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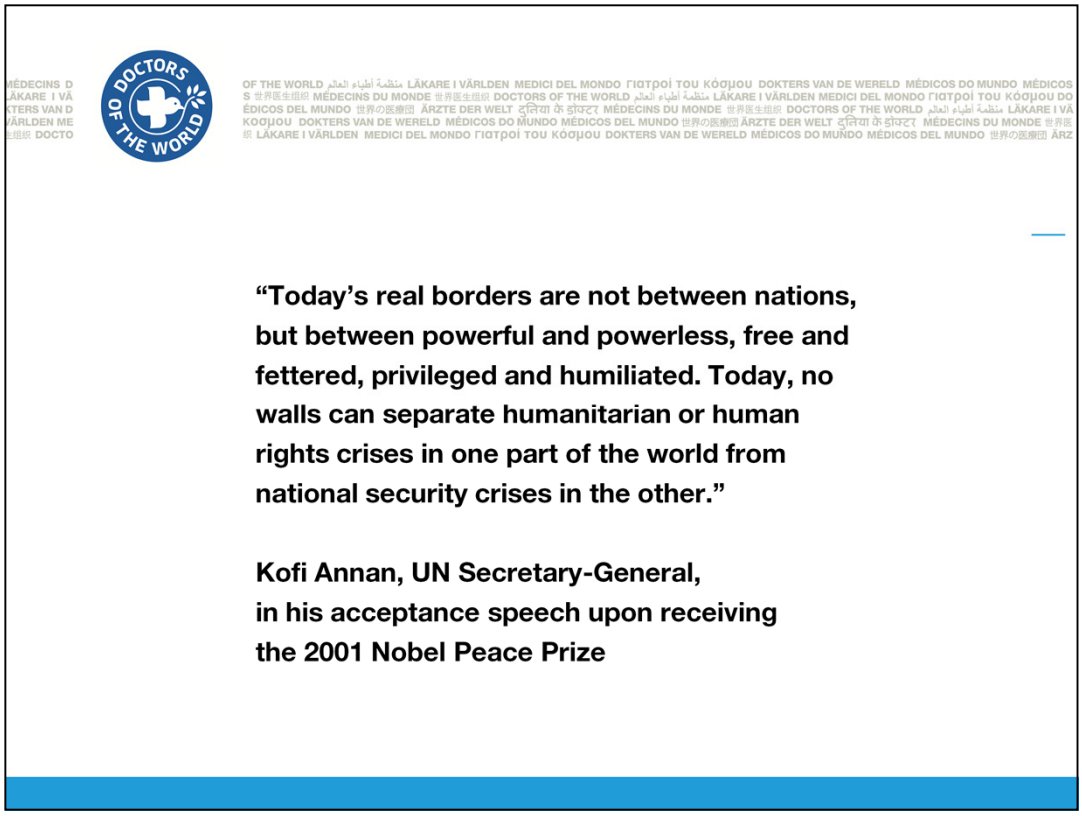
Global Health and Migration

Project:London – Doctors of the World UK


DOCTORS OF THE WORLD
“Today’s real borders are not between nations, but between powerful and powerless, free and fettered, privileged and humiliated. Today, no walls can separate humanitarian or human rights crises in one part of the world from national security crises in the other.”
Kofi Annan, UN Secretary-General,
in his acceptance speech upon receiving
the 2001 Nobel Peace Prize

Outline

1. Migration and global health
2. 'the migrant'
    - International conventions
    - False dichotomies
    - Scale
3. Push & Pull
4. Health, human rights and internal immigration control
5. European context
6. Migrants and health in the UK
7. Project:London: Migrants, Myths and Misinformation
    - Everyone has access to healthcare in the UK
    - Migrants have expensive problems
    - 'Health Tourism' drains NHS resources

People are increasingly on the move for political, humanitarian economic and environmental reasons. But migration is not something new. Human beings have been moving around since we first started walking upright, from our earliest origins in Africa spreading out across the globe and populating more of less every corner of the planet.

Scale: estimated 175 million people, or 2.9% of the world's population currently living temporarily or permanently outside of their countries of orgin – and this does not include the large number of uncounted undocumented migrants.

When we talk of migration and health we think of south to north migration. But estimated only 2 out of 5 migrants originating in the developed world live in a rich developed OECD country. South to south migration at least as high. Not to mention IDP.

INTERNATIONAL CONVENTIONS: United Nations 1951 Convention Relating to the Status of Refugees is very focused on

End of 2WW – 20-30 million people displaced in Europe alone – urgent need to deal with situation

Focus on “well-founded fear of being persecuted” but world more complex and reasons for migration more complex

People may be fleeing poverty and insecurity as much as totalitarianism. Important tool but also need a little more. People fleeing totalitarian regimes believe they are doing so for economic reasons – e.g. North Korea 95% of people say they left because of poverty, only 2% for political reasons

Home Secretary Teresa May wants to introduce limitations on access to health care for people from A2 countries fearing that when the restrictions are lifted later this year there will be a flood of Romanians and Bulgarians coming to the UK.

