



Treatment and Management of HIV and AIDS for Asylum Seekers and People of Undetermined Immigration Status in the UK is an independent report produced by an expert medical panel. The initiative is supported by an unrestricted educational grant from Bristol-Myers Squibb Pharmaceutical Limited. The views of the authors do not necessarily represent those of Bristol-Myers Squibb Pharmaceutical Limited.

Treat with respect

HIV, Public Health and Immigration

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The Panel sees no good economic, public health or moral argument for refusing treatment and believes public health should be the prime consideration in this case.

The core message of this report is the need to maintain good public health services for HIV.

It is estimated that 33-50% of patients eventually diagnosed with HIV have had previous contact with the medical profession over health problems associated with HIV.

In 2003 approximately 38 million people worldwide were living with HIV and 5 million were newly infected - the largest number in any single year since the first case of HIV was identified in 1981.

The Panel draws attention to the fact that treatment of other communicable diseases and sexually transmitted infections remain free to failed asylum seekers on the grounds of protecting public health.

Executive summary

In the United Kingdom, the prevalence of HIV is rising to epidemic proportions and is affecting every community, irrespective of age, gender, ethnicity and sexuality. Heterosexual transmission is now the most common mode of infection.

In this report an expert panel of experienced physicians highlights several issues of concern. The Panel believe that the Government's decision to withdraw services from failed asylum seekers and others of undetermined immigration status with an inability to pay for their care, a policy designed to deter health tourism, will add to the HIV epidemic (see appendix). Without sufficient healthcare and social support these individuals cannot control their infection and in turn this could lead to the onward transmission of HIV to other people.

For those individuals who fail in their application to remain in the UK it is likely that some will die if anti-retroviral treatment is withdrawn. This is not sensible on public health or humanitarian grounds.

The Panel maintains that there is no convincing evidence that people already diagnosed with HIV are entering the UK for the purposes of seeking NHS treatment. However, people, unaware of their HIV status, entering the UK on student, visitors or working visas, or seeking asylum fall sick and subsequently diagnosed HIV positive. This may then lead to an application to remain in the UK on compassionate grounds.¹

The panel is concerned that the asylum applications of such individuals are now more likely to fail than in the past and therefore the NHS will be faced with increasing numbers of AIDS patients who are not entitled to care. As well as running contrary to good public health practice, the Panel believes Government policy in this area is excessive. The withdrawal of NHS treatment for failed asylum seekers and others of undetermined immigration status does not extend to all disease areas. Those with sexually transmitted diseases other than HIV continue to receive treatment irrespective of their legal status.

This policy extends to other serious infections and blood-borne viruses such as tuberculosis (TB) and hepatitis C. This discriminatory policy, the Panel believes, is illogical, especially as the rate of newly diagnosed cases of HIV continue to rise dramatically.

Many individuals living with HIV who eventually develop AIDS come into contact with medical services with symptoms highly suggestive of the underlying cause many months or years prior to infection being diagnosed.

The risk this lapsed time poses to public health should not be ignored and it is widely recognised that voluntary HIV testing in both community and hospital settings should be encouraged.

Unfortunately, new entitlement to NHS care policy suggests individuals from areas of high HIV prevalence resident in the UK may often be ineligible for diagnosis and investigation by the NHS as they present with symptomatic HIV disease.

For those asylum seekers living with HIV the Panel strongly recommends that in the interests of public health they are only dispersed to areas that can provide sufficient care and services for their needs. In some cases the Panel believes dispersal is not suitable at all, especially where patients are gravely ill or for pregnant women. In such cases patients should only be dispersed through the direction of their GP or treating physician.

To do this effectively the Panel believes that a statutory obligation should be placed on the National Asylum Support Service (NASS) to consider medical reports prior to dispersal and that no HIV patient is dispersed until a treating doctor has been consulted and new treatment arrangements are in place.

The Panel believes the Government can resolve the uncertainty surrounding care and treatment for people living with HIV quickly and effectively, either by reclassifying HIV as a sexually transmitted infection, a move that would entitle individuals of any status to receive appropriate care, or as any other blood-borne virus that poses a significant risk to public health. Until present Government policy on this issue is reformed it will continue to have serious public health implications for society at large.

Key report recommendations

1. We recommend that HIV is re-classified as a sexually transmitted disease that warrants free medical care irrespective of immigration status and as a first cost-effective public health measure we urge the Government to immediately reconsider its position on withdrawing HIV treatment to failed asylum seekers and others of undetermined immigration status who do not have an ability to pay.
2. We recommend that a statutory obligation is placed on NASS to consider medical reports properly prior to dispersal, and that no HIV patient is dispersed until the treating doctor has been consulted and new treatment arrangements are in place.
3. We recommend that asylum seekers are only dispersed to areas that can provide sufficient care and services for their needs. In cases of severe poor health or pregnancy we further recommend that asylum seekers are not dispersed or only under the direction of their GP or treating physician.
4. We recommend that the Government reimburse PCTs during the same financial year that treatment commenced.

Foreword by Neil Gerrard MP

I welcome the publication of this report as a timely move that highlights the pressures faced by the NHS in delivering care for asylum seekers and people of undetermined immigration status living with HIV in the UK.

