access to medical care beyond that provided for in the present legislation would likely render the circular unlawful.

¹⁰⁵ Health Services (Persons not ordinarily resident in Northern Ireland) Regulations (Northern Ireland) 1970.

¹⁰⁶ The Circular refers to "family health services for persons not ordinarily resident". This term is not defined but DHSSPS has clarified it is an umbrella term for GPs and other primary care services (correspondence to NIHRC 22 December 2009).

¹⁰⁷ General Medical Services Regulations (Northern Ireland) 1997 SR1997/380, revoked by the General Medical Services Transitional and Consequential Provisions (No 2) (Northern Ireland) Order 2004 SR2004/156, and the Health Services (Persons not ordinarily resident in Northern Ireland) Regulations (Northern Ireland) 1970, SI1970/56, revoked by the Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2005.

¹⁰⁸ HSC 1999/018. Available:

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_4004148 [accessed 12 January 2010].

In initial discussions with the Commission, the DHSSPS made it clear that it regarded the 2005 Visitor Regulations as applicable to primary care. This was also the understanding of BSO, which applied restrictions and entitlements based on the 2005 Visitor Regulations to both primary care and hospital care access. In practice, this relied on the 'ordinary residence' test and, where needed, the visitor exemption test under the 2005 Regulations being applied when an application for a medical card was processed by BSO.¹⁰⁹ By assessing ordinary residence and visitor exemptions at this stage, rather than at the stage of any referral to hospital, the same restrictions are applied to primary as to hospital care.

It appears that if the 2005 Visitor Regulations were applied, primary care should be a service exempt from charges for visitors by virtue of Regulation 4(5)(b) which prevents charges being levied for non-hospital services.¹¹⁰ The restrictive approach also does not sit well with the provisions of the present GMS Regulations. Under the 1997 GMS Regulations, applications to join a GP practice list were restricted to those who were ordinarily resident or exempt visitors under the 1970 Visitor Regulations.¹¹¹ Under the present 2004 GMS Regulation, this qualification is removed, with a GP practice having

¹⁰⁹ Unless a person enters hospital via Accident & Emergency or other direct services, referral from a GP practice, which depends on registration, is usually the gateway to other HSC services. GP consultations also constitute the vast majority of HSC appointments; therefore, the decision-making procedure is the key element to health checks. There is no statutory basis for medical cards; they are effectively the administrative vehicle by which registered access to primary care and any subsequent referral to hospital care is processed.

¹¹⁰ At the time, the DHSSPS disputed this interpretation of Regulation 4(5) which reads "No charge shall be made in respect of any services forming part of the health services provided for a visitor... (b) otherwise than at, or by staff employed to work at, or under the direction of, a hospital" (DHSSPS Memo to NIHRC 22 December 2008). An interpretation of the similar provision in English/Welsh regulation 3(b)(SI 1989/306) is set out in Department of Health (England) Guidance as "the treatment given elsewhere than at a hospital, or treatment given by someone who is not either employed by or under the direction of the Trust. This means that some services provided in the community will be chargeable only where the staff are employed by a Trust (for example District Nurses employed by the local PCT) but not where they are employed by a general practitioner (for example practice nurses)" (NHS Implementing the Overseas visitor Charging Regulations, 2004). In Scotland, see: Regulation 3(b) SI1989/364); this was amended between 2006 and 2008 to permit charges also to be levied for dental and optician services, which had briefly been brought in to the definition of health services (SSI2006/141 and SSI2008/290).

¹¹¹ Regulation 19(1). The DHSSPS has also issued a template for standard GMS contracts under the present 2004 GMS Regulations which, despite not being presented by the Department as such, could also be considered an official policy guidance document relevant to entitlements. In accordance with the 2004 Regulations, these contracts make no reference to restrictions on the basis of ordinary residence or qualified visitors (Standard General Medical Services Contract (NI), DHSSPS, March 2004).

discretion to accept 'any person' on their list, regardless of whether they reside in the practice area.¹¹² Any refusal must be on reasonable grounds which do not relate to non-discrimination grounds such as ethnicity.

