Ethics in practice

Eligibility of overseas visitors and people of uncertain residential status for NHS treatment

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Current UK regulations deny free treatment for HIV to illegal immigrants and failed asylum seekers. Is this policy resulting in unjustifiable harm to infants who are born to infected mothers?

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This is the second in an occasional series of articles, edited by Michael Parker and Julian Savulescu analysing ethical issues that confront health professionals in daily practice

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A pregnant woman from Africa who has been in the United Kingdom for six months is found to be HIV positive on antenatal screening performed by her general practitioner. Testing by an HIV physician shows that she has a high viral load. The physician plans to start antiretroviral therapy to reduce the risk of transmission of HIV to the fetus. In the meantime, the woman attends the hospital antenatal clinic and is asked to prove her eligibility for treatment. She is unable to provide her passport and is then denied access to the consultant. The woman defaults from further follow up by HIV or obstetric services.

The issues

Although fictional, this case reflects cases that have occurred recently. Do doctors who discover a pregnant woman is infected with HIV have a duty to provide antiretroviral treatment, without seeking to determine her right to reside in the United Kingdom, when intentionally denying therapy would allow as many as one in three babies to be born with HIV?

More generally, what are the rights to free NHS treatment of overseas visitors and people of indeterminate residential status? This is the subject of a current Department of Health consultation,[1] which proposes further restricting access of "overseas visitors" to NHS care. We argue that, far from restricting care, we should provide access to free NHS care for overseas visitors and people of uncertain residential status.

Background considerations

Asylum situation

In 2002, there were 84 130 applications for asylum in the United Kingdom, but only 10% of requests were granted.[2 3] Asylum seekers come to the United Kingdom to escape adverse economic, cultural, or social circumstances or because of the lack of provision of adequate health care. Some will either avoid the asylum system altogether or reside illegally after a failed application. Those with HIV infection may discover their status only when they attend health services, such as during pregnancy. HIV prevalence among women giving birth in England and Scotland increased in 2002 to 0.14%, with the highest HIV prevalence (2.47%) in women of sub-Saharan Africa origin.[4]

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The fictional case study reflects recent cases where asylum seekers have had to prove their eligibility for NHS treatment

Preventing vertical transmission of HIV

The risk of transmission of HIV from a pregnant woman to her fetus is linearly related to maternal viral load.[5] The rate of transmission in an untreated population of breast fed infants is 25-35%. Antiretroviral treatment reduces the prevalence of HIV in infants.[6] Identification of cases of maternal HIV infection, and use of antiretroviral treatment, is now standard care in the United Kingdom.[7] This reduces the transmission rate to below 1%.

Access to health care

Asylum seekers in the United Kingdom are eligible for NHS treatment only if they have made an application to remain in the country or have been detained by the immigration authorities (box 1).[1 8] Those who have not made an application for asylum or have had an application refused are not eligible for NHS treatment. The exceptions to this rule are emergency care, treatment of sexually transmitted infections (excluding HIV), and other conditions that threaten public health (box 2).[8]

Box 1: Eligibility for full NHS treatment

Eligible
- Anyone who has been living legally in the United Kingdom for 12 months
- Permanent residents
- Students in the United Kingdom for >6 months
- Refugees or asylum seekers who have made an application to remain in the United Kingdom
- People detained by the immigration authorities
- People from countries with a reciprocal agreement

Not eligible
- Students on courses for <6 months
- Those who have not yet submitted an asylum or refugee application to the home office
- Those who have had an asylum application turned down and exhausted the appeals process
- Illegal immigrants

Current and proposed revised regulations to NHS care may deny pregnant women and their infants appropriate medical care.[1 9] According to the minister for health John Hutton: "We must remember that the NHS is a national institution and not an international one . . . The aim of the proposals . . . is to ensure that the NHS is first and foremost for the benefit of residents of this country."

In 2003, amendments to the National Health Service (Charges to Overseas Visitors) Regulations 1989 were proposed with the aim of preventing free hospital care for failed asylum seekers and others with no legal right to be in the country.[9] In the consultation on the revised regulations,[9] the Department of Health states:

> The Regulations . . . confer powers to levy charges and to pursue payment of them as far as is considered reasonable . . . But best practice is to ensure that overseas visitors are aware of the expectation to pay charges, and likely cost, before they start treatment, so they can consider alternatives like a return home, if they are well enough to travel.

Many illegal (undocumented) immigrants and failed asylum seekers will be unable to pay. Additionally, if insensitive discussions about payment for treatment result in inadequate antenatal care and the birth of an HIV infected infant, this creates an avoidable burden on healthcare services, wherever the woman finally resides.

