Médecins du Monde UK
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UN Human Rights Council's Universal Periodic Review mechanism (UPR)
Submission of Medecins du Monde UK
19 November 2007

We submit the following evidence which we believe raises concerns about the UK government's failure to adhere to Human Rights instruments of which it is a signatory. We respectfully as the Universal Periodic Review Working Group to address the same.

Brief Summary of the Organisation

Médecins du Monde UK – Doctors Of the World UK is an international medical humanitarian organisation whose volunteers provide healthcare to vulnerable populations in both developed and developing countries. Our aim is to provide healthcare for people in situations of crisis or social exclusion around the world. In order to be effective in the long term, *Médecins du Monde*'s work goes beyond providing healthcare. Based on the information and testimonies collected through our medical practice, we identify and highlight violations of human rights, particularly with regard to accessing healthcare.

Médecins du Monde was founded in France in 1980 *Médecins du Monde UK* was established in 1998 to contribute to the world-wide work of *Médecins du Monde*. After a needs assessment which highlighted the problem of access to healthcare among the UK's most vulnerable, Project: London was opened in January 2006. Project: London is a completely free and confidential service, proving temporary health care in and support to those who are unable to access mainstream health services. Project:London advocates on behalf of individuals in order to ensure such access.

It is through its operation of Project:London that Medecins du Monde UK gathered data about access to health care which forms the basis for this submission. The full report is annexed hereto.

Project:London findings

The National Health Service (NHS) provides primary and secondary care, free at the point of service. But in 2004 the government placed limitations on who is in fact eligible for this care. A change in regulations resulted in limits placed on migrants' access to Secondary Care. And there is a pending proposal to place similar restrictions on Primary Care. Although it has been said that the reason for the restrictions was financial, the government has

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acknowledged that it has no data to support the conclusion that the restrictions would result in a cost savings.

92% of our service users were not British citizens of whom 60% were undocumented migrants. Those in the latter category, along with failed asylum seekers, were the target of the government's restrictions on health care. The restrictions placed on secondary care have had an adverse impact on the same population's access to primary care. Among the group of patients we saw, nearly 40% were fully entitled to NHS services and yet unable to access them.

Entitled and still refused

Sam's story

As an asylum seeker, Sam should not be refused primary care on entitlement grounds.

Having fled Zimbabwe, Sam sought asylum in the UK in 2006. He arrived at the clinic very anxious and worried about having to leave his daughter in Zimbabwe. He had lost contact with her and didn't know her whereabouts.

Sam approached the clinic after he moved to London from Kent. Once he had settled into more stable accommodation he called the Project: London team to help him find a local GP surgery. We gave Sam the details of a GP surgery that had told us they would register him. As an asylum seeker, Sam is clearly entitled to both primary and secondary care. Sam called the GP surgery himself the following day and found they were not willing to register him. Project: London contacted the GP surgery again and clarified that Sam should not be refused registration. Sam was then able to visit the surgery and arrange an appointment.

There is a great deal of confusion about eligibility, based partially on the failure to distinguish between access to secondary care (which is limited by law) and access to primary care (which is in some cases guaranteed and in other cases within the discretion of the GP). Among our patients, a large portion fit into this latter category and thus were neither entitled to nor restricted from care.

General Practitioners and administrators have a very poor knowledge of the new rules and regulations regarding entitlement to NSH. This lack of knowledge is partly to blame for the fact that the vulnerable groups we work with are facing such difficulties in accessing health care. All Project:London service users receive support to get registered with a General Practitioner and/or to access the health service needed, depending on their medical condition. Our experience when we advocate on their behalf shows that professionals working in healthcare services have a very poor understanding of entitlement to NHS, and there particular confusion about the differences between asylum seekers, refugees and visa overstayers. Since entitlement stems from status, this is a serious problem as it sometimes results in refusal of treatment where treatment is either guaranteed or left at the discretion of the GP.

The following case studies provide some concrete illustrations of the consequence of refusal of care.

Refused asylum and refused care

Jamal is one of the Project: London service users who was refused care by a professional.

Jamal is an Iraqi national, who was a victim of the chemical bombardment of Hallabjah, Iraq when he was about 8 or 9 years old. The chemical attacks have left him with health care issues that required continuous treatment.

"During 2003, I fled Iraq after the war had begun, in fear of my life because prior to the war, my cousin had helped the old Iraqi regime and had killed Kurds in the area. Once the new Iraqi and Kurdish parties began to rule the province, I knew my life would be in danger because of our family relationship. All my family were killed, so I fled to Syria before Baghdad was captured.

