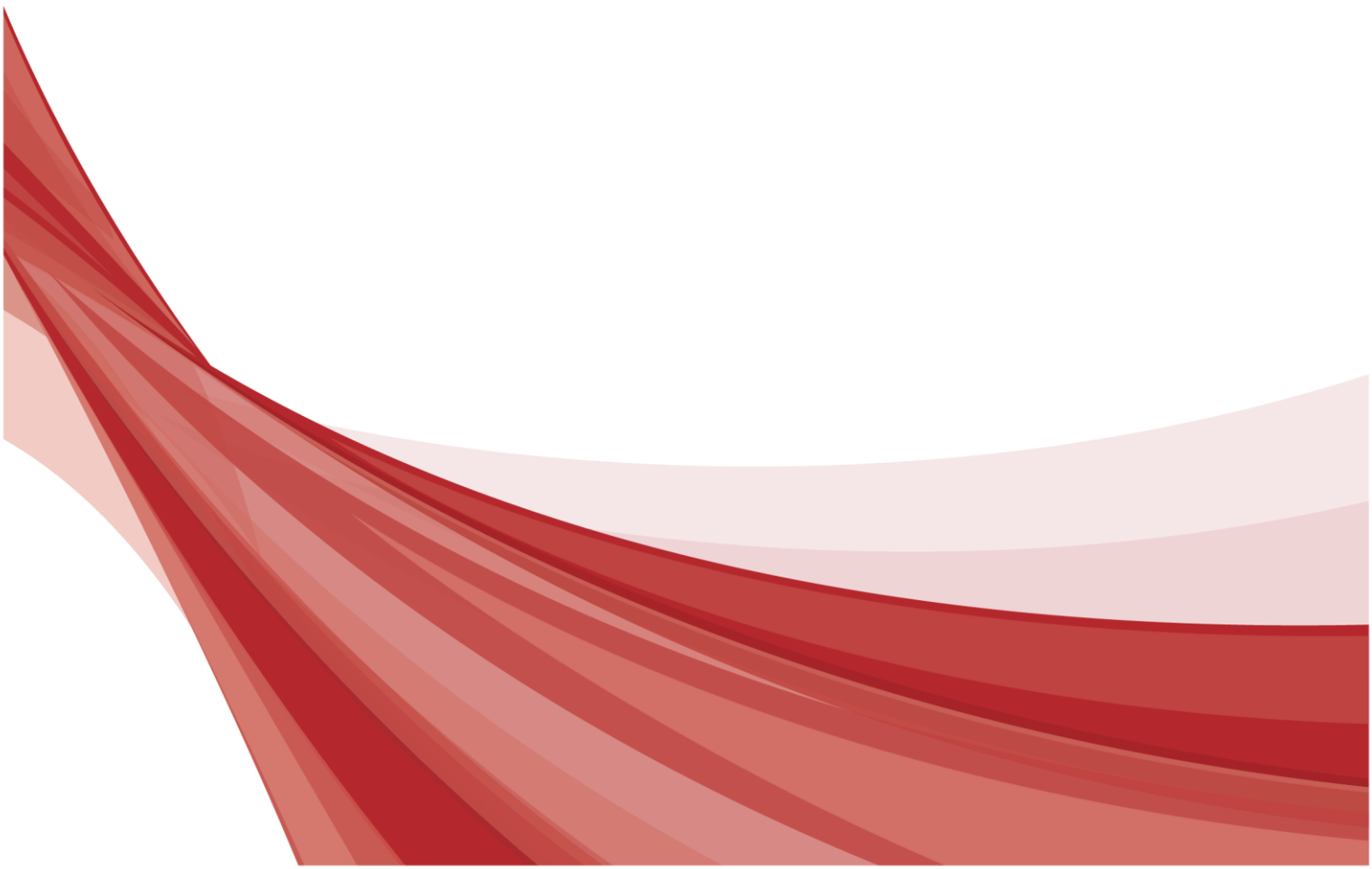
Response to ‘making a contribution’

Response to the Department of Health consultation on extending charges for overseas visitors and migrants using the NHS in England



Introduction

1.1 The Trades Union Congress (TUC) has 52 affiliated unions, representing almost six million members, who work in a wide variety of sectors and occupations. The TUC has a long history of opposition to racism and xenophobia, and has consistently highlighted and campaigned against discrimination against black and minority ethnic (BME) workers in the British labour market. The TUC believes in a rights-based approach towards migration which ensures equal rights for people at work whether they are indigenous or migrant workers.