Health as a tool of internal migration control.

There is generalised fear that our NHS, with its healthcare free at the point of care, is a great 'pull' to migrants all over the world and that people come here specifically to access healthcare (more on this later)

But all our experience and all the research actually points to 'push' factors, reasons why people could no longer stay in their own countries as the greatest determinants of migration. Everything is interconnected in a globalised world and cheap coffee prices in the super market are intimately linked with the living conditions of poor coffee farmers across the globe. The north – south divide plays a huge role.

Why do we leave? NATURAL DISASTERS

OPPORTUNITIES

WAR

POVERTY

CHALLENGE

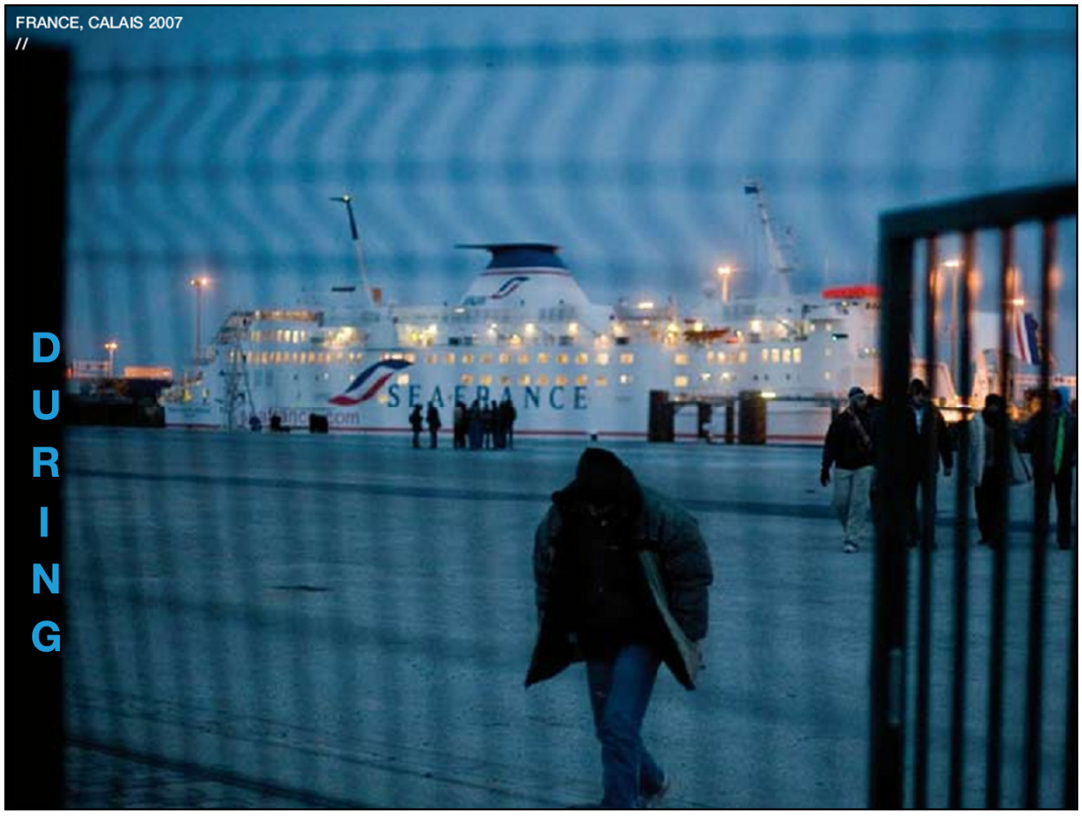
LOVE

Often those who leave are from wealthier families that can afford to get them out. this also affects their health – the so called healthy migrant effect – more on this later with the NHS

Some migrants have experience horrific violence in their countries of origins. Some have been tortured or experiences other trauma and this is not always easy to overcome, even in a new country so it may continue to affect the person's health. But this is by no means the case for everyone.

Also, the most vulnerable remain vulnerable throughout the process – as many as 70-80% of all women in detention centres in the UK are survivors of sexual violence. Unaccompanied children have had to live through experiences far beyond their maturity level.

2009 survery across 11 cities in europe showed that 59% of patients at our clinics live with, or have experienced, violent situations before, during or after their migration.



Journey is long and arduous. For many it takes months – involves long journeys over land and sea. Often at the hands of agents who help make arrangements with documents and transportation. Conditions during journey can leave some with severe health problems

Harmful living and working conditions. Those with no rights are extremely vulnerable to exploitation with many working long hours for far less than minimum pay under very dangerous conditions. This again affects their health.

Contribute to wider social determinants of health and maintaining health inequalities

For other the situation is worse – detention, isolation and violence. Some struggle to get over what they have experience before or during their journey. But there is a lot of research suggesting that for many migrants their health actually gets worse after arriving in their host country

Often left with great debts from paying for the journey over. If their choose to apply for asylum the process itself can be brutal, and dehumanising

Isolation increases vulnerability

From the same survery referenced before: And as many as 24% said they have experience violence since arriving in Europe

Universal Declaration on Human Rights (1948) - Art. 25: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Not to be understood as the right to be *healthy*.

