



No System to Abuse

Immigration and health care in the UK

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CHAPTER ONE

INTRODUCTION

NHS TOURISM IS Britain's new growth industry. The use of the National Health Service by people who have not paid for it is a major problem in London and Britain's big cities. Thirty years ago it was different. The consultant of the Accident & Emergency department in St Stephen's hospital on the Fulham Road summed up the attitude. Small, energetic and a member of the British Communist Party, he held strong views about whom he was prepared to treat. 'Are you a British Citizen?' he would demand, 'Are you a British Resident?' Everyone else he directed to the nearest private hospital. 'The NHS is for those that pay for it,' he would bellow at their departing backs.

St Stephen's hospital no longer exists. Neither does that attitude. Few are prepared to safeguard the NHS, communist cardholder or not. The Home Office and the Department of Health have ducked the issue. We lack an effective immigration policy and the result is seen every day in the A&E departments and on the hospital wards of our inner cities. We lack an effective method of checking entitlement to the NHS then wonder at its abuse. The Government threatens NHS staff who complain publicly with the loss of their job and everyone else with the stigma of racism.

This is a problem confined largely to our inner cities. The manager of an Accident and Emergency department at a rural hospital burst out laughing when he was asked whether he had

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ever used a translator. He had an Italian name, 'I'm as exotic as you get around here,' he explained. This does not diminish the problem. It is clear that the NHS has become a powerful incentive for sick people in the Third World to leave their homes and come to this country, claim asylum and enjoy free medical care.

There are three issues: the numbers of people from abroad who are entitled to use the NHS; the severity of the diseases in Eastern Europe and the Third World, and the cost of treating those diseases; and finally, the ease with which people who are not entitled to NHS treatment can get it.

Who is entitled to free access to the NHS?

The sheer numbers of foreigners who are entitled to health care is increasing all the time. Asylum seekers, people here on work permits and student visas of more than six months and their dependants – anyone from a grandmother, parent, spouse or children that the student or worker can support – are all entitled to free health care. The numbers in all three categories are expanding dramatically under this Government. In 1998 the Department of Health's own website estimated that London held more than a quarter of a million refugees. Last year, 120,000 asylum seekers entered this country – another new record. No one can be sure how many will arrive this year nor can they predict next year's intake.

At the same time, the Government has decided to increase the number of work permits from 41,000 in 1996 to a target of 175,000 every year. Student visas have also increased to 339,000 a year. These numbers do not include dependants. Britain is also granting the right to live and work in the UK – and use the NHS – to all eight of the Central European countries about to join the EU in May next year. France and Germany, for example, have put this off until 2011.

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Where people are coming from – and why it matters

The Government wants, for understandable reasons, to increase the intake of students and workers from Eastern Europe and the Third World. Applicants from there received two thirds of student visas, and the majority of work permits. Unfortunately TB, Hepatitis B and HIV are all endemic in these parts of the world. They are contagious, life-threatening diseases. HIV and Hepatitis B are incurable and require expensive treatment, for life. These diseases are now taking hold in the UK.

The evidence is stark. According to the Department of Health, there were about 6,800 cases of TB reported in 2000. Rates of TB in London have doubled over the last 15 years with 50 people a week developing the disease. TB Alert estimates the NHS needs to spend £10 million a year. In each of the last four years, 95% of all new cases of Hepatitis B in this country came from abroad. Each patient costs the NHS about £10,000 a year. The disease can result in liver cancer, or the need for a liver transplant and is more infectious than HIV. We are now contemplating vaccinating the UK population in order to protect them from the danger – a danger that the Government has created.

The ease of cheating the system

Margaret Arnett, a former overseas manager at St. Helier Trust and founder of the Overseas Visitors Support/Action Group declared in 1998: 'The NHS is being drained of million of pounds a year by overseas visitors receiving 'free' medical treatment to which they are not entitled.'¹ In 1992 the A&E department of St Mary's Hospital calculated that non-eligible patients cost them a 'substantial' 4.7% of the total budget – an 'underestimate' they believed. The evidence is that things have got a lot worse since then.

It is impossible to define with any accuracy the numbers of people who are taking advantage of the NHS. For access to free

¹ *The Health Service Journal*, 12 November 1998, p. 32.

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health care is open to abuse as a look at every stage of the process reveals. There are two particular routes to specialist treatment in an NHS hospital: through an A&E department or referral from a GP. To the determined health tourist, both routes are relatively easy to navigate.

The Government appears oblivious to the cost of healthcare for the increasing numbers of people. It has made little attempt to draw up budgets, make plans or collect data. Sir Andrew Green of Migration Watch has pointed out:

Over the last ten years, a third of a million asylum claimants have been refused while there is no evidence that they have left the UK. Others are smuggled in but there is nothing to stop them claiming health care. Nor is there any effective check on tourists, visitors or those who overstay their visas.

Many other countries demand a variety of exhaustive health tests before migrants arrive in the host country. A Filipina nurse, astounded by the laxity in the UK, explained the procedure before taking a job in Dubai. The authorities refuse to admit anyone – let alone a nurse – who was infected with HIV. They insisted those nurses diagnosed with Hepatitis B sign a document agreeing to pay for their own health care. The controls in the UK are ineffectual. A diagnosis of HIV infection – far from being a barrier to entry – is grounds for a successful claim of asylum and treatment in this country for life.²

² The countries that do require an HIV test before immigration are: Australia, Belarus, Belize, Bulgaria, Canada, China, Cuba, Dominican Republic, Egypt, Georgia, Hungary, India, Iraq, Jordan, Kuwait, Kyrgystan, Latvia, Lebanon, Libya, Malaysia, Mauritius, Micronesia, Moldova, Montserrat, Oman, Papua New Guinea, Paraguay, Qatar, Russia, Saint Kitts and Nevis, Saint Vincent, Saudi Arabia, Seychelles, Singapore, Slovakia, Spain, Syria, Taiwan, Tajikistan, Turkmenistan,

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But who would not want life saving treatment for their family? And do everything possible to get it? A Filipina nurse with cancer explained: 'It's quite simple. In the Philippines I would be dead. I can not afford the treatment there that I receive here for free.' Would we not do the same? And could we really turn away the sick who asked for help?

Governments, though, are different. Governments are not meant to act as individuals. They are voted in to take decisions on behalf of their citizens. We are finding it difficult enough to fund a National Health Service. Can we really afford an International Health Service? At present, little stops the one turning into the other. What should anger us is the lack of controls and lack of government will – not the sick people. The sheer numbers may cause disquiet. As individuals, their stories are unbearably moving. A nurse in communicable diseases summed it up, 'It's not the people using it that are at fault. It's the system that allows itself to be screwed.'

Turks and Caicos Islands, Ukraine, United Arab Emirates, United States, Uzbekistan, Yemen. See *The Times*, 13 December 2002.

