'Inglan is a bitch': hostile NHS charging regulations contravene the ethical principles of the medical profession

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ABSTRACT

Following the recent condemnation of the National Health Service charging regulations by medical colleges and the UK Faculty of Public Health, we demonstrate that through enactment of this policy, the medical profession is betraying its core ethical principles. Through dissection of the policy using Beauchamp and Childress' framework, a disrespect for autonomy becomes evident in the operationalisation of the charging regulations, just as a disregard for confidentiality was apparent in the data sharing Memorandum of Understanding. Negative consequences of the regulations are documented to highlight their importance for clinical decision makers under the principles of beneficence and non-maleficence. Exploration of the principle of justice illuminates the core differentiation between the border-bound duties of the State and borderless duties of the clinician, exposing a fundamental tension.

Inglan is a bitch
dere's no escapin it
Inglan is a bitch
yu haffi know how fi survive in it
(Linton Kwesi Johnson, 1980)

INTRODUCTION

In honour of the trust and vulnerability shared within the unique doctor–patient relationship, medical professionals must protect the ethical values that define their role. The UK Faculty of Public Health, Royal College of Physicians, Royal College of Paediatrics and Child Health (RCPCH) and Royal College of Obstetrics and Gynaecology recently came together to express their deep concern over the National Health Service (NHS) charging regulations and call for their suspension.[1] This article argues that the reforms introduced to the NHS England, designed to restrict access to healthcare for those deemed not 'ordinarily resident', prevent doctors from meeting their ethical duties and moral obligations. This clash of principles results from the fundamental opposition of the defined boundaries of the State compared with those of clinical care.

BACKGROUND

The Immigration Act[2] introduced in 2014 paved the way for a series of reforms to restrict access to public services for illegal immigrants as part of the Home Office 'hostile environment' policy. Consequently, the NHS (Charges to Overseas Visitors) Regulations 2015[3] and 2017[4] were enacted, leading to changes in provision of healthcare for those deemed not 'ordinarily resident' in England. The assessment of ordinary residence is made on the following criteria: can the person prove they are lawfully in the UK? Is the person here on a voluntary basis? Can they prove they are properly settled in the UK for the time being?[5] Being properly settled is an assessment based on details such as length of stay, proof of address, proof of utility bills, stability of residence arrangement, proof of employment, proof of bank account and family arrangements.[5]

Exemptions to the policy include asylum seekers, refugees, children under the care of a local authority and victims of trafficking. Failed asylum seekers are not exempt even while appealing their asylum decision. Services that remain free to all are 'primary care, accident and emergency, walk-in centres, minor injuries units, contraception services (excluding termination of pregnancy), specific communicable diseases (eg, tuberculosis), palliative care, school nurses, district nurses and NHS 111 services. Other specific treatments that are always free include treatments for consequences of sexual or domestic violence, female genital mutilation and torture'.[6] If a person is deemed as not 'ordinarily resident', they are now subject to 150% tariff charges for most secondary care including maternity care (antenatal and postnatal) and NHS funded community-based treatments. These services must now be categorised into 'urgent' or 'immediately necessary' -in which case care is provided prior to seeking payment -and 'necessary but non-urgent' - in which case payment must be received before care will be provided.[5] Clinicians have voiced concerns, claiming the reforms legally enforce their direct involvement in border control.[1 7 8]

The identification of chargeable patients within NHS trusts is overseen by a new non-clinical position titled Overseas Visitors Manager (OVM). These managers are often supported by administrators in the areas with high numbers of chargeable patients, such as London trusts.

For more details on implementation of the NHS charging regulations, including a complete list of the infectious diseases exempt from charges, see also *Understanding changes to NHS charging regulations for patients from overseas*[6] and the British Medical Association (BMA) guidance on *Access to healthcare for overseas visitors*.[9]

Those citizens from the European Economic Area (EEA) and Switzerland who are currently living in England and can prove ordinary residence are eligible for free NHS care, under bilateral agreements. If the UK leave the European Union (EU) without an exit deal, these citizens will continue to

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receive the same eligibility but those from the EEA or Switzerland that move to England after the exit day will be required to prove ordinary residence *and* hold a European Temporary Leave to Remain card from the Home Office. To make the distinction between those who arrived before and those who arrived after exit day, residents who were previously living here will need to provide evidence of this to the NHS when requiring treatment. Visitors to the UK from the EEA or Switzerland who arrive after the exit day will be expected to pay for any required NHS treatment, either through personal or insurance-based funds.[10] If an exit agreement is reached, however, this may change. At the time of writing, the political situation is fragile and many outcomes remain possible.