It is the right to the enjoyment of a variety of facilities, goods services and conditions necessary for the realization of the *highest attainable standard of health*.

It contains both freedoms and entitlements

The notion of "the highest attainable standard of health" takes into account both the individual's biological and socio-economic preconditions and the resources that are available within a State.

Freedoms include the right to control one's health and body and the right to be free from interference, such as the right to be free from non-consensual medical treatment and experimentation.

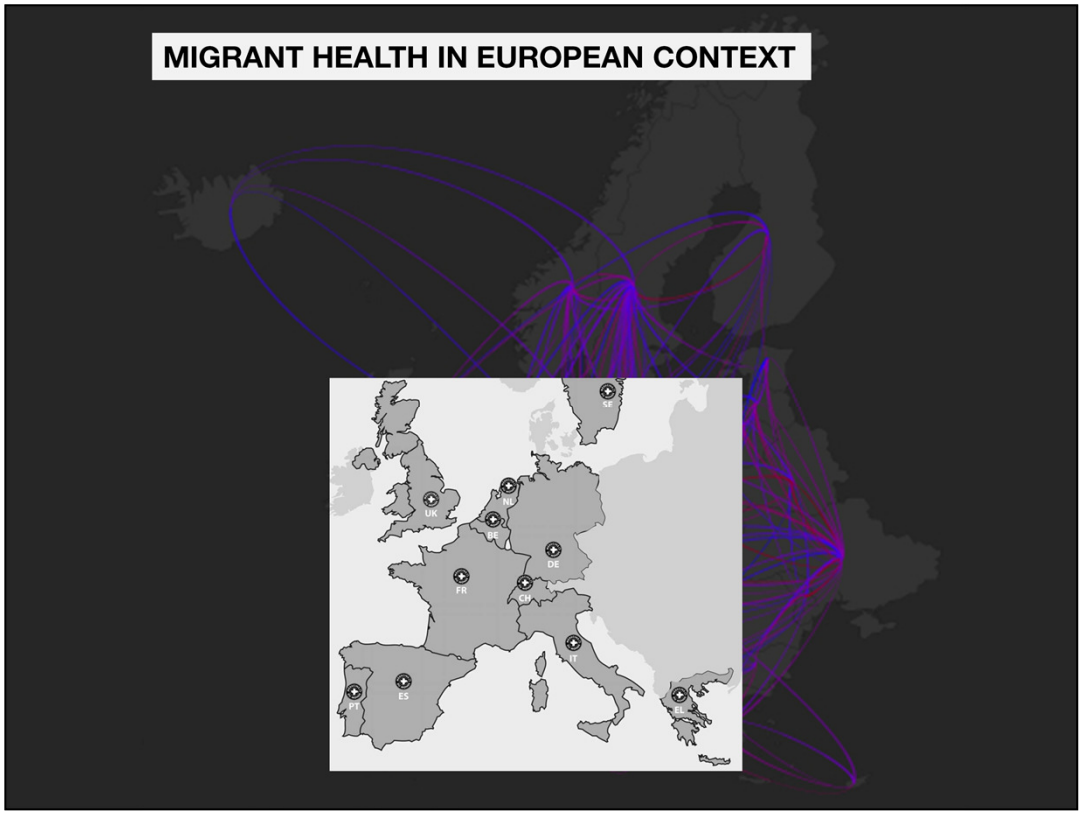
Entitlements include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable standard or level of health.

Each human right entails a right holder (the individual) and a duty bearer (the state).

Why does it matter, why is it important to recast right to health in terms of human rights?

Because it entails both an ideological construct and a framework for leagislative and practical responses. It reframes to right to healthcare for migrants not to special provisions for a vulnerable group, but a right for everyone (including migrants) based on them being human beings and not migrants.

Public health – not a focus of this talk but something that comes up again and again when talking about migration and health. Important topic. Also for the UK. What is the best way to ensure that an increasingly globalised world can deal with public health threats. To ensure that everyone is registered and accessing healthcare so that issues can be detected and treated.

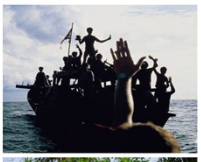


Migration is not something that affects people from exotic corners of the world. A large proportion of migration to and from the UK happens within the EU or wider European setting, obviously.

MDM/DOW has clinic in 11 countries and collect and compare data from all these clinics. The rules of access are different in different settings – one of the documents on the reading list covers a summary of the rules. But this is not a UK issue.

Since I know most about the UK I will focus on that setting for now: we run a clinic:


MIGRANT HEALTH IN THE UK
High quality
care for all
NHS



WHO ARE DOCTORS OF THE WORLD?

