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Right to Health for All

Why the Home Office should not have access to NHS patients' data, and why NHS professionals should not be expected to guard our borders (if we are to take human rights seriously)

"Hundreds of pregnant women without legal status are avoiding seeking NHS antenatal care because of growing fears that they will be reported to the Home Office".[1]

A Memorandum of Understanding between NHS Digital (formerly Health and Social Care Information Centre), the Home Office and the Department of Health ("MoU") came into effect in January 2017. The intention of this MoU is to formalise and facilitate the access to NHS patients' non-clinical information, including their home address, by Home Office Immigration Enforcement authorities. The MoU claims that the disclosure of data is a matter of "public interest" because of the "importance of maintaining effective immigration controls [to] remove/prevent the entry of those who might pose a danger to the public, [and] harm the economic wellbeing of the country".[2]

It has been estimated that around 600,000 undocumented people live in the UK, including children who were born in the country.[3]

[1] The Guardian, "Pregnant women without legal status 'too afraid to seek NHS care'", 20 March 2017.
[2] Home Office, Department of Health and NHS Digital, *Memorandum of Understanding*, 1 November 2016, para. 7.9.
[3] Full Fact, "Why we can't say for sure how many illegal immigrants are living in the UK", June 2014.

In accordance with international law, governments can control their borders and regulate migration, but not at the expense of human rights. Everyone is entitled to healthcare regardless of their immigration status.

This paper shows why and how the transfer of non-clinical personal data between the NHS and immigration authorities can seriously impair the enjoyment of the right to the highest attainable standard of health for thousands of people living in the UK, which constitutes a breach of the international human rights obligations of the UK.

The international right to the highest attainable standard of health

The United Kingdom has set an example by subscribing voluntarily to a number of human rights treaties, several of which protect the right to health. One of them is the International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by the UK in 1976. Article 12 ICESCR reads as follows:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

As a Party to this treaty, the United Kingdom must guarantee that the right to health is exercised without discrimination of any kind (Article 2(2) ICESCR), and

in particular the UK must ensure that men and women enjoy this right equally (Article 3).

The UN Committee on Economic, Social and Cultural Rights (CESCR), which monitors States' compliance with the ICESCR, has been clear: The rights contained in the ICESCR "apply to everyone including non-nationals, such as refugees, asylum-seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation".[4]

The principle of non-discrimination is essential for the accessibility of the right to health, and healthcare services must be affordable for all, especially most disadvantaged groups.[5] Ensuring the access to health facilities on a non-discriminatory basis is a minimum core obligation derived from international human rights law.[6] In other words, it is an obligation that must be immediately and fully secured for everyone.

Governments must ensure that nationals and foreigners have access to "preventive, curative and palliative health services", regardless of their immigration status.[7]

As observed by the UN Special Rapporteur on the Right to Health in his global study on the enjoyment of this right by migrant workers:

> "Policies linking access to health systems with immigration control discriminate against irregular migrants. In some countries, health-care providers are required, under threat of criminal sanction, to report irregular migrants to immigration authorities, which may lead to detention and deportation. As a result, instead of seeking formal channels of care, irregular migrant workers resort to unsafe and illegal options.

[4] CESCR, *General Comment No. 20: Non-discrimination in economic, social and cultural rights*, 2009, UN doc: E/C.12/GC/20, para. 30.
[5] CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, 2000, UN doc: E/C.12/2000/4, para.12.b.
[6] Id, para. 43.a.
[7] Id, para. 34.

> This renders them vulnerable to abuse, exploitation and increased health risks."[8]

"Strict walls should exist between healthcare personnel and law enforcement authorities" because the opposite may frighten undocumented migrants away from seeking medical healthcare when they need it.[9]

The European Committee of Social Rights has established that "legislation and practice denying entitlement to medical assistance from [undocumented] foreign nationals" are contrary to the European Social Charter, which was ratified by the UK in 1962; access to sufficient healthcare is "a prerequisite for the preservation of human dignity".[10]

Public authorities must assess the different effects that policy measures may have on men and women given the structural inequalities within society. Discrimination on the basis of the immigration status affects women to a different degree and in different ways. For example, the unfair deterrence derived from law enforcement officials having access to patients' personal information is likely to have an aggravated effect on pregnant women, who would be cumulatively discriminated against for being a woman, being a migrant and lacking an authorisation to reside in the country.

