Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Proposed Legislation on Overseas Visitors' Access to Free Healthcare: Law Centre (NI) Briefing

4 December 2013

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Mr Neil McKittrick	British Red Cross
Ms Liz Griffith	Law Centre (NI)
Mr Justin Kouame	Northern Ireland Community of Refugees and Asylum Seekers

The Chairperson: We have Liz Griffith, Law Centre policy officer; Justin Kouame, chair of the NI Community of Refugees and Asylum Seekers; and Neil McKittrick, the British Red Cross refugee services manager. You are very welcome. There will be a 10-minute presentation from you, and, following that, I will invite questions from members.

Ms Liz Griffith (Law Centre (NI)): I thank the Committee for the invitation to come to talk to you about a relatively discrete issue, which is access to healthcare for refused asylum seekers. I also thank the Department, if they are here, in particular Robert Kirkwood, for liaising with us.

I will begin with a brief round of introductions, and then we will move on to the meat of the presentation. I am from the Law Centre, which seeks to promote social justice through legal and policy services. We represent a number of asylum seekers in respect to their legal status and accessing healthcare. I hope that you have seen a paper that was circulated to you. Page 6 of that paper contains a number of case studies. Many of those are drawn from our clients.

Mr Justin Kouame (Northern Ireland Community of Refugees and Asylum Seekers): I am the chair of the Northern Ireland Community of Refugees and Asylum Seekers, which provides advice, information, support, activities, educational opportunities and a voice for refugees and asylum seekers in Northern Ireland. I am here today because the regulation proposed by the Department will have great impact on members of the organisation.

Mr Neil McKittrick (British Red Cross): I am the service manager for the British Red Cross, and I am based in our University Street office in Belfast. The British Red Cross helps vulnerable asylum seekers and refugees in Northern Ireland to access essential services and adjust to life in a new country. From our experience of working with this group, some of whom are among the most isolated and vulnerable people in society, we have gained knowledge, insight and expertise in the challenges they face and the needs that they have.

Ms Griffith: That is who we are. I will begin by providing an overview of our arguments and highlighting the very real problems that are being experienced. Justin will walk you through the asylum process, very quickly, so that all of us are clear about the terminology being used. Neil will present the benefits of our proposal, and I will sum up and comment on a way forward.

We believe that our argument is quite simple; we are looking for Northern Ireland to provide free universal healthcare to all asylum seekers, based on clinical need, while they remain in the jurisdiction. When we say "universal", we mean primary and secondary care. That is the approach taken by Scotland and, more recently, Wales, and we would say that those devolved Administrations provide a tried-and-tested model of how to do this. You will be aware that there are a number of organisations that support this concept. In fact, 18 organisations have expressed their support, and I believe that you have a list of those organisations. In our view, it includes an impressive array of migrant organisations, faith groups, statutory human rights organisations and medical practitioner representatives. I am pleased that some members from Horn of Africa People's Aid Northern Ireland (HAPANI) are here today.

At the moment, refused asylum seekers in Northern Ireland are not entitled to be registered with a GP. That means that they do not have primary care. They are also not entitled to hospital care, which is commonly referred to as secondary care. In practice, the only way that they can receive treatment is through an A&E department. Our experience is that that causes a range of difficulties. Indeed, we would argue that this set of restrictions benefits nobody. First and foremost, it puts patient health at risk because people with manageable conditions such as asthma, for want of an inhaler that could easily be prescribed by a GP, are deteriorating until a point when the patient becomes critically ill and a much more serious medical intervention through A&E is necessary.

Secondly, the restrictions are a public health issue because, without GP access, adults and their children cannot be vaccinated. Thirdly, the fact that the system is inadvertently funnelling people into A&E is possibly putting pressure on hospital resources for issues that could be more appropriately dealt with in the community. We believe that the Department of Health's ethos at the moment is to promote community interventions. Our finding is that when patients are admitted to hospital for serious issues, they are in hospital wards for much longer because the medical and social work staff are reluctant to discharge them into the community when they are not being discharged into the care of a GP. All of that brings a cost to the taxpayer.

Finally, the situation creates difficulties for medical practitioners because they are hampered in the types of treatment that they can provide, and it creates difficulties for people in the voluntary and community sector, who are trying their best to assist while knowing full well that they are not a substitute for a GP.

The regulations that are before you today will extend access to secondary care to one category of refused asylum seekers. We welcome that direction of travel, but we feel that there is an opportunity to go further and ensure that all asylum seekers have an entitlement. The difference between what the Department proposes and what we propose is just 35 people. It is 28 applicants, and when dependants are included, it is 35 people. Unfortunately, there is no proposal before you at the moment that will provide primary healthcare to refused asylum seekers. We feel very strongly that, to be effective, healthcare must be holistic. It must include primary and secondary care. If not, it is unworkable and fraught with medical and administrative difficulties. Accordingly, we are seeking a way forward that will provide clear entitlement to primary and secondary care.