International medical humanitarian NGO

Founded in 1980

Now composed of 15 international offices.

In 2010 the international network used £94 million to run 365 projects in 78 countries with the help of more than 3,000 volunteers working overseas we helped 1.6 million of the worlds most vulnerable access healthcare

Goals:

To provide medical care to vulnerable populations before during and after a crisis.

To bear witness and denounce human rights violations and obstacles to healthcare

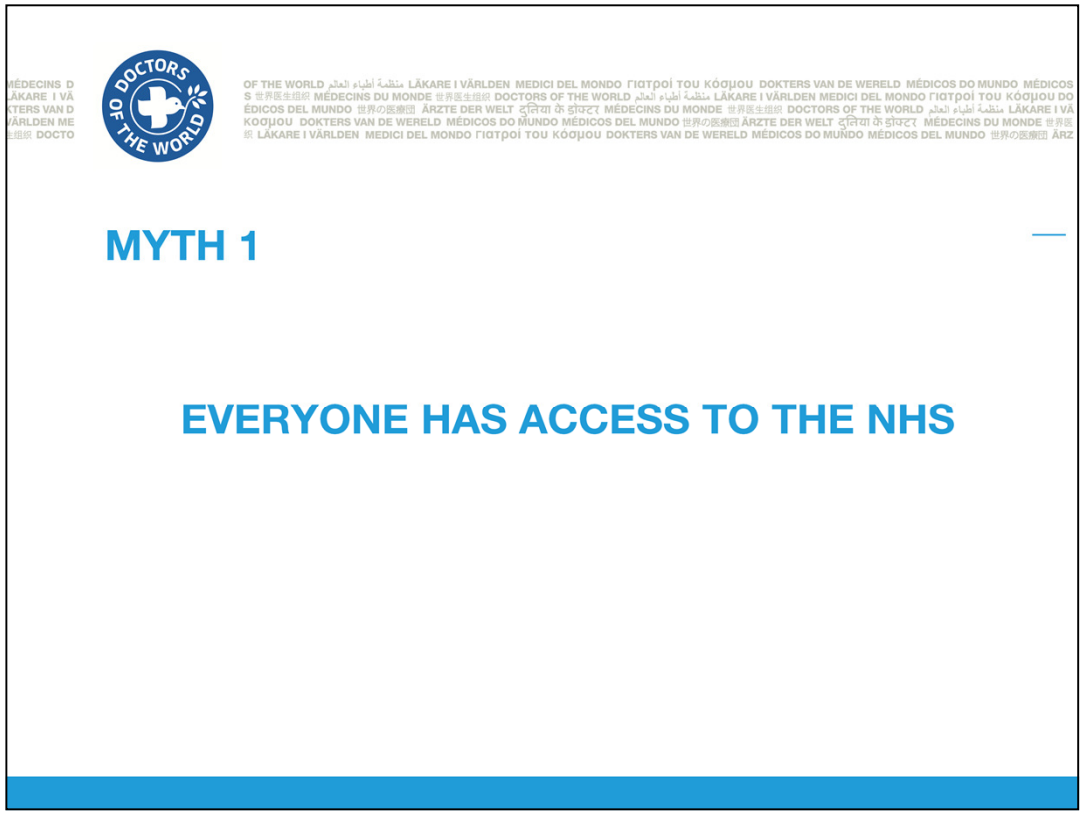
PROJECT:LONDON'S OBJECTIVES

- To improve access to affordable healthcare for vulnerable people:
  - To offer acute medical care to those who present to the project
  - To use the information gathered from service users to advocate for better health provision for them from the relevant bodies or agencies
  - To help people access NHS and other relevant services whenever possible
- Reaching out to those most vulnerable
  - Homeless people - Sex workers - Migrants

Project:London is NOT an alternative to the NHS.

HOW DO WE HELP PEOPLE?