Many have criticised the regulations for their level of complexity and opportunity for misinterpretation.[6 11–13] OVMs have also reported struggling to reach a conclusion on ordinary residence in practice.[14] Although there are logical and appropriate reasons behind the many exemptions of charges, such as the prevention of transmission of infectious disease in the interests of public health and the intricacies of Britain's exit from the EU, this has led to a set of abstruse and constantly evolving guidelines that are impractical to implement and inaccessible to the 1.5 million NHS employees required to understand them. A survey of the members of the RCPCH found that over 70% of respondents did not feel confident determining who is exempt or when to charge upfront and when to withhold treatment. This level of complexity, in turn has led to patients being deterred from accessing services which are in fact not chargeable[11 15 16] and patients being incorrectly charged for free services[17] or denied access to emergency treatments until they paid.[11] These concerns raise the question, were the regulations *really* worth introducing in the first place? While some may argue the intention was to reduce the load on an already stretched health system, in reality the charging regulations have increased the burden.

A Memorandum of Understanding (MOU) between the Home Office, Department of Health and Social Care and NHS Digital came into effect in January 2017, allowing the Home Office to make information requests on non-clinical details, for example address and unpaid debt information, of suspected immigration offenderswithout the need for court order.[18] After much campaigning by doctors, members of parliaments and patients, this MOU was suspended due to concerns about the 'hostile environment' created and the potential consequences to individual and public health. Since October 2017, general practitioners have been required to request information from new patients to determine their immigration status[5] and this practice continues today.

CASE STUDY

The following case study will be used to illustrate a number of the most dangerous features of the charging regulations. It is a well-known and highly publicised case which exemplifies the Windrush scandal. Sylvester's situation acutely demonstrates the unjust and unsafe nature of the policy and asks you to consider whether it is worth pursuing. Sylvester was not unique, there were numerous cases of the Windrush generation who suffered greatly through increased restriction to public services as a result of the Immigration Act, and had it not been for the huge public outcry, they may have continued to suffer.

This particular case represents those in a population who, by most accounts, should be treated to the equal rights that citizenship brings but because of historical and political injustice these persons—members of the previous British Empire—have been treated as second-class citizens. These second-class citizens exist in many societies today, living in the grey areas between belonging and not belonging to an 'organised community' and are easily persecuted under policies which involve discrimination of the 'other' through ambiguous categorisation of people.[19]

Sylvester Marshall was born in Jamaica but brought to the UK by his mother as a teenager in the 1970s. His mother worked as a nurse for the NHS and Sylvester later worked as a mechanic, contributing taxes and national insurance. As a child, his Jamaican passport was lost and Sylvester never applied for a British passport. The Home Office did not keep records or produce official papers for those who had been granted leave to remain and like many of the Windrush generation, it is likely that Sylvester's landing card was destroyed by the Home Office in 2010.[20] Sylvester was diagnosed with prostate cancer in 2016 and was receiving NHS specialist care. A decision was made between himself and his clinical team that he would receive radiotherapy treatment; however, on arrival at his first session, he was asked to produce a British passport to prove he was lawfully living in the UK. As he did not have one, he was advised he would need to pay £54 000 before proceeding with treatment.[21] From this, we can determine that the Sylvester's clinical team had made the decision that the radiotherapy treatment was 'necessary but non-urgent'. The timeframe to this urgency is based around the concept of the patient being an overseas visitor and therefore a 'necessary but non-urgent' treatment can be left until the person returns to their home country. In Sylvester's case, his home country was the UK and he had not returned to Jamaica for over 40 years. This decision effectively denied him of ever receiving the radiotherapy to treat his cancer.