The everyday situation healthcare professionals and their patients face is a far cry from the passionate discussions that typify present political debate on asylum and HIV. The expert medical panel has brought into focus the consequences of what are, by and large, political decisions on individual welfare and wider public health.

The Panel writes with authority and with experience of HIV and public health that is difficult to match and which makes its conclusions and recommendations impossible to ignore. It makes important observations on the differences and similarities between policies on HIV and other infections and how this affects HIV diagnosis and treatment. Above all, it makes it clear that maintaining public health must remain the constant in the ebb and flow of political decision making.

Though I congratulate the Government on its dedication to tackling HIV I do fear its hard work is in danger of being undermined by pressures that are pulling apart the delicate structure of HIV diagnosis, treatment and care of asylum seekers and others of undetermined immigration status.

The Panel's recommendations of re-classifying HIV as a sexually transmitted disease; considering medical reports and the views of treating clinicians before dispersing asylum seekers; dispersing asylum seekers to areas that can provide sufficient care and reimbursing the financial cost of treatment; are simple steps that can make the difference between success and failure in meeting Government objectives.

I hope therefore the Government will respond positively and constructively to this report and its recommendations and I urge it to act decisively and with compassion when addressing this major public health concern.

Neil Gerrard MP

Chair, All-Party Parliamentary Group on AIDS

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Introduction

HIV is a communicable disease for which there is no cure and therefore is a public health issue.

This report presents an overview of the key concerns and recommendations of an independent expert medical panel of physicians relating to HIV and asylum seekers and people of undetermined immigration status in the UK.

The core message of this report is the need to maintain good public health services for HIV.

In producing this report, the Panel has drawn on many years of personal experience and professional knowledge and the experiences of colleagues in general practice and secondary care, to provide expert views.

In 2003 approximately 38 million people worldwide were living with HIV and 5 million were newly infected - the largest number in any single year since the first case of HIV was identified in 1981. ⁱⁱDespite rapid advances in antiretroviral treatments that have increased the lifespan of those living with HIV, since 1981 approximately 20 million people have died from the disease. ⁱⁱⁱ

HIV is on the increase again in the UK. In 2003 there were 6,606 new reported infections compared to 5,711 in 2002, both figures showing a marked increase from the 1998 total of 2,835 new cases. ^{iv} Data to the end of 2003 shows that approximately 53,000 people were living in the UK with HIV. During the same year there were 766 new cases of AIDS and 475 deaths. ^v

The Health Protection Agency recently reported that, of the 35,428 HIV-infected patients who received treatment in 2003, 12,688, (approximately 33%) were African. ^{vi} This emphasises the need to proactively engage immigrant communities from countries with a high prevalence of HIV in prevention and treatment campaigns.

New drugs and therapies have made a dramatic difference by increasing the longevity and quality of life of those living with HIV (see Fig. 1 and Table 1). However, much of this success is dependent upon diagnosing the disease early enough to initiate an effective programme of treatment at the most optimum time.

The Panel's motivation for writing this report is not simply a consequence of increased rates of infection, but the result of Government policy and existing health and social practices that its feel run contrary to good public health management.

Nowhere is this better illustrated than in the Government's decision to deter health tourism through the withdrawal of therapy and treatment from those with an inability to pay. This may make sound political sense but for HIV the public health and economic costs will outweigh any benefits. The resulting dichotomy - substantial increases in HIV infection vs. less accessible services - is a serious test for public health and public health practitioners.

From October 2003 to September 2004 just 10 countries accounted for 19,955 applications for asylum in the UK. ^{vii} Of these the panel estimate that 899, or approximately 1 in 22 will be living, some unknowingly, with HIV (see Table 2). However, asylum seekers are likely to represent only a small proportion of people migrating to the UK each year from these countries. The majority are likely to enter the UK through other legal means, such as on work and student visas and seek asylum status when these expire.

Though the Panel does not profess an expertise in asylum policy, it does experience the effects of it every day. This report therefore makes recommendations, based on the Panel's experiences, of how the asylum process and health practices could work better and together, to ensure better public health and fair and ethical treatment for those living with HIV, while allowing the authorities to continue processing asylum applications quickly and effectively.

The core message of this report is the need to maintain good public health services for HIV. To support their case the Panel has divided this report into four key sections, each of which highlights some of its key concerns and recommendations for Government to follow. These sections are:

1. Access to treatment for asylum seekers and others of undetermined immigration status living with HIV
2. A more considered approach to dispersing asylum seekers living with HIV
3. Adequate and targeted funding
4. Early diagnosis and testing

The Panel draws attention to the fact that treatment of other communicable diseases and sexually transmitted infections remain free to failed asylum seekers on the grounds of protecting public health.

As medical practitioners the Panel maintains that everyone, irrespective of nationality, should be entitled to medical care for HIV while they are resident in the UK and on the grounds of public health we caution against refusing treatment for failed asylum seekers and others of undetermined immigration status prior to their deportation.

