TRANSFORMING THE UK'S RESPONSE TO HIV

NAT

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The Myth of HIV Health Tourism

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A report by NAT that addresses and refutes allegations of HIV health tourism to the UK

1. Introduction

Migration has been one of the most seriously debated issues in UK politics recently. As such it is vitally important to separate the facts and evidence around migration from the fears and misinformation.

Allegations have been made about health tourism to the UK both in general and in relation to a specific health condition - HIV. These claims have affected both Government policy and popular perception. But in fact there is no evidence to demonstrate that HIV health tourism to the UK exists. The paper specifically addresses and refutes allegations of HIV health tourism to the UK, and offers recommendations to improve Government policy and media reporting.

NAT (the National AIDS Trust) is the UK's leading charity dedicated to transforming society's response to HIV. We provide fresh thinking, expert advice and practical resources. We campaign for change.

2. Defining 'HIV health tourism'

The phrase 'health tourism' generally describes the practice of choosing to travel abroad in search of medical treatment that is either unavailable or too expensive to access at home. For example, in recent years many people from the UK have travelled as 'health tourists' to middle-income countries, such as India and Thailand, to access low-cost – but not free – treatment.[1]

For the purposes of this paper, the term 'health tourism' refers in particular to the claim that foreign nationals are leaving their home country with the main and express purpose of receiving free healthcare in the UK. The debate on this issue is not, however, unique to the UK, and is found in many other countries in Europe, all of which are being affected by changing global patterns of migration.[2]

This paper focuses on claims of health tourism to the UK in relation to a specific health condition – HIV. We refer to this as 'HIV health tourism'.

Allegations of 'HIV health tourism' imply the following:

- Significant numbers of migrants come to the UK aware of their HIV status
- They come to the UK with the primary and express purpose of accessing the life-saving HIV treatment (anti-retroviral therapy or 'ARVs') not accessible and/or not affordable in their country of origin
- They are misrepresenting their reasons for entering the UK (be it tourism, family, work or study) or their claims for refugee status or humanitarian protection, in order to access this treatment and care.[3]

This paper specifically addresses and refutes allegations of HIV health tourism to the UK. It should also be noted that many of our arguments apply as powerfully against the wider claims of health tourism which persist in UK media and politics.

The politics of 'HIV health tourism'

3. The politics of 'HIV health tourism'

This claim of 'HIV health tourism' was first made in a series of newspaper articles that portrayed many HIV positive migrants – and asylum seekers, in particular – as 'HIV health tourists' and a threat to public health.[4, 5, 6, 7] The articles focussed on recent HIV statistics which indicated the extent to which new cases of heterosexually acquired HIV originate overseas or in people of African descent.[8] Whilst the claims of health tourism were unsubstantiated, they gained widespread currency in media commentary and politics.[9] When joined with claims of health tourism in relation to other conditions, they were an important background to Government decisions altering the access of certain categories of migrant to free NHS care.

Why is it important to investigate and test these claims of HIV health tourism?

One good reason is that in effect they make a serious charge against the integrity and truthfulness of many HIV positive migrants to the UK, effectively alleging that stated reasons for migration to the UK are at best a pretext and at worst totally untrue. Given the discrimination and marginalisation experienced by many migrants we must question very carefully any claim which might add to social hostility.

As importantly, the claim of health tourism has been central to the Government's policy of charging refused asylum seekers and other migrants without lawful residency status for healthcare.

The Government argues that free NHS care for those without what they deem to be a legitimate reason to migrate to the UK acts as a 'pull factor', encouraging illegal immigration and discouraging refused asylum seekers from leaving. Charges for NHS care for certain categories of migrant were introduced to end the 'pull' of free NHS care and address the so-called problem of 'health tourism'.

In its response to a Health Select Committee report, the Government stated that it "remains convinced that deliberate abuse of the NHS by overseas visitors, across a range of services, is not just a potential threat but a very real one... That applies as much to HIV treatment as to any other hospital service."[10]

HIV is the only serious communicable condition or sexually transmitted infection where certain migrants are subject to NHS charges – for all these other infections NHS care is always free on public health grounds irrespective of residency status.[11] Is there really evidence of HIV health tourism which would justify on grounds of immigration policy the singling out of HIV for NHS charges alone amongst all serious or sexually transmitted infections?