However, the application of the 2005 Visitor Regulations to medical card applications means GPs cannot exercise discretion to include 'any person' on their practice lists. The application of the 2005 Visitor Regulations to primary care does mean that a broader number of persons (who fall into the specified exemption categories) are admitted to GP lists than were under the 1970 Regulations (and therefore the 2000 policy circular). Nevertheless, GP access is restricted in a way applied nowhere else in the UK, and GP discretion is restricted in conflict with the 2004 GMS regulations.

Following further requests for clarification, the DHSSPS recently stated that its position is now that the 2005 Visitor Regulations do not apply to primary care.¹¹³ The DHSSPS regards the 2005 Visitor Regulations as the only regulations to have been issued under article 42 of the 1972 Order making services available to persons who are not ordinarily resident, and hence regards publicly funded GP services as unavailable to persons who are not ordinarily resident. The DHSSPS argues that the GP discretion to register 'any person' on to their list has now to be read as 'any person who is ordinarily resident' in the context of article 42. The DHSSPS does however make it clear that this should not apply to 'immediately necessary treatment' provided to any person under the GMS contract.¹¹⁴ The DHSSPS has therefore instructed BSO not to use the 2005 Visitor Regulations to assess primary care entitlement, but to allow registration only for those who are ordinarily resident, while taking into account, also, other relevant legislation, including EEA rights (European Health Insurance Card, cross border workers, accession nationals, etc) and reciprocal agreements.¹¹⁵

The DHSSPS has now clarified that, having reviewed the implications of removing the 'ordinarily resident' criterion, its ongoing policy intention is to maintain a link between that status and access to publicly funded primary care, as was explicit in the 1970 Stormont Regulations. Setting out its rationale for doing so the DHSSPS argues:

¹¹² GMS Regulations Schedule 5, Part 2, para 15(1).

¹¹³ The Department's position thus seems to be that primary care is not among the 'services forming part of the health services' to which the 2005 Visitor Regulations apply.

¹¹⁴ DHSSPS memos to NIHRC, 20 May, 22 June and 14 December 2010.

¹¹⁵ DHSSPS memo to NIHRC, 14 December 2010, paras 5 and 17.

...this distinction in the legislative framework between Great Britain and Northern Ireland justifiable and proportionate, given that Northern Ireland has a land frontier with another EU state which does not have an entirely analogous system of publicly funded healthcare. We believe that a policy initiative which seeks to discourage persons crossing the border for the purpose of availing of publicly-funded health services is, in the Department's view, proportionate given the overriding statutory imperative in Section 2 of the Health and Social Care (Reform) Act (NI) 2009.¹¹⁶ [...]

With regard to an evidence base for the need for the ordinary residence requirement, anecdotal evidence points to a significant number of people registered with GP practices in Northern Ireland who are in fact residents of the Republic of Ireland. BSO counter fraud carry out work in relation to the misuse of health services by those who are Republic of Ireland residents.¹¹⁷

The DHSSPS further regards the provision of emergency treatment in A&E Departments, as well as immediately necessary treatment from a GP to all regardless of residency, as a sufficient healthcare safety net to meet human rights obligations (in both domestic and international instruments).

In addition to assessing the proportionality of this policy in relation to permitted legitimate restrictions under instruments such as ICESCR and ICERD, there is also the question of whether the particular restriction is proportionate to the policy aim. The stated aim of the measure is to restrict persons resident in the Republic of Ireland from registering with Northern Ireland GPs. It is clear however that the impact of doing so through an 'ordinary residence' requirement goes well beyond this aim, as many persons who are living short term in Northern Ireland (but do not yet qualify as ordinarily resident - including visitors ordinarily resident in Great Britain) are also prevented from being included on a GP's list. Given this, the measure could be indirectly discriminatory.¹¹⁸

¹¹⁶ Section 2 sets out the Department's general duty in relation to 'people in Northern Ireland'.

¹¹⁷ DHSSPS memo to NIHRC, 14 December 2010, paras 8 and 11.

¹¹⁸ The Race Relations (Northern Ireland) Order 1997 (as amended). Indirect racial discrimination would take place if there is detriment from a rule that is applied to all cannot be met by a significantly different proportion of a particular racial group, and the rule cannot be justified irrespective of the nationality, ethnic origin etc. It would also take place if the public service applies a criterion that puts a minority ethnic group at particular disadvantage and cannot be shown to be a proportionate means of achieving a legitimate aim.