We appreciate it is the Government's intention to deport refused applicants within weeks of an asylum decision. However, the Panel maintains that a full range of HIV services must be in place to cover any eventuality including the failure to deport within a set time period.

The Panel believes that asylum seekers and others of undetermined immigration status are extremely unlikely to be in a position to reimburse the NHS for the services they receive and as individuals living with a highly infectious disease it would be unethical and detrimental to public health to discontinue treatment.

The Panel draws attention to the fact that treatment of other communicable diseases and sexually transmitted infections remains free to failed asylum seekers on the grounds of protecting public health. It is wholly irrational for HIV to be excluded from this list. As the Government itself has highlighted, "about as many people in England develop TB each year as now become infected with HIV." ^{viii} Yet treatment for TB remains free to all.

The Panel has seen no evidence to suggest that large numbers of people are seeking asylum simply to access HIV treatment and believe that failed asylum seekers would become more reliant on more costly emergency services, to which they are still entitled, when a withdrawal of treatment leaves them vulnerable to other infections.

The Panel sees no good economic, public health or moral arguments for refusing treatment and believes public health should be the prime consideration in this case.

As medical practitioners the Panel maintains that everyone, irrespective of nationality, should be entitled to medical care for HIV while they are resident in the UK. On the grounds of public health we caution against refusing treatment for failed asylum seekers and others of undetermined immigration status prior to their deportation.

Refusing treatment also sends out a wrong message on how serious the Government is on tackling and preventing HIV and in some cases can raise serious moral questions. For example, there are no exemptions for refusing treatment to a pregnant woman even though this will greatly increase the chances of transmitting the disease to the unborn child. In 2003, mother to infant infections accounted for 133 newly diagnosed cases of HIV. ^{ix} The Panel expects this number will rise significantly if treatment is withdrawn.

The Panel sees no good economic, public health or moral argument for refusing treatment and believes public health should be the prime consideration in this case. We believe the cost savings and deterrent effect of refusing treatment are negligible though the public health consequences are great.

The panel is concerned that a substantial number of HIV-positive individuals receiving treatment in the UK have made Article 3 applications and that the Home Office frequently contests these applications.

We recommend that HIV is re-classified as a sexually transmitted disease that warrants free medical care irrespective of immigration status and as a first cost-effective public health measure we urge the Government to immediately reconsider its position on withdrawing HIV treatment to failed asylum seekers and others of undetermined immigration status who do not have an ability to pay.

Access to treatment for asylum seekers and others of undetermined immigration status living with HIV

A more considered approach to the dispersal of asylum seekers living with HIV

The current policy of dispersal is being implemented with no real regard to the health needs of the individuals affected, or to wider considerations of public health. All treating physicians are aware of the difficulties raised by inappropriate dispersal of patients living with HIV. In many cases, dispersal takes place with little reference to, or consideration of, the clinical judgement of doctors or the needs of patients.

The survey also found that asylum seekers may only receive 24 hours notice before dispersal and that little or no medical assessment is made prior to dispersal.

We recommend that asylum seekers are only dispersed to areas that can provide sufficient care and services for their needs.

The Panel's estimate that 899 asylum seekers living with HIV entered the UK between October 2003 to September 2004 suggests that cases may be more widespread than previously thought and, therefore, should be of concern to the responsible immigration authorities and especially the National Asylum Support Service (NASS).

NASS is responsible for the well-being and processing of asylum seekers and, therefore, must take into account the health concerns of individuals when considering the timing and location of dispersal, preferably in coordination with local authorities and treating physicians. The Health Act 1999 makes co-operation between the NHS and local authorities mandatory and we believe a similar arrangement should apply to NASS.

A recent paper in the British Medical Journal (BMJ), which surveyed doctors working in genitourinary medicine and determined their experiences and opinions of the dispersal of asylum seekers living with HIV concluded that "most doctors who treat HIV positive asylum seekers have unsuccessfully contested dispersal."^x

The survey also found that asylum seekers may only receive 24 hours notice before dispersal and that little or no medical assessment is made prior to dispersal. The Panel agrees with the finding of the BMJ paper and re-affirms that it is unacceptable to disperse HIV positive asylum seekers without proper medical assessment and without appropriate transfer of medical details.

The Panel recommends that a statutory obligation is placed on NASS to consider medical reports prior to dispersal, and that no HIV patient is dispersed until the treating doctor has been consulted and new treatment arrangements are in place.

The Panel also recognises the longer-term needs of asylum seekers living with HIV. As there are no data to indicate where HIV positive asylum seekers are being dispersed to, we can only assume that a process of even distribution irrespective of nationality and medical condition is in place. As attested by Case Study 2, this can lead to individuals being dispersed to areas not experienced in delivering effective care and treatment for HIV. Inadequate care and support will not only have a negative impact on individual health, but may also damage public health by increasing the risk of HIV transmission to others.

In consideration of this and problems associated with language, culture, a mistrust of authority and the emotional and physical strain many asylum seekers will already have experienced, **we recommend that asylum seekers are only dispersed to areas that can provide sufficient care and services for their needs. In cases of severe poor health or pregnancy we further recommend that asylum seekers are not dispersed or only under the direction of their GP or treating physician.**

The Panel maintains that prevention of HIV or its early diagnosis and effective treatment is not just a right in itself but represents a responsible use of taxpayers' money.