CHAPTER TWO

HIV

HIV INFECTION is one example of what is happening now. Genitourinary (GU) clinics are the main provider of HIV diagnoses and treatment. Previously most HIV infection in this country was confined to the gay community and to intravenous drug users. Immigration is changing that. Last year, according to the National Aids Trust, Africans accounted for 34.7% of all HIV infections while being less than 1% of the population. Immigration has transformed HIV in the UK into a mainly heterosexual disease. Rates amongst women, the majority from sub-Saharan Africa, have trebled since 1990: 77% percent of HIV positive women who gave birth in the UK in 2001 were born in sub-Saharan Africa. As one doctor in a GU clinic remarked, '95% of our patients are now heterosexual and from Africa.'

Despite the surge in patients, the clinics have not received a penny in extra funding for staff or drugs. One doctor said hopefully they were trying to subdivide the rooms in an effort to increase space. Another told me, 'Rising numbers means we are constantly seeing new patients. The initial interview is very demanding and time consuming. Often they can't speak English.' Another pointed out that HIV infection in a young, heterosexual community means, 'We have to set up clinics for families and pregnant women and provide crèches – and all with no more money!'

HIV

‘In the Sudan, I would be dead...’

Zinab comes from Sudan but her story is typical. She moved to the UK in 1999 with her husband and three children. She has since had another child. In Sudan, Zinab’s family owned a number of shops and was considered wealthy. Médecins Sans Frontières, a French charity, diagnosed Zinab as HIV positive and offered her a handful of pills. It was too expensive, they explained, to give more. Quite how this was meant to help the now distraught Zinab is unclear. She asked for a prescription but the drugs were unavailable in Sudan.

Finally she sent the prescription to an aunt living in Kilburn in north London. The aunt took the precious piece of paper to her GP who told her he could not prescribe through the NHS and sent her to a chemist. There the aunt received a shock. A month’s supply would set her back £580. She left empty handed but continued to ask around. Finally an AIDS charity told her of the help available from the NHS, social services and local support groups. Overjoyed the aunt telephoned Zinab who had no idea that treatment was free in the UK. Zinab’s husband contacted a people smuggler who charged the family an affordable £4,700.

On arrival the family claimed asylum, settled in north London and registered with a GP. Zinab’s husband and two of her children also proved to be HIV positive. Four of the family are now on anti-retroviral drugs, which they will be on for life. They have received refugee status and get about £370 a week from social services. The cost of the drugs together with treatment and benefits add up to about £80,000 a year for this one family. For Zinab there was no choice. As she said, ‘since I got this medicine, I am healthy. In Sudan, I would be dead. My children would be dead or orphans. Now we have a happy life.’

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‘The virus must spread into the resident population...’

Zinab is one of an ever-increasing number. A report by doctors working in Genitourinary Medicine to Parliament describes how ‘the unprecedented demand’ in 2002 affected all patients suffering venereal disease. Waiting time for a first appointment has doubled from five to six days the year before when ‘concern was first expressed’ to 12 working days for men and 14 for women. The numbers of new patients waiting ‘unacceptably long’ is more than 40,000 and growing.

Early appointments are vital not only for the patient but in order to contain the spread of disease. One GU clinic admitted their waiting time was a month, ‘And would be three months if we did not have constant walk-in clinics.’ Doctors also believe a high number of Africans with HIV go undiagnosed either because they are illegal or afraid of the stigma. One said, ‘It is a major public health concern. The virus must spread into the resident population. We are not seeing it yet because it takes five to ten years to appear. But if something is not done, we will have the heterosexual AIDS epidemic we have so far avoided in the UK.’ It is not just Africans. HIV infection is now growing fastest in China and Russia. Another doctor was equally pessimistic, ‘The Department of Health gives us no guidance. We don’t know what is government policy. Is there one?’

Government policy is, indeed, not clear. The Department of Health states that people can be diagnosed for HIV and receive counselling for free but not treatment. However, as Zinab and her family discovered, infection with HIV is grounds for a successful asylum claim. The Human Rights Act means that people can not be returned to a country where the appropriate medical care is not available. Patients are constantly asking their GU doctors for letters affirming HIV infection in order to pass onto immigration lawyers.

The report by GU doctors points out the price of this policy. The present caseload of 23,000 costs the NHS ‘in excess of £345

HIV

million' a year rising to £5 billion over their lifetime. That is if the numbers stay the same. But the numbers are open ended and so, therefore, are the costs. UNAIDS, the United Nations agency, estimates that 42 million people are infected with the deadly virus, 70% in sub-Saharan Africa. The NHS is their only hope and a powerful incentive to migrate. There is nothing to stop the relatively well-off like Zinab from paying traffickers and claiming asylum in the UK. But what about those too poor to afford a smuggler or without an aunt in Kilburn?

One HIV patient costs on average £15,000 to look after annually in the UK. On the other hand an Indian generic drug maker like Cipla charges less than \$1 day to provide one patient in Africa with a cocktail of medication. And GlaxoSmithKline now provides the anti-retroviral drug, Combivir, in 63 of the poorest countries for just 90 US cents a day. So for every one person we help in the UK, we could save 50 left in Africa (and this is not taking into account the cost of social security). How can we justify this discrepancy? Rafaela Ravinetto, pharmaceutical co-ordinator at Médecins Sans Frontières explained, 'There are six million people in urgent need of receiving anti-retroviral therapy in the world and the vast majority are not getting it.' As Anthony Browne in *The Spectator* pointed out, 'Spending these vast sums in Africa itself would save millions of lives, not just thousands.'

CHAPTER THREE

TB

HIV AND THE EFFECTS of the Human Rights Act is a relatively new phenomenon. TB has been a public health priority for over a hundred years. Like HIV, the reason is numbers. But unlike HIV, free treatment for TB on the NHS does not in itself attract large numbers of patients from the Third World – most people can get treatment in their own countries. The problem is that the disease is now rapidly spreading through the immigrant community.

In 2001, there were 6,800 reported cases of TB. The Department of Health points out that 60% of tuberculosis cases in this country now occur in people born abroad, the majority of whom have arrived within the last ten years. Asylum seekers account for 17% of these cases. In 1987 people with tuberculosis in London accounted for just 14% of all tuberculosis in the country. By the year 2000, that share had increased to 50%. Numbers since 1998 have nearly doubled in the capital.³ The World Health Organisation describes the difficulties of treating mobile populations when treatment takes six months. It has warned, ‘As many as 50% of the world’s refugees could be infected with TB. As they move, they may spread TB.’

³ *Getting Ahead of The Curve – A strategy for infectious diseases*, Health Protection Agency, 2003.

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“The last step before the afterworld...”

The results are disastrous in certain areas of London. Newham now has the same rates of infection – 123 people per 100,000 of population – as India. Brent’s are worse than Tajikistan and China, and almost double that of Brazil. ‘There is no sign of any let up in the relentless rise of TB in the capital, which now has more cases than any other city in Europe,’ said Dr John Moore-Gillon, a member of the British Thoracic Society’s joint TB committee speaking at a conference in 2001.