I will pass over to Justin, who will talk you through the asylum process.

Mr Kouame: Thank you, Liz. Some 140 asylum applications were lodged in Northern Ireland in 2012. While a person waits for a decision on their claim, they are entitled to obtain government support, known as National Asylum Support Service (NASS) section 95 support, under section 95 of the Immigration and Asylum Act 1999. They receive accommodation and about £36 for living. Asylum seekers must comply with immigration restrictions, which means that they must report regularly at the Home Office but cannot work and must not claim benefits. Some decisions are made quickly, while

others take months or years, especially when there are appeals involved. In general, about one third are granted refugee status. Others are refused. Some people make voluntary returns, some move to Britain and some are forcibly removed.

Some refused asylum seekers are entitled to obtain government support, known as NASS section 4 support, under section 4 of the Immigration and Asylum Act 1999. However, some refused asylum seekers do not qualify for government support and, therefore, are completely destitute. This category includes people who are collecting the necessary evidence to submit new claims for asylum; people from countries, such as Syria, that are too dangerous for the Home Office to remove them to; and people who cannot leave Northern Ireland for bureaucratic reasons. We estimate that, in the 2012 figures, 28 asylum cases fell into that category. When dependants are included, we are talking about 35 people. Although these people do not qualify for government support, they usually continue to comply with immigration restrictions. If they do not comply, they risk being detained. We do not know what happened to those 35 people. Some go on to obtain refugee status, and others eventually leave Northern Ireland.

Mr McKittrick: Thank you, Justin. The Department's approach is to tie healthcare to government NASS support. However, the asylum application and support system is not as linear as being one straight-line process. The reality is much more complex. It is a system in which you are sometimes in support, out of support, and then back in support. That is taxing on the individual. Often they are not aware of where they are in the system. We believe that it would be a mistake to tie healthcare to a complex system that has people in and out and is reliant on a large amount of paperwork and tight deadlines.

The reality of a complex asylum system is that, sometimes, somebody on section 4 support, for example, will just be given government support for a period of three months. We see it as problematic to tie somebody's healthcare needs to three-month support, especially when, after another two months, the person is back into support. So, they have been ill, and they can get provision. They then drop out of provision but remain ill and then come back into provision. It is not feasible to tie the system to chunks like that. It is based on a government decision-making process that is often unclear to everybody who is connected to it.

In particular, there are issues around section 4 support, to which the Department looks to tie people's status and healthcare. In section 4, the burden of proof is on the applicant. It is a complex system, and administrative boundaries are very tight. There are repeated instances of administrative mistakes that mean that people do not get what they are entitled to. In fact, a recent Red Cross report shows that the largest group of destitute asylum seekers are people waiting for section 4 support to begin. They have that entitlement, but the support has not yet begun. In our view, those systematic delays are unacceptable. Somebody is already without food and accommodation, and these proposals will link their healthcare provision to it as well.

When you are on section 4 support, you drift in and out of support. Sometimes the first time that you know that you are no longer entitled is when you put in your card to access your funds and find that they are no longer available. People come to my office and say, "My card is not working. I am not in support, and I do not know why. I do not know what I have done or what I am supposed to do."

That is the reality of the system. I will give you just one example. We had a gentleman who came to the Red Cross with severe post-traumatic stress disorder. Through his GP, he was referred to Knockbracken, where he stayed for a period of weeks. When he was released, his section 4 support stopped, so he was unable to get care from the community care team. We then had to refer him to A&E for treatment. He was back in the system later down the line, and now he is out of the system once again. That gentleman is here only because he has a mental health problem that means he cannot be returned. He cannot be treated — or is treated only intermittingly — for the very issue that is keeping him here. It is very important to say that it is real people that we are dealing with, even though the numbers are very small.

I turn now to the second issue that I would look to address. We understand that the Department is concerned that providing healthcare will act as a possible incentive for people to come to Northern Ireland. We have the benefit of seeing what has happened in Wales and Scotland in that regard. Wales and Scotland are bordered by England, which does not have these provisions but has, by far, the greatest number of asylum seekers. There is no evidence that the number of asylum seekers in Scotland has increased since they adopted universal healthcare for asylum seekers. The same is true for Wales, which adopted it in 2009. There has actually been a dip in the number of people applying for asylum in Wales. When people apply for asylum, they are unaware of the facilities and benefits that

exist, and they are definitely not aware of where to go for healthcare. That does not factor in their consciousness. Those figures are on page 5 of the Law Centre report.