This report does not aim to address the wider policy issue of charging for NHS care, which we and others have done elsewhere.[12] We do, however, aim to demonstrate that claims of HIV health tourism are false, thus ending a slur on the motivations of many people who have come to the UK and removing one of the Government's main justifications for a harmful, costly and inhumane charging policy.

FACT

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HIV amongst migrants to the UK

4. HIV amongst migrants to the UK

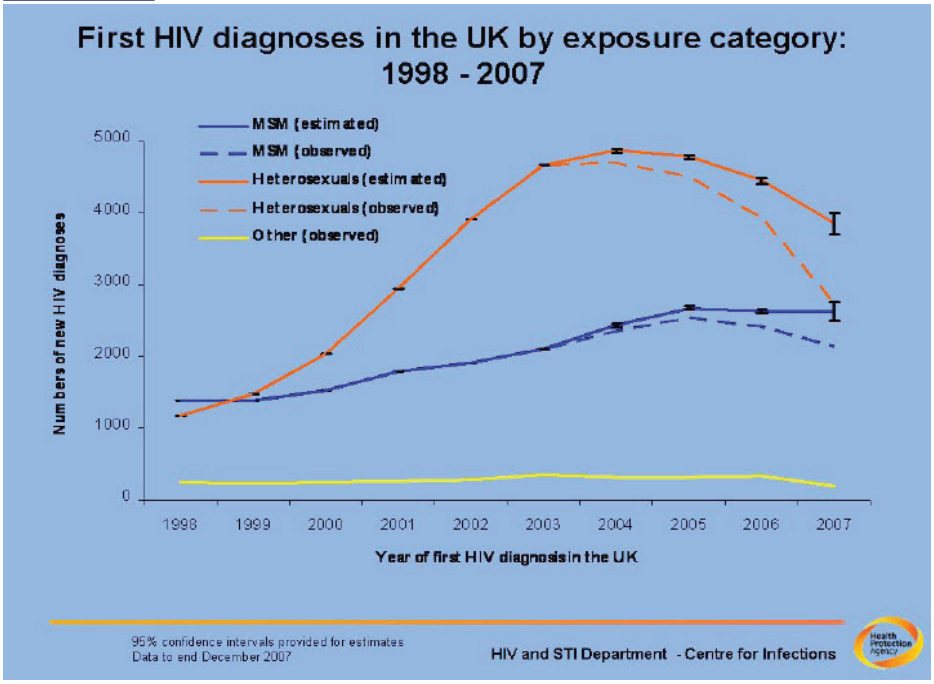
The HIV epidemic in the UK has changed considerably since the 1990s, when it was an epidemic predominantly affecting men who have sex with men (MSM). Since then, the numbers of heterosexuals living with HIV in the UK have increased substantially, the majority of them being people who have migrated from overseas. Heterosexuals now account for over 52 per cent of all people with HIV in the UK. In 2006 60 per cent of new HIV diagnoses were of infections probably acquired abroad. 35 per cent of all adults living with HIV in the UK were born in Africa.[13]

In other words, migration to the UK of people infected with HIV over the past 10 years has profoundly changed the nature of the HIV epidemic in the UK and significantly increased the number of people in this country living with the virus. The majority of HIV-infected migrants have come from sub-Saharan Africa, as can be seen in Graphs 1 and 2.