- Provide social consultation to assess each service users' needs
- Doctors present at clinic to provide acute care and to advocate for ongoing healthcare access
- Provide case management to ensure a service user has been able to access the care they required
- Provide information about other non-medical services that may be useful to the service user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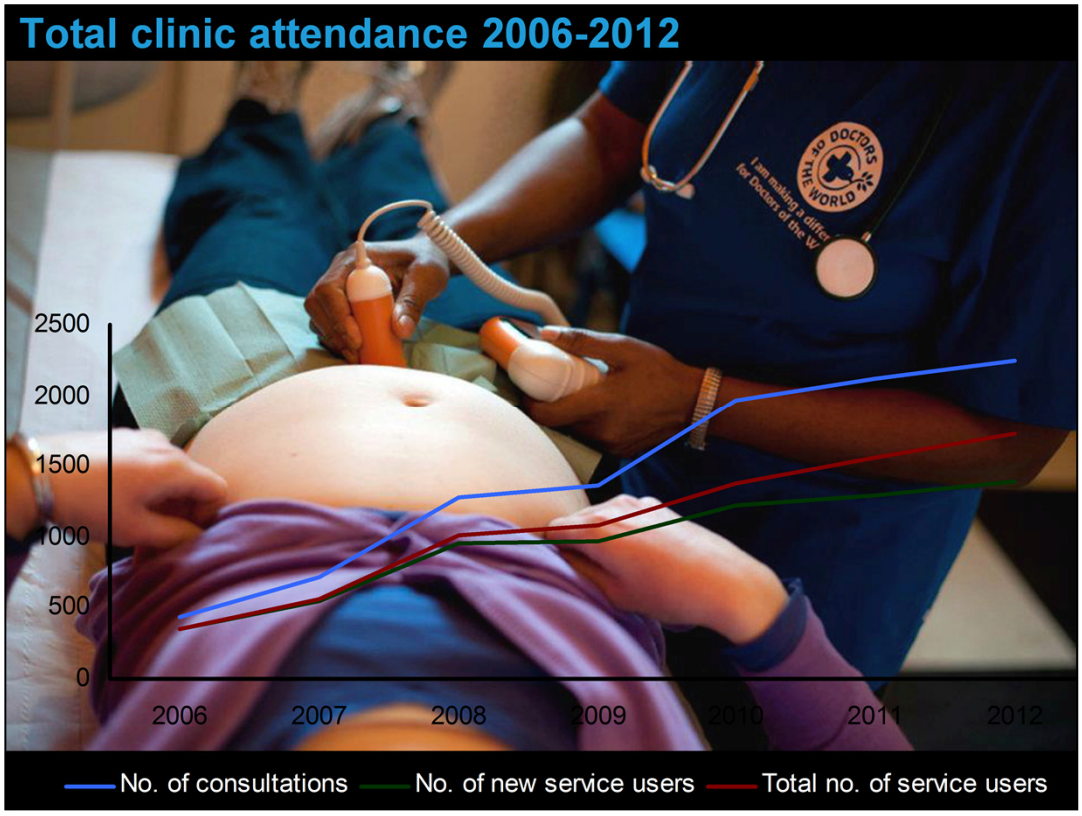
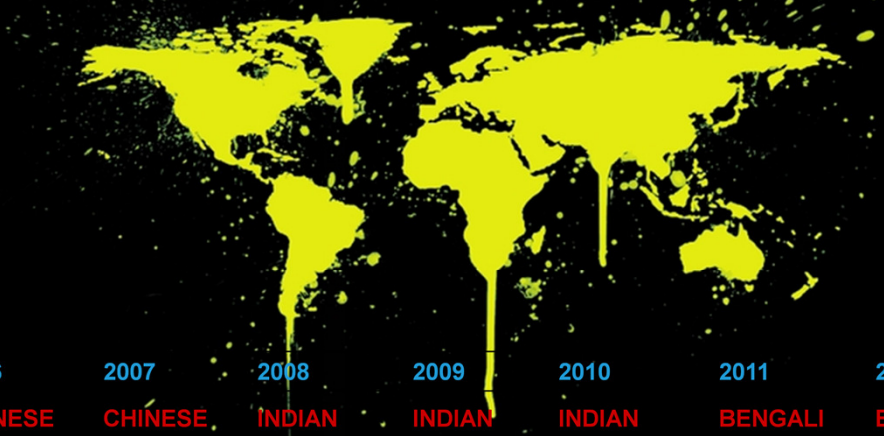
MYTH 1
EVERYONE HAS ACCESS TO THE NHS


THEORETICAL ACCESS DOES NOT CURE DISEASE
ADMINISTRATIVE DIFFICULTIES
LACK OF KNOWLEDGE
LANGUAGE BARRIER
CARE REFUSED BY HEALTH PROFESSIONALS
FEAR OF BEING REPORTED


Total clinic attendance 2006-2012
2500
2000
1500
1000
500
0
2006
2007
2008
2009
2010
2011
2012
No. of consultations
No. of new service users
Total no. of service users

Country of origin of service users at Project:London, 2006-2012



2006	2007	2008	2009	2010	2011	2012
CHINESE	CHINESE	INDIAN	INDIAN	INDIAN	BENGALI	BANGALI
DRC	DRC	BRAZILIAN	CHINESE	CHINESE	INDIAN	CHINESE
BRITISH	INDIAN	PHILIP.	PHILIP.	BENGALI	CHINESE	INDIAN
ERITREAN	BRAZILIAN	CHINESE	ERITREAN	PHILIP.	UGANDAN	PHILIP.
IRANIAN	ERITREAN	ERITREAN	BENGALI	BRAZILIAN	BRAZILIAN	UGANDAN