Since the introduction of these regulations, clinicians have been expected to make judgements on the clinical urgency of these cases as part of the charging regulation process without any prior consultation or training to facilitate this role. There has been no official guidance from clinical bodies on how to make these judgements. Therefore, there is likely to currently be a spectrum of approaches and opinions within the profession which may sometimes lead to questionable decisions. The Windrush generation is just one example of a population who does not fit neatly into a defined category of immigration policies. People are not commodities that can be reduced into simplistic categories; they have complex and intricate histories behind their immigration status.

If we continue to allow immigration enforcement to seep into delivery of public services, then there may be many other subsections of society which get caught in the crossfire. One contemporary example is the entitlements of EEA citizens which currently hang in the balance of Britain's exit negotiations. If we start to question those already on UK soil about their entitlements to basic services such as healthcare, then we risk getting caught into an ethical tangle of who therefore *does* 'deserve' care over others. At what point in the spectrum of grey areas do we draw this arbitrary line? This tussle is clearly reflected in the complex list of exemptions and vague criteria towards ordinary residence in the NHS charging regulations. As migration and globalisation are increasingly factors of life, can we continue to stick to rigid ideas of national sovereignty while maintaining an ethical approach? Would you be comfortable denying a person in front of you health advice, based on their immigration papers? Some things seem more important than paperwork.

BREACH OF DOCTOR'S ETHICAL CONDUCT

In the UK, medical professionals are duty bound, through compulsory registration with the General Medical Council (GMC), to professional ethical standards, titled *Good Medical Practice*. First published in 1995, they formalised the expectations of doctor's ethical conduct.[22] One of the most influential frameworks of biomedical ethics is the four principles by Beauchamp and Childress[23]: respect for autonomy, beneficence, non-maleficence and justice. These principles outline the most important concepts with which to judge the relationship between doctor and patient. First developed by the American philosophers in the wake of the Tuskegee Syphilis study scandal, they act as an important reminder of the abuse that can be experienced at the hands of the medical profession if such an ethical framework is ignored.

Doctors working for the NHS clearly have obligations and responsibilities while representing the public sector organisation. In the main, the core values of the NHS constitution and *Good Medical Practice* are overlapping, for example, the NHS constitution states, 'You have a duty to protect the confidentiality of personal information that you hold'.[24] The new legislation on charging regulations puts into law clinician's involvement in the process of charging those deemed not 'ordinarily resident', placing doctors' professional ethical standards into conflict.

However, while the NHS constitution currently contains no information suggesting staff should exclude patients from care based on their immigration status, it does contain many statements that directly contradict the ethical stance of the charging regulations. For example, 'You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation'.[24] Considering the NHS was built on the idea that healthcare should be free for all at the point of access, this is the sentiment one would expect. An investigation by Medact found that two-thirds of relevant trusts had provided no specific training to staff on the NHS charging regulations, suggesting resistance to policy implementation.

The NHS charging regulations and their breach of the ethical code of conduct governing UK doctors will be deconstructed using the four principles as a framework.

Respect for autonomy

This principle sits at the heart of ethical healthcare provision and a patient-centred approach that defines contemporary UK medical education. In the move away from medical paternalism, its value has been increasingly recognised and can be defined in Kantian terms as treating patients as ends in themselves rather than simply means.[25]

The NHS charging regulations legally enforce that secondary services must assess a patient's 'ordinary residence' before proceeding with clinical care. This prioritises an individual's immigration status above their autonomy, directly contradicting *Good Medical Practice* to 'treat patients as individuals and respect their dignity and privacy' and 'never discriminate unfairly'.[26] The State's need to police its border overrides respect for the individual and autonomy can no longer be guaranteed.

In Sylvester's case, he was given autonomy in his treatment prior to the questions over his immigration status. However, on arrival for radiotherapy, his options quickly altered as he was now expected to pay vast sums or produce passport documentation. This effectively left Sylvester without choice as the out-of-pocket cost was unaffordable but he still felt entitled to treatment based on his UK residence of over 40 years. The NHS charging regulations led to denial of Sylvester's autonomy and present a barrier to medical professionals fulfilling their ethical duty.