TB, like HIV, is a global problem. More people are dying of tuberculosis in the world today than at any time in history. In 1993 the World Health Organisation declared tuberculosis to be a global emergency. The spread of HIV infection, and, in some areas the growth of Multi-Drug Resistant (MDR TB) strains, have helped the disease to increase its hold on Sub-Saharan Africa, the Indian subcontinent, South East Asia and Russia – especially Russian prisons. HIV and TB form a lethal combination, each speeding the other’s progress. TB is the leading cause of death amongst people infected with HIV. The director of one Russian penal colony described how TB amongst his prisoners had made it, ‘the last step before the afterworld.’

TB is a contagious disease. Like the common cold, it spreads through the air. Only people with pulmonary TB are infectious. When infectious people cough, sneeze, talk or spit, they propel germs, known as bacilli, into the air. Left untreated, each person with active TB will infect on average between 10 and 15 people a year. But people infected with TB will not necessarily get sick or be infectious themselves. TB bacilli can lie dormant in the body for years. When the immune system is weakened, the chances of getting sick with TB increases. One third of the world’s population is currently infected with the TB bacilli.

Treatment of TB is effective but fiddly. It requires the patient to be identified then supervised to ensure they take the full course of medication over six to eight months. Tests are repeated after two

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months to check progress and again at the end of treatment. Contacts must be followed up to check if the infection has spread. Effective treatment is vital not just for the individual but also for the health of the community. As the World Health Organisation warns, 'Poorly supervised or incomplete treatment is worse than no treatment at all.'

When people fail to finish their treatment or are given the wrong treatment, they can remain infectious. The bacilli in their lungs may develop resistance to TB drugs. People they infect will have the same drug resistant strain. Drug resistant TB is treatable but it requires up to two years of chemotherapy. It is also very expensive. One case can cost £250,000 to treat. When New York suffered an MDR TB outbreak 11 years ago, it cost £110 million and took four years to control. Five years ago MDR TB cases were unheard of in Britain. Now one in 50 cases is MDR TB. It is considered such a public risk that carriers can be sectioned.

Why are the figures for TB and MDR TB rising so dramatically? A look at every stage of the process reveals a public health system overwhelmed by numbers.

“Are you mad? How can we possibly screen every student coming to this country?”

It starts on our borders. The Home Office claims that everyone from a country with a high incidence of TB intending to stay in the UK for longer than six months is screened on arrival. When the Department for Health tested the system at Heathrow in 1997, it found that only 23% of new entrants were examined at the airport – mainly those who did not give a valid address in the UK. Things do not appear to have improved.

'Complete nonsense,' said an immigration officer of the Home Office's claim. 'Who we decide to screen has little to do with the possible risk of infection. Everything to do with the availability of staff.' The first barrier is the Immigration Officer. He must decide who looks sick enough to be screened, whose name to forward and

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who to wave through. The decision is based on capacity rather than need. Heathrow and Gatwick are the only arrival points with a TB unit. The rest, including all shipping ports, other airports and Eurostar terminals, lack both a resident medical inspector – usually a local GP turns up when he can – and an X-ray machine. An immigration officer explained, ‘You can’t hold a passenger for a day or even several days to see the Port Medical Inspector.’ He will simply complete a form with the patient’s name and address and leave it in the Port Medical Inspector’s office. In Heathrow, where there is only one unit amongst four terminals, an immigration officer has to break off what he is doing to escort the passenger to the unit. Then he has to wait and bring him back. One explained, ‘It becomes a long drawn out process. Often it’s easier just to take down the name and address.’

Immigration officers soon learn. As one explained, ‘I’ll say to my supervisor, “I’ve got a young man here with a year’s student visa, I think needs looking at.” My supervisor will retort, “Are you mad? How can we possibly screen every student coming to this country?” So I don’t bother.’ Twenty year old Stephen Muchengeti from Zimbabwe was one of those students who slipped through the net. He had only recently arrived in the UK and was five weeks into his nursing course at Southampton University when he was found dead at his hall of residence. He had died from pulmonary tuberculosis.⁴

The patient dispatched to the TB unit at Heathrow is examined by any one of the eight medical inspectors who provide 24 hour cover. They see about 200 people a day rising to 300 at weekends and perform 175 X-rays a day. ‘On average, we find one person a day with TB. Last Sunday it was three,’ explained one medical inspector. Despite the link between HIV and TB now in the Third World, the inspector is not allowed to take blood for an HIV test. As for a medical history, ‘They don’t understand half the time, so we don’t do it.’

⁴ BBC News, 29 November 2002.

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He is meant to refer those with suspected pulmonary, that is active or infectious TB, to a hospital with a isolation unit. But often, especially at weekends when the unit is at its busiest, there are no beds available. The doctor explained, 'It's always a problem. Last weekend I had six people but only one bed. I wanted to isolate all of them. One chap had not seen his wife for a year. She had come down from Newcastle to meet him. What could I do? I didn't want to make her come back again. Nor did I want him infecting his family. In the end I let him go.'

The UK requires passengers from certain countries to apply for a visa. Those coming here for more than six months from a country with a high incidence of TB have to produce an XY form. This shows they have had an X-ray before leaving. Their state of health is revealed in a code on the form supposedly only known to the UK Port Medical Inspectors. But passengers often find out the code and alter it to their advantage. The Port Medical Inspector pointed out that New Zealand, Australia and the US use 'incorruptible medical referees' to examine people wishing to go to those countries. The radiographer has to sign the forms with their name. He went on, 'Whereas in this country passengers can turn up with any old film, without any name which we will accept if it looks fairly recent.' India presents a special problem. 'We are supposed to re-examine any X-rays from India.' Passengers from India with seemingly impeccable medical references often turn out to be infected with TB 'partially treated or not treated at all.'

It is clear that people infected with TB are entering this country without the knowledge of the authorities. Professor Peter Ormerod, spokesman for the British Thoracic Society, described the system as 'not comprehensive.' Only 40% of his patients had been picked up at their point of arrival. 'The channel ports don't even have an X-ray machine,' he added.

The Port Medical Inspector passes on the names and address of those people from countries with high rates of TB who plan to stay in the UK for longer than six months to the local Primary

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Health Care Trust. They in turn forward it to the Consultant in Communicable Disease for that area. A letter is dispatched to the new arrival urging them to register with their local GP so that their health can be monitored. People infected with TB can develop it any time.

“Do a letter and send it to the address on the form. Then just file it away...”

As at the airports, this system is overwhelmed by numbers and is far from effective. The Department of Health studied 11 health authorities in 1997 and found that they had failed to follow up half of their asylum seekers and refugees. They had wrongly assumed that those deemed a risk had been examined at Heathrow. The research also discovered that health authorities varied widely in the proportions of new entrants whom they attempted to contact, (from 27% to 100%), the time taken to attempt contact (from 5 to 33 days) and a successful follow-up (from 41% to 95%).⁵ Things have got worse since then.