1.2 The TUC welcomes the opportunity to respond to the Department of Health's consultation on extending charges for overseas visitors and migrants using the NHS in England[1] as we have serious concerns about the negative impact they are likely to have both on patient care and staff in the health sector.

1.3 The TUC is opposed to health charges for overseas visitors and migrants to use the NHS, as we made clear in our evidence to the Department of Health's 2013 consultation.[2] We believe health care should be free for all at the point of need.

1.4 The TUC is opposed to the present proposals to extend health charges to primary care, community care, prescriptions and fertility treatment as we are concerned that they will increase discrimination, have a negative impact on public health and public finances and prevent vulnerable groups from seeking the medical care they need.

The myth of 'health tourism'

2.1 We have concerns about the premise on which the Department of Health justifies its proposals to extend health charges for migrants. The consultation document states health charges for non-EEA temporary visitors are necessary because 'it is fair that people who are in this country for a short time, and are not ordinarily resident here, should meet the costs of all NHS healthcare they receive…Ultimately, this is a cost born by UK residents and taxpayers.'

2.2 However, this does not reflect the fact that the NHS is funded from general taxation to which everyone in the country contributes, including non-EEA migrants, through tax contributions whilst working or simply through paying VAT in everyday consumption. Non-EEA migrants contribute additionally to the NHS as health workers, with recent figures from the Nursing and Midwifery Council showing 9.9% of NHS nurses are non-EEA citizens.[3]

2.3 NHS data suggests that non-payment of fees for secondary care, which currently incurs charges for temporary non-EEA migrants, is not a considerable cost for the

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/483870/NHS_charging_acc.pdf

2 https://www.tuc.org.uk/international-issues/equality/migration/tuc-comments-government-plans-charge-migrants-use-nhs

3 http://www.bbc.co.uk/news/health-33201189

health service. Non-payment of health fees by non-EEA migrants currently represents approximately 0.011% of the NHS budget.[4] The impact of this cost is small in comparison to the £20 billion of savings that the Government's austerity cuts have imposed on the NHS. Furthermore, the non-payment of fees for secondary care may be due to lack of NHS resources to contact and locate the patient or the patient being deceased, rather than deliberate fee evasion.

2.4 The TUC believes it would be more efficient and equitable to eliminate health charges for non-EEA citizens rather than introduce additional charges, as the Department of Health is proposing.

2.5 In our consultation response, we will answer those questions we are best placed to answer. The TUC supports the responses of our affiliated unions.

Equalities and Health Inequalities

QUESTION 1: We propose to apply the existing secondary care charging exemptions to primary medical care and emergency care.

QUESTION 2: Do you have any views on how the proposals in this consultation should be implemented so as to avoid impact on:

• people with protected characteristics as defined under the Equality Act 2010;

• health inequalities; or

• vulnerable groups?

3.1 The TUC believes the proposed charges will increase health inequalities and impact negatively on those with protected characteristics under the Equality Act (2010) and vulnerable groups.

3.2 The TUC believes health care should be free at the point of need. We believe these proposals contravene the UK's obligations as a signatory to the Universal Declaration of Human Rights which includes a right to medical care and the International Covenant on Economic, Social and Cultural Rights which requires states to take the necessary steps to create conditions ensuring access to healthcare for all.

3.3 While Department of Health guidelines state that 'where treatment is deemed as immediately necessary, it will always be given without seeking prior payment or a deposit [and patients] must not be denied emergency medical care', there are a number of non-emergency conditions that will become emergencies if not addressed at an early stage. The present proposals to extend health charges to primary care and

[4] http://www.theyworkforyou.com/wrans/?id=2013-05-16b.155471.h&s=speaker%3A24772#g155471.r0

care provided in community settings will mean that migrants who cannot afford the charges will be forced to wait until their condition becomes an emergency, and much more dangerous to their health and costly to treat, before seeking medical attention.