Primary care: legal certainty

There are also significant questions regarding the legal certainty of the present policy position. The engagement of an ECHR right, such as Article 8, requires that decisions on entitlements, as well as being non-discriminatory, be made in accordance with the law. Having an entitlement that one is unable to access, because there is no mechanism to allow one do so, can be unlawful.

The DHSSPS does recognise that HSS(PCD)10/2000 is outdated and intends to overhaul the guidance in this respect. The Department appears to regard the present legislative framework as sufficient to provide for its policy intention of linking primary care to ordinary residence. This is questionable on several levels.

First, there appears to be a selective interpretation of when the 'ordinary residence' restriction applies to services under the 2004 GMS Regulations. Further to Article 57A of the 1972 Order (as amended), General Practitioners are obliged to provide particular "essential services" under mandatory terms of the General Medical Services Contract set out in the 2004 GMS regulations. GPs are not allowed to ask for, or accept, payment for services provided for under the terms of the contract.¹¹⁹ Regulation 15(3) and (5) provide for the full range of health services provided by GPs for patients which are either '*fully registered*' with them or who are registered as *temporary patients*. Under Regulation 15(6) GP practices on request must provide the *immediately necessary treatment* of any person who has had an accident or any medical emergency in the practice area.

Second, the 2004 GMS Regulations do not restrict access to a GP practice list to ordinary residence or qualified visitors, or otherwise contain residence restrictions, but allow access to "any person".¹²⁰ A GP practice has discretion to accept any person on to its list of patients, even if they are not resident in the practice area or if they are registered with another practice. The application to become a registered patient is made by taking an existing medical card or application form to the GP practice. The 2004 Regulations provide

¹¹⁹ Under Regulation 24, GP contractors (hereafter GP practices) are not allowed to ask for or accept payment from patients for these or other services provided under the contract. Under Regulation 24(3), when a patient presents for treatment and claims to be registered but cannot produce a medical card, and the GP has reasonable doubts as to their registration, the GP can seek a reasonable fee which can be reclaimed by the patient. Schedule 4 of the Regulations sets out the circumstances where GP practices may charge fees to a patient – which covers private patients and other matters falling outside of the core services included within the contract (for example, immunisations for travel abroad).

¹²⁰ Regulation 26, Schedule 5, Part II.

that if the GP practice accepts the patient, the Board must include them on the GP Practice list.¹²¹

The DHSSPS maintains that this part of the 2004 Regulations should be read as “any person’ who is ordinarily resident” as there is no legal basis to provide such services to those who are not. However, the Department is simultaneously arguing that the duty in the same Regulations to provide *immediately necessary treatment* to “any person” owing to an accident or any medical emergency in the practice area¹²² should be read as “any person”, and not restricted to those ordinarily resident.

It should be noted that the preceding GMS Regulations in 1997, which were drafted when primary care was restricted by the 1970 Visitor Regulations, did explicitly restrict entitlements to register with a GP to those who were ordinarily resident.¹²³ This would indicate that the ‘ordinarily resident’ restriction was not intended to apply to services provided under the 2004 GMS contract.

Any restriction of GP care to those ‘ordinarily resident’ would engage compatibility not only with UN human rights instruments but other UK treaty commitments, including those in the EU, Council of Europe, NATO and bilateral treaties. The DHSSPS has given assurances that BSO also recognises EEA rights when examining applications. However, it is unclear how the DHSSPS can argue that it cannot lawfully make GP services available to persons who are not ordinarily resident, but simultaneously give assurances that it is doing so where EEA rights are engaged.

GP discretion

It is notable that while respecting the principle of GP discretion for full registration, the Regulations already contain a framework as to when a person should be registered as a temporary patient, centred on a three month period.¹²⁴ There are also short-term duties

¹²¹ Schedule 5, para 15. If a practice becomes ‘full’, the practitioner must formally close their list and is then at liberty to accept only immediate family members of existing registered patients (para 29).

¹²² Under Regulation 15(6) of the 2004 GMS Regulations.

¹²³ General Medical Services Regulations (Northern Ireland) 1997 (SR 1997/380) regulation 19(1). Neither set of Regulations was explicitly made under article 42 of the 1972 Order.