The letters themselves are a problem. An administrator responsible for dispatching the mail pulled a notification of arrival form from a bursting folder. ‘This one is typical,’ he said. The entrant had come in on a work permit from a country with endemic TB. He had five dependants. ‘It was returned as address unknown. Lots and lots of letters get returned. The people change their names. They move and no attempt is made to follow them up. If they have vanished, nothing is done.’

He was shocked to discover that the names were not even entered onto a database. In fact, no database existed. ‘Every morning I come into the office and the incoming fax is just full of these forms passed onto us by the Primary Care Trust of people from TB country coming to live in our area.’ When he first started

⁵ *Guidance on reducing the risk of infection to New Entrants to England*, Public Health Medicine Environmental Group, March 2001.

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work, he panicked. ‘How was I going to cope with all these numbers?’ But his colleagues took a more relaxed view. ‘Don’t worry,’ they told him. ‘Do a letter and send it to the address on the form. Then just file it away.’ They showed him a big, box file where they put all the names. ‘And there they stay and no one ever looks at them again!’ There is no attempt to check the new arrivals have actually registered with a GP ‘it’s up to them to go’ or been tested for TB. ‘So possibly infectious people are sitting in a class room or working and no one knows or does anything about it.’ He explained that, even if they did try to register with a GP, most of them in that area had already closed their books. ‘New names keep coming out of the fax machine but the number of GPs stay the same, the amount of money from the government stays the same. It’s crazy.’

For the new arrival who does register with a GP, his problems are not over. Lack of awareness amongst professionals is leading to delayed diagnosis and poor control. In two studies the British Thoracic Society discovered a high number of patients who attend Accident and Emergency departments in London with TB are not being diagnosed. Research at Newham Chest Clinic, east London found that among 243 cases of TB, 121 had previously been to an A&E department and in 61 of these TB was not suspected. Another study at the Middlesex Hospital involving 168 TB cases found 46 patients were seen in A&E. In a third, a diagnosis of TB was neither made nor considered. ‘It is down to individual doctors to recognise tuberculosis – but we now have two generations of doctors have not, in their professional lives, seen tuberculosis,’ says Peter Davies of the Liverpool tuberculosis research unit at University Hospital, Aintree. ‘Training is just not adequate, and this something that, over the last ten years, has driven me to distraction.’⁶

⁶ Quoted in *The Guardian*, 11 October 2000.

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“Often their only contact is a mobile phone number...”

Fatima is one victim of misdiagnosis. She and her husband arrived from South East Asia with their two children. Her sister was already living in London, ‘To be honest I was a little bit jealous of all her stories of the good life she and her family were enjoying,’ she admitted. As an asylum seeker Fatima was detained at Dover until the Port Medical Inspector could examine her. She was declared fit despite a cough. The cough got worse. She went to her GP and he offered her a course of antibiotics. She began to lose weight. Then her children started to cough. They did not get better either but she put it down to their damp flat. The GP checked them for asthma and offered inhalers. Finally after a year she was diagnosed with pulmonary TB. In that time she had infected both her husband and children. The family is now cured but neither parent works. Despite the cure, they still receive disability and attendant allowance.

The new arrival with TB who is receiving treatment faces another problem – the lack of staff to treat him. An audit by Professor Peter Ormerod of the British Thoracic Society of 43 high incidence TB districts in England and Wales revealed that 86% had insufficient staff to treat patients. In London only one out of 21 TB hotspots had adequate staff. At the same time notifications of TB in England and Wales have increased by nearly 20%.⁷ Levels of staff are crucial to controlling TB. TB nurses and clerical staff are needed to treat and monitor those with TB, trace relatives of the infected and to screen high risk groups.

The minimum ratio is one full time tuberculosis nurse or Health Visitor for every 40 patients with full clerical staff. However one TB nurse told me she was responsible for 200 patients. ‘Its very difficult to keep on top of things,’ she admitted. She is meant to visit patients at home and check if they are taking their medicine – crucial to halt the spread of Multi Drug Resistant

⁷ British Thoracic Society web site.

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TB caused by patients failing to finish their treatment. The continual arrival of new patients into her area meant this frequently did not happen, 'as it is I am working myself to death'. Patients often disappeared half way through treatment, 'If they are staying with a sponsor, they don't want their sponsor to know. And if they are working, they can't get time off and, anyway, don't want their employer to know.' Despite the possibility of unfinished treatment leading to an increase of MDR TB, 'we don't have the legal clout to get them in.' The power did exist to section those patients with MDR TB so dangerous does the Department of Health consider it to the community. However those patients had to be found first, 'They can disappear because no one has checked their address. Often their only contact is a mobile phone number.'

At the same time there is a shortage of lung specialists. 'The lung specialist to patient ratio is at a critical level and is currently running at only half the European average,' pointed out Dr John Harvey, Chairman of the External Relations Committee. By 2005 specialist levels may well be a third short of numbers needed. Lung specialists take care of everything in both adults and children ranging from lung cancer to asthma. Lung disease is the number two killer in the UK and it exerts a huge burden on the NHS. It is the most common reason for emergency medical admission to hospital. One TB nurse pointed out the pressure that the rising number of TB patients are placing on already over-stretched resources.

It is plain that our public health system for dealing with those infected with TB is not working. The World Health Organisation guidelines specify that there must be an efficient system of diagnosis and thoroughness in ensuring patients complete their course of treatment. There also must be the political will. This is obviously lacking. The Government has promised more funds but as Professor Peter Ormerod remarked, 'that promise is not worth the paper it is written on.'

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“The NHS just wants to pretend the problem does not exist...”

In this situation what are the NHS's priorities? A document recently circulated to primary health care trusts in London is revealing. Helpfully entitled in capitals LONDON PRIORITIES 2003 –2006, out of its three pages TB and HIV are each allocated just one paragraph. The rest is taken up by the real concern of the NHS, 'Ethnicity Monitoring'. Missed targets on ethnic coding, the NHS fears, will lead to a challenge by the Commission for Racial Equality 'who are empowered to take legal action against public bodies' who fail to meet the duties of the Race Relations (Amendment) Act 2000. There follow two detailed pages on how to avoid this. TB and HIV, on the other hand, get just ten bullet points on the last page. PCTs are urged to 'maintain' the quota of one nurse per 40 notifications – maintain, here, being an optimistic choice of verb – and to recognise the growing numbers of people 'requiring long term therapies and support for HIV/AIDS' while reducing delays at GU clinics. No clue is given as to how this is to be achieved when numbers in both categories are growing all the time, but funds and staff are not.

It is clear from this document the NHS has failed to grasp that ethnicity monitoring is not just a target. It is about people. It is about the black minorities who are, ironically, most vulnerable to the rise in TB and HIV. They tend to live in those inner city areas afflicted with the same levels of TB as the Third World and with the highest incidence of HIV infection in the country. Equality is not much consolation to the sick. Unlike the powerful Commission for Racial Equality, they and all the other immigrants at risk in our inner cities, are not empowered to take action against public bodies who fail to protect them. And no one from the Government is speaking up on their behalf. As one TB nurse said, 'The NHS just wants to pretend the problem does not exist.'