That leads us to conclude that our proposal for universal healthcare will not act as a draw for asylum seekers. Instead, it will improve patient and public health, be a more appropriate use of health resources, have savings for the public purse and be much easier for medical, voluntary and community staff to administer. I have often been in the unqualified position of people presenting a GP's prescription to me, saying, "I cannot go to my GP. I am in pain and need this medication." I have taken those people to a pharmacist and asked, "Can the Red Cross buy over the counter what would be available with this prescription or the best substitute?" Pharmacists are baffled. They cannot provide the stuff, and the gentleman just has to go on living in pain until he maybe re-engages with the system, based on his status.

Although many asylum seekers are healthy, they will get ill from time to time, particularly if they become pregnant. Additionally, some have complex mental and physical health needs due to their experience of conflict and torture. It is essential that Northern Ireland's health framework ensures that healthcare is accessible when there is a clinical need. We are not aware of any organisation or people who work with asylum seekers that think that it would be wrong to adopt our amendments. I would just like to remind you that we are talking about a very small number of people.

Ms Griffith: Our preference is for the regulations to make provision for universal access to those in the jurisdiction on the basis of clinical need. Unfortunately, the regulations before you do not do that. We take the view that they are flawed for two reasons. The first is that they will exclude a small number of refused asylum seekers not in receipt of section 4 support. That is, they will require a whole mechanism to be constructed around identifying and excluding 35 people. That is the focus of our amendment.

The second reason that the regulations are flawed is that they are looking at providing only secondary care, so they cannot provide an holistic health treatment or package. Under these regulations, a person may be able to receive treatment in a hospital but is then not able to go to their GP and get a prescription or vaccination.

It seems to us that there are a couple of ways forward. Our preferred option is for the Department to adopt our amendment and, additionally, to widen the scope of the regulations to provide primary healthcare. We are conscious that the Department is under time constraints due to the regulations being bound up with other regulations and an EU directive. Therefore, it may be difficult to implement practicably what we suggest. The alternative is that if these regulations were passed with the small amendment that we propose, that would deal with the first issue. The second issue is primary care, and the Department wrote to us this morning to say that it agrees to engage with us to discuss how to look at the primary care issue. We welcome that commitment. If that is the route that the Department goes down, however, we would like the Committee and Department to agree to a timescale, and we would like to come back to you and report on the progress of that piece of work.

We are happy to answer any questions that you may have.

The Chairperson: Thank you all for that. Is it the case that refused asylum seekers, or failed asylum seekers, as it is called here, are not entitled to register with a GP?

Ms Griffith: That is right. These regulations will improve things, because they will provide some refused asylum seekers with an entitlement that they do not currently have, but in relation to only secondary care.

The Chairperson: OK. We are working our way through this. Obviously, we took some time to consider this, and it is our understanding that the regulations would allow certain categories of people free access to GP services, including failed asylum seekers who are on government support schemes. Is that not your interpretation?

Ms Griffith: It is not. I have spoken to the Department about this very issue, and I was told that Part 2 of the regulations, which includes the asylum seekers, applies only to secondary care. So, we could be in the quite bizarre situation where an asylum seeker has an entitlement to secondary care but not to primary care. Of course, it is normally a GP referral that gets you from primary into secondary care.

The Chairperson: I am glad that you made a reference to the letter from the Department. It is in our tabled papers today. There seemed to be a suggestion in that — I think that you are going some way to clarify it now — that there was confusion around the issue of the type of care. However, you are being very specific. You say that it is about secondary care, although your preferred option is that it should be universal care for all, depending on clinical need.

Ms Griffith: Yes.

The Chairperson: And just a final point: what numbers are we talking about? Neil said that we are talking about a relatively small group, but we received a figure of 20 last week, 50 this week, and I heard one of 38 today.

Mr McKittrick: We are in a position where we cannot give accurate figures because that is really the responsibility of the UK Border Agency (UKBA) or the Home Office. They cannot separate their figures from current figures for the Northern Ireland/Scotland area. We asked them for those figures in anticipation of this. What figures do have we, Liz?

Ms Griffith: We have made some calculations and used data available, both UK-wide data and data provided by the Home Office here. I acknowledge that the number that I have given you has changed and that I have increased it slightly, and that is to be sure that we are giving you the most expansive number that we can calculate. That is found at page 2 of the information that I have given you. Out of 140 people claiming asylum, we think that 28 will ultimately fall into the category of being refused and not being in receipt of government support. So, we say that the number is 28, but when you add dependents to that, it rises to about 35. There is normally one dependent per four applicants.