¹²⁴ GP Practices can accept patients as *temporary residents* if the practice is satisfied that the patient is temporarily away from their normal place of residence (and not getting services elsewhere); or if the patient does not have a fixed place of residence. A person can be a temporary resident if their period of residence is over 24 hours but not intended to be for more than three months (GMS Regulations, Schedule 5 para 16). The temporary registration ends after three months, or earlier if the GP practice gives notice.

towards those whose applications are rejected.¹²⁵ While GP practices maintain discretion, refusals to accept a patient must not be unreasonable.¹²⁶ The GP Practice must have reasonable grounds which must not be discriminatory, including grounds of racial group. Reasonable grounds include the patient not living in the GP Practice area. Refusals and the reason for the refusal must be notified in writing within 14 days. Written records of all refusals and reasons for doing so must be kept and provided to the Board on request.¹²⁷ BSO has indicated to the Commission that it had not compiled or analysed the reasons for refusal from practices.

The DHSSPS provided in correspondence further clarification as to its interpretation of the legislation in which it is argued that “it may be reasonable to refuse if the [GP] contractor is not satisfied the patient is entitled to free health services”.¹²⁸ However, if a person is prevented from accessing primary care to which they are entitled, on the grounds that they do not have free access to secondary (hospital) care, and this disproportionately impacts on minority ethnic groups, it may be held to constitute (indirect) racial discrimination, which is prohibited both in the 2004 GMS Regulations and anti-discrimination law. The DHSSPS correspondence agrees that GP practices, as independent contractors, have full discretion to register any patient onto their list, regardless of whether they have a medical card. However, the Department then goes on to state that a request for evidence of health services entitlement is “generally a prerequisite” for inclusion on a contractors list, and that:

If a person cannot either produce evidence of a health service number or a medical card that has been issued to them, this makes usage of health services difficult. While technically such a person can still register with a GP, in reality they would have to pay for any

¹²⁵ If a patient has applied to be registered (as a full or temporary patient) and has been rejected (and is not registered with another practice) the GP practice must provide, for a period of 14 days, primary medical services for immediately necessary treatment. The same is the case for any person present in the practice area for less than 24 hours.

¹²⁶ Under paras 32 and 34, the health Board has power to assign new patients to GP practices. This is when a patient wishes to be assigned a GP and is temporarily or permanently resident in the Board’s area and has been refused registration. In making assignments, the Board must have regard to the patient’s wishes and circumstances, distance between the GP practice location and the patient’s residence, whether the patient has previously been removed from a list, and other factors. Rather than ‘ordinary residence’, the concept of residence in this instance appears to refer to locating the patient to a nearby GP practice, and Board’s jurisdiction (on 1 April 2009 the four health Boards were reduced to one).

¹²⁷ As above, para 17.

¹²⁸ DHSSPS memo to NIHRC, 22 December 2009. Within this, the DHSSPS also interprets the Regulations as permissive of charging for primary care; this issue is dealt with in the previous chapter.

services (apart from the immediately necessary category of treatment) that they would receive, so a GP would normally seek this type of evidence as a matter of course, before entering into a contractually binding doctor-patient relationship.¹²⁹

In this instance, the DHSSPS appears to concede that visitors do have entitlements to publicly funded primary care in theory, but in practice the administrative arrangements in place prevent those rights from being realised.

Hospital care

There is no DHSSPS guidance, other than the 2005 Visitor Regulations, relating to accessing hospital care. The 2005 Regulations, as amended, therefore remain the instrument by which BSO – along with Boards and Trusts where applicable – determine entitlements.

The types of services, sub-categories of visitors, and circumstances when there is an exemption from charges under the 2005 Visitor Regulations largely mirror the equivalent instruments in Great Britain. Northern Ireland has not followed Wales in adding failed asylum seekers¹³⁰ to the list of exempted visitors. In addition, neither maternity services, treatment for children nor treatment for HIV/AIDS are included. The DHSSPS has committed to exploring the feasibility of additional exemptions for maternity treatment, treatment of children and failed asylum seekers.

The visitors exempt from charges under Regulation 3(b) are persons who are present in the UK for approved purposes including employment (with a UK-based employer) or self-employment. This exemption is also made in regulations in Great Britain but is particularly relevant to Northern Ireland to the situation of cross-border workers. The visitor must demonstrate to the satisfaction of the HSC Board, or the respective HSC Trust, that they fall into one of the above categories. Boards and Trusts should therefore have procedures in place in order to make this determination. The Commission has been informed that no HSC Trust has its own policy guidance in relation to this matter, nor does the new Health and Social Care Board.¹³¹

¹²⁹ DHSSPS memo to NIHRC, 22 December 2009.