CHAPTER FOUR

PSYCHIATRIC PATIENTS

IT IS NOT JUST MEDICAL CARE that attracts the NHS tourist. Some consultant psychiatrists and managers claim that a ‘significant’ proportion – as high as 40% of London acute psychiatric beds – is taken up by foreigners, including refugees and asylum seekers. This should not be confused with the higher proportion of mental illness amongst Caribbean men who are not included in these figures.

“There is no checking procedure whatsoever...”

In an exchange of letters in the *British Medical Journal* as far back as 1996, Alice Parshall, then consultant psychiatrist at Gordon Hospital, stated that ‘psychiatric tourism is well known.’ She had repeatedly presented audits showing that ‘the phenomenon has an impact on our inpatient service.’ Her data showed that about half the people admitted were homeless and a half were ‘from overseas.’

Charles Tannock and Trevor Turner, then consultant psychiatrists at University College Hospital and Hackney Hospital, claimed that at least a tenth of all patients taking up their beds were from overseas. They described the intake of the previous two weeks. One 17-bed ward in Hackney had admitted, ‘a psychotic patient from Sierra Leone, a Barbadian with learning difficulties and a manic Australian.’ On a similar ward the previous month, ‘Two manic patients (from New York and Argentina) a mute man from Guadeloupe, a Nigerian with persecutory delusions and a Kurdish patient seeking asylum who had been in Britain for two months.’

PSYCHIATRIC PATIENTS

The situation has if anything deteriorated. Psychiatric clinics like those for sexually transmitted diseases operate a walk-in service. There is no need for a referral from a GP. A patient can make an appointment directly with a psychiatric consultant. As one consultant explained, no one is going to question entitlement. 'Clinics are used to dealing with frightened, angry and anguished individuals whose answers are vague at best. The priority is to stabilise them. Not to ask where they came from.' A manager of a psychiatric hospital confirmed that once the patient is stabilised, 'There is no checking procedure whatsoever. We won't compare a name against the register of voters. We won't ask for a passport or a birth certificate.' Many, like Zinab and Hakim, have relatives in this country. Access to a local address made it difficult to establish true residency status. To discourage investigation further, overseas visitors detained under the Mental Health Act of 1983 or receiving treatment for a mental condition included in a probation order by a court are exempt from charges.

Why is psychiatric tourism to the UK so popular? Like HIV infection, insanity is grounds for a successful claim of asylum. Then facilities in Southern, Eastern Europe and developing countries are, if they exist at all, harsh and primitive. Families are ashamed of insanity. Erratic behaviour gets talked about. It harms marriage prospects because insanity is considered hereditary. Far better to dispatch relatives to a place where treatment is free, humane and, above all, anonymous. One psychiatric consultant reeled off the nationalities he had seen that month, 'Greece, South Africa, India, China and lots from Eastern Europe.' A nurse talked sadly of a Turkish girl on her ward abandoned by her relatives. When the girl had to have an operation, a sister came over from Turkey but then left almost immediately.

NO SYSTEM TO ABUSE

“We know that the NHS will pick up the bill...”

It costs about £1,500 a week to keep a patient on an acute psychiatric ward. Patients can stay for months. Once out of hospital, it does not stop. Patients move into care in the community. This means registration as an outpatient with a consultant, visits by a psychiatric nurse and social services.

All this costs money. Charles Tannock, now a Conservative MEP, recalled his attempt as consultant psychiatrist at University College Hospital to retrieve funds. Most countries refused to get involved. Embassies proved, ‘singularly unhelpful.’ They told him, ‘We know from previous experience that the NHS will pick up the bill.’ And they were right. The NHS paid for patients to fly home, each accompanied by two nurses. Charles Tannock discovered the NHS even boasted that there is a special department for repatriation. It is not surprising that patients arrive regularly for treatment. One South African suffers an episode every two or three years. When he feels it coming on, he takes a plane to the UK. Once better, the NHS flies him home with his two nurses – three long haul airfares. This expensive exercise might happen two or three times a year. As one administrator remarked, ‘It is a significant cost.’

The Department of Health refuses to admit these people exist. Little data is collected on them and they are unlikely to appear on any census form so, as Charles Tannock pointed out, ‘no specific provision is made for their funding.’ There is one problem. These invisible people take up beds. London is suffering from an acute shortage of psychiatric beds. Bed occupancy rates are well above 100% with some units actually running at over 120%. For best care, bed occupancy should be no more than 85%. This allows patients to be placed in hospitals near to their families with effective aftercare and an allocated key worker. The shortage of beds forces patients to take the first available – sometimes in a different part of the country – sometimes meaning months away from their family. As one manager said, ‘We employ people just to phone around the country in search of the vacant bed.’

PSYCHIATRIC PATIENTS

It also means consultants cannot admit every seriously ill patient. They have to pick and choose and leave the rest to manage in the community. This puts extra strain on outpatient lists, visiting nurses and social services. One psychiatric nurse is meant to care for 18 to 20 patients in the community. Instead in some parts of London it is more like 40 to 50 to each nurse. Nurses find themselves unable to make essential visits or chase up patients who fail to take their medication. Does this pose a danger to the public? The manager picked his words carefully, 'I am not saying that there are more dangerous people on the streets. I am saying it increases the risk.'

CHAPTER FIVE

THE LURE OF THE NHS

ZINAB, FATIMA AND THEIR FAMILIES are entitled to NHS care. But there are many who are not. NHS tourism is a growing business.

A nurse in communicable disease, thwarted by her Trust from auditing the figures, declared ‘The NHS are deliberately trying to hide the data,’ She went on, ‘I am so sick and tired of the whole business, I just want to run away.’ One senior consultant put the figure (and he admitted this included asylum seekers and refugees) at a staggering 20% of patients on his inner city ward round. Psychiatric doctors, depending on their hospital, claimed a quarter to a half of acute psychiatric beds in London are occupied by people who have no right to be there. One consultant in a London teaching hospital described how the problem had ‘crept up slowly over the last few years.’ It had now reached the level, ‘where I and my colleagues think it is scandalous.’

They might think so but no one is saying much. As one put it, ‘you’ll have management down on you like a ton of bricks.’ Data is hard to come by. Administrators themselves are reluctant to provide figures. One explained, ‘This Government is really vicious once the gloves are off. It’s more than a senior manager’s job is worth to collaborate with the opposition.’ Those that did talk – and many were from the Third World themselves – insisted on anonymity.

THE LURE OF THE NHS

“My son is alive. In Somalia he would be dead...”

The NHS tourist runs up big bills. Many are in search of expensive treatments that do not exist in their own country. Consultants talked of sums anywhere from £50,000 upwards for treatments such as renal dialysis or leukaemia. Our surreal asylum policy is responsible for a further complication. Anyone able to afford a people smuggler can arrive in this country, claim asylum and enjoy free NHS care. The NHS often inspires them to migrate in the first place.