Health inequalities

3.4 These charges will disproportionately disadvantage any migrant with a medical condition that requires primary care, and accompanying prescriptions of medication, that cannot afford the charges. In particular the following groups are particularly vulnerable:

- Pregnant women: antenatal care is very costly and so it is very likely that pregnant women who face these charges who are on a low income, such as undocumented migrants and those who are spouses of low-paid workers, will not seek antenatal care. It is widely recognised that antenatal care is essential for detecting conditions such as pre-eclampsia, gestational diabetes, anaemia and urinary tract infections. Without access to antenatal care, the risk of developing these conditions is greatly increased. Women not able to afford antenatal care will have to resort to using the Accident and Emergency services if they develop an emergency health condition which is a much more costly way to provide treatment.

  The proposed charges will lead to more women giving birth without any medical assistance - as already happens in a small but significant number of cases per year - endangering the life of both mother and child. Given that charging already exists for medical terminations, pregnant women could find themselves in the invidious position of being unable to afford a termination and unable to afford NHS antenatal care and medical attention in labour.

- Disabled people and in particular, people with mental health conditions: some disabled people will need regular medication to manage their impairment. Others will require continuing treatment. Some people with mental health conditions will depend on regular medication, others may have fluctuating conditions, some may need therapy or counselling. They may be at serious risk of deterioration of their condition if they are deterred from seeking help by fear of the cost. Furthermore, disabled people as a group are among the poorest people in society and already face higher costs than non-disabled people in managing their everyday life, meaning that for many additional charges for healthcare - whether or not related to their impairment(s) - would force them to choose between medication, food or heating.

- Undocumented workers: this group are already less likely than others to seek medical treatment as they are afraid of being reported to immigration officials. As undocumented workers do not have a right to work legally they are more likely to be on a low income and not able to afford fees. These charges will mean undocumented workers are likely not to seek treatment until they have an urgent condition that will require emergency treatment, by which time their conditions may have become a serious risk to their health.

- Failed asylum seekers: research suggests asylum seekers are already less likely to access health care despite being disproportionately likely to have serious conditions that require treatment. Data collected from 112 asylum seekers at a specialist clinic in Brixton found that 54% of patients had been turned away, often more than once, from mainstream GP surgeries, despite being entitled to free healthcare. Fifteen individuals in this group had at least one serious communicable disease (five were HIV positive,

six had acute hepatitis B, two were infectious for hepatitis C and three had active TB) and ten were pregnant women.[5] Narrowing the criteria under which failed asylum seekers can claim free health care means even asylum seekers that are exempted from charging will not seek treatment for fear of being charged.

- Children: overseas visitors on low incomes and undocumented migrants will be unlikely to take their children to be treated unless they have critical health conditions for fear of not being able to pay the health costs. The TUC believes this will put children's lives at risk, as parents may delay taking a child that develops a rash or another seemingly minor symptom to the doctor. Illnesses like meningitis - that is identifiable by a rash in the initial stages - develop very rapidly and may result in death if a child does not receive treatment quickly. These health charges will also seriously jeopardise the health of children with long-term conditions such as cystic-fibrosis which necessitate lengthy and expensive stays in hospital. This contravenes the UK's international humanitarian obligations to protect children's healthcare, which include its commitments under UN Convention on the Rights of the Child. This states in Article 4 (Protection of rights) 'the state must take all available measures to make sure children's rights are respected, protected and fulfilled' and Article 24 that 'the state must provide every child present on UK territory the same healthcare services as nationals'.

- Black and Ethnic Minority (BME) groups: these charges would compound inequalities already experienced by ethnic minorities who are already marginalised in their ability to access care due to issues of language and lack of accessible information.

Impact on health staff

3.5 The TUC has serious concerns that the measures would turn health professionals into immigration officials. We believe the document checks required by this charging system increase the chances of discrimination in frontline service delivery against individuals with the protected characteristics of gender, race and ethnicity. People who are not white or do not speak English fluently are more likely than their white English-speaking counterparts to have their entitlement questioned by staff administering the system.

3.6 The TUC does not believe adequate steps have been taken by the Department of Health to ensure health trusts provide adequate training for staff to administer a charging system in a way that does discriminate against certain groups. An organisation affiliated to Still Human Still Here cites evidence of a clinic in Doncaster where there was 'a continuing problem of asylum seekers without photo ID being refused registration.'