Of course, Sylvester possessed some degree of agency in this process. There may have been earlier opportunities for him to formalise his legal status. But does this omission equate to exclusion from healthcare access? There are many reasons why Sylvester may have felt it unnecessary to apply for a passport. He may have lacked the money to travel abroad, the skills to navigate complex eligibility criteria or perhaps been afraid of contacting the authorities based on the record of abuse that has been suffered by West Indians at the hands of the British state.

In this case, the State fails to comply with Article 2 of the Universal Declaration of Human Rights which states that all human rights, including the right to 'a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care', must be 'exercised without discrimination of any kind'.[27] The WHO expects countries to make progress towards achieving sustainable development goal 3.8 on Universal Health Coverage.[28] The current movement on charging acts to oppose this principle in England.

Within *Good Medical Practice*, doctors are encouraged to 'take prompt action if (they) think that patient safety, dignity or comfort is being compromised' through policies or systems, and 'put the matter right' where possible.[26] Sylvester's safety, dignity and comfort were all compromised through enactment of the NHS charging regulations.

Confidentiality

Confidentiality is commonly aligned to the principle of respect for autonomy in deciding who accesses the patient's personal information.[29] It can also be viewed as an 'implied promise' of the doctor–patient relationship.[30]

The *Good Medical Practice* states that 'you must treat information about patients as confidential' and 'you must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession'.[26] Trust is central to all aspects of medical care, from accurate history taking and examination to management plans. For trust to be formed, patients must be assured implicitly or explicitly that their autonomy will be respected. The implicit assumption relies on faith in institutional practices, in this case medical confidentiality. This sits at the cornerstone of the Hippocratic Oath—an ancient embodiment of the professions' commitment to the value of confidentiality.

A third ethical framework to consider confidentiality is consequentialism, which would focus on the outcomes of breaching confidentiality. Although in most cases the negative consequences would outweigh the positive and therefore negate breaking confidentiality, under this principle there may be some occasions where disclosing details could be argued as beneficial. This form of justification was used in the Home Office MOU to permit sharing of patient data—the agreement was for use where the 'public interest in disclosure outweighs the public interest in maintaining confidentiality'.[18] Data were shared from NHS records if individuals had not contacted the Home Office and had committed an immigration offence, for example exceeded their time to stay in the UK.[31]

The MOU stated that disclosing data on immigration offenders is a 'matter of high public interest' due to their negative impact on the economy and their financial impact on public services.[18] What was not fully considered was the potential negative consequences. First, the risk to public health and second the fundamental insult to an individual's autonomy. While the data sharing MOU is now suspended, reporting of patients to the

Home Office with debts of greater than £500 continues,[32] which could constitute grounds for refusal.[33]

The data sharing MOU signifies a move reminiscent of Agamben's theory: the State reduces certain populations to 'bare life' by constituting a 'permanent state of exception' (1998, 2005).[34 35] Underlying the principles of the agreement is the notion that because of the immigration offender's exceptionality of circumstances, as compared with the average citizen, the severity of State interference and control is warranted. This 'governmentality', as described by Foucault[36]—a state process designed to produce, care for or dominate individual subjects—conflicts with the biomedical focus on the individual's right to confidential treatment.

Following the introduction of the data sharing MOU and with increasing securitisation of the health system via the charging regulations, faith in medical confidentiality has been disrupted. Patients are not seeking necessary healthcare such as antenatal care unless they reach crisis point[15] or they may under-report symptoms, leading to worse health outcomes, presentation of more advanced disease and increased transmission of communicable diseases.[37] Additionally, these reforms more closely align healthcare with the 'establishment', impacting on access to care for marginalised communities.[38] All contribute to worsening population health and higher incurred costs of 'cure' rather than 'prevention'.[37] The loss of the 'implied promise' in the doctor–patient relationship and lack of respect for autonomy is fundamentally opposed to the medical profession's approach to care. This conflict of ethos is absolute and cannot be reconciled.

Beneficence and non-maleficence

It is a doctor's duty to ensure that there is overall net benefit to the patient[25]; embodied by the phrase 'first, do no harm'. Since the birth of evidence-based medicine, doctors are obliged to consider empirical evidence of harms and gains. Changes to service provision, which impact the risks and benefits, should only be introduced after generation of evidence to guide clinicians. The harms posed by the NHS charging regulations to individuals, outlined below, are becoming evident; however, none were robustly investigated by government bodies prior to implementation.