Box 2: Care available to those who are ineligible to full NHS care

- Emergency or immediately necessary treatment
- Treatment of sexually transmitted diseases (except HIV)
- Treatment of specified illness on public health grounds, such as notifiable diseases and those to which specific public health enactments apply
- Services provided in an accident and emergency department
- Family planning
- Compulsory psychiatric treatment

Grounds for treatment

There are two grounds in the current and proposed guidelines on which we believe women of uncertain residential status with HIV can be treated to prevent vertical transmission to the infant: emergency or immediately necessary care and communicable diseases and public health.

Emergency or immediately necessary care

Emergency or immediately necessary care is free. This is treatment which "in the professional opinion of the health care clinician is immediately necessary."[1] This is not further defined. It could cover treatment of HIV infected pregnant women, although HIV is explicitly excluded.

At any rate, this principle is a valid one. Overseas visitors should not be allowed to die or suffer serious harm—that is, enduring disability or impairment of quality of life—when we are able to easily prevent it. But limiting treatment to acute or immediately threatening conditions is inappropriate because of the moral principles on which providing emergency care is grounded. One basic and widely accepted moral principle is the principle of temporal neutrality.[10] This principle states that the time at which a harm occurs makes no moral difference. A harm occurring tomorrow has the same moral importance as a harm (of the same magnitude and certainty) occurring in one year's time.

Another basic moral principle is a duty of easy rescue: that when we do something that provides appreciable benefits to another person and minimal cost to ourselves, we should perform that act.[11] For example, if we pass a small child drowning in an ornamental pond, we should pluck the child from the water if the only cost to us is getting our shoes wet.

These two principles ground a duty to treat those of uncertain residential status in the United Kingdom. For the NHS as a whole, the cost of treating relatively small numbers of overseas visitors and persons of uncertain residential status who will suffer (now or in the future) if not treated now is likely to be trivial. The benefit to them is enormous. The NHS has a duty of rescue to treat such people, whenever a delay in treatment would have serious effects. Delay here means that they would suffer harm now or in the future as a result of not being treated during their stay in the United Kingdom. We call such treatment urgent. Antiretroviral treatment is necessary to prevent transmission of HIV to the unborn child. It is urgent care, even if the unborn child has no rights and such treatment is not immediately necessary.

It is true that the NHS is not an international health service. But it is a national service, and it has ethical obligations to treat those who are within the geographical distribution of its effective control. If use of NHS resources to treat people of uncertain residential status would compromise the care of UK residents, this would be a reason to restrict care. But current immigration patterns and controls do not suggest that there would be a large burden on the health system.

Moreover, providing treatment to prevent vertical transmission of HIV could save the NHS money—for example, by preventing the need for emergency care of an unnecessarily HIV infected infant with pneumocystis pneumonia. Just because we cannot treat people

all over the world does not imply that we should not treat them in the United Kingdom, if we can. Moreover, healthcare inequality within the United Kingdom can only have adverse social effects for the individual who is prevented from receiving treatment and for others in that person's local community. If the costs of such care were great, this might be a reason to restrict entry into the country more tightly or remove illegal immigrants more effectively. But there is no evidence that this is the case.

Communicable diseases and public health

Treatment for sexually transmitted infections and some other communicable diseases on public health grounds is free for those ineligible for other NHS treatment. The principle here is that overseas visitors should not create a threat to the local community. Testing for HIV is also free for everyone in the United Kingdom, but treatment is not. However, individuals are not required to give their name or address when attending the genitourinary medicine clinic for such treatment.[12] People who are ineligible for free treatment for HIV could thus receive it if they didn't declare their residential status. For pregnant women who are not entitled to NHS care, genitourinary clinics therefore provide a possible point of access for antiretroviral treatment. However, if they are referred to hospital obstetric services their status may become apparent and they would be liable for the full cost of their medical care. This is inconsistent and irrational.

The relevant issue here is whether antiretroviral treatment can be denied to a pregnant woman who is unable to pay, because of the consequences for her unborn child. The moral obligation to prevent transmission of HIV to the unborn child is sufficient grounds to treat. This is not on the grounds of any right of the unborn child to treatment but simply on the grounds of preventing future harm now (temporal neutrality) at little cost.

More generally, an argument exists for considering HIV the same as other sexually transmitted diseases and providing free treatment for all cases on public health grounds:

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Most immigration is driven by economic considerations

Summary points

- Current regulations for treatment of overseas visitors or people of uncertain residential status are unethical
- Medical treatment should be provided when it will prevent serious harm without undue cost
- Treatment should also be provided for infectious diseases that present a risk to public health, including HIV
- Concerns about creating incentives to come to the United Kingdom should be tackled by tighter policing of immigration

- It may reduce viral load and thus the infectivity of the patient. (In pregnant women, this will probably mean one fewer person is born with HIV)
- It provides a point of access for counselling and education about behaviour that puts others at risk
- By caring for the patient, it would increase the sense of community and responsibility in the patient and possibly reduce behaviour that threatens others
- It will provide more accurate statistics on the true incidence of HIV in the UK
- The numbers requiring treatment are likely to be low and the costs tolerable.

