Medical ethics and the healthcare rights of citizens and others

In his article in this issue,¹ Taylor sets out a compelling critique of the fairness of government policy on charging failed asylum seekers for both primary and secondary medical care delivered by NHS staff or in NHS facilities. He argues that this is an unjust and irrational policy, which risks the health of failed asylum seekers, and also the public health, by discouraging them from seeking necessary treatment and preventative care. He shows that this exacerbates existing injustice to this vulnerable group, who typically start out in poorer health and are considerably worse off, in social and economic terms, than the general population. Moreover, as he points out, much of this relative disadvantage is created by government policy. For while the migrant may enter in poor health and with few resources, current policy acts to discourage or prevent him or her from improving his or her situation in any way other than leaving the country.

As Taylor shows, the explicit goal of policy in this area is to discourage migrants from coming here, save in a few very special categories (highly skilled migrants with visas, 'genuine' refugees) where the State has an interest in such migration continuing or is under an international or regional legal obligation to admit migrants in the special category. The NHS has a special place in this political context. For many years the government has argued that the NHS is a major attracting factor in migration to the UK, and that illegitimate claims to free treatment represent a major charge on the exchequer. The government's overseas visitor charging policy, in tandem with its immigration policy, is designed to ensure that NHS resources are used only by those fully entitled to them (thereby ensuring that those entitled to them are able to enjoy them to a fuller extent than if they were spread more widely).

The government has fought to uphold this policy in the courts, most recently in the judicial review case R (on the

application of YA) versus Secretary of State for Health [2009]. It has also defended its policy against criticism from the House of Commons Select Committee on Health, and much criticism from within the professions and the academic community.^{2,3} However, a recent decision by the Welsh Assembly means that while failed asylum seekers are charged in England, they receive free treatment in Wales.⁴ So it is far from clear that there is a political consensus on this policy, and the operation of the policy in practice is murky, to say the least. As the Court of Appeal allowed in YA, NHS Trusts have a discretion over whether to charge any given overseas visitor, and this discretion is not controlled by the Secretary of State's guidance.

There are difficult issues of ethical principle at stake here. On the one hand, the NHS is a public service, similar in most respects to the social welfare system, which is designed as a benefit system for citizens of the UK. In a climate in which parties compete for votes by seeking to appear more populist than each other over the rigour of their immigration policies, and in which a punitive government policy exists over benefit fraud of all kinds, the argument that failed asylum seekers have no social welfare entitlements beyond the bare means of survival and an expectation of early and fair removal from the jurisdiction has considerable force. This force is largely political; but there are ethical reasons in its favour. Roughly speaking, these derive from the notion that social rights derive from participation in a social contract. Non-citizens are not parties to this contract, and derive such benefits not as rights, but simply on the basis of charity, like-for-like contribution to the State through legitimate work and taxation or direct payment, or reciprocal agreements with their home states. There is no right to charity; and it may be withdrawn should the non-citizen claimant lose permission to remain in the country or otherwise place themselves beyond the

limits of hospitality (through criminal acts, for instance).

However, this reasoning sits poorly with the ethos of medicine, and of the NHS. It also sits poorly with the ethics (although perhaps not the formal law) of international human rights. It is part of classical medical ethics that doctors treat those in need, without regard to their status (or sex, race, or sexuality). While constraints of cost and resource did shape what doctors were able to do, and for whom, status, as opposed to need and clinical benefit, has not been an acceptable criterion for resource allocation for a very long time. It is not surprising that many doctors, like Taylor feel deeply uncomfortable at government policy on charging indigent overseas patients. More generally, the social contract argument seems to overlook the international human rights ethos that all human beings share equal capacity to suffer and require food, clothing, shelter, and medical care, and that there is a minimum standard below which people should not be permitted to fall through state action or discriminatory treatment.

If we look to the law to help patients like Mr YA, we are likely to be disappointed, as the courts have retreated further and further from the expansive reading of international human rights law in the late 1990s, which saw denial of treatment through repatriation as 'inhuman and degrading'. Instead, the medical profession needs to make its voice heard, to call on the government to uphold ethical standards even where it may be politically inexpedient. And the profession should play its part in public debates across the European Union to protect some of society's most vulnerable people from the effects of a populist policy which is increasingly harsh toward migrants.