The UN Committee on the Elimination of Discrimination Against Women has reminded States of the need to "recognize such intersecting forms of discrimination and their compounded negative impact on the women concerned and prohibit them, [as well as the] need to adopt and pursue policies and programmes designed to eliminate such occurrences, including, where

[8] Special Rapporteur on the Right to Health, *Report on the right to health of migrant workers*, 2013, UN doc. A/HRC/23/4, para. 41.
[9] CESCR, *Duties of States towards refugees and migrants under the International Covenant on Economic, Social and Cultural Rights*, 2017, UN doc: E/C.12/2017/1, para. 12.
[10] ECSR, *FIDH v. France*, Complaint No. 14/2003, Decision on the Merits of 8 September 2004, para. 31-32; and *CEC v. The Netherlands*, Complaint No. 90/2013, Decision on the Merits of 1 July 2014, para. 125.

appropriate, temporary special measures" aimed at accelerating de facto equality between men and women.[11]

How the Memorandum of Understanding interferes with the human right to health

Nobody is supposed to be denied for maternal, emergency and primary healthcare in the United Kingdom.[12]

However, Doctors of the World and other medical charities regularly see migrants for whom this is not guaranteed, and the policies implemented in recent months persist in the breach of their human right to health.[13]

The transfer of patients' data from the NHS to the Home Office did not start in 2017. NHS Digital has issued quarterly datasets of personal data trace requests since 2014,[14] but law enforcement authorities have made requests at least since 2008.[15] According to the NHS Digital data register, the Home Office made 8,127 requests for patients' details between January and November 2016, a three-fold increase on the monthly average for 2014 (2,937 in twelve months).

The intended purpose of the MoU that entered into force in January is to facilitate and formalise the exchange of personal data between NHS services and immigration enforcement officials, and therefore it is to be expected that these

[11] CEDAW Committee, *General recommendation No. 28: Core obligations*, 2010, UN doc: CEDAW/C/GC/28, para. 18; Article 4(1) of the Convention on the Elimination of All Forms of Discrimination Against Women, ratified by the UK in 1986.
[12] Section 1(3) of the NHS Act 2006 and National Health Service (Charges to Overseas Visitors) Regulations 2015.
[13] See Doctors of the World's campaign #StopSharing, and individual cases in it. Doctors of the World, *2015 UK Report*, 2016; Maternity Action, *The Impact on Health Inequalities of Charging Migrant Women for NHS Maternity Care: A Scoping Study*, 2017.
[14] Source: NHS Digital Data Register.
[15] Sir Nick Partridge, *Review of data releases by the NHS Information Centre*, 17 June 2014.

numbers will go up this year. Between December 2016 and February 2017, the latest available data, the Home Office made 1,141 requests.

The sharing of personal information between the NHS and the Home Office compromises the principle of **confidentiality** between patients and doctors. In the words of the European Court of Human Rights:

> "Respecting the confidentiality of health data is [...] crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community."[16]

In light of evidence gathered in the UK and other countries, Public Health England, an official and independent body, has warned of the "unintended serious consequences" of the sharing of information between medical professionals and immigration officers. Like the European Court of Human Rights, Public Health England has alerted of the pernicious **deterrent effect** that this policy is likely to have on migrants living in the UK irregularly:

> "If patients have concerns that their personal information, even simple identifiers, could be shared with law enforcement or immigration enforcement agencies for the purposes of pursuing them for actual or alleged breaches of law or immigration rules, then this risks creating a real barrier to their engagement. Any barriers, actual or perceived, to patients accessing healthcare can have serious consequences. In particular this may impact upon asylum seekers, refugees and undocumented migrants or migrant groups legally in the UK who may be distrustful of sharing personal information for fear that it could be

[16] European Court of Human Rights, *Z v. Finland*, Judgment of 25 February 1997, Application No. 22009/93, para. 95.

> accessed by migration enforcement to locate them or their friends and family."[17]

Public Health England echoed research based on qualitative interviews with foreigners living in the UK that reported that some undocumented migrants "waited until their situation had worsened to access care and that late diagnosis had led to deaths in some cases".[18]

There are strong reasons to believe that the consequences are even more severe for **migrant women**. In addition to the pay gap and to women's more precarious access to work, the unbalanced distribution of family care responsibilities in society is bound to have disproportionate effects on women living in particularly vulnerable situations, such as undocumented migrant women. Furthermore, this policy is likely to have a significant impact over women's sexual and reproductive rights.