Funding could be allocated through a new system or through existing programmes such as the AIDS Support Grant.

Adequate and targeted funding

The cost to the NHS of onward transmission and a failure to manage HIV amounts to millions of pounds each year.^{xi} Based on the Government's own estimates, the Department of Health believe "the monetary value of preventing a single onward transmission is between £0.5 and £1 million in terms of individual health benefits and treatment costs."^{xii}

Thus, providing treatment and preventing onward transmission of HIV from the estimated 899 asylum seekers living with HIV who entered the UK between October 2003 to September 2004, would save between £500 million and £1 billion over an average lifetime. The Panel estimates the annual cost of treatment would be approximately £13.5 million (see Table 2).^{xiii}

The Panel, therefore, maintains that prevention of HIV or its early diagnosis and effective treatment is not just a right in itself but represents a responsible use of taxpayers' money.

Annual costs of £13.5 million, though not considerable when compared to £1-2 million per week paid out by NASS on unoccupied properties for asylum seekers,^{xiv} do justify the need for Government to assess more accurately the number of asylum seekers living with HIV, their location of dispersal and to provide sufficient funding to offset costs incurred by local healthcare providers.

Funding for disease areas is largely dependent on local epidemiological data that cannot take into account newly arrived asylum seekers. Therefore, PCTs may incur costs that they have not budgeted for. This can be a key concern to smaller PCTs with small budgets and especially to those that have no history or little experience of dealing with HIV.

We recommend the Government reimburses PCTs during the same financial year that treatment commenced.

The Panel believes funding in this way would bring three notable benefits: it would reduce the disproportionate cost on local health providers; provide for a better quality of service to the patient; and also support the Panel's recommendation of only dispersing those living with HIV to areas where quality support and service is available.

Funding could be allocated through a new system or through existing programmes such as the AIDS Support Grant. This would have many benefits as the scheme promotes joint planning arrangements between local authorities and health services, and asylum seekers are recognised as a key minority group. The scheme also allows joint working with voluntary organisations and the delegation of functions to partners in the statutory or voluntary sectors.^{xv}

Early diagnosis and testing

We urge the Government to create an environment of transparency and reassurance to encourage asylum seekers and others of undetermined immigration status to volunteer for testing. In our experience this will not be an easy task as a poor command of English, mistrust of authority and fear of deportation can combine to create an unproductive environment and missed diagnostic opportunities.

It is estimated that 33-50% of patients eventually diagnosed with HIV have had previous contact with the medical profession over health problems associated with HIV.

The issue of testing and whether it should be compulsory or voluntary, is contentious. A report from the House of Commons Health Select Committee recommended voluntary testing and rejected any moves to a policy of compulsory testing for asylum seekers. A position supported by the All Party Parliamentary Group of AIDS who suggested that any mandatory tests would be impractical, hugely expensive, unjust and dangerous, would be likely to breach the UK's human rights obligations and could increase the threat to public health.^{xvii}

The Panel agrees with the arguments forwarded for voluntary testing and as practising clinicians would feel uncomfortable working in an environment of compulsory testing. We therefore recommend that no system of compulsory HIV testing be introduced for asylum seekers and others of undetermined immigration status; and that measures are taken to identify the most appropriate method for voluntary testing.

It is estimated that 33-50% of patients eventually diagnosed with HIV have had previous contact with the medical profession over health problems associated with HIV.^{xviii} We believe that if these patients had been diagnosed earlier, their treatment prospects would be better and the risk of them infecting other people would have been greatly reduced.

The Panel therefore urges the Government to review the testing regime for HIV in the UK and to consider a greater role for general practice and specialist nursing in diagnosis and counselling.

Under the criteria of Level 1 services for sexual health and HIV commissioning, primary care practices will be expected to deliver basic services including HIV testing.^{xix} Though we welcome this positive development we question the continued need for counselling in a hospital setting.

The Panel therefore urge the Government to review the testing regime for HIV in the UK and to consider a greater role for general practice and specialist nursing in diagnosis and counselling.

General practice already carries out testing for other infectious diseases, with doctors and specialist nurses often providing the necessary counselling and support for their patients. With ongoing support from specialist HIV services and through effective counselling training, we believe GPs and nurses are in a good position to provide such support for HIV, as recommended in the HIV Commissioning toolkit and the National Strategy for HIV.^{xx}

The Panel believes primary care will help deliver a more accessible and comprehensive diagnostic and treatment service for the wider community as well as for asylum seekers and others of undetermined status.^{xxi}

The Panel also believes the implementation of the National Strategy for Sexual Health and HIV should be seen as a priority and that the 10 years set aside for its implementation is not conducive to the Government's urgency in tackling HIV and sexually transmitted infections.

This view is supported by a response from Brook, FPA, Medfash, NAT and THT to the Government's 'Choosing Health?' public health consultation, which revealed HIV and sexual health were only mentioned in about 40% of SHA strategies and even amongst those 40% few had any specific proposals or development commitments.^{xxii}

Though the Panel support the Government's position that the strategy should be developed and implemented locally to suit the local health and social environment, this example highlights the need for greater co-ordination at a central level.