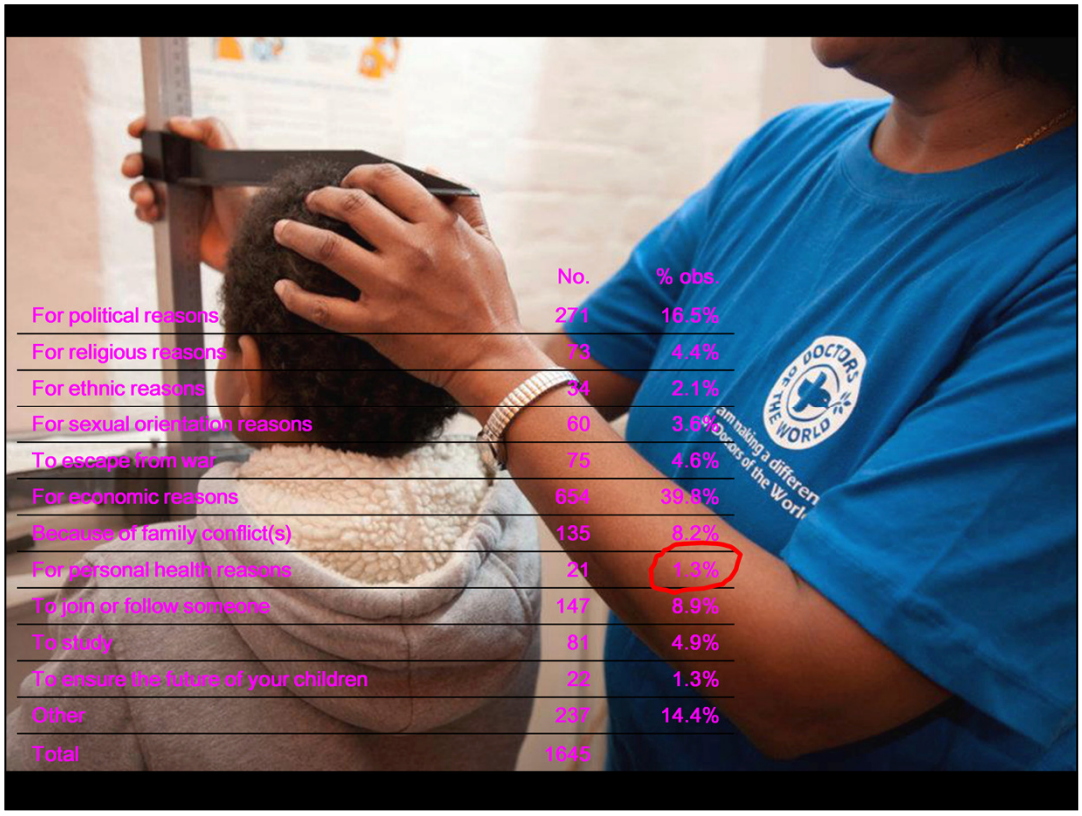
MYTH 2

MIGRANTS HAVE EXPENSIVE PROBLEMS


2011
1. Musculoskeletal
2. Digestive
3. Psychological
4. Skin
5. Cardiovascular
6. Pregnancy
7. Respiratory
2012
1. Musculoskeletal
2. Digestive
3. Psychological
4. Respiratory
5. Cardiovascular
6. Skin
7. Pregnancy

MYTH 3

‘HEALTH TOURISTS’ DRAIN NHS RESOURCES



Service user mainly fleeing poverty and on average they have been in the UK for 3-4 years before seeking medical care. Some even as long as 13-14 years without accessing care

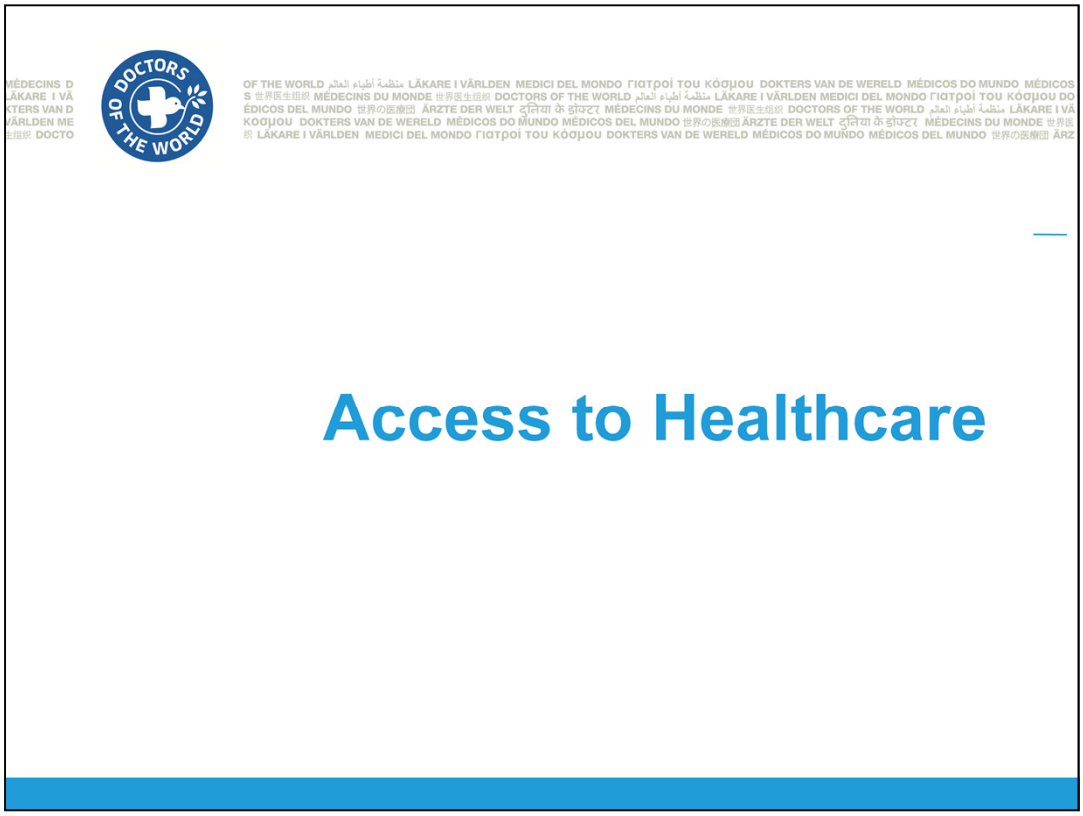
Healthy migrant effect – tend to be 20-30 and managed to get out, so relatively healthy. Estimated that approximately 750,000 undocumented migrants in the UK, 1% of population – even if they consumed healthcare at the same rate as British nationals (for we have seen above that they have similar problems) this would only constitute %1 of a 120 billion NHS budget. But we know that they do not consume as much healthcare since more than a quarter of all health care we consume during our lifetimes is consumed during the last year of our life – since they are young and relatively healthy this would be even less.