Mr McKittrick: An unknown number of those people will then go on, possibly, to get status anyway. Being refused status at a particular time does not prevent you trying again. It is very complex; every case is really a unique one. From our calculations, even in the broadest sense, we estimate that the number would be 35 and certainly no more than 40 people. The Red Cross provides food vouchers and cash to people who are destitute, and, in 2012, 35 people accessed our service for those goods. Those are people who are homeless, have no right or entitlement to any funds or welfare, and are completely destitute. The Red Cross is available to them, and, in 2012, we saw 35 of those people. That is as good a figure as we can give.

Ms Griffith: That would chime with our calculation that there are about 35 people in that category.

Mr McKittrick: We would be unable to bring the 35 people in to you, because their situation changes constantly.

The Chairperson: OK. Thank you.

Mr Beggs: It would be helpful if you would explain why some of the failed asylum seekers would not qualify under section 4 or section 95.

Mr McKittrick: Section 4 sets narrow parameters. The ones that we are aware of are that you have to be making reasonable steps to leave the UK; you cannot leave because of a physical impediment; there is no viable route of return; you are involved in a judicial review; or there is a human rights reason for you not returning. The people we speak to often have an entitlement to section 4 support, but they are not yet in a position to submit the evidence that would substantiate their case.

Mr Beggs: Have they already applied and failed?

Mr McKittrick: No. People will not be allowed to apply unless they meet certain criteria. So, if you are advising somebody on whether to go for section 4 support, it may be that he wishes to submit a new claim for asylum. In order to do that, he needs expert evidence and there are many hurdles in the way of achieving that. A lot of it is not at people's own discretion. They are not necessarily in control of the process. Somebody may fall within section 4 and then fall outside it, maybe because the support lasts for three months; or, in order to continue under section 4, they need evidence from doctors. That takes time. So, they bounce in and out of it. It is the process of bouncing in and out that is —

Mr Kouame: Where there is no bouncing in and out, there is no safe return home and the Home Office is certain that it is not a safe country to return someone to, then they will be deemed to be a failed asylum seeker and will not be given status. However, that person will continue to report to the UKBA. The UKBA will know exactly the reason why that person has received a failed asylum decision; that the person is still in the country because there is no safe route by which to send them back to their country.

There are also cases where the Home Office itself has lost the applicant's paperwork. It cannot find the documents. The person will be destitute. There are cases where, especially if you take someone from mainland China, Syria or Zimbabwe, the Home Office is conscious of that, but the person still will not get status and will be a failed asylum seeker staying in the country with no support. You see cases of that.

Mr Beggs: In the information that has been given to us, a letter from the Minister states that section 4 support is given by the UK Border Agency to failed asylum seekers who are taking reasonable efforts to leave the UK, but for whom there are genuine barriers to their return home. So, it says that if there are genuine barriers, support is available. Is that not the case?

Ms Griffith: There are a couple of issues there. There are different criteria for applying for section 4 support, which we have referred to. First, you have to be destitute. Secondly, you have to sign up to return at a time when it is safe to do so. So, the Home Office will say that, at the moment, there is no viable route and there is a genuine barrier to your returning home; however, if that is lifted, you have to agree to go. Some people who are still fighting their claim are not prepared, understandably, to sign that because, by doing so, they lose their ability to pursue their claim. Therefore, I would query that.

Mr Beggs: The other aspect relates to section 95, under which you would qualify for support if you were destitute.

Ms Griffith: It is not enough to be destitute. You have to be —

Mr Beggs: So, it has to be both.

Ms Griffith: Yes. You have to be destitute and actively cooperating to return home and have a medical condition that prevents you getting on a plane, let us say. Those are the two.

Mr McKittrick: They are the two amendments, yes. The other point for people in that position is that you may not have the evidence to make your case but that does not mean that you do not have a legitimate fear of persecution. You are faced with the option that you can get section 4 support if you agree to go home. What you are saying is that, because of the trauma that you have been through, you do not have the ability to present all the evidence that you think is available on your case. Those people still have an abject fear of going home. They would rather live here penniless and without any access to healthcare than face the risk of going home and, potentially, being killed.

Mr Beggs: If we were to provide total free healthcare in any circumstance, how would that compare with the situation in the Republic of Ireland? Are we likely to get more failed asylum seekers coming here?

Ms Griffith: In the Republic of Ireland, most asylum seekers are housed in direct provision, as it is known. If you are in direct provision, you have entitlement to healthcare regardless of the stage that your claim is at. In addition, if you are the subject of a deportation order, again, you would have access to healthcare in the Republic.