¹³⁰ Asylum seekers who have exhausted their application process and have not been granted refugee status.

¹³¹ The Board was established on 1 April 2009 and replaced the previous four Health and Social Services Boards. In the transitional period these boards continue in shadow form as 'legacy Boards'. One of these Boards (Southern) had issued a 'Dear Colleague' letter to GP Contractors in the area with flowchart

The formulation in the 1972 Order of making 'services available' differs from the equivalent provision in English legislation which does not circumscribe the availability of services in this way, but has the starting point that any service is free unless there is a charging regime.¹³² The contrary Northern Ireland formulation of the starting point being whether services are available was set out in the 1970 Visitor Regulations and is framed in present day Regulation 3 as "visitors to whom services forming part of the health services shall be available". In England, Wales and Scotland, the formulation is "overseas visitors exempt from charges".¹³³ The 2005 Visitor Regulations are permissive, allowing charges to be levied (when visitors do not fall into exemption categories) but not placing a statutory obligation on health service providers to charge patients for health services.

The DHSSPS subsequently queried whether the entitlements under Regulation 4(5) (services exempted from charges) only applied to sub-categories of visitors listed elsewhere in the Regulations. This interpretation had been derived from Regulation 3 (categories of visitors to whom services shall be available), which the DHSSPS interpreted could mean that these services could not be provided to other visitors. The Commission established that this had not been the interpretation in practice to date (rather the interpretation had been that such services will be available without charge). Attention was also drawn to such an interpretation preventing access for most visitors to services which included accident and emergency, which would be incompatible with ECHR Articles 2 and 3. The Commission welcomes the DHSSPS commitment to amend the Regulations so that it is clear that the services in Regulation 4(5) are available to all visitors free of charge.¹³⁴

BSO and other guidance

BSO (formerly CSA) has issued four circulars to GP practices providing guidance on verification of entitlements.¹³⁵ Much of this guidance focuses on the issue of provision of copies of supporting documents to verify identity or residence when seeking to register with a GP practice. In January 2007, BSO (then CSA) advised that

information based on the 2000 DHSSPS circular (Primary Care Medical Advisor, Department of Primary Care, 23 April 2007).

¹³² Section 1(3) of the National Health Service Act 2006.

¹³³ Regulation 3 of SI1989/306 and SI1989/364 respectively.

¹³⁴ DHSSPS memo to NIHRC, 20 May 2010.

¹³⁵ CSA Director of Family Practitioner Services Circular MMS/1435, January 2007 (untitled); Circular MMS/1441, June 2007: Evidence to Confirm Identity Details; Circular MMS/1469, March 2008: Verification of Identity Details; Circular MMS1470 April 2008: Asylum Seekers.

EEA residents should provide passports, ID cards or the European Health Insurance Card (EHIC) and that non-EEA nationals should be asked to provide a visa, work permit, employment contract, asylum confirmation letters or other relevant information indicating residence. This circular stated that, to avoid discrimination, evidence of identity should be sought from all applicants. Problematically, later guidance (in June 2007) indicated that such verification should be restricted to “persons who come from abroad”. It was subsequently clarified that all new patients should be asked for documents (March 2008).

The guidance indicates that the GP practice can verify EEA documents, but copies of non-EEA documents must be sent to CSA. An exception to the EEA requirements is provided for the A2 countries (Romania and Bulgaria) which joined the EU in 2007. The January 2007 circular states that A2 migrant workers should have work permits, and the June 2007 guidance states that ‘immigration regulations’ require a work authorisation for A2 migrant workers, and this document should be forwarded. While the authorisation can prove long term residence, the singling out of this document may lead to visitor or other residence treaty rights not being assessed, and risks practice staff accepting the EHIC from other EEA nationals but not Romanians and Bulgarians.

Also potentially problematic is that the CSA guidance indicates that persons who have been in “the UK for the greater part of a year or longer and have a settled purpose for being here” are entitled to NHS treatment. This appears to restrict the interpretation of ordinary residence beyond even the intention to stay for six months set out in the DHSSPS primary care policy guidance document, HSS(PCD)10/2000.