Article from HPA study shows that less than 32.5% register with GPs (poor data based on people eligible for TB screening at UK ports, but still best data we have)

You might think that this is good as it further saves money – but in fact it may end up being very costly for the NHS. As the other two thirds have no choice but to go to A&E when they fall sick – this costs three times as much as a visit to GP. Also, conditions not prevented or diagnosed early would end up costing a lot more. £160 a year to manage diabetes in GP surgery. £1000s of pounds in in-patient care and disability if not managed properly.

One admission to intensive care for a patient with HIV-related pneumonia costs as much as two years of antiretroviral treatment.

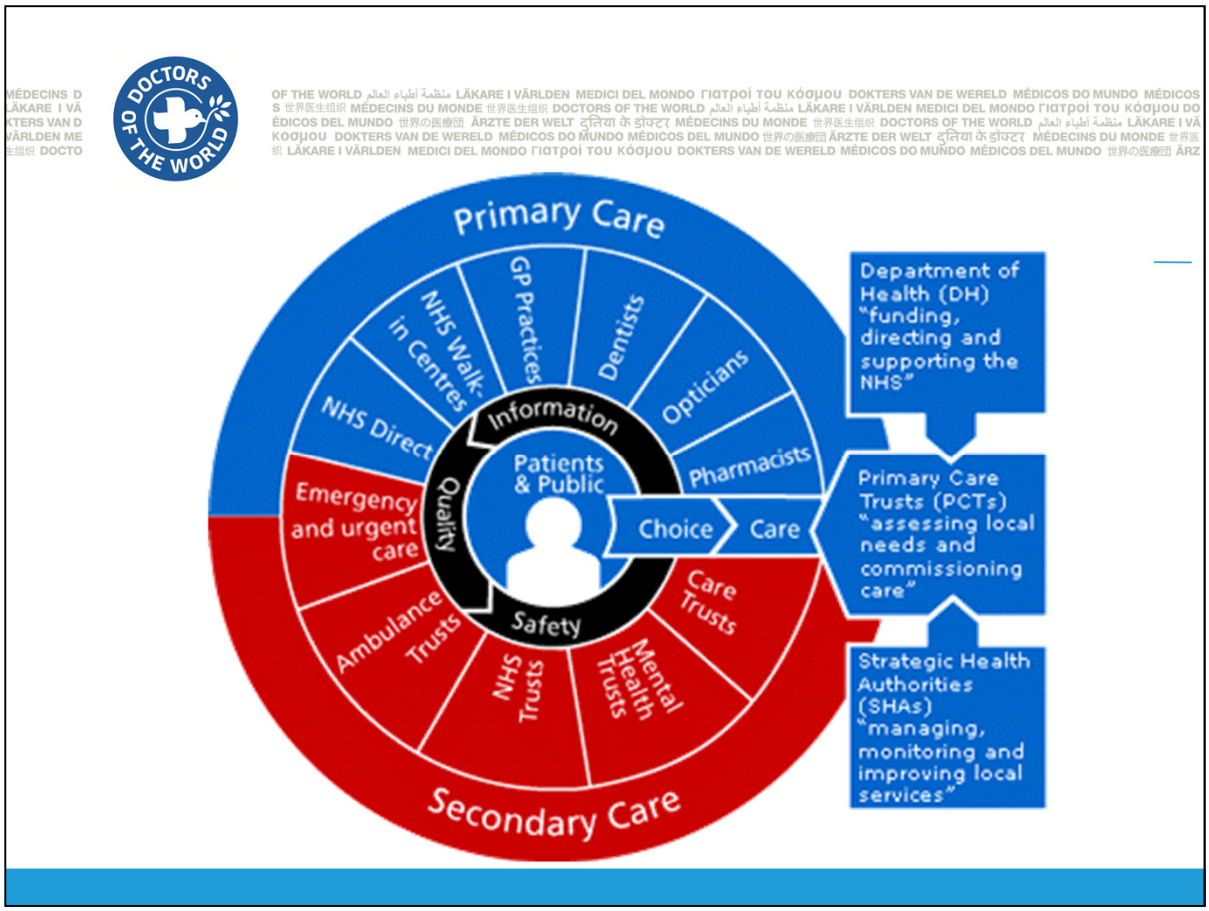
ANY QUESTIONS?