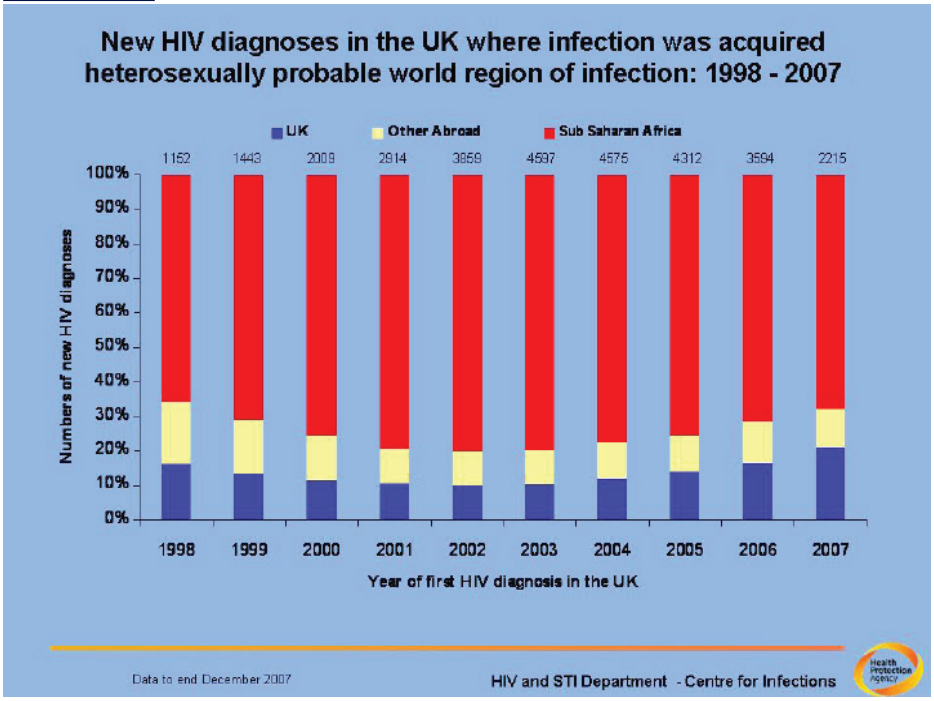
These facts are important but **they are not when taken alone evidence of HIV health tourism.** They give no information as to whether individuals were aware of their infection when they travelled to the UK, or what their reasons might have been for migration here.

In the next section we look at what needs to be demonstrated by those who claim that HIV health tourism exists.

GRAPH 1



GRAPH 2



What would demonstrate that HIV health tourism exists?

5. What would demonstrate that HIV health tourism exists?

We list below some of the evidence which **would demonstrate** the reality of HIV health tourism – and then what is **in fact** the case.

- Possible evidence: Research evidence that accessing healthcare in general, and HIV healthcare in particular, is a significant factor in migration decisions.

  Fact: Research evidence shows that a desire to access particular benefits or healthcare provision is not a factor in migration patterns.

- Possible evidence: Migration patterns which reflect over time the distribution of the HIV pandemic and problems of treatment access.

  Fact: Migration patterns bear no relation to the distribution of HIV prevalence across the globe.

- Possible evidence: Significant changes in migration patterns to and from the UK due to the withdrawal of free NHS care for certain categories of migrants.

  Fact: There are no discernible impacts of recently introduced NHS charges on migration of people to or from the UK.

- Possible evidence: Levels of HIV infection amongst migrants significantly higher than those in their countries of origin.

  Fact: Levels of HIV amongst migrants to the UK are in general significantly below HIV levels in their countries of origin.

- Possible evidence: Accessing HIV tests or treatment immediately or very soon after arrival in the UK.

  Fact: There are on average very significant delays between migrants arriving in the UK and their accessing HIV testing and treatment.

We will now look at each of these issues in turn to explore the evidence in more detail.

5.1 No evidence to suggest health tourism a significant factor in migration decisions

We first consider direct research evidence that accessing healthcare in general, or HIV care in particular, is a significant factor in migration decisions.

People migrate to the UK from all over the world for a wide variety of reasons, including employment; to study; to join family; and, in a minority of cases, as refugees or to seek political asylum. There are many, complex reasons why people are forced to leave their countries of origin and claim asylum in a safe country. These include fleeing from armed conflict, political and social unrest, persecution, exploitation, or genocide in their country of origin.[14]

A 2002 Home Office report on the decision making of asylum seekers concluded that **there was no evidence to suggest that asylum seekers had a detailed knowledge of the UK's asylum policies or welfare benefits.** The report found that the main reasons why people seek asylum to the UK, as opposed to another country, are their country's historic, particularly colonial links with Britain, the presence of family and friends, and the fact that English is a global language.[15]

There is also evidence suggesting scant knowledge of the existence of HIV treatment, or of the concept of free NHS healthcare among African migrants, prior to their arrival in the UK.[16]

More broadly, Government Ministers have publicly stated on a number of occasions that they do not in fact have evidence for 'HIV health tourism'. Melanie Johnson, then Minister for Public Health, giving evidence to the House of Commons Health Select Committee, said: "I do not have any figures to supply you with on this. I concur with the point that it is difficult to measure it, and we do not have reliable information."[17]

Anecdotal reports

The 'evidence' that does exist is anecdotal and relates to 'health tourism' in general. In fact, the 2004 Department of Health (DH) consultation document on amending legislation to exclude 'health tourists' and irregular migrants from free NHS hospital care makes no specific mention of alleged 'HIV health tourism'.