Evidence is building for the documented harms which patients have suffered since the introduction of the charging regulations. Doctors of the World, a non-governmental organisation which runs clinic in London for excluded people such as destitute migrants, report that a third of their patients avoided seeking care when they required it.[16] Maternity Action describes severe mental distress caused to pregnant and new mothers and even women feeling pressured into abortion or adoption due to the financial strain.[15] The mothers illustrate the dehumanising and humiliating process of being harassed for money by NHS trusts and threatened with reporting to the Home Office.[15] A survey of RCPCH members revealed four children presenting to A+E with life-threatening conditions after delay in attending due to the charging regulations and two intrauterine deaths which may have been avoided if mothers had not avoided antenatal care.[13] The BMA report a case of a patient dying in her 30s due to her not seeking help for an eye cancer which she believed she would be refused treatment for and a rise in sexual transmitted infections due to barriers in accessing sexual health clinics.[11] Only 3% of trusts conducted an equality impact assessment of the policy and no Trust was monitoring for discriminatory impact or the health outcomes of their patients.[12]

Delays in treatment due to the 'ordinary residence' assessment cause unnecessary harm. This is exemplified in the Sylvester's case, where his prostate cancer is left to progress. *Good Medical Practice* tells us, 'If you assess, diagnose or treat patients, you must promptly provide or arrange suitable advice, investigations or treatment where necessary'.[26] The charging regulations are likely to cause psychological distress to affected patients. In an interview, Sylvester stated, 'I don't know what is going on inside; it is really worrying me. It feels like they are leaving me to die'.[21] These additional harms caused to patients are profoundly opposed to the principle of non-maleficence.

When weighing up the risks and benefits, catastrophic financial costs for those not 'ordinarily resident' will need to be considered. This may alter the clinicians' approach: there is already evidence of delays in secondary care referrals and clinicians feeling forced to seek primary care alternatives.[11]

Fears that contact with health services may lead to incarceration in a detention centre, denial of leave to remain or being 'sent home' to potentially harmful environments exist, deterring migrants from accessing healthcare.[15] Additionally, the Home Office has confirmed that unpaid bills with the NHS may be grounds for refusal of asylum.[33] These negative repercussions may outweigh the benefits of non-urgent treatment for those affected.

Justice

The concept of justice is dependent on the frame used to define the population or community included. The medical profession's frame is to treat every patient as an individual, looking past personal characteristics, for example, nationality, gender and criminal history. In effect, medics are trained to be borderless and consider the entire human race as one. This is summarised by *Good Medical Practice*: 'You must treat patients fairly and with respect whatever their life choices and beliefs' and 'give priority to patients on the basis of their clinical need'.[26] Under this model, it is clear that the NHS charging regulations contravene the principle of justice.

This borderless framework is fundamentally opposed to State sovereignty, which defines itself by 'the border'. The State applies the concept of justice only to the population within its borders and therefore those from outside are seen as a threat to the justice of its people; a threat to their 'right of exemption'.[39] Hence, 'health tourists' deny UK citizens their right to healthcare. The central argument for the reforms rests on the concept of 'fair' allocation of resources, based on the application of 'fair' to those who are British citizens. This clash of definition for the serviced population poses a problematic tension and is core to the ethical breach of doctor's duties under the NHS charging regulations.

This tension echoes the debate in human rights literature. The French Declaration of the Rights of Man 1789 was framed on 'the citizen', excluding many at the time including women and Jews. The Universal Declaration of Human Rights and subsequent Human Rights movement have never shaken off this assumption of 'human' as 'citizen'.[40] Arendt summarised a situation where political forces could render populations without 'the right to have rights' and without the 'right to belong to some kind of organised community'.[19] Sylvester's story is an example of somebody who was excluded from the UK community and denied his entitlement to healthcare. Today, the Universal Declaration of Human Rights is inevitably operationalised at State level, leading to denial of human rights for 'outsiders', under the guise of law and order.[41]