Bearing these factors in mind we believe the Government should do more to encourage Strategic Health Authorities (StHAs) to implement effective strategies or, preferably, to add HIV services to the Quality Framework of the GP contract when it is renegotiated in 2006.

Conclusion and Recommendations

Conclusion

As clinicians we remain committed to maintaining a public health service that can respond to the challenges posed by an infection such as HIV. However, we believe our objective is being critically undermined by policies and practices not conducive to delivering effective care.

The Panel strongly urges the development of a better way of co-ordinating the activities of all services responsible for the development of policy and delivery of care for asylum seekers and those of undetermined immigration status living with HIV.

Recommendations

1. We recommend that HIV is re-classified as a sexually transmitted disease that warrants free medical care irrespective of immigration status and as a first cost-effective public health measure we urge the Government to immediately reconsider its position on withdrawing HIV treatment to failed asylum seekers and others of undetermined immigration status who do not have an ability to pay.
2. We recommend that a statutory obligation is placed on NASS to consider medical reports properly prior to dispersal, and that no HIV patient is dispersed until the treating doctor has been consulted and new treatment arrangements are in place.
3. We recommend that asylum seekers are only dispersed to areas that can provide sufficient care and services for their needs. In cases of severe poor health or pregnancy we further recommend that asylum seekers are not dispersed or only under the direction of their GP or treating physician.
4. We recommend that the Government reimburse PCTs during the same financial year that treatment commenced

Case Study 1 and 2

Miss SB, a lady from Ethiopia who was caught up in the conflict with Eritrea was entitled to care as an asylum seeker. She had a very low CD4 count and was started on therapy.

Initial therapy caused a great deal of vomiting and she required considerable interaction with our Adherence Nurse who tried to persuade her to take a regime on a regular basis.

Unfortunately she spoke little English and so a translator, who became a close personal confidant, usually came with her.

With no notice at all to the medical authorities and as far as we can understand to her, she was dispersed at less than 24 hours notice to a location on the south coast. She arrived with no medical records and nobody spoke her language.

Consequently she stopped treatment and some three months later made her way back to London with a very low CD4 count, a high viral load and cavitating tuberculosis.

A 23-year-old African woman presented to her GP in May 2004 about 3 months pregnant. She saw the community midwife and agreed to have all routine antenatal screening tests, including an HIV test.

She was then given an appointment to attend the Antenatal Clinic of her nearest hospital to get the results and have her first routine appointment with the Obstetric team.

She came to the busy antenatal clinic and was told, in the open reception area of the clinic with no privacy, that she would have to see the 'Overseas Visitor' Officer first, to establish her eligibility for free treatment. The pregnant woman, already anxious about her results and the appointment, was very embarrassed by the whole process and left the clinic, before seeing anyone, feeling very ashamed and frightened. She did not return.

Several weeks later - during a routine review of all the new positive HIV results, the Antenatal HIV team came across a positive result of a pregnant woman about whom we knew nothing, as she had never registered at the Hospital. They did not know at what stage the pregnancy was

or how many weeks pregnant she was at the time of the test. Some women present late in pregnancy for their tests so she may already have delivered and, as far as the hospital knew at the time, she did not even know the results of her HIV test.

The newborn would be at a high risk of already being infected and, if not already infected, would be at ongoing risk of HIV infection due to breastfeeding. The HIV team managed to track her down and persuade her to come to the Hospital, reassuring her that she would not have to pay for treatment. She was then told her HIV result.

At that time she was already 6 months pregnant so there was barely time to offer her optimal intervention. However she agreed to have treatment for her HIV. The baby has now been born and the baby's HIV tests have so far been negative, but the final HIV tests for the baby will be at 18 months.

Appendix

a) Definition of HIV and AIDS

HIV

"HIV is short for Human Immunodeficiency Virus. HIV attacks the body's immune system, making it hard to fight off infections. HIV particularly attacks the white blood cells called CD4 cells, which sets the immune system in motion when infections enter the body. HIV infects CD4 cells and uses them to make new copies of HIV, which go on to infect more cells. The lower a person's CD4 count, the weaker their immune system will be." (Source: Terrence Higgins Trust)

AIDS

"AIDS stands for Acquired Immune Deficiency Syndrome. When a person's immune system has been damaged he or she is open to other illnesses, especially infections (e.g. tuberculosis and pneumonia) and cancers, many of which would not normally be a threat. Before effective treatments, if someone with HIV got one of these illnesses the person was said to have AIDS. However, it is no longer a widely-used term. Doctors may instead call this 'late stage' or 'advanced HIV infection.'" (Source: Terrence Higgins Trust)

b) Withdrawal of healthcare provision from failed asylum seekers with an inability to pay for care

On 1st April 2004, The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004 were introduced under powers conferred upon the Secretary of State for Health by sections 121 and 126(4) of the National Health Service Act 1977.