Even in relation to other conditions, the DH document only provides anecdotal evidence from "NHS staff [who] have also told us that there seem to be more people who visit the UK mainly in order to access health care and evade charges."[18] Given the complexity and difficulty with which, for example, asylum claims are assessed, it is difficult to see how an individual healthcare worker can know so quickly and confidently what the motivation was for a patient migrating to the UK. Too often there is an assumption that someone ill on or soon after arrival in the UK must have come here to access healthcare. This is of course very far from being necessarily true.

It is of course always possible that a few individuals move to the UK for health-related reasons. The question is not whether this **ever** occurs, but whether many migrate for this reason - whether, in other words, it is a statistically (and economically and politically…) significant phenomenon. There is no properly researched evidence to suggest that this is the case. Indeed, as stated above, research suggests the opposite.

5.2 No evidence that migration patterns to the UK reflect the distribution of HIV prevalence across the globe

Do patterns of migration to the UK reflect the global burden of HIV infection, and in particular HIV infection where there is no access to treatment?

In 2006, the latest year for which UK immigration data are available, almost 105 million people entered the UK, of whom 12.9 million were non-European Economic Area (EEA) nationals. The majority were short-term tourists: but 309,000 were students (45 per cent from Asia; 14 per cent from non-EEA Europe; and 8 per cent from Africa) and 145,000 had work permits, or were dependants of people with work permits (54 per cent from Asia; 24 per cent from the Americas; 9 per cent from Africa).[19]

There is no evidence that patterns of asylum applications follow HIV prevalence (or indeed any other specific health condition) – as one might expect if one believed the myth of 'HIV health tourism'. The greatest number of asylum applications in 2007 originated in individuals from low HIV prevalence countries, notably Afghanistan (2,495), Iran (2,210), and China (2,120).[20]

In addition, as Table 1 shows, the number of applications from sub-Saharan African countries in 2007 did not relate to HIV prevalence, but rather to armed conflict, human rights abuses and persecution. This strongly suggests that HIV status is incidental to asylum application.

TABLE 1

Applications for asylum from sub-Saharan Africa, 2007[21]

Rank	Country	Global HIV prevalence ranking
1	Eritrea	37
2	Zimbabwe	4
3	Somalia	below 50
4	Nigeria	21
5	Other Africa	n/a
6	Democratic Republic of Congo	26
7	Sudan	below 50
8	Cameroon	16
9	Uganda	29
10	Ghana	34

5.3 No evidence of a discernible effect of charging on numbers with HIV migrating to or from the UK

If HIV health tourism were a significant factor influencing migration to the UK, and if NHS charges were an effective deterrent, we would expect with the introduction in 2004 of charges for some migrants with HIV that there would be fewer people with HIV coming to the UK.

But in fact we are not and will never be able to deduce the reality of HIV health tourism from any impacts of the introduction of NHS charges. This is for two reasons – first, even if HIV health tourism existed, the charging system does not effectively address the issue; and secondly, migration is too complex a phenomenon for such an impact to be readily identifiable from the host of factors affecting migration trends.

Ineffectiveness of the charging system

NHS charges fail really to address the purported problem of 'health tourism'. Charging refused asylum seekers or visa overstayers does not deny them healthcare on arrival and for the months or years during which their asylum claim is outstanding or their visa valid. Furthermore, for those who begin a course of treatment such as HIV care and medication before the refusal of their claim or expiry of their visa, the treatment continues free of charge whilst they remain in the UK (the so-called 'easement clause').

Those diagnosed with HIV only after the refusal of claim or expiry of visa, and who are thus liable to NHS charges, are precisely the individuals least likely to be health tourists, since they waited so long and too late before accessing testing and care (or indeed were infected in the UK).

With charging for the most part irrelevant as a response to the claims of health tourism, no safe inferences can be drawn from trends subsequent to the introduction of charges in 2004.

Complexity of migration trends

In any event, migration trends since the new 2004 charging system do not provide any evidence of HIV health tourism.

We do not know the HIV status of people recently or currently arriving in the UK. Diagnoses of HIV amongst people from sub-Saharan Africa have plateaued in the last couple of years. But as those diagnosed arrived on average in the UK five years previously (see section 5.4) it is impossible to claim the 2004 new charging regulations have made any contribution to this trend.