Hakim's story is typical. A farmer from Somalia, he has five daughters and one, much loved son then aged ten who suffered from congenital heart disease. Hakim went to the best doctors in Somalia but they affirmed that there was no treatment for the boy. 'Take him to Europe,' they said, 'it's your only hope.' Hakim recalled a cousin in London to whom he now wrote enclosing his son's medical notes. The cousin visited a private hospital who priced the operation, airfare and accommodation at £20,000. But as Hakim said, 'For a Somali this is an undreamt amount of money. Never in my entire life could I hope to see such money.'

His cousin suggested Hakim use a people trafficker. For £5,000, a trafficker offered to bring over not just his son but the entire family. They would all be eligible for free treatment, not to mention a peaceful and secure existence. As Hakim remarked, 'There was no question which was the better deal.' His cousin put up £2,000. Hakim raised the rest by selling his animals, house and land. His cousin coached him in what to say on arrival in order to claim refugee status. Once settled in London, Hakim took his son immediately to a GP. The boy's lips were turning blue. He was referred to a specialist and operated upon within the month. He is now cured.

Hakim and his family have become British citizens. He does not work. He has never been to school and lacks any qualifications. When asked for his views of the NHS, he says

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simply, 'We came to heaven from hell. My son is alive. In Somalia he would be dead.'

“Purely kindness to a co-religionist...”

Access to the NHS is open to abuse as a look at every stage of the process reveals. There are two routes to specialist treatment in an NHS hospital: through an Accident and Emergency department or referral from a GP. Many consultants saw GPs as a problem. 'They are less than honest,' remarked one. Another was more forthright, stating, 'They connive with the patient.' Margaret Arnett, the former overseas visitors manager with direct experience of this, pointed out that GPs can charge overseas patients at their own discretion, 'So non-UK residents are often able to use GP services for free and can be given a NHS number with no questions asked by the health authority.' Consultants complained of being sent tests and X-rays from a local NHS hospital arranged by the GP for an obviously private patient from abroad. Other GPs take on patients temporarily then refer them to an NHS consultant without mentioning their status.

Ali, a 28 year old Iranian married with three children was registering with his local GP when they discovered they were both Shia, the GP from Pakistan. The GP offered to coach Ali in the symptoms of epilepsy in order to claim a disability allowance when assessed by an independent doctor. 'My doctor said don't claim kidney pains or TB because they can test your urine or X ray your lungs. But they can't test epilepsy because it's too expensive to send everyone for a CT scan.' The independent doctor declared Ali epileptic although he has never had epilepsy in his life. He now receives disability allowance. His wife gets attendance allowance for looking after him. He also gets income support and child benefit not to mention a flat from the council, free schooling and health care. He claims he is getting nearly £400 a week and has no intention of ever working. Social services say they have no idea of the maximum amount a claimant could receive. How

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much of this went to Ali's helpful GP? 'Purely kindness to a co-religionist,' was Ali's stern reply.

Patients new to a GP have to fill in the Family doctor services registration. This asks for your town and country of birth and the date you first came to live in the UK. Perhaps here the NHS is safeguarding the interests of the taxpayer. The lady at the Primary Health Care Trust whose job it is to check these forms soon put me right. The question was asked only for 'administration purposes' and allows her, 'to avoid unnecessary paperwork.' Otherwise she would have to go through the national database to ensure the patient was not already registered with another GP. She certainly did not check if the patient was entitled to NHS care. That was up to the GP.

But GPs are instructed not to ask questions.

One London borough sent round a letter in January this year to its directors of Primary Care. They were 'very concerned' to find GPs in the borough asking refugees and asylum seekers for documentation. 'THIS PROCEDURE,' it continues in capital letters in case anyone should miss the point, 'IS CONTRARY TO DEPT OF HEALTH AND BMA ADVICE.' The Department of Health advice states that, 'There is no obligation for any patient to produce documentary evidence of identity – the GMS1 form requires only a name, address, and some medical details.' Any investigation into entitlement, another London borough warned, might lead to a charge of racism. The Department of Health's Website reassures GPs anxious to know how to differentiate between the unentitled and an asylum seeker. Everyone is entitled to emergency treatment so there is no point in checking. This fails to address the crucial issue. How can a GP act as a gatekeeper to NHS consultants and hospital care if he has been ordered not to check?

Curious GPs find themselves penalised. One Chinese GP described his dilemma. An Iraqi patient eager to claim disability benefit produced a weak ankle. 'The injury was so old, I could not even see a scar.' Unimpressed, the GP told him to get a seated job

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in packing or security, adding, 'the longer you take sick leave, the more difficult it will be to get a job.' He explained that most GPs just sign or make the referrals, 'but I want to do it properly. This is taxpayer's money.' The Iraqi did not take kindly to this advice. He made a formal complaint to the Primary Care Trust who reprimanded the GP. 'The authorities gave me no support. I have lost all trust in them. If they don't support us, who will?'

“Would you stand at Gatwick airport and hand out £1,000 to every visitor?”

The other path to a consultant and hospital treatment is through an Accident and Emergency Department. The manager of one A&E department of a London hospital put it bluntly, 'If the English taxpayer knew how many overseas visitors we treat, they would be horrified. In my casualty department one in 20 people should not be there – and that does not include asylum seekers and refugees. I get no funding for them. We are very frightened to stand up and say that this is a fact.'

In the inner cities, this affects everyone else using the service. In Wales 84% of patients see a doctor within one hour of arrival. In London only 30% do. One London hospital spends £178,000 a year just on translators. In the rural hospital in the West Country they have never needed one. One senior house officer in A&E explained, 'a large proportion of the population in my area is not registered with a local GP and has no idea of how to access appropriate healthcare.' In other words Accident and Emergency departments are where the hidden world of the economic migrant reveals itself.

It is not just the economic migrant. The American with a sore throat is also a problem. The 1989 Act of the NHS (Charges for Overseas Visitors) Regulations states that no charges will be recovered from any overseas visitor for treatment at an Accident and Emergency department. Otherwise access to the NHS is based

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on residence in the UK. Anyone who has lived here for 12 months is entitled to free care. So are students and workers in the country with visas for not less than six months. Apart from the EU, we also have a reciprocal arrangement with 22 countries to provide urgent treatment for any condition which arose during a visit to the UK. Surprisingly UK State Pensioners who live abroad also fall into this category ‘regardless’ as the Department of Health puts it, ‘of any previous UK taxes or contributions they have paid’. However once admitted onto a ward, the foreign patient – not to mention the British pensioner over from Spain – is liable for costs. There are many ways around as a visit to some of London’s A&E departments will show.

The A&E receptionist is meant to ask a new patient if they have lived in the UK for less than 12 months. This is by no means automatic. It depends on the receptionist and how she is feeling that day. One only questioned those who did not speak English or spoke it with an accent. Another asked hardly anyone. A Chinese girl, unable to provide a GP or an address, offered a mobile phone number without question. The receptionist shrugged, ‘I don’t want to be accused of racism,’ she said. One Overseas Manager admitted, ‘half of my receptionists don’t like asking. They feel uncomfortable. I say, “Would you stand at Gatwick airport and hand out £1000 to every visitor? No you would not!”’