Asylum applicants awaiting an initial decision on their asylum claim, the outcome of an appeal or a judicial review as well as those who are granted refugee status or exceptional leave to remain, exceptional leave to enter or humanitarian protection will continue to have free access to all NHS accident and emergency, maternity and in-patient/out-patient services.

The impact of the regulations means that unsuccessful asylum seekers at the end of the asylum process will, in future, have to pay for non-urgent, in-patient NHS hospital care.

The diagnosis and treatment of certain communicable diseases, necessary to protect public health, will remain exempt. These diseases will include TB, Polio, meningitis, food poisoning and hepatitis.

Treatment of sexually transmitted diseases including HIV/AIDS will be limited to a diagnostic test and the necessary counselling for the test or its result. Therefore, any overseas visitor with HIV/AIDS referred to a hospital will be liable for charges unless otherwise exempt.

Asylum applicants and those who are granted either refugee status or exceptional leave to remain or enter or humanitarian protection will be entitled to free primary care medical services provided on the NHS.

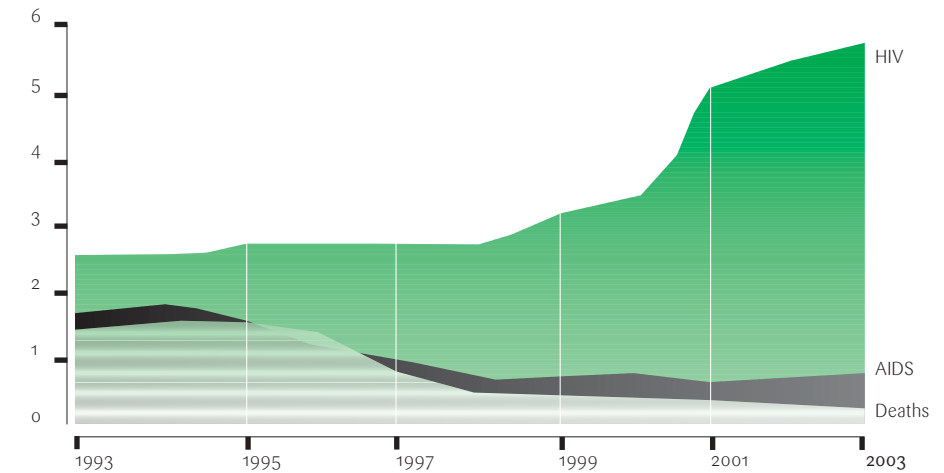
Appendix

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c) Facts and figures on HIV

1. In 2003 approximately 38 million people worldwide were living with HIV and 5 million were newly infected - the largest number in any single year since the first case of the disease was identified in 1981. (Source: UNAIDS, 2004)
2. Despite rapid advances in antiretroviral treatments that have increased the lifespan of those living with HIV, since 1981, approximately 20 million people have died from contracting the disease. (Source: UNAIDS 2004)
3. In the UK, cumulative data to the end of 2003 shows that 53,000 in the UK were living with HIV. (Source: UNAIDS, 2004)
4. Total cost of care in 2002-2003 was estimated to be approximately £345 million with additional costs of £30 million pending further diagnoses. (Source: National Association of NHS Providers and AIDS Care Treatment, Evidence to the House of Commons Health Committee.)
5. According to the National AIDS Trust “there are still up to 400 avoidable deaths from AIDS a year, mainly as a result of late diagnosis.” (Source: NAT Response to ‘Choosing Health? A consultation on action to improve peoples health.’ 2004)
6. According to the Department of Health “the monetary value of preventing a single onward transmission (of HIV) is estimated to be between £0.5 and £1 million in terms of individual health benefits and treatment costs.” (‘Effective Commissioning of Sexual Health and HIV Services’, Department of Health, January 2003)
7. The Expert Medical Panel estimated that at least 899 asylum seekers living with HIV entered the UK during October 2003 to September 2004, equivalent to approximately 20% of the total number of new cases reported in the UK last year
8. The estimated annual cost of providing treatment for 899 asylum applicants with HIV is estimated to be £15 million, equivalent to approximately 3 months rent paid on unoccupied properties by the National Asylum Support Service

Figure 1: Indicating numbers of diagnosed cases of HIV and AIDS and mortality figures



Numbers of diagnoses recorded, particularly for recent years, will rise as further reports are received.
Source: Health Protection Agency

Table 1: HIV and AIDS diagnosis and deaths in HIV infected individuals

HIV and AIDS: diagnoses¹ and deaths in HIV-infected individuals

United Kingdom	Thousands		
	HIV	AIDS	Deaths
1993	2.6	1.8	1.6
1994	2.6	1.9	1.7
1995	2.7	1.8	1.7
1996	2.7	1.4	1.5
1997	2.7	1.1	0.7
1998	2.8	0.8	0.5
1999	3.1	0.7	0.5
2000	3.8	0.8	0.5
2001	5.0	0.7	0.5
2002	5.7	0.8	0.4

Numbers of diagnoses recorded, particularly for recent years, will rise as further reports are received.
Source: Health Protection Agency

Appendix

continued

Table 2. Estimated number of asylum seekers with HIV and AIDS and estimated yearly cost of treatment