The circulars do deal with the issue of avoiding racial profiling, indicating that verification of identity should be undertaken of all applicants, and pointing out that only asking some persons on the basis of skin colour or accent could constitute racial discrimination. CSA then goes on to express grave concern regarding reported incidents of problems faced by Portuguese nationals of East Timorese origin, indicating there should be no differential treatment to other Portuguese citizens. CSA reminds GP practices that any decision to refuse persons who are from minority ethnic backgrounds who are entitled to register may constitute discrimination. This guidance is particularly welcome and positive in human rights terms as it reduces the risk of racially constructed stereotyped assumptions influencing document request decisions.

In relation to other guidance, the Department of Health (England) issued a circular in 2006, which was sent to ‘Northern Ireland NHS

Boards' (sic), references the accession of Romania and Bulgaria to the EU in 2007 and indicates that both are to be treated in the same manner as other EU member states.¹³⁶ CSA also issued a handbook to GP practices (also used by internal staff), entitled *Health and Social Care in Northern Ireland*. This is a multilingual and comprehensive booklet providing information on the health and social care services, and how to access them. The handbook is clearly aimed at service users rather than practitioners and touches briefly on the issue of entitlement, referencing resident and visitor entitlements. It states that the requirement for a medical card is ordinary residence, set out as resident in the UK for a settled purpose for more than six months.¹³⁷

There are independent publications aimed at service users and their advocates which address the issue of eligibility for free health care. These include the Commission's own multilingual booklet series (produced jointly with the Law Centre Northern Ireland) *Your Rights in Northern Ireland: A Guide for Migrant Workers*, which sets out basic eligibility requirements, including that a GP Practice can only refuse registration on 'reasonable grounds' that are non-discriminatory. More generally, the guidance urges patients to seek independent advice regarding exemptions to payment.

Summary

Hospital care: DHSSPS has not issued any policy guidance in relation to hospital services. The present legislation in Northern Ireland is permissive of charges being made on visitors for hospital care subject to a number of exemptions set out in legislation. This does not include maternity care, nor care for refused asylum seekers. All persons deemed 'ordinarily resident' are eligible for full access to hospital services and therefore how this concept is interpreted in practice is important. The primary care guidance provided by HSS(PCD)10/2000 as to the concept of ordinary residence, which summarises key points from the *Shah* judgment, appears to be the only formal guidance as to how the concept is to be determined by BSO decision makers. BSO itself has, in one circular, suggested a more restrictive interpretation, and some of the information sought on the application form risks a 'real home' test being applied. Further, the Board and Trusts do not appear to have any internal guidance in relation to visitor regulation 3(b) regarding persons present in the UK for an approved purpose. It is not clear if this function is delegated to BSO.

¹³⁶ Update on EU enlargement and Overseas Visitors rights to primary care treatment in the UK, 13 December 2006 (Gateway reference 7587).

¹³⁷ CSA, *Health and Social Care in Northern Ireland*, p10.

Primary care: The GMS regulations do not allow for charging for GP services delivered as part of the GMS contract. Under the 2004 GMS regulations, GP practices are at liberty to accept patients onto their list regardless of status, and cannot refuse if to do so would be unreasonable or constitute racial discrimination. While there is GP discretion regarding full registration, the stipulation for temporary patients (and therefore clearly the intention) is for persons who intend to reside for less than three months to be registered as temporary patients. GP practices are also to provide all immediately necessary treatment required by any person due to an accident or medical emergency in their practice area.

The DHSSPS has issued policy circular HSS(PCD)10/2000 in relation to primary care. However, this predates by around five years the enactment of the present Visitor and GMS Regulations and is based on repealed legislation. It has become clear that in practice the stipulations of the outdated policy circular and those in the 2005 Visitor Regulations continued to be applied to primary care until relatively recently, meaning Northern Ireland is the only part of the UK to restrict access to primary care in this way.