> *"I feel trapped. I'm in a situation where I need to go to the hospital but I can't, because I feel my information might not be confidential. I can't imagine being separated from my partner. Maybe they would make me go back without my baby too. I would be separated from one or even both of them."* (Six-month pregnant Ugandan woman who sought antenatal care from Doctors of the World because she was too scared to visit her GP; she is married to a UK citizen and has lived in the UK for five years)
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> *"I felt like I was carrying the weight of the whole world. I was worried that if I went to the hospital and the immigration authorities know about it, they might get me and deport me. But if I didn't go to hospital, then what about the lump?"* (Filipina woman who received an appointment for a biopsy but did not attend out of fear for the consequences; she works in the cleaning service and has lived in the UK for several years without visa).[19]

[17] See Public Health England's response to the inquiry by the Parliamentary Health Select Committee, made public in April 2017.
[18] Based on: Farah Seedat, Sally Hargreaves and Jonathan s. Friedlan, "Engaging New Migrants in Infectious Disease Screening: A Qualitative Semi-Structured Interview Study of UK Migrant Community Health-Care Leads", *Plos one* 9 (10), 2014.
[19] Both of these cases were documented by Doctors of the World. Source: The Guardian, "Crackdown on migrants forces NHS doctors to 'act as border guards'", 20 April 2017.

In spite of the warnings by medical charities, health professionals and Public Health England, the Department of Health has said to be satisfied about the MoU's compliance with the public sector equality duty under section 149 of the Equality Act 2010. In its response to an inquiry by the House of Commons Health Select Committee, the Department of Health claims that the evidence about the deterring effect is not "statistically clear", but mentions the possibility of commissioning research on this within two years.[20]

However, two years would be too late. Human rights impact assessments should have been conducted before the MoU took effect. The Department of Health must take seriously the reliable evidence and worrying testimonies about the damning effects on irregular migrants' right to health, particularly women. The Department of Health and the Home Office must stop this policy now without compromising the provision of healthcare and the enjoyment of this human right any further.

The sharing of information between the NHS and immigration authorities can also pose significant risks from a wider **public health** perspective. Some immigrants may bear specific risks associated to their migratory status, and untimely diagnosis and treatment of infectious diseases (tuberculosis, HIV, hepatitis, etc.) may have harmful mortality and morbidity consequences, not to speak of its cost-ineffectiveness.[21] Fear of being reported to immigration authorities has been scientifically documented as one of the main reasons why an individual may delay the diagnosis and care.[22]

[20] Department of Health's response to the inquiry by the Health Select Committee, April 2017.
[21] See data from: Health Protection Services, *Migrant Health: Infectious diseases in non-UK born populations in the United Kingdom. An update to the baseline report*, 2011.
[22] Steven Asch *et al*, "Why Do Symptomatic Patients Delay Obtaining Care for Tuberculosis?", *American Journal of Respiratory and Critical Care Medicine* 157(4), 1998.

The MoU's goal is immigration control, but it has been accompanied by reinvigorated efforts to **charge individuals** that are not legally entitled to healthcare.[23] Both the National Audit Office and the House of Commons Committee of Public Accounts have expressed concerns about the lack of effectiveness of the measures taken by the Department of Health and the NHS to identify chargeable patients and to recover the costs incurred in treating overseas visitors.[24] The cost of so-called "health tourism" has been estimated as 0.3% of overall NHS spending, and it can include care and treatment provided to some of the 5.5 million British nationals living abroad who may require or choose the NHS services when visiting the UK.[25]

Whilst attempting to reduce the deficit derived from "health tourism" is a respectable policy goal, it should not be pursued at the expense of the human right to health of people living in the UK.