Richard Ashcroft,
Queen Mary University of London, School of Law, London.

Provenance
Commissioned; not peer reviewed.

REFERENCES

1. Taylor K. Asylum seekers, refugees, and the politics of access to health care: a UK perspective. *Br J Gen Pract* 2009; **59**(567): 765–772.
2. Ashcroft RE. Standing up for the medical rights of asylum seekers. *J Med Ethics* 2005; **31**(3): 125–126.
3. Cole P. Human rights and the national interest: migrants, healthcare and social justice. *J Med Ethics* 2007; **33**(5): 269–272.
4. BBC News. Failed asylum seekers health help. 15 July 2009. <http://news.bbc.co.uk/1/hi/wales/8151255.stm> (accessed 2 Sept 2009).

DOI: 10.3399/bjgp09X472575

ADDRESS FOR CORRESPONDENCE

Richard Ashcroft
 Queen Mary University of London, School
 of Law, Mile End Road, London, E1 4NS.
 Email: r.ashcroft@qmul.ac.uk

Health literacy: a necessity for increasing participation in health care

Current UK government policy places much emphasis on increasing patient participation in health care, stressing that access to better information is required to support patients' participation and to enable them to make choices in their own health care.¹ Patient participation has great practical value in achieving better health outcomes among those who actively participate in healthcare decisions compared to those who do not.² Previous studies have shown that patients are not currently involved to the degree that they would prefer,³ and that this desire for engagement is consistent regardless of social background and educational status.⁴

Those who currently participate in healthcare decision making tend to be younger, female, educated, articulate patients of higher socioeconomic status.⁵ While the range of methods for patient communication in clinical settings has grown, most are dependent on higher levels of literacy and numeracy. There is relatively little published evidence concerning attempts to encourage people from lower literacy backgrounds to make informed health decisions through the use of different types of decision support materials or approaches.^{6,7}

Differences in literacy and numeric skills lead to marked variation in an individual's ability to obtain relevant health information, and in their opportunity and capability to apply that information in interactions with health professionals and services.⁸ It

follows that without careful implementation, current government policies may inadvertently exacerbate existing inequalities in health by favouring those already advantaged as a consequence of their education and basic skills.⁹ It is possible that this is one of the reasons why, despite an overall increase in health in the UK population, the 'inequalities gap' between the most and least advantaged in society is widening.¹⁰

POOR HEALTH LITERACY AS A BARRIER TO PARTICIPATION IN HEALTH CARE

Functional literacy (the ability to read simple text and write simple sentences about everyday life), is a basic skill enabling people to participate more fully in society. There is consistent evidence indicating a link between low literacy and poorer health outcomes. People with lower literacy levels are generally 1.5 to 3 times more likely to have poor health outcomes than people with higher literacy levels.⁸ The prevalence of low literacy in England is surprisingly high.

The most recent (2003) English national survey of literacy, numeracy, and use of information technology, also known as the The Skills for Life survey, assessed the extent to which these basic skills were present at a level needed to achieve full potential (Level 2 in the National Qualification Framework). This is described as 'being able to understand a range of

texts of varying complexity accurately and independently, and to extract information of varying length and detail from different sources'.¹¹ This survey of 8000 people of working age was based on a direct measurement of skills (for example, on being shown a poster for a concert, questions were asked such as 'where is the concert, how much will it cost for two people to attend?'). The results were divided into levels which were based on the English national curriculum and showed that 56% (literacy), and 75% (numeracy) of those surveyed have skills below those needed to achieve their full potential, while the opportunities offered by modern information technology, such as the internet, are only fully used by a very small percentage of the population (9%).¹¹

Such results provide practical challenges in health communication. The majority of printed information leaflets used in health care already have a reading age higher than the average population.^{12,13} Interventions to promote participation, shared decision making, and informed consent may only therefore reach a proportion of the population.

Low literacy and numeracy may contribute to inequity of access to the benefits of prescription medication. It is known that people with low literacy skills are more likely to make mistakes in interpreting medication instructions and warning labels.¹⁴ This increases the risk of both unintentional sub-optimal compliance