Given the many factors which affect migration trends it will in fact always be impossible to demonstrate incontrovertibly population-level impacts on migration trends of such a charging policy. Asylum applications are declining significantly across Europe for a variety of complex reasons, including tighter border controls.[22] Although asylum applications have declined from a peak of 84,130 in 2002 to 23,430 in 2007, these declines began before changes to NHS regulations were discussed or implemented.[23] But declines in such migration from high prevalence countries will have a natural impact on the numbers arriving infected with HIV.

Applications from the country with the fourth highest HIV prevalence in the world, Zimbabwe, have actually increased each year since 2005.[24] However, this does not imply that individuals from Zimbabwe are 'HIV health tourists' – rather, the main impetus for Zimbabwean asylum seekers coming to the UK is their need to flee persecution, human rights abuses and political unrest.

If health tourism is a significant phenomenon we might also expect those without a right to access free treatment, such as those who are in the UK without legal status, to be more likely to leave the UK, with the supposed reason for their travel to the UK removed. There is however no evidence of a significant increase in voluntary removal from the UK. And those who are agreeing to voluntary removal are overwhelmingly from countries with low HIV prevalence.[25] In other words, it is unlikely there will be many leaving voluntarily who are HIV positive.

In summary, there is no evidence of HIV health tourism from the impact of the introduction of NHS charges, and it is unlikely there ever will be.

5.4 No evidence that HIV prevalence amongst migrants is higher than in the general population of their country of origin

In all cases HIV-infected migrants are a small proportion of those coming to the UK from another country, as indeed is the proportion of those who arrive with any sort of pre-existing health condition.

Were HIV status to be a significant reason for migration from high prevalence countries we would expect to see HIV prevalence to be higher amongst migrants from a particular country than the prevalence rate in that country itself. But in fact the opposite is usually true – migrants from most sub-Saharan African countries are disproportionately HIV negative when compared with their country of origin.

Data from 2006 from the Health Protection Agency and UNAIDS show that rates of HIV infection amongst migrants from sub-Saharan Africa are either similar to or, in most cases, significantly below that of their populations in country of origin, as can be seen in Table 2.

Surveys of HIV prevalence amongst pregnant women are commonly used when trying to assess rates of HIV in a population with a generalised epidemic. The prevalence percentages for most African countries will be derived from modelling this data. Thus the data in both columns of Table 2 are comparable for our purposes.

TABLE 2

Summary of estimated HIV prevalence, 2006[26]

Country of origin	Estimated prevalence of HIV amongst women giving birth in the UK (per cent)	Estimated prevalence of HIV amongst all adults in country of origin (per cent)
Ivory Coast	4.9	4.7
Kenya	2.1	5.1
Nigeria	1.7	3.9
South Africa	1.4	18.3
Tanzania	2.6	6.5
Uganda	6.5	6.7
Zimbabwe	9.8	18.0

Research from the Health Protection Agency (HPA)[27] and the Audit Commission[28] suggests that migrants are not a 'burden' to the NHS. And, in its 2007 publication, *Enforcing the Rules*, the Home Office stated that: "Illegal migrants are unlikely to place a great strain on the NHS as most are thought to be young and therefore relatively healthy."[29]

In fact migrants can be more vulnerable to ill-health after arrival in the UK as a result of poor living conditions, difficulties accessing healthcare and other services, and lack of money for basic needs.[30, 31] Factors that place asylum seekers at higher risk of HIV acquisition within the UK include poor access to safer sex education[32] and low levels of HIV testing.[33]

5.5 No evidence of disproportionate accessing of HIV testing and treatment soon after arrival in the UK

If migrants travel to the UK knowing their HIV status with the aim of accessing life-saving treatment, we would expect data to reveal that migrants with HIV access tests and/or clinical care and treatment soon after arrival.