Mr Kouame: If you have made a claim in the Republic of Ireland, and you come here and make a claim and do not disclose the fact that you claimed previously in the Republic of Ireland, when the Home Office finds out, it will send you back to the Republic because you have to claim in your first country of entry. Someone coming from the Republic cannot just go to a GP for health treatment. They may get treatment at A&E, but they need to be registered with the GP first. So, there will be a primary check to see if they are registered with a GP. Once it is determined that a person has already claimed in the Republic, he will be sent back there on the basis of the Dublin convention.

Mr McKittrick: The final point is that there has been no evidence of that in Wales and Scotland, which have offered these provisions. They have not been flooded with people coming from England for their

healthcare. We have no evidence to suggest that that would happen from the Republic to Northern Ireland either.

Mr Beggs: There may be completely different circumstances North and South compared with England and Wales.

Mr McKittrick: There are, but if you live in Bristol or on the Welsh border, you could easily go across to Wales. I appreciate what you are saying, but there has been no evidence of it in Scotland, England or Wales.

Mr D McIlveen: I think that we are all agreed that this is quite confusing. There is a lot of information that is quite complicated to take in. I want to try to get my head around the people who are being supported under section 4. If we are saying that they are being supported on the basis that they are actively working and engaging with the UK Border Agency to find a way home, can we therefore imply, turning it on its head, that those who are not being supported under section 4 are therefore not engaging with the UK Border Agency to find a way home?

Ms Griffith: I can respond to that. The letter that we got from the Department this morning specifically refers to people who are not cooperating with the UKBA, and that suggests that any refused asylum seeker who is not in receipt of section 4 is somehow not cooperating. That might be true in so much as they have not said, "Yes, I will go back at the first opportunity", but they are cooperating on a weekly basis; they are going to the Home Office, reporting, signing in, and have given their fingerprints. They are cooperating in so much as they are not working and are abiding by other immigration restrictions. It is incorrect to say that that category of person is not cooperating.

Mr D McIlveen: My heart absolutely goes out to the people who find themselves in that position, but access to primary and secondary healthcare may be the only thing that is keeping them engaged with the UK Border Agency. I am purely taking on the role of devil's advocate, but if we were to endorse this policy, do we run a risk of almost incentivising people not to cooperate with the UK Border Agency? If those people who are not currently supported under section 4 are not engaging with the UK Border Agency —

Ms Griffith: They are engaging. They are reporting every week.

Mr D McIlveen: I mean on the healthcare side of things. Do we run a risk of almost sending out the message that there is now no onus on people to engage with the UK Border Agency because, effectively, the healthcare provision, in itself, could provide enough incentive to stay here?

Ms Griffith: It could, but the main incentive for people to comply with the Home Office is that failure to do so results in their temporary admission being revoked and them being detained.

Mr Kouame: In my experience, health professionals and nurses working with asylum seekers find it extremely difficult to get them to go for a GP appointment or to hospital. Even though people on section 4 have access to healthcare, they do not see it as a priority because their priority is their case with the Home Office. Where they come from, healthcare is not free, and sometimes it is not even in existence. Some individuals with mental health issues do not want to go to hospital. The nurse will come to their house and try to get them to go, and we have constant evidence of nurses telling people to go for GP appointments. There is no incentive. Maybe it is there, but I do not see it.

The point is that if the individual has children those children have access to free education. They go to school. They may be sick and they may be carrying something and infect or contaminate the friends in their class. If education is free, I see that as being a bigger incentive than healthcare. The last time I visited the health service was in December 2012, because, where I come from, healthcare is not free. If I have a headache, I prefer to go to the chemist and buy paracetamol for 60p than wait in a GP's surgery to get the same thing. The reality is that asylum seekers do not make appointments. Every health professional will tell you that that is not an incentive. We are running a risk because children do not have access to healthcare: they will go to school at 8.00 am every day, and run the risk of contaminating their friends in school. I do not think that healthcare is an incentive. The reality is very different.

Mr McKittrick: Unless it affects your substantial case, which, as Liz said, is that you are not accepting, as soon as possible, the right to return and you think that you have a chance of succeeding

to get refugee status because you are fearful of what will happen to you on your return. That is the reason why people would not apply for section 4 support. Everybody I know who is destitute would like to have section 4 support. If you do not have it, you do not get access to healthcare, which is important and why we are here, or access to any money. You have no accommodation. I know, for a fact, that the people we are talking about are sleeping in Botanic Gardens or are staying with friends or whatever. By giving them healthcare, all you are succeeding in doing is making them healthy rather than incentivising them to go for section 4 support. All those other incentives are there, but such is people's fear of agreeing to go home because they will be killed, they will refuse to take them because that is the overwhelming reason.