Top 10 applicant nationalities ¹	Quarter	No. of applications	% Prevalence HIV/AIDS in applicants country of origin ²	Probable no. of applicants with HIV/AIDS	Probable yearly cost (£) of treatment for HIV/AIDS ⁴
1. Somalia	3rd 2004	570	1	6	90,000
	2nd 2004	540		5	75,000
	1st 2004	1000		10	150,000
	4th 2003	1245		12	180,000
		3,355		33	495,000
2. Iran	3rd 2004	935	0.3 ³	3	45,000
	2nd 2004	685		2	30,000
	1st 2004	725		2	30,000
	4th 2003	735		2	30,000
		3,080		9	135,000
3. China	3rd 2004	620	0.1	1	15,000
	2nd 2004	595		1	15,000
	1st 2004	615		1	15,000
	4th 2003	855		1	15,000
		2,682		4	60,000
4. Zimbabwe	3rd 2004	535	33.7	180	2,700,000
	2nd 2004	505		170	2,550,000
	1st 2004	545		184	2,760,000
	4th 2003	685		231	3,465,000
		2,270		765	11,475,000
5. Turkey	3rd 2004	N/A	0.1	N/A	N/A
	2nd 2004	N/A		N/A	N/A
	1st 2004	460		1	15,000
	4th 2003	635		1	15,000
		1,095		2	30,000
6. Dem. Rep of Congo	3rd 2004	N/A	7.8	N/A	N/A
	2nd 2004	N/A		N/A	N/A
	1st 2004	405		32	480,000
	4th 2003	385		30	450,000
		790		62	930,000
7. Pakistan	3rd 2004	460	0.1	1	15,000
	2nd 2004	475		1	15,000
	1st 2004	405		1	15,000
	4th 2003	545		1	15,000
		1,885		4	60,000
8. India	3rd 2004	400	0.7	3	45,000
	2nd 2004	310		2	30,000
	1st 2004	385		3	45,000
	4th 2003	485		3	45,000
		1,580		11	1,650,000
9. Iraq	3rd 2004	475	0.3 ³	1	15,000
	2nd 2004	410		1	15,000
	1st 2004	340		1	15,000
	4th 2003	585		2	30,000
		1,810		5	75,000
10. Afghanistan	3rd 2004	380	0.3 ³	1	15,000
	2nd 2004	355		1	15,000
	1st 2004	285		1	15,000
	4th 2003	385		1	15,000
		1,405		4	60,000
Total		19,955		899	13,485,000

Sources

¹ Data from Home Office Report Asylum Statistics: 4th Quarter 2003 to 3rd Quarter 2004. NB All figures are exclusive of dependents and are considered provisional by the Home Office.

⁴ % HIV prevalence from UNAIDS website.

³ % HIV prevalence from AIDS epidemic update 2003 (North Africa/Middle East is 0.2-0.4, 0.3 used as an average).

⁴ The National Association of NHS Providers of AIDS Care and Treatment (PACT) estimate the yearly cost of managing a patient with HIV/AIDS to be £15,000.

N/A Country not included in Home Office figures for top 10 applicant countries for that quarter.

Table 3. Methodology used in deriving estimated numbers of asylum seekers living with HIV

It is essential to estimate as accurately as possible numbers of asylum seekers and others of undetermined status living with HIV in the UK. Such estimates can then be used to calculate the cost of treatments and, consequently, ensure funding is sufficient and correctly targeted. Estimates should be calculated using data that is reliable and robust; such data should also be easy to interpret and use. Only then can relevant forecasts of future trends and costs be made with confidence and authority.

We have used data provided by the Home Office and available figures on the prevalence of HIV world-wide in an attempt to achieve 2 objectives: firstly, to calculate from the top 10 applicant countries a probable number of asylum seekers with HIV for the period October 2003 to September 2004; and secondly, to calculate the cost of treating infected asylum seekers assuming fair and even distribution. Estimates are presented in Table 2 and were obtained using the method below.

Table 2 has been calculated using data from Home Office Asylum Statistics, quarter 4 of 2003, and quarters 1-3 of 2004 (4 quarters = 12 months), table 2, bottom page 2 (Top 10 applicant nationalities quarter).

Column 1 = Country of applicants origin
Column 2 = report quarter (3rd, 4th etc.)

Column 3 = Number of applicants per country.

This figure has been obtained from page 2 of each relevant report.

Column 4 = percentage prevalence of HIV and AIDS in applicants country of origin (data obtained where possible from UNAIDS website).

Column 5 = probable number of applicants with HIV and AIDS. This figure has been obtained by dividing the percentage prevalence of HIV and AIDS in each country (given in column 4) by 100 then multiplying this figure by the total number of applicants e.g.

- 505 applications for asylum were received from Zimbabwe.
- Prevalence of HIV and AIDS in Zimbabwe = 33.7%
- Probable number of applicants with HIV and AIDS = $(33.7/100) \times 505 = 170.185$ or 170 (rounded down).

This calculation has been performed for each quarter and for each country giving a total in bold in column 5.

The yearly cost of looking after a patient with HIV has been calculated as £15,000 (Ibid page 46). Therefore, the probable yearly cost (column 6) has been calculated by multiplying totals for each quarter column 5 by £15,000.