In fact the opposite is the case. Recent data from the HPA supports previous studies showing that there is a significant amount of time between arrival in the UK and HIV diagnosis. In 2007, the average time between UK arrival and HIV diagnosis was almost five years, and this has increased over time – from almost four years in 2005, and four-and-a-half years in 2006.[34]

Research undertaken in 2003 by Terrence Higgins Trust and George House Trust amongst migrants using HIV services showed that by far the most common reason given for testing was the onset of symptomatic HIV (i.e. when they had become seriously unwell (58 per cent)). Others were diagnosed as part of routine ante-natal screening (17 per cent) or tested after the death or a diagnosis of a partner (15 per cent). Only two people in their sample of 60 reported being diagnosed before entry to the UK and only one person has accessed a test unprompted after arrival in the UK.[35] If their service users had come to the country to access HIV treatment, we would expect to see a far greater percentage accessing testing voluntarily and soon after arrival.

We would, however, also make clear that even where in a very small number of cases people migrate to the UK knowing their HIV status, there is no evidence to suggest that accessing free HIV treatment to be their main motivation in coming to the UK, or even to have entered into their thinking.

These figures underscore what we already know about low rates of HIV testing in African communities, high levels of stigma and denial in relation to HIV risk, and high rates of late diagnosis. As the House of Commons Health Select Committee reported in 2005, "What little evidence exists in this area in fact seems to suggest that HIV tourism is not taking place. It suggests that HIV-positive migrants do not access NHS services until their disease is very advanced, usually many months or even years after their arrival in the UK, which would not be the expected behaviour of a cynical 'health tourist' who had come to this country solely to access free services."[36]

More than 40 per cent of Black African men have their HIV infection diagnosed late, which greatly increases the risk of illness and death in the short-term.[37] Black African migrants are disproportionately affected by late diagnosis compared with other vulnerable groups, and evidence strongly suggests that this late diagnosis is not linked to recent arrival in the UK but rather for the vast majority to delays in accessing testing once here.[38]

In sub-Saharan Africa, a very small proportion of individuals seek HIV testing, even in the highest prevalence countries. Only one in 10 sub-Saharan Africans have ever tested for HIV, and only two HIV-positive individuals in 10 are aware of their diagnosis.[39] HIV is highly stigmatised in sub-Saharan Africa, and the stigma remains within African communities in the UK.[40] This results in widespread denial of HIV risk among African migrants; even though many come from countries of high HIV prevalence, few consider the possibility that they might have HIV, and, in one recent study, two-thirds of Africans testing HIV-positive were surprised by their positive test result.[41]

Further evidence on the more general claims of health tourism are found in a recent report by Medecins du Monde UK, who operate a free health clinic in London to help migrants access mainstream health care, which concludes that they "saw no evidence of the so-called 'health tourist' who comes to the UK seeking expensive treatment. Our patients had been in the UK for an average of three years before accessing care."[42]

There is compelling and robust evidence that 'HIV health tourism' does not exist. Most migrants come to the UK unaware of their HIV status and do not test for HIV until an average of five years following arrival, due to a combination of factors including denial and HIV-related stigma and fear.

Conclusions and recommendations

6. Conclusions and recommendations

There is no evidence to demonstrate HIV health tourism to be a significant or real motivation for migration to the UK.

There is considerable evidence to demonstrate that HIV health tourism cannot be a significant reason for the migration to the UK of HIV-infected individuals, in particular

- the lower rates of HIV prevalence compared with country of origin
- the long average delays between arrival in the UK and accessing HIV testing and care
- and the evidence available on the actual motivations of migrants coming to the UK.

Recommendation 1

Claims in the UK media of HIV health tourism are contradicted by the facts.

Journalists should ensure accuracy in their reporting on migration to the UK and desist from making claims that HIV health tourism is taking or has taken place. Any claims in the media of HIV health tourism should be consistently challenged under the Press Complaints Commission Code of Practice Clause 1 [Accuracy].

Recommendation 2

Since the provision of free HIV treatment has no bearing on migration trends, the basis for the Government's policy of charging for HIV treatment is wholly undermined. It has been demonstrated elsewhere that the policy actually increases costs to the NHS and endangers public health.[43]

The Government must review its policy on NHS charging so as to exempt HIV treatment from charges.

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TRANSFORMING THE UK'S RESPONSE TO HIV

NAT

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About NAT

NAT is the UK's leading charity dedicated to transforming society's response to HIV. We provide fresh thinking, expert advice and practical resources. We campaign for change.

All of NAT's work is focused on achieving four strategic goals:

- Effective HIV prevention
- Early diagnosis of HIV through ethical, accessible and appropriate testing
- Equitable access to treatment, care and support for people living with HIV
- Eradication of HIV-related stigma and discrimination.

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