The majority claimed to have lived in the country for more than 12 months. The receptionists made no attempt to check their name and address against, for example, the voters’ register. As one receptionist explained, ‘We don’t check anyone. How could we? You can call yourself Mickey Mouse and give an address in Disney Land for all anyone cares.’

One A&E manager pointed out the consequences of lax security. ‘Relatives of families already living here fly over and use their uncle or cousin’s address. Some with chronic conditions come backwards and forwards on six-month visas for treatment. We see many women and children from outside Europe. You can

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fly here with a child and get treatment. Women are coming over all the time from the Third World to give birth on the NHS. The abuse is blatant.' Another A&E manager said bitterly, 'At the same time as so much money is being spent on treating foreigners, I can't afford to take on more nurses or even an extra porter because there is not enough in the kitty. It's a can of worms that no one wants to deal with.'

A&E is only meant to offer treatment for an ailment arising in the UK. Consultants complained NHS tourists had serious diseases of long duration. As one said, 'They arrive at Heathrow, take a taxi to my A&E and are referred to us with illnesses like chronic leukaemia, HIV infection or renal failure. They know about it. They have had it for some time. They are coming here deliberately.' The shortage of London beds means an emergency from A&E gets priority. The operation on the patient who has waited months will have to be cancelled. One consultant said bitterly, 'The NHS tourist blocks beds, bounces elective admissions and uses up scarce resources. And these are well-off people who can afford an airline ticket. At this moment in my hospital we have a judge and the brother of a minister taking up NHS beds.'

Another consultant put it bluntly, 'Today I am operating on a rich person from the Third World who has come to me through A&E as an emergency. This means I had to cancel the operation I was meant to perform on the poor, elderly Caribbean who has waited six months for his operation, is a citizen of this country and paid taxes all his life. Tell me the morality in that?'

One case had even been referred to the clinical ethics committee by concerned consultants. The hospital had admitted a sick child to a private bed. The parents' embassy promised to pay. Half way through treatment, the embassy refused to honour any further bills. The parents got an extension to their visa and the NHS took over treatment, 'It was costing £600,000 to keep that child alive and it had been in hospital for a year. It was a tragic, hopeless case. We had these aggressive, un-entitled parents

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insisting on a bone marrow transplant at a cost of £185,000 on the outside chance it might help their child. When we refused on clinical grounds, they made a formal complaint.’

Another consultant recalled the brother of a minister from Africa whose sight had begun to fade. He took a flight to London and turned up at A&E where he was diagnosed with HIV infection. ‘He knew he had HIV because his wife had it and he had been secretly dipping into her pills. We now had a man resistant to medication. So we had to treat that. Then he went blind and needed social services when he was discharged. He lives here now and the whole thing has cost hundreds of thousands of pounds.’

One member of the NHS claimed that some NHS staff are themselves abusing the system. In her hospital, a staff doctor had brought over his father from India for treatment. The son arranged registration with the local GP before arrival. The old man saw a consultant within five days, ‘when the current waiting list is 15 months.’ She complained of another elderly gentleman whose son also worked as a doctor who arrived with a shopping list of problems – hernia, cataract and gall bladder. His son arranged for him to see a fellow consultant in the hospital the following day. Soon after the old man flew home where he planned to wait until the date of his operation.

“Once the sum goes over £20,000, I am told not to issue any more invoices. The figures look so terrible on the books...”

The overseas manager is meant to pick up on the NHS tourist. But with no system of registration, they rely on doctors, nurses and A&E receptionists reporting a suspicious patient to them. Many are too busy or unwilling. When they do, even an energetic and motivated manager was not optimistic about her success rate, ‘There are two of us and 1400 beds.’ If she does catch up with a patient, they may simply announce they have no money, ‘What can I do? They’re lying in bed in front of you. You can’t get blood

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out of a stone.’ Or they claim they have been in the country for twelve months, ‘And how am I meant to prove different? We are not allowed to ask to see their passports. They can announce they are Saddam Hussein or George Bush for all we can do. Our debt-collecting agency said if only we could take down their passport number it would help. But we are not allowed to do that.’

She said bitterly, ‘When UK citizens travel abroad, we take out health insurance. Why don’t people coming here do the same?’ Even when they did, she had problems. She found herself, for example, helpless against American insurance companies, ‘Some patients put in a claim then keep the money themselves.’ Even when the patient proved honest, the American insurance company took a year to pay – no doubt phased by the NHS’s eccentric billing, ‘we don’t itemise and every trust charges differently.’ Of the money owing to her by overseas patients, she got back about half every year, ‘and that’s a vast improvement.’ Another London hospital admitted they managed less than a third. Managers felt they rarely had the backing of their trusts. As one said, ‘In my trust once the sum goes over £20,000, I am told not to issue any more invoices. The figures look so terrible on the books.’

CHAPTER SIX

CONCLUSIONS

THE NHS IS BEING EXPLOITED. It is attracting sick migrants to come to this country. Individuals cannot be blamed for abusing the system. There is no system to abuse.

Once migrants are in this country, it is too late to withhold health care. Indeed do we really want to? Far better to have an immigration policy that restricts the numbers who come here but treats those that are chosen properly. The Government does the opposite. It allows in unlimited numbers but then fails to provide the extra services required. The Department of Health warns GPs that asylum seekers arrive with, 'multiple health problems... including risk of TB/Hep B, mental issues, physical and mental effects of torture and flight, language and cultural issues, also a lack of understanding of the NHS system.' It then insists there will be 'no central pot' and no money for interpreters. The extra work asylum seekers create (GPs told me a first interview can take an hour) will not be reflected in 'increased capitation or other fees'. As one frustrated nurse in communicable diseases put it, 'We have hundreds of asylum seekers arriving every quarter into our borough. But the number of GPs stays the same. The number of hours they work stays the same. So what is meant to give?'

The Department of Health is unfair on NHS staff, on genuine asylum seekers and on the ordinary citizen. Ironically it is most unfair on those who live in the inner cities – many of them former immigrants themselves. It is time the Government collected data on how much asylum seekers are costing the NHS and made

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suitable provision. We also need to address other issues. Is treating the relatively well-off from the Third World in the UK, the best use of resources? Should we not be introducing health checks like other countries? Even on Ellis Island, doctors picked out those with infectious diseases and returned them home.

The NHS tourist puts hospitals in an invidious position. The Department of Health's attitude is clear. They do not want to know about, let alone address the problem. 'It is,' they state, 'for individual hospitals to determine whether, in accordance with the Regulations, a patient is liable to be charged for treatment or not.' The onus is on the doctor to tackle the patient. Most are unhappy with this role. They complained, 'We are doctors not policemen.' As one explained, 'By training and by inclination our job is to treat the sick person in front of us. We are not trained or inclined to start questioning them and apply bureaucratic rules.'