E.g., in the 2nd quarter 2004 it has been estimated that 170 asylum seekers from Zimbabwe may be infected by HIV. Multiplying this figure by £15,000 gives a total yearly cost of treatment of £2,550,000.

When performing these calculations using Home Office data, particularly from NASS, it became clear that data were difficult to interpret with clarity. This made many of our assumptions, even the most simplistic, very difficult to corroborate. The Panel therefore support the findings of the recent National Audit Office (NAO) review that identified "weaknesses in the process of compiling the statistics and their presentation,"^{xxiii} and urge the Home Office to implement the NAO's recommendations as soon as possible.

However, and despite these recognised deficiencies, we considered use of Home Office and NASS data justified, as no other credible data source was available.

References

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- iii Ibid, page 3, also see graph 1 and table 1 in the appendix
- iv HIV and other Sexually Transmitted Infections in the United Kingdom in 2003. Health Protection Agency, November 2004, page 10
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- xv Support Grant for Social Services for people with HIV/Aids: Financial Year 2004/2005. Local Authority Circular LAC (2004) 19, Department of Health
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- xviii The Epidemic of HIV in London. Professor Brian Gazzard (further details)
- xix Effective Commissioning of Sexual Health and HIV Services, January 2003, Department of Health, page 29
- xx Ibid, page 34
- xxi For a more in depth look at the issue of normalising testing please refer to ‘Take the HIV Test’, BMA Foundation for AIDS. 1998
- xxii Joint Response to Public Health Consultation - ‘Choosing Health?’ Brook, fpa, MedFASH, NAT, Terrence Higgins Trust, 25th June 2004
- xviii Asylum and migration: a review of Home Office statistics. Report by the Comptroller and Auditor General, HC625 Session 2003-04: 25 May 2004, page 3

Biographies



Professor Brian Gazzard

Brian Gazzard qualified at Cambridge University in 1970 and became an MD from the same institution in 1982. He was elected a Fellow of the Royal College of Physicians in 1983. Following training in gastroenterology at King's College Hospital under Professor Roger Williams and St Bartholomew's Hospital with Sir Anthony Dawson, he became a Consultant in that speciality at St Stephen's and Westminster Hospitals (now combined as Chelsea and Westminster Hospital) in 1978. He saw his first AIDS patient in 1979 and became co-ordinator and then Clinical Director of the HIV/GUM Unit until 1996. In 1997 he became Professor of HIV Medicine and Clinical Research Director of the same Unit. His main interests are in gastrointestinal manifestations of HIV disease and in antiretroviral therapy. In 2002, in recognition of the achievements of the HIV/GUM Unit at Chelsea & Westminster Hospital, Professor Gazzard was awarded a prize for clinical leadership at the 20th anniversary celebration of the Terrence Higgins Trust and the Outstanding Achiever for Health award from the DHSS.



Dr Jane Anderson

Jane Anderson is Director of the newly established Centre for the Study of Sexual Health and HIV at Homerton University Hospital NHS Foundation Trust, and is honorary Senior Lecturer in HIV Medicine at Barts and The London, Queen Mary's School of Medicine and Dentistry. She has been involved in the clinical care of people with HIV infection for over 20 years, with a particular interest in gender, women and families. Recent research includes qualitative work with women from African backgrounds living with HIV in London, ongoing studies working with African men and a study characterising the attributes and needs of people with HIV using services in North East London. Jane is the Honorary Secretary of the British HIV Association, co-chair of the African HIV Research Forum and a medical advisor to Positively Women.



Dr Jonathan Ainsworth

Dr Ainsworth qualified in Medicine in 1984, training at Imperial College, St Mary's Hospital, London. He specialised in HIV Medicine and Genitourinary Medicine in 1990 and has been a Consultant Physician and Lead Clinician in HIV Medicine at the North Middlesex Hospital since 1996. The hospital in Edmonton North London has a large HIV unit, the Coleridge unit. Opened in 1996 in a district general hospital the Coleridge unit is one of a number of HIV services in outer London that treat a majority of heterosexual patients largely from Africa.



Dr Chris Wood

Dr Christopher Wood has been a Consultant HIV Physician working in North London for the last 8 years. He met his first HIV positive patients in 1988 and began working in HIV Medicine full-time in 1990, under Professor Brian Gazzard. Dr Wood has a number of interests in HIV care, including Antenatal HIV Care, the care of HIV serodiscordant couples and the care of Asylum seekers with HIV disease. He believes in the need to work in partnership with patients and the communities affected by HIV and has close links with the HIV African voluntary sector and peer support initiatives. He has frequently given invited lectures in a number of different settings and has written on the subject of antenatal care and the experience of working with African HIV positive patients. In 2002 he was lead author of a Prize winning Poster Presentation, concerning Psychosocial aspects of Antenatal HIV care, at the bi-annual International Glasgow ‘Drug and Therapeutics’ Conference. He is also on the writing committee for the latest version of the British HIV Association (BHIVA) Guidelines for Antenatal HIV care that will be published later this year.