Contrary to its own regulations, at least one NHS trust has reportedly sent letters to asylum seeking women warning them that their maternal care provision could be suspended unless they paid high fees.[26]

Some NHS hospitals have started asking for passports or other forms of ID to corroborate patients' eligibility.[27] No single document can confirm or deny whether an individual is entitled to healthcare. More importantly, unless the

[23] Department of Health, "Recovering the cost of NHS treatments given to overseas visitors", 6 February 2017. The Department of Health has introduced "financial incentives" to encourage hospitals to increase charging (HC Committee of Public Accounts, *NHS treatment for overseas patients*, February 2017, p. 13). It has also considered the imposition of sanctions for trusts that fail to collect relevant information towards that goal (Department of Health, *Visitor & Migrant NHS Cost Recovery Programme Implementation Plan 2014–16*, July 2014, pp. 20-21 and 30; HC Committee of Public Accounts, *NHS treatment for overseas patients*, February 2017, p. 7).
[24] National Audit Office, *Recovering the cost of NHS treatment for overseas patients*, November 2016; House of Commons Committee of Public Accounts, *NHS treatment for overseas patients*, HC 771, February 2017.
[25] Full Fact, "Health tourism: What's the cost?", December 2016.
[26] The Guardian, "Pregnant women without legal status 'too afraid to seek NHS care'", 20 March 2017.
[27] HC Committee of Public Accounts, *NHS treatment for overseas patients*, February 2017, p. 11.

verification is done systematically for every individual entering into a public hospital, it is hard to imagine how a nationality test could be carried out without incurring in some sort of profiling based on the physical appearance.

Unsure about whether they could be deported if they visited a public hospital, seeking the medical treatment or consultation they need is a high-risk venture for undocumented migrants living in the UK.

In light of the right to health recognised in international human rights law, NHS professionals should not be expected to guard the national borders.

Conclusions and recommendations

Like other European countries,[28] in recent years the UK has introduced measures that have disproportionately affected the enjoyment of the right to health and other human rights by undocumented migrants, particularly women.

Migration law and policy must be in line with human rights as proclaimed in international law.[29] Under international human rights law, which is binding for the UK, undocumented migrants are entitled to economic and social rights. Public authorities are not allowed to discriminate against migrants because of their nationality or their immigration status. They must also have due regard to the cumulative and intersectional effects that their policies, actions and inactions, have on equality and human rights. National legislation must ensure and public authorities must respect undocumented migrants' access to adequate healthcare, including preventive, curative and palliative services. Hospitals and healthcare professionals should not be required to report data on the

[28] European Parliament Committee on Civil Liberties, Justice and Home Affairs, *The impact of the crisis on fundamental rights across Member States of the EU: Comparative analysis*, 2015, ch. 5.
[29] See Office of the UN High Commissioner for Human Rights, *The Economic, Social and Cultural Rights of Migrants in an Irregular Situation*, 2014; EU Fundamental Rights Agency, *Handbook on European law relating to asylum, borders and immigration*, 2014.

immigration status of their patients to immigration officials. Everyone should be reassured that they will not be reported if they seek medical help.

- As recommended by the UN Committee on Economic, Social and Cultural Rights, UK authorities must "take steps to ensure that temporary migrants and undocumented migrants, asylum seekers, refused asylum seekers, refugees and Roma, Gypsies and Travellers have access to all necessary health-care services and [...] that health facilities, goods and services should be accessible to everyone without discrimination".[30]
- The Home Office should not have access to NHS patients' data. Access to information regarding migration status should only be made available with a court order.
- NHS professionals should not be required to report patients' non-clinical information for immigration purposes.
- Considering the legal duty to have due regard to the need to reduce health inequalities,[31] the Department of Health should assess thoroughly the human rights impact of the transference of patients' personal information from the NHS to the Home Office, particularly on the rights of migrant women. The Memorandum of Understanding should be suspended until such assessment is complete. Any future policy on the matter should include independent monitoring mechanisms to assess its impact on human rights and equalities.

[30] CESCR, *Concluding Observations: UK*, 2016, UN doc: E/C.12/GBR/CO/6, para. 55-56.
[31] Section 4 of the Health and Social Care Act 2012.

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Doctors of the World (DoTW) UK *is part of the Médecins du Monde network, an international humanitarian organisation providing medical care to vulnerable populations.*

In the UK, DoTW runs a volunteer-led clinic and advocacy programme with GPs and nurses that helps the most vulnerable members of the community to get the healthcare they need. In 2016 DoTW saw 1,924 patients, including refugees, asylum seekers, undocumented migrants, victims of trafficking and homeless people.