Ms Griffith: I see the point you are making about whether we could be, inadvertently, encouraging behaviour that we do not want to encourage. We are very clear that healthcare should be entirely separate from immigration. We should not be trying to conflate the two things. Healthcare should be provided on the basis of clinical need. That should be the impetus for providing healthcare. We do not use the carrot of healthcare to try and encourage any other desirable activities, such as getting it only if you go to school or comply with the tax man. We should not be trying to use as a way of enforcing immigration control. That would be a very dangerous departure from the way in which it is currently understood and provided.

Mr D McIlveen: Regrettably, the lines cross. The Act came out primarily around overseas visitors. Obviously, it has become a little bit more convoluted because of this issue. There is a difference between regular healthcare that national-insurance paying citizens such as us enjoy the privilege of and particular need, if somebody finds themselves seriously ill or whatever. That is where the lines cross. Unfortunately, we are not dealing with people who have the same legal protections as us. It is about how you deal with that. Is an asylum seeker an overseas visitor or a long-term resident? That is where the issue lies.

Ms Griffith: For us, the key distinction in the discussion of overseas visitors is that other visitor categories could ultimately obtain healthcare through different means. They could pay for healthcare through private means, or they could return to their states and receive it. This is a group of people who have no access to any other alternative healthcare system. The Law Centre is involved in a case in which the Home Office has lost a man's travel documents. He cannot go anywhere; he is in limbo. If a clinical need should arise, there needs to be a lawful mechanism so that he can receive treatment.

Mr Wells: I have just one question. Are you aware of people who do not fall into any of these complex categories and who just refuse point blank to cooperate with the authorities? They destroy their papers, clam up and say nothing.

Mr McKittrick: None of those people access our services. In our service, anyone who is an asylum seeker or a refugee is free to come to the Red Cross and avail of access. We base it on their need, and I have not encountered people who are that way inclined. You are asking whether there is a subculture of people who do not present to the Border Agency.

Mr Wells: In the case of someone who does not fall into these special hardship categories and who stays silent and says nothing and refuses to cooperate with the authorities, do you accept that the state authorities are perfectly entitled to say to that they will not cooperate with them?

Mr McKittrick: If someone were refusing to cooperate with the UKBA, they would not be able to have the documentation that would allow them to access medical services.

Mr Wells: The Department's submission talks about people who are not cooperating with the UK Border Agency.

Mr McKittrick: It talks about cooperating, as in qualifying for the schemes that it runs. What we are saying is that a person who is not cooperating, as viewed by the Department, could still be turning up to the Home Office. He could be saying, "Here I am, I am presenting myself. This is my address. You know who I am. There is my fingerprint". Going by the definition of not being in a scheme, you are deemed to not be cooperating because you are not in one of these schemes. Actually, you are cooperating, and the Home Office can find you at any time, because it has your address. So, you will not have absconded from your responsibility to the Home Office. You are very much active at the Home Office. You very much seek to get your case on track again so that you can try to get out of this fraught situation into some sort of status. So, if you are not cooperating with the Home Office at all,

you will not be able to access the healthcare that you are asking for. I think that the term "cooperating with the UKBA" is confusing in that regard. Not cooperating with the UKBA in the sense of not qualifying for the strict procedures for these schemes does not mean, in a practical sense, that you are not cooperating with the UKBA. You are doing that by giving your fingerprint, telling it who you are and giving your address.

Mr Kouame: Also, the members who help at the Northern Ireland Community of Refugees and Asylum Seekers (NICRAS) want to know what stage the person is at with their application. We do not support people who do not have any application as an asylum seeker or refugee. We do not do that, because we want to make sure that the person is in the process. The S96 states that failure to comply with the UKBA can lead to a fine of up £5,000 and imprisonment. Once you fail to do that and you show up one day to report to the UKBA, they will definitely ask when you are going to be removed.

We do not encourage such things in our organisation. People should not come in and receive help when they do not have any type of contact with the UK Government.

Mr Brady: Thanks very much for the presentation. Liz, you probably made a point that I was going to make. In my view, there are two separate issues. This question may be simplistic, but it seems to me that there is an obvious difference between an overseas visitor and someone who is an asylum seeker. I imagine that, if you apply to be an asylum seeker, you have to go through a fairly rigorous procedure to be accepted as such. The reason that you are an asylum seeker is because you have had to leave your country of origin for a good reason. If you follow David's rationale, then people are queuing up to come here just to get healthcare, but I cannot imagine that that is the case. It seems to me that we are talking about people who, like all of us, only need to access healthcare when they need it. As you say, you go to a chemist and buy paracetamol. You do not go to your GP. That probably applies to most of us, so there is an obvious difference.

