



## Joint Committee on Human Rights

### Call for evidence on legislative scrutiny priorities for 2013-14

NAT (National AIDS Trust) is the UK's leading charity dedicated to transforming society's response to HIV. We provide fresh thinking, expertise and practical resources. We champion the rights of people living with HIV and campaign for change.

NAT welcomes the opportunity to respond to the Joint Committee's call for evidence on legislative scrutiny priorities for 2013-14, and below we comment specifically on the published Care Bill and the so far unpublished Immigration Bill.

### Executive Summary of Recommendations

- **NAT recommends the Joint Committee on Human Rights scrutinise the possible impact of the Care Bill on disabled people's rights (including those living with HIV) as enshrined in the UN Convention on the Rights of Persons with Disabilities and domestic UK legislation.**
- **NAT strongly recommends the Joint Committee on Human Rights scrutinise the likely effect of the Immigration Bill on migrant access to NHS primary and secondary care services and the impact this will have on their Article 2 (ECHR) and Article 12 (CESCR) rights.**

## A. The Care Bill

1. People living with HIV are disabled according to the definition included in the UN Convention on the Rights of Persons with Disabilities. They are also protected against discrimination and harassment under the disability-related provisions of the Equality Act 2010. The new Care Bill addresses areas of policy that are directly linked to those covered by the Convention's Article 19 'Living independently and being included in the community' and Article 28 'Adequate standard of living and social protection'.
2. People living with HIV can for a variety of reasons need to access both open access social care and Fair Access to Care Services (FACS) assessed local authority social care. Several NAT reports explore the importance of social care to improving the health and social outcomes of people living with HIV,<sup>1</sup> and also some of the difficulties they can already have in accessing assessed social care.<sup>2</sup>
3. NAT believes the Care Bill offers significant opportunities to improve the rights of people to access social care; reforming and revising the relationship between

<sup>1</sup> NAT, June 2011, '*The impact of social care support for people living with HIV: the results of NAT's snapshot survey of healthcare professionals*', <http://www.nat.org.uk/Media%20library/Files/Policy/2011/Social%20Care%20Survey%20June%202011%20FINAL.pdf>.

<sup>2</sup> NAT, June 2013, '*Access to Social Care in England: local authority assessments*', [http://www.nat.org.uk/media/Files/Publications/June\\_2013-Policy\\_Briefing\\_Access\\_to\\_Social\\_Care.pdf](http://www.nat.org.uk/media/Files/Publications/June_2013-Policy_Briefing_Access_to_Social_Care.pdf).

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people who need social care, and the local authorities who manage the assessment process and commission these services.

4. The Care Bill introduces the welcome concept of a general duty on local authorities to promote the well-being of an individual in the social care system. The duty to prevent the need for care and support is also welcome, as is the duty in Section 4 to provide information and advice relating to care and support for individuals and carers.
5. Included in Sections 9 and 10 of the Care Bill is a right to an assessment for individuals and carers. NAT believes it is important that this assessment is a collaborative process that involves the disabled person and that for people with complex conditions like HIV it allows the inclusion of information provided by support workers, social workers as well as medical professionals.
6. It is positive step that the Bill introduces a duty on local authorities to cooperate and a further duty to ensure the portability of care packages between local authorities. NAT is however keen to highlight that these new duties require further scrutiny in how this cooperation and portability will be regulated when it comes to more specialist care. People with more complex needs should not be discriminated against, and it is important that the system ensures that care packages are genuinely portable.
7. NAT is concerned that migrants and others subject to immigration control who already face difficulty in accessing social care may now find it more difficult. Schedule 3 of the Nationality, Immigration and Asylum Act 2003 already restricts support to key groups, unless withholding services could breach human rights or EEA treaty rights. NAT believes local authorities need to make a human rights based assessment before denying care, and that the right to a social care assessment should not be restricted.
8. The No Recourse to Public Funds (NRPF) Network (NRPF) has published research which showed that in the financial year of 2009/10, local authorities supported 1,825 adults with care needs who were subject to NRPF.<sup>3</sup> Their analysis estimated that there were at least 3,000-6,000 similar adults with care needs. While NAT is unaware how many of these people are living with HIV, there are higher levels of HIV prevalence in some migrant communities.
9. NAT believes that the Joint Committee's scrutiny could add to the understanding of the Bill's impact in this area. The Bill seeks to replace the existing exclusions on accessing social care for persons subject to immigration control set out in: sections 21(1A) and (1B) of the National Assistance Act 1948, section 45(4A) Health Services and Public Health Act 1968. Further restrictions on access to the provision of advice and information could have a negative impact on the health and well-being of people living with HIV, who although they now have access to free HIV treatment, may still need social care.
10. The introduction of national eligibility criteria in Section 13 could be a positive step, reducing inequities in assessments, decisions and the provision of social care between local authorities. The new eligibility criteria will be introduced in regulations that are going to be published alongside the Bill. The committee may wish to comment on the draft regulations when they are published.