Providing treatment would be a small contribution to our national obligation to treat HIV at a global level. The United Kingdom does not do enough to help the world HIV community. Although there are other more important interventions that could meet these obligations, this would be a small positive contribution.

Incentive to illegal immigration and visiting for the purposes of medical treatment?

Would providing free treatment act as an incentive to visit the United Kingdom or immigrate illegally for the purposes of medical treatment? Most immigration is driven by economic considerations. But there may be some incentive to visit. The appropriate response to creating such an incentive is not to deny medical treatment to those who are in the United Kingdom. It is important to separate two issues that have been conflated in the Department of Health consultations: firstly, who receives free medical treatment while in the country and, secondly, who is let in or allowed to remain. If the concern is that providing free medical care will act as incentive to come to the United Kingdom, another approach is to police more tightly who enters and remove those with no legal entitlement to be here. This might also reduce the number of people requiring medical treatment who do not have entitlement.

It may be reasonable to deny entry into the United Kingdom if the sole purpose is to seek free medical care without adequate insurance. But that is another issue. The difficulty for the immigration authorities would be policing such a policy. For those without

medical insurance, compulsory medical examination (including HIV testing) would raise serious ethical and moral difficulties. A proposal of free treatment for overseas visitors does not affect who is let into the United Kingdom or when someone is deported. Immigration authorities, not doctors, should be enforcing the immigration policy.

Proposal

We have argued that the Department of Health's current and proposed criterion that emergency and immediately necessary medical treatment should be provided to overseas visitors and people of uncertain residential status should be replaced by a criterion of urgent medical treatment. Urgent medical treatment is medical treatment to prevent either risk to the public (in the case of infectious disease) or serious harm to an individual (now or in the future). Concerns about creating incentives to visit or illegally immigrate for health care should be dealt with by more rigorous policing of entry and exit by immigration authorities. Rather than tightening access to NHS services, we should relax the current unethical restrictions, and offer medical care to all those within our borders who require treatment before leaving the United Kingdom.

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Blue limbs (the importance of history and examination)

I have come across an unusual hospital presentation of "blue limbs" three times in my years of practice, though the incidence in the population is likely to be high.

As a surgical house officer, I encountered the condition twice within a couple of weeks. On the first occasion I was covering the wards when I was bleeped regarding a patient who had developed blue hands. A rare problem, I thought, and a number of possible medical and severe scenarios ran through my head. As I approached the ward, I expected to find a case of either Raynaud's syndrome or a rather ill patient, perhaps cyanosed or with superior vena cava obstruction!

To my surprise, I found a man sitting comfortably on the bed. Puzzled, I inquired diligently about respiratory, circulatory, and neurological symptoms. He was perfectly well with no abnormal symptoms or signs apart from the blue colour of his hands. It was after the examination turned out to be normal that I took greater note of his purple, paisley print pyjamas. I discovered these were new and, on touching the material, found that the colour rubbed off easily.

The second case of blue hands occurred on the same ward a few weeks later. On account of my recent experience, the scenario I anticipated was less dramatic (that is, "common things are common") and approached the ward confidently. Alas, on this occasion the patient had no purple pyjamas. I added an extra feature to the examination routine—try rubbing the colour off the hands—and was delighted when it worked. We were a little stuck for clues, but, looking around, we came across his newspaper and found the sports page he'd been holding had a large dark blue picture background.

The third and most challenging case occurred many years later when, as senior surgical house officer covering vascular referrals, I was bleeped by the paediatric registrar. He was puzzled by a teenage girl who had developed blue legs. His examination had revealed normal pulses and no other abnormalities. I assured him that I had some experience in "similar cases."

The white girl was accompanied by her concerned mother and seemed slightly embarrassed. She was well built for her age and had no abnormal symptoms. Her legs, from hip downwards, were a faint blue-grey colour not dissimilar to that found in vascular insufficiency, but all other signs, including warmth and pulses, were normal. However, the previous examination had been incomplete—her socks had not been removed. Beneath the white socks was the clue to the mystery: the feet and ankles were of normal colour sharply demarcated from the blue above the sock line.

The girl only then revealed that she had just bought a pair of grey jeans and had worn them that day for the first time. She later noticed her legs had changed colour, but, in spite of her efforts and a warm bath, the colour remained.

We now had the full story, yet the final proof and treatment were still missing. After hopelessly rubbing and wiping the legs with water, I found, at the bottom of my white coat pocket, the solution—the faithful alcohol swab.

It is therefore important to remember in cases when all conventional knowledge fails—take a full history, make a thorough examination, and use a little imagination.

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