I assume that, whether it is primary or secondary healthcare, you only want to access it because you need it, not because it is there. It is like many other things in that it is there but you will only use it if you really need it. Those are two separate issues, in many ways. I imagine that there are many asylum seekers, whether they have failed or are cooperating in some aspects but not necessarily in others, who do not need to access medical care. We are talking only about the ones who need medical care, and that is a fundamental right for anyone, whether they are an asylum seeker or not. Does someone have to become seriously ill? Justin made the point about someone who has asthma and goes to a GP for an inhaler which prevents the condition from progressing to the point where it will be much more expensive and will require a lot more care. That is common sense.

Ms Griffith: Perhaps I could expand on that, because that was a Law Centre case. It concerned a woman from Zimbabwe who was an asylum seeker and who had asthma. While her case was pending, she was going to the doctor regularly to get a prescription for an inhaler. Her case was refused and she was de-registered from her GP's practice. Her inhaler ran out and she could do nothing until she became so ill that she was rushed to hospital in an ambulance and admitted to intensive care. She spent five days on a hospital ward. I looked up the NHS figures, which indicate that the cost of a bed in intensive care for one night is £1,500. The cost of a GP visit is £25. She was in hospital for five days. How can that make sense? I agree with the points that you made.

Mr Kouame: I agree with them as well. There was a similar case involving a man from Zimbabwe who had TB. He was in the system. He was so ill that he was taken to hospital and stayed there for nearly a month. He went out of the system and he did not have access to treatment but carried on going to the Royal Victoria Hospital. The nurses felt that they had to help him and give him his treatment. Otherwise, he would not have been able to finish his treatment.

The point I want to make is that we are not talking about asylum seekers; we are talking about people. Asylum seekers are in a temporary situation. It is not a religion, a culture, an identity or a type of organisation. People find themselves in a temporary situation and they are not on their own in that. That can be very short or very long, depending on the immigration process.

Even today, it is extremely hard for asylum seekers from Syria to get a positive decision from the UKBA. Sometimes the person has to prove that he has documents, but how can you do so from a country where there is fighting? We do not even know the logic behind someone becoming a refugee, but we are talking about human beings here. I will not say that they are being denied, because that is a big word, but restricted.

I know of an asylum seeker who went out of the system. He applied for section 4 support and he started working two weeks ago and is paying tax. Things can change in a matter of weeks or months or years. The Committee should look more into the human side than at a temporary situation that a human being may be in for two weeks, three weeks or a month. The UKBA may say that it has made every effort to make a decision within six months, but the reality is different. We have members who have been waiting for an asylum decision for five, seven or 10 years. The situation on the ground is totally different.

The Chairperson: Thank you for that, Justin.

Mr Beggs: The Minister has indicated that failed asylum seekers who make a fresh application, perhaps because they have additional information to strengthen their case, would be exempt and would receive health support. That is right; if people can be in the UK legally we should support them. There has also been talk about overseas visitors and why the country needs to charge them.

I would be interested to hear your views on another category that I have not heard being talked about, which is illegal economic migrants. Should they also get free healthcare?

Ms Griffith: Economic migrants are dealt with in the regulations. If they can meet —

Mr Beggs: What about illegal economic migrants? Do you think they should get free healthcare? They are not legally in the country.

Ms Griffith: Sorry, illegal?

Mr Beggs: Yes. Should illegal economic migrants also get free healthcare? If you provide free healthcare for everybody, you provide it for everybody.

Ms Griffith: Speaking as the Law Centre, we have in the past argued that there might be benefits in that approach, specifically a public health benefit, but that is not what we are arguing here. We are saying that it is a very small, knowable and discrete number of asylum seekers and, while they are here, they should be getting healthcare. We would like to maintain that narrow focus.

Mr McKittrick: I am certainly not of an opinion on that issue. We are here to deal with the asylum seeker point. You made the point that if people re-engage with the system then they will be entitled to healthcare. That is quite often what happens; it is just that there is a period of time in which they do not have the wherewithal or ability, usually because they are waiting on other evidence, to re-engage with it. The point you make is absolutely right. Then they get back in the system, but why do they have to wait for maybe one month or six weeks between times? Why does their support have to break while they re-engage?

We would never advise people to simply toss in a fresh asylum claim in the hope that they would get healthcare out of it. The asylum system and legal system are much more detailed than that. You present a case when you think you have all of your evidence lined up. If somebody wants to get expert evidence, they often have to travel to England to get it. They have to schedule an appointment and that all takes time. That is the period that you are talking about when they do not have access to healthcare. Then, when they do make their claim, they re-enter the system. The problem is that, in the month, two months or however long it is before, they get ill and they cannot get help. This would complete that circle.