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<sup>3</sup> NRPF Network, March 2011, 'Social Services Support to people with No Recourse to Public Funds', [http://www.nrpfnetwork.org.uk/policy/documents/NRPF\\_national\\_picture\\_final.pdf](http://www.nrpfnetwork.org.uk/policy/documents/NRPF_national_picture_final.pdf).

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11. NAT, like other disability charities, made representations during the consultation on the then draft Care and Support Bill<sup>4</sup>, suggesting that the national level of eligibility should be set below substantial. Having a national set of criteria in terms of equity, fair treatment, and transparency in decision making should be an improvement, but by setting the level of national eligibility too high it could exclude large numbers of disabled people from the care and support they need. It is also unclear in Section 13(5) what support will be on offer to those who still have social care needs, but don't meet either the existing local, or new national, eligibility criteria.
12. **NAT recommends the Joint Committee on Human Rights scrutinise the possible impact of the Care Bill on disabled people's rights (including those living with HIV) as enshrined in the UN Convention on the Rights of Persons with Disabilities and domestic UK legislation.**

### B. The Immigration Bill

1. The draft Immigration Bill is yet to be published. However, information provided by the Government in the Queen's Speech and other public announcements indicates that it will include provisions which will undermine some migrants' rights to health.
2. People from sub-Saharan Africa are disproportionately affected by HIV and around a third of people living with HIV in the UK were born in Africa. This means that migrant access to healthcare is vital to the UK's efforts to tackle HIV.
3. NAT has for many years campaigned for increased migrant access to HIV testing and treatment. In November 2012, HIV treatment was made freely available to everyone living in England. However, to access this treatment, migrants must be able to enter the healthcare system. We are concerned that the Immigration Bill will restrict this access.
4. This restriction of access will have consequences for the Article 2 and Article 3 rights (European Convention on Human Rights) of migrants living in the UK. As observed by the JCHR in its 2006-07 Session Report on the Treatment of Asylum Seekers, "under the ECHR, discrimination in the enjoyment of Convention rights on the groups of nationality requires particularly weighty justification."<sup>5</sup>
5. In addition, the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises in Article 12 "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Steps to be taken by states should include "the prevention, treatment and control of epidemic, endemic, occupational and other diseases". As is explained below, the proposed measures will have an impact on both the health of people living with HIV and the needs of migrant populations who are particularly at risk of contracting HIV. This will fly in the face of current efforts by the NHS and public health to tackle the HIV epidemic in at-risk communities and improve overall standards of health.
6. The UN's Committee on Economic, Social and Cultural Rights (CESCR) has stated that in its view Article 12 puts states are under an obligation to refrain "from

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<sup>4</sup> NAT, October 2012, Consultation response to the Draft Care and Support Bill.

<http://www.nat.org.uk/media/Files/Policy/2012/Oct-2012-Draft-Care-and-Support-Bill-NAT-Response.pdf>

<sup>5</sup> JCHR. 2007. The Treatment of Asylum Seekers. Tenth report of session 2006-07.

<http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf>

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denying or limiting equal access for all persons, including... asylum seekers and illegal immigrants, to preventive, curative and palliative health services".<sup>6</sup> This opinion has been repeated by the Committee on the Elimination of Racial Discrimination (CERD)<sup>7</sup>.