One of my relatives paid someone to help me leave Iraq but I did not know where he would end up. I was made to travel in the back of a truck and was then abandoned just outside London. I didn't know where I was or where I had to go to claim asylum. The police found me and advised me to go to the Home Office in Croydon to claim asylum.

I claimed asylum and while my claim was being processed I was housed in South London where I was given a small room and food daily but was able to access a GP regularly and was receiving psychological help from an organisation. Then, in 2005, my asylum claim was refused and I was left without any support for housing or healthcare.

Refusal of my asylum claim meant I was left destitute. Fortunately, friends have let me stay at their homes but constantly moving from home to home has impacted further on my health. I required constant help for eye problems that I developed since the chemical attack in Iraq.

I have preferred to live in the UK as I feel more secure but I believe that I was healthier in Iraq where my family were easily able to afford my healthcare. The psychological impact of the chemical attacks and my family's death has meant that I require counselling as well as tablets to aid my treatment. The counselling organisation put me in touch with Project: London and I went to get help with accessing a GP.

The GP I had been registered with, refused to see me anymore because I had had to move out of the NASS accommodation for asylum seekers. I desperately needed an appointment to get a prescription for the drugs needed to treat my eye problems.

After several calls from a Project: London support worker, the GP eventually agreed to see Jamal again for one more appointment since it was urgent. Eventually, we were able to find a GP that agreed to register him and was willing to offer an interpreting service for Jamal. He has been very happy with the level of service they are providing. He continues to receive treatment and his eye problems have been investigated to assess the damage. He also continues to receive support for his psychological problems.

Vulnerable, destitute and without access to health care

Robert

Many Project: London service users are surviving on very limited resources, sometimes only the support of friends or other community members.

After demonstrating against the government, Robert was imprisoned in the Democratic Republic of Congo for his political activities. Fearing for his life, he escaped prison. Helped by friends, Robert used someone else's passport to flee his country. It took him two to three months to organise his

departure from the time he escaped prison and the flight.

Robert arrived in Dover in January 2000, where he claimed asylum on the day of arrival. Unfortunately, his asylum claim and appeals have been rejected. He is now being supported by another organisation which is trying to help him with his immigration status.

He is not eligible for any form of support from the government and as such he can only survive thanks to charitable friends and churches. He is relatively satisfied when he has £30 per month. He has been in the UK for more than six years now and he says that this limbo situation is in makes him really nervous and depressed.

Secondary Care

Although the regulation provides an exemption for access to "immediately necessary" treatment, our data show that this exemption has not in fact been applied.

Unable to access effective hospital treatment

Mr X was a refused asylum seeker, who came to Project: London suffering from chronic myeloid leukaemia. Because of his status, he was refused access to a drug which may have been able to prevent his condition worsening.

He told the Project: London team about his experience: 'When I first went to the hospital in June 2006, the doctors treated me well and were good to me. They started to see me but then released me suddenly. I just couldn't understand, this country respects human rights but then they 'chased' me out. They found out that I had been refused asylum but I didn't know that I wasn't an asylum seeker anymore because I had never received the letter.'

'I am very scared about going back to my country as they could send me to prison for several months and force me to stay in poor conditions. I'm not sure they will give me treatment. I'm scared of going back because I don't want to be a burden on my family. My wife and parents will borrow money to for medication and get into debt. I don't want this because I'm going to die anyway and they will get stuck after I'm gone. I don't call them much otherwise they will worry about me.'

When his condition worsened a year later, he was admitted to hospital for chemotherapy which was deemed immediately necessary and given on an emergency basis. Since it was too late to reverse the course of the cancer, there were very limited treatment options. He was given palliative care to ease the immediate pain, stabilised sufficiently for safe travel and given the financial support needed to return to his home country.

Government guidance is clear that all maternity care should be considered as '*immediately necessary'* because of the serious risks associated with pregnancy. Although subject to charging, maternity services should be provided to all women irrespective of their status or ability to pay. The requirement to provide '*immediately necessary treatment'* is written into GP contracts although doubts have been raised about whether clinicians are in fact involved in making the decisions about whether a patient needs '*immediately necessary*' treatment[1] .