Rawls states that distributive justice should be achieved by ensuring that any existing inequalities must not lower the expectations of those least advantaged. He argued that equality

should set the baseline for society and inequalities are only to be tolerated if they improve everyone's situation.[42] To employ this interpretation of justice to the introduction of the charging regulations, we need to decide who we include in our definition of society. Rawls worked by the framework of the citizen, so using his concept we can choose to exclude those not deemed 'ordinarily resident' from our definition and think about the least advantaged UK citizens. There are many possible outcomes of the regulations that appear to lower the expectations of this group such as an increase in infectious diseases which tend to show greatest prevalence in the poorest citizens, increased animosity between the citizen population and the migrant/visitor population which could reduce well-being (this is most relevant for the least advantaged UK citizens because they tend to live and work in the same locations and therefore come into more direct contact), deterioration of the mental health of migrant/visitor population which could impact on citizen population in a number of ways, increase in homelessness and possibly an increase in crime rates as the visitor/migrant population are pushed into destitution as a result of poor health or the costs of healthcare.

The only perceived benefit to the least advantaged in the citizen population of this policy would be a potential 0.07% increase in the NHS pot for the entire population's potential use of healthcare, and as will be discussed below the reality of recovering these funds may never be realised. If we were truly concerned with achieving Rawls' definition of distributive justice, then there are many better ways to improve the least advantaged's proportion of the NHS pot such as fairer distribution of healthcare resources through greater Government support of health equity initiatives, for example, the Deep End primary care movement based on Tudor Hart's inverse care law.[43]

If we choose to broaden the definition of membership of society and include those deemed not 'ordinarily resident' but still on UK soil, then we can see clearly how the NHS charging regulations worsen the situation of the least advantaged. Under this definition, the least advantaged population on UK soil must surely be those vulnerable populations who are living outside the protective frameworks of citizenship and have a host of barriers to prevent them bettering their individual circumstances. Not all migrants/visitors on UK soil, such as richer economic migrants from places such as the USA and Russia, will be within this category; however, those at the least advantaged end of the scale must surpass the level of disadvantage of the poorest of UK citizens.

To employ another of Rawls' theories and seek further clarification on his moral position, we can use his thought experiment: the veil of ignorance. This would support the idea of dismantling the charging regulations as, if your position in society was concealed from you before the policy decision was taken then few people would agree to such a marginalising policy.

The reforms were introduced at a time of heavy anti-immigration media coverage and politically motivated rhetoric over the condition of the NHS budget.[44] The preceding years of austerity led to heightened scrutiny of public service spending.[45] Media coverage[46 47] and policy-makers debate[48] focused on 'health tourism': travel to the UK specifically for NHS services. Populist media adopted the phrase and represented it as the main motive for change, despite government-commissioned research estimating it to contribute only 0.07% to the total NHS spend[49 50] and estimations from UK Office of National Statistics that net migration for medical treatment moves out of the UK rather than into it.[51]

Despite the governments claim that £156 million could be saved through the new charging system, the current estimate is that only £15–25 million gross income is being recovered.[14] The costs of administrating the system are estimated to be greater currently than the recovered costs—a net loss to the NHS.[14] Using a rough back of the envelope calculation, if there are 99 NHS trust in England and a rough approximation of 220 overseas visitors managers employed in them on a band six pay salary, then this cost alone would equate to £6.5 million spent on OVMs salaries per year. Plus, this does not take account of any of the additional administrative staff required in their team or the other operational costs. The majority of NHS trusts report hiring external debt recovery agents to deal with unpaid debts.[14] Despite heavy-handed approaches, these external agents have limited success with only approximately 7% of debts being recouped and charge large fees regardless of the outcome.[52]

Evidence from studies conducted in Europe suggest that exclusion of migrants from routine healthcare is not a cost-effective approach.[53–55] The additional financial costs to the NHS through delayed presentation of medical conditions leading to greater overall costs of healthcare and increased rate of infectious diseases due to fear of seeking medical attention have not been published. These are extremely difficult to calculate accurately but must be taken into consideration.