### **Migrant Access to NHS services**

7. Amongst other areas, the Immigration Bill will deal with migrant access to NHS services. The official briefing to the Queens Speech states that "the Bill would regulate migrant access to the NHS, ensuring that temporary migrants make a contribution."
8. People who are not 'ordinarily resident' in the UK, including short term visitors, may already be asked to pay for any secondary care services they use (unless they meet one of a list of exemptions). The migrants most affected by these rules are short-term visitors and irregular migrants (including refused asylum seekers and visa-overstayers).
9. There are currently no NHS charging rules for primary care for overseas visitors equivalent to those for secondary care, nor any legislation dealing explicitly with migrant access to primary care. GP surgeries are able to register anyone at their practice, regardless of immigration or residency status. Short term migrants who will be in the area for less than three months may be registered as a 'temporary resident'.
10. This suggests that, as previously indicated by the Department of Health; the Government is planning with this bill to introduce similar restrictions on primary care access as exist for secondary care. At a minimum, this will affect irregular and temporary migrants, but it is possible that proposals will be broader than this and impose charges on a wider range of migrants.
11. Universal access to primary care is an important underpinning principle of the NHS. Primary care is the first point of consultation for a patient, after which decisions can be made about whether it is appropriate to recommend secondary care services. Primary care services aim to reach the whole community. To limit access to primary care whether through charges or another means will effectively lock some migrants entirely out of the healthcare system. This is likely to lead to irregular migrants in particular being denied their Article 2 (ECHR) and Article 12 (ICESCR) rights while in the UK.

### **The role of primary care in HIV testing and treatment for migrants**

12. In the case of HIV, primary care is a vital site of diagnosis for at-risk migrant populations. African-born men and women are much less likely to seek an HIV test at a sexual health clinic than the other group most affected by HIV in the UK (gay and bisexual men). Between 2006 and 2009, one in three BME people diagnosed with HIV were tested outside of a sexual health setting, compared to one in five newly diagnosed white people.<sup>8</sup>

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<sup>6</sup> UN CESCR. 2000. General Comment 14: "The right to the highest attainable standard of health."

[http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En)

<sup>7</sup> CERD. 2004. General Recommendation No.30: Discrimination Against Non Citizens.

<http://www.unhcr.ch/tbs/doc.nsf/0/e3980a673769e229c1256f8d0057cd3d>

<sup>8</sup> Meaghan Kall et al. 2012. Where do we diagnose HIV? Monitoring new

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13. Primary care has been the cornerstone of recent efforts to increase rates of HIV testing in migrant populations and reduce rates of late diagnosis. In 2011, NICE published new public health guidelines to increase uptake of testing amongst African men and women, including recommendations on routine offers of HIV testing by GPs to this group.<sup>9</sup> These guidelines re-emphasised the recommendations made in the UK National Guidelines for HIV Testing (BHIVA, BASHH, BIS).<sup>10</sup>
14. Around a quarter of African-born people living with HIV in the UK do not yet know they have it. The problem of undiagnosed and late diagnosed HIV is most severe in migrant communities. In 2011 over 60 per cent of African-born men and women were diagnosed with HIV late, meaning after they should have already started treatment.<sup>11</sup> People who are diagnosed late are much more likely to develop serious illnesses (and in some cases, AIDS) which are preventable with access to treatment.
15. Primary care access is also vital for pregnant women, as illustrated by the current 'ASAP' campaign to encourage women to see their GP as early in their pregnancy as possible. For pregnant women living with HIV, prompt access to antenatal care is vital, especially if they are not yet diagnosed. With appropriate interventions, mother-to-child-transmission of HIV will happen in less than 1% of cases; where transmission does occur, this is associated with late access to antenatal care. Universal access to primary care is therefore also vital for the health and rights of children of women living with HIV.
16. Any policy which restricts migrant access to primary is likely to undermine efforts to decrease rates of undiagnosed and late diagnosed HIV and mother-to-child-transmission of HIV in migrant communities. Without prompt diagnosis, they are unable to access the HIV care to which they are entitled and are much more likely to become ill, in some cases very seriously.
17. **NAT strongly recommends the Joint Committee on Human Rights scrutinise the likely effect of the Immigration Bill on migrant access to NHS primary and secondary care services and the impact this will have on their Article 2 (ECHR) and Article 12 (CESCR) rights.**

**Sarah Radcliffe**  
**Policy & Campaigns Manager**

**NAT**  
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diagnoses made in non-traditional settings. IAC, Washington DC, Poster 161

<sup>9</sup> NICE.2011. Increasing the uptake of HIV testing among black Africans in England. Public Health Guidance

33. NICE. 2011. Increasing the uptake of HIV testing among men who have sex with men. Public Health Guidance 34.

<sup>10</sup> BHIVA/BASHH BIS. 2008. UK National Guidelines for HIV Testing.

<http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf>

<sup>11</sup> Health Protection Agency, *HIV in the United Kingdom*, 2012.