

Entitlement to hospital treatment in the NHS

In 1977 powers to charge those not 'ordinarily resident' in the UK for NHS care were first introduced, and rules governing eligibility for free NHS care have become increasingly complex since. In this issue (p. 156), Dubrey et al present an interpretation of the current regulations and express concern that the treatment of ineligible patients presents a threat to the UK health system. Here we suggest the opposite: increasing attempts to restrict the access of vulnerable humans to health care present a threat both to individual and public health. We challenge all clinicians to provide immediately necessary care and to protect public health.

Immediately necessary care

There is evidence that patients have come to harm as a consequence of the incorrect interpretation of charging regulations, including pregnant women giving birth without any medical care (Kelley and Stevenson, 2006). It is therefore critical that health-care workers have a good understanding of the regulations, particularly as they relate to more vulnerable migrants. A simple and vital rule that covers many situations is this: if you feel that care is immediately necessary, you must provide it.

If treatment is felt to be immediately necessary (either to save life or to prevent a condition becoming life threatening) or urgent (not immediately necessary but which cannot wait until the person can be reasonably expected to return home), it should be provided regardless of ability to pay (Department of Health, 2004). All maternity care should be treated as immediately necessary but, beyond this, there are no published rules. Many physicians will feel that a good proportion of secondary care – from diabetic reviews to cancer treatment – is either immediately necessary or urgent.

Where charges are levied, hospitals are only permitted to chase payment for treatment as far as is reasonable. Destitute

patients should have their debts written off. Whereas charging for some treatments is permitted under NHS regulations, withholding immediately necessary treatment is neither legally nor ethically acceptable.

It should be remembered that asylum seekers are seeking refuge from war, violence or persecution. They are fully entitled to NHS care until they have had two appeals rejected. Courses of treatment commenced before both appeals have been rejected should be continued until the patient leaves the country – the so-called 'easement clause'. Treatment in an emergency department unless or until the patient has been accepted as an inpatient, treatment of notifiable diseases and pandemic influenza, treatment of sexually transmitted infection (except human immunodeficiency virus; HIV) and detention under the Mental Health Act are always free to any patient. GPs remain at liberty to register any patient, regardless of his/her immigration status.

Protecting public health

Dubrey et al write from a specific perspective: the cardiology department and private patient suite of a west London hospital. Specialist cardiology services are weighted towards expensive procedures in chronic conditions. Other clinical areas – such as communicable disease treatment – bring different perspectives and contrasting conclusions.

The Health Select Committee took evidence from HIV specialists and was 'deeply concerned' that while drafting regulations neither the Department of Health nor the Public Health Minister had 'considered or understood the public health implications of refusing HIV treatment to people who, although not legally resident, continue to live in this country' (Health Select Committee, 2005). The authors suggest that concern should extend to other communicable diseases, even those notifiable diseases intended to be exempt from charging for treatment.

Take the example of tuberculosis. Patients present with symptoms and not diagnoses. The diagnosis of tuberculosis is often dependent on modalities available only in secondary care such as computed tomography scanning and sputum induction. Consequently, as tuberculosis is often not suspected by primary care clinicians at the time of referral (Smith et al, 2006; Metcalf et al, 2007), most cases of tuberculosis are diagnosed after a patient is referred to specialist care settings with non-specific symptoms. Therefore, the opportunity to have symptoms investigated in secondary care is a prerequisite for tuberculosis control. However, current regulations exclude known high-risk groups (like failed asylum seekers) from routinely accessing secondary care. The exemption of tuberculosis treatment from charging is a hollow reassurance to public health concerns if access to a diagnosis is not also free.

Evidence of health tourism

Dubrey et al cite an article which states that St Mary's accident and emergency department spends 4.7% of its budget on 'non-eligible patients' (Colville et al, 1996). However, one in three of these 'non-eligible' patients were from North America and another third from the Middle East – mostly Kuwait. Dubrey et al report this study as including only patients 'without insurance'. In fact, the authors did not collect data on whether patients had health insurance and acknowledge that those from North America and Kuwait probably did have insurance. Dubrey et al are misinterpreting the limited evidence and risk being accused of sensationalism in this regard. Other claims made in their article, in particular the claim that 12.5% of the world's population have some entitlement to health care in the UK, are unreferenced and therefore cannot be examined for similar misinterpretation. A figure of £30 million in unrecovered fees in 2004 is also cited (Furlong, 2008), which repre-

sents 0.03% of the annual NHS budget and will be dwarfed by foreign visitor VAT payments alone.

The fact is that there is a lack of evidence that health tourism is a major burden to the NHS. Indeed, parliament's Joint Committee on Human Rights has found that 'Witnesses, including the Health Minister, confirmed that no research had been carried out on the existence or extent of "health tourism" before the Charging Regulations were introduced' (Joint Committee on Human Rights, 2007).

Conclusions

To practice medicine humanely with the regulations as they stand, clinicians require a good grasp of a complex set of rules. They must provide immediately necessary care immediately, which includes not only free treatment in an emergency department but also maternity care and any secondary care which cannot reasonably wait until a patient leaves the UK. They must support destitute patients in their attempts to have unpayable debts written off. They must also care for the health of the population, which includes ensuring access to diagnostic facilities for communicable disease.

Hospital policies that deter people from accessing health care may not only damage

individual and public health, but could perversely cost the NHS more as diseases progress untreated. **BJHM**

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KEY POINTS

- NHS charging regulations are complex and their misinterpretation has harmed patients.
- Immediately necessary care may be chargeable, but should always be provided immediately.
- Notifiable disease requires access to primary care and secondary care diagnostic facilities.
- We do not know the extent of health tourism.