If fair allocation of resources *is* the core motivation for the policy, then it is clearly not having the desired effect as a cost-saving initiative and there is no suggestion that it necessarily will. There are many more evidenced and properly researched approaches to reducing waste of scarce NHS resources which could have been prioritised over this one, such as minimisation of prescription costs, improvements in use of technology and preventing the need for agency staff.[56 57] Numerous calls have been made for the government to be more transparent about publishing its decision-making process and the impact of the policy following its introduction.[1 58] A review conducted into the impact of the charging regulations has not been shared publicly and neither has Public Health England's review into the impact of the data sharing agreement.[32] As it seems evident that the motivation for this policy cannot be cost-effectiveness alone, political ideology appears to be its driving force which is problematic when making healthcare delivery decision.

While it can be reasoned that NHS charging regulations have been produced by democratic decision-making and should therefore be respected, history shows that democratic decisions have resulted in human rights abuses throughout the world, for example civil rights in the USA, apartheid in South Africa and anti-terrorist measures in many European countries. Part of the democratic process is to challenge and call-out those policies which may not have considered their negative consequences. Democracy occurs in incremental steps. Occasionally, a step is taken which members of the population disagree with and they can exercise their democratic right to oppose this and lobby for change. Doctors as a professional body have an obligation—for the good of society—to uphold their ethical code of conduct, which has been revised and developed over many centuries.

The public's willingness to pay their taxes to finance the NHS depends on the healthcare provided. Currently, there is no evidence available that quality of care has improved since the new policy has been implemented. Quality of healthcare in the UK compared with other EU countries in a very broad sense—as healthcare is hugely diverse and quality is a multidimensional concept—is good: the NHS has some of the lowest waiting times for operative procedures and some of the shortest hospital admission stays.[59] Some recent stagnations in quality

measures such as overall life expectancy[60] and infant mortality[61] have occurred since 2010 and 2014, respectively, showing, if anything, declining quality in public health and healthcare. There is growing evidence to link these falling measures of population health to the austerity policies of the current administration.[62 63]

At present, the communal agreement of a doctor's responsibilities between the profession and wider society does not require consideration of immigration status. There is no mention of 'citizen', 'visitor', 'residence' or 'nationality' in any of the *Good Medical Practice* documentation.[26] Therefore, while working as a doctor in England, all patients who walk through your door should be treated in the same way regardless of their reasons for being within the boundaries of the UK. If society feels strongly that consideration of these concepts should be incorporated into the role, then there needs to be a much wider public and medical debate on this issue. A clinical environment, which should promote healing, care and comfort to the sick, is not an appropriate space to enforce border control and clinicians are not trained for this role or its impact. These two functions have completely opposing priorities and cannot be brought under one roof without damaging the conduct of the other. This sentiment is outlined in the United Nations Global Compact for Migration, adopted by the UK Government in December 2018. If the Home Office believe it is important to reduce migrants' use of public services, they should focus greater attention on policing UK borders. The enforcement of such border control measures has no place under the jurisdiction of healthcare.Export to PDF (without watermark)

SUMMARY

Overall, this article demonstrates that new NHS immigration reforms are fundamentally opposed to ethical conduct core to the medical profession, evidenced with excerpts from *Good Medical Practice*. The case study focuses on the story of Commonwealth immigration in the wake of the Windrush scandal; a Jamaican born man, living and paying his taxes in the UK for over 40 years and denied free NHS cancer treatment. The case exemplifies the great sense of injustice experienced by many due to exertion of State border control through health services.

The argument is developed using the four principles of biomedical ethics to highlight contradictions between the new reforms and the ethical obligations governing doctors in the UK. It is revealed that recent government policies on access to healthcare for 'overseas visitors' deny doctors from providing autonomy and confidentiality to their patients. Consequences of the charging reforms are explored to better inform clinicians when seeking to reach the best possible outcomes for patients. Finally, the State's border-bound definition of justice contrasts with the border-free approach of clinical care, revealing a fundamental tension.

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Collaborators Katharine F A Reeve.

Contributors JMKR was responsible for the concept and co-writing of the article. She developed the concept after speaking with clients at the Helen Bamber Foundation and working alongside members of the Medact Migrant Solidarity Group. JMKR has an interest in reducing barriers to care for minority populations. She studied Public Health for Development at London School of Hygiene and Tropical Medicine after returning to the UK from Jamaica where she worked in public health research and primary care, predominantly at the University of the West Indies. CM helped to co-write the article. She has an academic interest in health inequalities.

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