Ms Griffith: That is what it is about — completing a circle.

Mr Dunne: Thank you for your evidence. Justin, you talked about two sad cases, and the cases studies are with us here. To clarify, had those people shown evidence of cooperating with the Border Agency, would they not have been able to go to their GP if they had some evidence with them? Is that not the case? We are told in the letter from the Department that they are either not just destitute or are those who are not co-operating with the UK Border Agency. Is that not the case? You have been saying earlier that some people report on a weekly basis. Surely if they had that evidence they could have had the medical care.

Mr Kouame: Yes, as an asylum seeker you have an ID card or section 96 photograph ID that you carry with you. That is the form that you use to visit your GP. When you visit your GP they will need

to photocopy it. Sometimes they even phone Bryson one-stop service, which is in charge of the asylum claiming process. The person that I mentioned earlier was in the system. He was in receipt of section 4 support and then his case was refused. He had TB. His solicitor showed that he could not have the level of treatment that he was receiving here if he were sent back to his country, so while his case was sent to the UKBA he continued to go to the Royal Victoria Hospital. He could not go to his GP anymore but he went to the Royal Victoria Hospital. That is why we are talking about secondary care. The nurse said, "What shall we do? Shall we stop his treatment?" If they did so, it was likely that his TB would come back again, so they carried on giving him a pile of medication every month. Then he came back on to the system when he got sufficient evidence to prove that he would not get the same level of treatment if he went back to his country. Sometimes, it is not dependent on the person himself but on how quickly he is able to bring fresh evidence.

Ms Griffith: I am just thinking about the types of question that you have been asking. It is extremely complex and at times it can be difficult to pinpoint exactly where somebody is in the system and what entitlement they have. If lawyers find that difficult, GP receptionist staff should not be asked to make those assessments. Would it not be much simpler if it were sufficient for a person arriving at the GP practice to present their asylum registration card, which all asylum seekers have? That would cut through the dense administrative and legal matters of somebody's status.

Mr Kouame: Even when someone goes to a secondary care venue such as A&E and gets a prescription from someone and takes it to a pharmacy, the pharmacist is not going to give him the medication because that prescription is not from a primary care source, from a GP. That is the reality. Giving those people access to secondary care means that they will still not benefit or be able to use a prescription unless it comes from a consultant. Do you have to get someone to go to A&E to try to see a consultant to get medication so that they can go to a pharmacy instead of going straight away to the GP? If he presents a prescription from an A&E department at a pharmacy, the pharmacist will not give him the medication unless the prescription came from a GP. That is where you see the difference between primary and secondary care. Giving someone access to secondary care still prevents him from having a prescription from a primary care source. It is a bit tricky.

Mr Brady: Going back to a point that Liz raised about public health, it seems to me to be bizarre that somebody suffering from TB, which is a notifiable and contagious disease, is told that, because of some regulation, they cannot continue that treatment — it is not that long ago in this part of the world that people were spending years getting treatment for TB in sanitariums in the 1950s. The people concerned are still suffering from TB, or at least it has been stabilised, presumably, and the treatment that they got is going to ensure that it is kept at bay or does not return. If they do not get that treatment, the TB will return and they will become a public health risk. It just seems to be a kind of a peculiar way of dealing with the human aspect, apart from anything else.

Ms Griffith: Yes, although TB is a slightly different case because it is an exempted treatment.

Mr Brady: I understand that but it is indicative of what we are talking about. TB is just an example. There could be other types of diseases or conditions. The point is that the person is being treated and, for some bureaucratic reason, that treatment is stopped, which impacts on their health, so we are back to the whole issue of the human being.

Ms Griffith: Specifically, if you are not going to a GP, how would you even know that you have TB?

Mr Brady: Exactly.

The Chairperson: I found that useful in clarifying a number of points. Liz, you outlined two options. Will you reiterate them so that we are all clear in relation to what you are asking today?

Ms Griffith: Our preferred option is for our proposed amendment to the regulations to be adopted and, secondly, for their scope to be widened to apply to primary and secondary care. We recognise that time constraints may make that difficult. Therefore, if our suggested amendment were adopted, that would solve the first problem. The primary care issue could then be dealt with through an engagement process that the Department has invited us to undertake.

The Chairperson: OK, that is clear. Thank you all. That was very useful. Rest assured of our commitment to do the right thing in the interests of everybody. Thank you for your attendance and presentation.