Another doctor had discussed the issue at the clinical ethics committee of his hospital. 'Once a doctor is in contact with a patient, it is too late. You have listened to a story of distress. You have a contract of care towards that patient. You must treat them to the best of your ability. You can not consign a gate keeping role to those who are carrying out care.' The two roles are in conflict. He went on, 'Who is entitled to care must be decided before a nurse, doctor or porter steps forward and says, "How can I help you."' Other countries manage it better. Two years ago I was wheeled paralysed into the Accident and Emergency Department of a New York hospital. Before I saw a nurse or a doctor, the patient manager came out to check my insurance and take credit card details.

What can be done?

There are two issues. Firstly, immigration is out of control. At the moment, anyone able to afford to pay a criminal gang can get to this country. Once they arrive on our shores, they can immediately claim asylum. If they have an illness for which they

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cannot get treatment in their own country, they have legitimate grounds to stay in this country and to receive free treatment. The NHS is therefore in an impossible situation. Under Human Rights Legislation, it is now legally bound to provide treatment for millions of people from the Third World. There is little to be done in the short term, beyond examining a quota system for immigration, the ways of enforcing such a system and the possibility of introducing entitlement or identity cards

The second issue is the abuse of the NHS by people who have no right to use it – the ‘health tourist’. Should the problem be recognised, then it is within the Government’s power to address the worst of the abuse. And once that is done, the abuse will stop of its own accord. For why risk travelling to the UK if there is a high chance of being caught out? To this end, the Government should consider steps such as:

- collecting data on the cost to the NHS of asylum seekers, health tourists and other immigrants;
- an appraisal of the implications of the Human Rights Act on automatic entitlement to asylum for all people who have a health condition that cannot be treated in their own country;
- ensuring that the costs of treating health tourists are actively recovered;
- ensuring that stringent and verifiable health tests are carried out before immigration from countries with a high rate of contagious disease;
- considering the merits of introducing entitlement cards;
- ensuring that the Private Patient Managers in hospitals have the incentive, authority and power to perform a gateway function effectively before the prospective patient is seen by medical staff.

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As individuals our impulse is to help. Who would not respond to Hakim's blue-lipped son? It is not just impulse but our duty as one individual to another. A Government's duty is different. Its first duty is to the citizens who have elected it. Citizenship is a set of rights and obligations given equally to all members of the community. But it is also a means of separating members from non-members in a world of limited resources. Because rights are costly, they cannot be for everybody. States are necessarily inclusionary and democratic to its members, exclusionary and undemocratic to the outsider. That is a fact many in the present Government seem to be no longer comfortable with. They appear to believe that all individuals are invested with inalienable human rights, which must be protected. The NHS is where ideology crashes into reality.

This Government is reluctant to appoint gatekeepers and give them powers. They seem unaware that in a society without gatekeepers, it is the weak, the inarticulate and the elderly – surely many of Labour's own natural constituents – who are the first to suffer.

A SELECTION OF RECENT PUBLICATIONS

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The Government has lost control of immigration. Britain is now seen as the softest touch in Europe. Government failure corrupts and criminalises. And immigrants, who are dependent on criminal gangs to claim asylum, are the first to suffer. The breakdown in the system is responsible for a man starving to death on the landing of small house in Streatham, a 10 year old working for a few pounds a week, sometimes just for food, in a factory in Wembley and a child imprisoned and forced into sex day after day in central London. Can the next generation of refugees survive all the indignities of immigration - the gangs, the slave labour, enforced prostitution, a sink estate in Glasgow – and go on, as their predecessors did, to dazzle us with their achievements?

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The pace of education reform needs to be stepped up, writes Conor Ryan, former special adviser to David Blunkett. There are still too many poor schools, and too many poorly educated children leaving school. He recommends: more “synthetic phonics”; an expansion of the Graduate Teaching Programme so that in-school training becomes the norm; radical reform of vocational education; the closure of any school not reaching its exam performance targets in 2005 and 2006; and greater private and voluntary sector involvement in education.

*Conor Ryan, former special adviser to David Blunkett, has now intervened
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The NHS is imploding. The huge increases in NHS spending will fail to produce the desired results unless the way the money is used is changed radically. The author – one of Britain's top cancer consultants – demonstrates that far too much of the new money has been, and will continue to be, wasted on a proliferating bureaucracy. Two reforms are essential: the balance of power and control in the NHS must be taken from the bureaucracy and given to patients; and the number of administrators in the NHS must be substantially reduced, thereby releasing funds to substantially increase the number and pay of nurses and allied professions.

...a report that will send shockwaves throughout Whitehall – Daily Mail

The pamphlet highlights the difficulty Tony Blair faces in delivering on his promises to transform the NHS with an extra £40 billion of public spending over five years – Financial Times

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The great divide in British politics is now clearer than ever: the divide over the moral and practical case for the size of the state. Those on the centre right should explain – consistently and repeatedly – why policies of tax and spend will not deliver. They should advocate a pro-growth agenda to argue that tax cuts can mean that households can afford to pay for services directly. The examples of Canada, Australia, Holland and Ireland all suggest that reducing the proportion of GDP that is spent by the state can go hand in hand with both increased living standards and improved services. The centre right in Britain must regain its intellectual self-confidence; must communicate a consistent message on why the Government's tax and spend policies will fail; must reclaim a growth agenda; and must argue for limited government.

But Conservatives would do better by turning, once again, to the Centre for Policy Studies... Their latest pamphlet should be required reading for every Conservative MP – Michael Brown in The Independent

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Blackwell and Kruger argue that only by giving control of spending to patients, and control of delivery to professionals will we have the level of healthcare which we all want. The authors recommend liberalising both the supply of healthcare (by making hospitals and doctors independent) and the demand for healthcare (by giving all those who wish to opt out of the NHS an “NHS Credit”).

An important and illuminating pamphlet... The right has been criticised for failing to engage with the debate over public services... the CPS pamphlet goes a long way to addressing that criticism – Peter Osborne, Sunday Business

POWER TO PARENTS

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John Redwood and Nick Seaton

The average cost per pupil at a state school in Britain today is between £4,500 and £5,000 a year – and is set to rise by 6% a year for the next four years. If all the money followed the child, all state schools would have a sum equivalent to the independent sector. So why not free all state schools from government, and give them the same legal status and autonomy as an independent school? New schools would be able to open and existing ones to expand, where there is demand. Parents would then have direct control over their child’s education. Government would be seen as a funder and regulator, not a provider, of education. Teachers would be seen as responsible professionals. LEAs would become service providers, catering to the needs of schools which want them, on a competitive basis. And most important of all, those children who currently have no choice but to endure the low standards and low aspirations that characterise failing inner-city schools would be set free of a system that has failed them.

The report makes a case of such striking originality that it deserves to be adopted immediately as Tory policy – and if the Conservatives don’t have the courage, perhaps Labour will do so – Edward Heathcoat Amory in The Daily Mail



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