DOCTORS OF THE WORLD
Access to Healthcare

NHS Constitution

- ***The NHS provides a comprehensive service, available to all*** *irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.*

- **2. *Access to NHS services is based on clinical need, not an individual's ability to pay.*** *NHS services are free of charge, except in limited circumstances sanctioned by Parliament.*


Primary Care
GP Practices
Dentists
Opticians
Pharmacists
NHS Walk-in Centres
NHS Direct
Information
Patients & Public
Choice
Care
Quality
Safety
Emergency and urgent care
Ambulance Trusts
NHS Trusts
Mental Health Trusts
Care Trusts
Secondary Care
Department of Health (DH) "funding, directing and supporting the NHS"
Primary Care Trusts (PCTs) "assessing local needs and commissioning care"
Strategic Health Authorities (SHAs) "managing, monitoring and improving local services"

PRIMARY CARE ACCESS

There are ***NO*** regulations regarding charging/eligibility.

All GP's have the discretion to accept or refuse **any** person as an NHS patient. (but they must not discriminate):

Immigration status & ordinary residence are irrelevant when registering with GP

No legislation or statutory guidance suggests people must be resident for a minimum length of time or have a visa in order to access primary care

So a GP ***can*** register e.g. refused asylum seekers, Undocumented migrants, overseas visitors

The law bit: *NHS (GMS Contracts) Regs 2004, Schedule 6 para 17* –

"…general discretion to register/refuse to register anyone in catchment area, so long as GP does not discriminate…"

SECONDARY CARE ACCESS

In April 2004, Department of Health introduced regulations, which restricted free access for overseas visitors and introduced charges for those overseas visitors who access secondary care services. **Where an overseas visitor is someone who is not considered *ordinarily resident*.**

However, this should be a question of charging, *not access*, to health care

(Treatment that immediately necessary and urgent must be given, but charges can be made & pursued)

»The Law bits: Ordinarily resident is: “a person in a country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of long or short duration”

ACCESSING SECONDARY CARE

As opposed to many other countries access to secondary care happens through GP referral, so registration with GP essential

BMA's *General Practitioners Committee's Guidance (February 2011)*

"It is not the duty of a GP to establish a patient's entitlement for free NHS secondary care treatment. This is the responsibility of the NHS secondary care provider. GPs should avoid making judgments about the likelihood of an individual patient being charged for secondary care and should refer whenever clinically appropriate."

Care must be provided if a clinician deems it:

- Immediately necessary treatment

  (Treatment deemed "immediately necessary" *must* be provided. Antenatal care is always 'immediately necessary')

- Urgent

  (Treatment which clinicians do not consider "immediately necessary", but which nevertheless cannot wait until the person can be reasonably expected to return home (e.g. cancer).

» So, when making referrals make sure that GP specifies that treatment is 'immediately necessary' and urgent if that is the case. Or go back and have them re-refer as urgent.

WHO OR WHAT IS EXEMPT FROM CHARGING?

Exempt categories of patient

- Asylum seekers incl. Sec4/95
- Refugees
- EEA nationals
- Dependency visa
- Work / Student Visa
- Those from countries with bilateral health agreements
- Victims of human trafficking

Exempt categories of treatment

- Accident & Emergency
- STIs (including HIV)
- Continuing course of treatment
- Sectioning under Mental Health Act 1983
- Treatment for infectious disease e.g. TB

Who is chargeable for secondary care?

Those not considered 'ordinarily resident'

- Visa overstayers
- Refused asylum seekers (if not receiving Sec 95/4)
- Irregular entrants
- Tourists
- Short-term visitors (including British citizens residing abroad)

Antenatal Care

- Maternity services are seen as **‘immediately necessary’** treatment
- All pregnant women regardless of their status are *automatically entitled* to access maternity services. This includes antenatal care and delivery of the baby in a hospital.
- ANC may not be free, but the Department of Health has acknowledged that maternity services should NOT be withheld if a woman is unable to pay for the service.

ANY QUESTIONS?

CONTACT DETAILS

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