Statement of Changes in Immigration Rules – October 2011

NAT is the UK's HIV policy charity. We have worked on migration issues affecting people living with HIV over the past several years, including the implementation of NHS treatment charges for overseas visitors. We welcome the opportunity to provide a statement to the Merits of Statutory Instruments Committee about the Statement of Changes to Immigration Rules laid on 10 October 2011.

We are very concerned by changes to the Immigration Rules, currently before Parliament, which make it possible for the UK Border Agency to prevent a migrant from entering or extending their stay in the UK if they have unpaid NHS debts above £1,000. This is outlined in sections 43 and 44 of the October 2011 Statement of Changes in Immigration Rules.

NAT believes that these new rules will have a serious impact on public health by dissuading migrants with HIV from accessing testing and treatment. We also think that the rules may lead to unlawful discrimination against disabled migrants within the framework of the Equality Act 2010. Finally, we question whether the new rules could be applied consistently and fairly, given the variation in implementation of charging rules across the UK.

1. Public health

HIV is the one communicable disease still subject to NHS charges and it particularly affects migrant communities. We know that treatment charges dissuade migrants from accessing HIV testing as well as treatment. Chargeable migrants who may suspect that they have been exposed to HIV are deterred from getting tested, even though the test is not subject to charges, because any treatment they access will result in a large, unpayable bill. These new immigration rules will add a further disincentive as the migrant will now also know that their bill will also put an end to any future plans they may have to obtain a visa or permission to stay in the UK.

One in 20 African migrants living in the UK has HIV, and the majority are diagnosed ‘late’, after the point when they should have started treatment. If they are not diagnosed and given treatment in good time they will become seriously ill, needing hospitalisation and much more expensive treatment and care. Accessing treatment also has an important preventive benefit for the community. Recent research shoes that being on treatment can reduce infectiousness by 96%.1 By contrast, those who are untreated or have interrupted treatment are more likely both to become seriously ill themselves and pass on HIV to others. We also know that those who are undiagnosed are the most likely to pass on HIV to others, and are responsible for more than half of new infections.2 Immigration restrictions which dissuade from testing and treatment for HIV within migrant communities will be disastrous for public health.

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2 Marks, G, Crepaz N, Janssen RS. ‘Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. AIDS, 2006 Jun 26;20(10):1447-50
2. Discriminatory impact of using NHS debt information in immigration decisions

Plans to limit entry or stay in the UK where there is an outstanding NHS debt will result in unlawful discrimination against disabled people. Migrants with HIV who incur debts above the £1,000 threshold will face immigration restrictions which would not apply if they did not have a disability (in law, HIV is a disability from the point of diagnosis). This is indirect disability discrimination as defined by the Equality Act 2010.

Working within the framework of the Equality Act, the Government has defended the indirect discrimination by claiming that it is a proportionate means of achieving a legitimate aim - the 'legitimate aim' being safeguarding NHS resources. However, as demonstrated above, deterring people from early testing and treatment will result in increased costs to the NHS. These include the costs of serious ill-health from untreated HIV and the future healthcare needs of those who are infected by undiagnosed, untreated sexual partners.

The assertion that this proposal safeguards costs also rests on claims that there will be a deterrent effect on others seeking to enter the UK to access free NHS care. However, there is no current trend of HIV ‘health tourism’ to address. The groups most affected by NHS charges for HIV treatment include refused asylum seekers, visa overstayers and those without papers, who have often been living in the UK for many years without lawful residency status. They are not ‘health tourists’. Most migrants who incur debts for HIV treatment had no idea that they would need such treatment when their arrived. On average, migrants are in the UK for almost five years before they even have an HIV diagnosis (and this was true when HIV treatment was not routinely charged in practice). In addition, we know that in Scotland, Wales and Northern Ireland, there is not the same practice of charging migrants for their HIV treatment as in England. There has been no mass movement of chargeable migrants to these nations. NAT produced a report on the myth of HIV health tourism in 2008, demonstrating that claims of HIV health tourism to the UK are wholly unfounded; the Government has not provided any evidence to the contrary.

3. Unequal impact of the new rules

At present, as has already been noted there are significant differences across the four nations in the application of NHS charges. There is also significant inconsistency within England. A migrant may be charged by one PCT, but not be by another. Nor is there any standard national approach to writing off debts when it is clear that these cannot be paid by the migrant. The guidance to trusts on implementing the charging rules makes it clear that writing off debt is possible, but there is no detailed advice on how best to identify patients who are unable to pay, or how promptly such a decision should be made, or on consistent criteria for such a decision.

There is therefore no consistency across the UK in relation to which migrants find themselves burdened with unpaid NHS debts - it is profoundly unfair, then, for these debts to affect their immigration rights.

NAT
October 2011

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3 Personal correspondence between NAT and HPA. Year of arrival is completed by clinicians for just over half of people who acquired their infection abroad.