The DHSSPS has set out that its ongoing policy intention has been, outside immediately necessary treatment, to maintain a link between 'ordinary residence' and access to publicly funded GP services. The stated aim of the measure is to restrict persons resident in the Republic of Ireland from registering with Northern Ireland GPs, although assurances are also given that EEA rights will be respected. In addition to assessing the proportionality of this policy in relation to permitted legitimate restrictions under instruments such as ICESCR and ICERD, there is also the question of whether the particular restriction is proportionate to the policy aim. The impact of the restriction goes well beyond this aim as many persons who are living short term in Northern Ireland (but do not yet qualify as ordinarily resident) are also prevented from being included on a GP's list. Given this, the measure could be held as being indirectly discriminatory. There are also significant questions regarding the legal certainty of the present policy position.

An alternative, as in the rest of the UK, is to explicitly remove any restrictions and permit GP discretion to regulate applications. In this instance, BSO would have to consider when to conduct the application assessment process to assess whether a person is entitled to free hospital care.

5. SUMMARY ANALYSIS AND RECOMMENDATIONS

This research paper set out to address two questions:

- (1) Are the restrictions on entitlements as they presently stand compliant with international human rights standards?; and
- (2) Is there sufficient legal certainty in practice around who is entitled to free medical treatment?

A summary analysis of the findings for each question is presented below, with the Commission's recommendations.

Are the restrictions on entitlements as they presently stand compliant with international human rights standards?

- **International standards:** The UK has made international human rights commitments that bind it to affording equality of access to medical care for all without discrimination, including to migrants of whatever status. While this right is not absolute, the onus is on the state to provide justification that any restrictions are proportionate, otherwise they could be held to constitute racial discrimination. There are also certain core minimum obligations which should not be subject to restriction, including access to primary care, and emergency treatment when the life of any individual is at risk or when to withhold treatment would be inhuman or degrading. Special obligations also exist in relation to provision for maternity and children's services.
- **UK policy:** There are no restrictions in the UK to free health care for all persons lawfully 'ordinarily' resident. There are restrictions for persons deemed non-resident ('visitors') to hospital services. These restrictions go beyond restrictions on visitors who have travelled specifically for medical care, and may go beyond what is proportionate in relation to the UK's human rights commitments. Any further restrictions could, in addition to being a retrogressive step, violate such commitments. For example, extending present hospital restrictions to primary care in the absence of a compelling evidence base would conflict with the UK's minimum legal obligations under the ICESCR.

- **Northern Ireland context:** Health care entitlement regulations in Northern Ireland are a devolved matter (save for the fact that the devolved institution could not adopt more restrictive measures if, as likely, they would conflict with the human rights commitments entered into by the UK as a whole). The present policy intention of the DHSSPS in Northern Ireland is to link access to publicly funded primary care to 'ordinary residence' (except for treatment that is immediately necessary). The stated aim of this restriction is to prevent persons resident in the Republic of Ireland from registering with Northern Ireland GPs. The proportionality of this restriction, and, therefore, its compatibility with human rights standards, is questionable.

The Commission recommends:

- **Primary care:** the DHSSPS should review its position in relation to primary care with a view to revoking the policy link to ordinary residence, and allowing the GP discretion provided for in the framework of the 2004 GMS Regulations. In doing this, the DHSSPS should produce an evidence base, beyond the anecdotal, to demonstrate if there is sufficient substantiation to justify the current policy rationale. If a restriction is maintained to meet this policy rationale, the method should be revised to a mechanism that ensures respect of the EEA rights of residents of the Republic of Ireland, and that other groups of persons living short term in Northern Ireland are not inadvertently caught by the measure.
- **Hospital services:** as an initial step, the DHSSPS should give particular consideration to adding additional exemptions from hospital charges for maternity care, children and failed asylum seekers. The DHSSPS should also examine whether, in an emergency scenario, access only to accident and emergency departments affords sufficient protection against death or inhuman and degrading treatment for visitors who are not otherwise exempt from charges and are unable to pay.

Is there sufficient legal certainty in practice around who is entitled for free medical treatment?

- The research has highlighted deficiencies in the clarity of formal legislation and policy, and in the arrangements in place to facilitate service users' access to the entitlements that they have.