The experience of the women coming to Project: London raises issues about whether pregnant women are in fact able to access primary care and hospital maternity care and there

[1] Hargreaves, S, Friedland, JS, Holmes, A and Saxena, S (2006) The identification and charging of overseas visitors at NHS services in Newham: a consultation. Final Report. June 2006

is urgent need for action to address this situation.[2] We identified a particularly worrying problem with access to maternity care which puts mothers and babies at risk. Thirty-nine pregnant women (23% of the women who came to the clinics) came for help in accessing primary care, antenatal care or termination of pregnancy. Over half of these women (51%) had not had any access to antenatal care before coming to the clinic and of these, two-fifths were at least 20 weeks into their pregnancy. This is significant, given that starting antenatal care past 20 weeks is itself a risk factor for maternal death, as are missing appointments and screenings. Over 70% of all the pregnant women coming to the clinic had tried to access either primary care or antenatal services but had experienced difficulties. And at least 30% of the pregnant women had not had access to HIV screening

Thinking about the hospital debt during delivery

Mr and Mrs A left Lebanon because they had been threatened by members of their families who objected to their inter-faith marriage. Their claim for asylum was refused and they have been receiving Section 4 support from the government, which exists for people who are unable to return due to factors beyond their control or for medical reasons. This section 4 support was in the form of accommodation and £35 in vouchers per week. Because their asylum claim was refused, they are not allowed to work in the UK. Mr A told us of their experience trying to access healthcare.

'….It wasn't easy registering with a GP. We had tried a lot of GPs who were not able to register us because there lists were closed. Then we had to find proof of address like a bill or something. Luckily my friend said I could put my name on the gas bill as a tenant had moved out. I managed to get both our names on the bill. It was only after this we were able to register.'

Four months into the pregnancy the overseas visitors officer started telling us that they would stop access to the hospital.. She was saying that they would stop access to the NHS services if we did not pay and when we questioned her on where my wife should deliver her baby she said we can deliver it at home. She didn't tell us that we could go to A&E.

So, once my wife was 5 months pregnant, she sent us a bill for £2,300 and told us that it would be £3,300 for a caesarean. She said we would have to pay during the pregnancy up until the birth. Once we had received the bill she started calling us telling us we had to start paying and kept on sending us bills and reminders. She doesn't understand that we are not working and don't have access to work and we are only getting £35 vouchers.

Mrs A told us that she was thinking of the debt during the delivery, ever conscious of the fact that a caesarean section would cost even more money.

Health Care Framework in the UK

There are well known economic, public health and ethical arguments for ensuring that all migrants have access to health services. But the UK government also has obligations under international law. Having ratified the International Covenant on Economic, Social and Cultural Rights in 1976 the UK is signed up to the '*right of everyone to the enjoyment of the highest attainable standard of physical and mental health*'.[i] The government has a duty to respect, protect and fulfil this 'right to health'. What this means, among other things, is that the Government must refrain '*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.*'[ii]

[2] "Helping Vulnerable People to Access Health Care", report of Project:London (July 2007).

It was never envisaged that these rights would be realised by each country, shortly after its signing of the International Covenant, the rights described in it – including the 'right to health' – would be realised instantly. But these rights are subject to 'progressive realisation.' A country which is progressively placing greater and greater limitations to the population is doing the precise opposite, in contravention of its obligations.

The 2004 regulations, which limit equal access to health services for refused asylum seekers and irregular migrants, have been described as violating the right to health.[iii] It is particularly troubling that the government now seeks to go even further in limiting access and is doing so without a proper economic or public health analysis. This extraordinary reversal in direction of travel is unsupported by the collection and analysis of data.

This is done against the backdrop of the increased understanding of the fact that health becomes more and more of a cross-border issue in this increasingly globalised world. The UK's Chief Medical Adviser recently argued that it was no longer possible to consider the health of the UK in isolation, proposing a cross-government global health strategy in recognition of the fact that '*people everywhere have a right to the highest attainable standard of health. Protecting and promoting health is a duty of our global citizenship*'.[iv]

While it is admirable to seek to redress health inequalities abroad, it is incumbent upon the government to address these same inequalities at home.

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[i] International Covenant on Economic, Social and Cultural Rights. Full ref
[ii] Committee on Economic, Social and Cultural Rights (CESCR), general comment No. 14
[iii] Hall, P (2006) BMJ ref
[iv] Department of Health (2007) Health is Global. Proposals for a UK Government-wide strategy. A report from the UK's Chief medical Adviser, Sir Liam Donaldson. London, DH.