- It is apparent that the 2005 Visitor Regulations were, for a number of years, applied to applications to register with a GP. The DHSSPS now regards the Regulations as not applicable to primary care. There is ambiguity regarding the basis for this.
- The DHSSPS argues that, in the absence of regulations, the present law does not allow publicly funded GP services to be provided to persons who are not ordinarily resident. However, the DHSSPS only appears to apply this reasoning to persons applying to a GP list, not to those needing immediately necessary care, nor those for whom there is an EEA or other treaty requirement. While access to immediately necessary care clearly needs to be protected and other treaty rights may be also be actionable, it is not clear what the legal basis is for the Department's interpretation that some of the services provided for in the 2004 GMS Regulations can only be provided to those ordinarily resident. The 2004 Regulations, unlike their predecessor Regulations, do not include such a qualification.
- The DHSSPS primary care policy circular HSS(PCD)10/2000, which predates by around five years the enactment of the present Visitor and GMS Regulations, is still in force and could be held to be unlawful should it lead to restrictions that are beyond what is presently provided for in the law.
- There is at present no DHSSPS guidance on secondary (hospital) care other than the Visitor Regulations themselves.
- The definition of ordinarily resident is important in the interpretation of BSO as to who is allowed full access to health care services. At present, there are some indications that an unduly restrictive interpretation could result from existing evidence-gathering methods and guidance.
- The Board and Trusts discharge a particular function in relation to determining entitlements of persons present in the UK for an approved purpose (for example, cross-border workers). It is not clear if this function is delegated to BSO, conducted internally, or not discharged at all.
- There is an ambiguity in the drafting of Regulation 3 of the 2005 Visitors Regulations which sets out categories of visitors to whom health services "will be available", rather than the formulation in the corresponding Regulation in England, Wales and Scotland which refers to visitors "exempt from charges". The commitment of the DHSSPS to rectify this is welcome.

- There is a lack of legal certainty in relation to EEA rights, in particular in relation to nationals of Romania and Bulgaria. At present all EEA nationals, including Romanians and Bulgarians, are afforded an initial residence period of three months. After that period, they must show that they are exercising a treaty right such as employment. Residence rights are then extended for as long as the person is exercising freedom of movement rights. It is not clear if such preliminary periods of residence on the basis of EEA rights are always counted towards meeting the 'ordinary residence' criteria. If not, EEA nationals still have visitor rights to treatment during their visit (except if a person travels for the purpose of medical care which is dealt with by separate regulations). However, in practice Romanians in particular appear to have difficulties in accessing either. The information gathering process for Romanian and Bulgarian nationals differs from that for other EEA nationals. While there is a difference in relation to exercising freedom of movement for employment, it is not clear how other treaty based or visitor rights are recognised.

The Commission recommends:

- The DHSSPS should take the necessary steps to ensure that there is no ambiguity in relation to entitlements to access publicly funded primary care services and that a clear framework is provided in law.
- In light of the review recommended above, a consequential amendment (or policy direction) may be required to ensure that the full set of GP primary care services, including access to a GP list (subject to GP discretion), are genuinely available to "any person" under the terms of the 2004 Regulations.
- The policy circular HSS(PCD)10/2000 should be withdrawn. Guidance should be issued to GP practices based on the stipulations of the 2004 GMS regulations. This should include reference to human rights and anti-discrimination legislation, and include advice on preventing racial discrimination through racial profiling and indirectly discriminatory criteria.
- The DHSSPS should discharge its commitment to amend the wording of regulation 3 of the Visitor Regulations to ensure clarity.
- Guidance on the Visitor Regulations should be issued and include reference to obligations under human rights and anti-discrimination legislation.

- BSO should have clear internal guidance referencing the established common law definition of ordinarily resident.
- BSO should also ensure that its procedures address the full range of entitlements for Romanian and Bulgarian nationals.
- In providing the service on behalf of the HSC Board, BSO should exercise its power to seek records of refusals for GP registration by practices, and analyse the reasons for refusals by practices or by BSO itself.
- The Board and Trusts, or BSO on their behalf, should have procedures for facilitating hospital care for persons present in the UK for an approved purpose (for example, cross-border workers).
- In light of a settled policy position being reached by the DHSSPS in relation to primary care, the medical card application process should be amended to ensure that the process for assessing entitlement for hospital treatment does not prevent access to primary care. If the assessment takes place at the point of registration, and a patient is not deemed ordinarily resident or a qualified visitor for hospital treatment, but is subsequently referred from a GP some time later, a procedure may be needed to ensure that their circumstances are reassessed.