3.7 While the Department of Health has stated that urgent and immediately necessary treatment should always be provided, this is not always occurring in practice. *The Independent* reported a case in March 2014 where a heavily pregnant migrant woman carrying a dead, unborn child was too afraid to seek the urgent medical she needed after being told she would have to pay the NHS thousands of

[5] Polly Nyiri, *A specialist clinic for destitute asylum seekers and refugees in London*, BJGP, November 2012.

pounds to remove the foetus. The woman could not pay the fees and could not access care without accruing debt which would have prevented her from being able to obtain a visa to live with her husband in the UK.[6]

3.8 The TUC believes it is essential for staff in emergency, primary and community health settings to receive training that makes clear that, regardless of the immigration status of their patient, care must be provided to patients in need.

3.9 Health professionals have expressed concerns about their ability to deliver quality care to patients due to the additional requirements of the charging regime for migrants. Qualitative research conducted for the Department of Health in 2013 found that the Overseas Visitor Officers, practice mangers, administrative staff and members of the Border Force interviewed 'questioned whether a charge should be levied for genuine emergencies and very importantly, what the effect might be on patients who are unable to pay.'[7]

3.10 The Department of Health has noted in its response to the consultation that:

'Collectively the majority of responses were opposed to the proposals to extend charging into other services…Clinical concerns extended to charging for A&E, again associated with delay in treatment whilst eligibility was established and also with the ethical considerations.'[8]

3.11 The TUC calls on the Department of Health to respond to the concerns raised by its research and health unions and withdraw health charges for migrants.

Public health

3.12 The TUC believes denying primary care access to those in need poses a public health risk. Whilst the consultation document states there will still be exemptions for treatment of infectious diseases and sexually transmitted infections (STIs), it would be very difficult to put such an exemption into practice. Often people are not aware they have a communicable disease. Diseases such as HIV are often only spotted in routine GP check-ups or during ante-natal screening. If such diseases are not treated quickly there is a risk that life-threatening infections could spread to the wider population.

3.13 Primary care is the site where the majority of immunisations take place that would guard against diseases that pose a public health risk such as measles and TB. While the consultation document states that the 'diagnosis and treatment of infectious diseases' would be exempt from charging, it isn't clear that this would

[6] The Independent, 20 March 2014 http://www.independent.co.uk/news/uk/home-news/heavily-pregnant-immigrant-carrying-dead-child-wouldnt-seek-help-as-she-was-afraid-shed-have-to-pay-nhs-under-health-tourism-rules-9205591.html

[7] Creative Research, *Qualitative Assessment of Visitor and Migrant use of the NHS in England*, 23 September 2013, page 27.

[8] Department of Health, *Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England*, December 2013, paras 53 & 56

cover immunisation which is essential to guard against the spread of infectious diseases.

3.14 A further public health risk is created by the fact that these proposals risk the well-being of the considerable number of health professionals who are non-EU citizens. If medical staff have infectious diseases that have not been diagnosed due to their inability to pay upfront fees, then all those patients in their care are endangered.

QUESTION 5: We have proposed that GP and nurse consultations should remain free to all on public protection grounds. Do you agree?

4.1 Yes

QUESTION 8: We propose removing prescription exemptions for non-EEA residents to whom surcharge arrangements do not apply and who are not in one of the charge-exempt categories identified in section three. Do you agree?

5.1 The TUC believes any arrangement to recover costs from EEA citizens must not contravene the rights to health care for EU citizens established under European Social Security Coordination legislation.

5.2 The TUC is concerned that these proposals may lead to EEA residents without an EHIC or PRC receiving medical care that they need as they are not able to pay the charge, this will in particular affect vulnerable groups in need of ongoing care, mentioned above.

QUESTION 13: We propose removing eligibility for an NHS sight test and optical voucher from non-EEA residents to whom surcharge arrangements do not apply and who are not in one of the charge-exempt categories identified in section three. Do you agree?

6.1 No. The TUC believes removing migrants that fall into the exempted categories for prescriptions charges – which include those aged over 60, pregnant women, disabled people and young people aged under 16 - will disadvantage already vulnerable groups in terms of care and treatment.

QUESTION 15: Our proposal for A&E is to extend charging of overseas visitors to cover all treatment provided within all NHS A&E settings, including Walk-In Centres, Urgent Care Centres and Minor Injuries Units.

Do you agree?

7.1 No

QUESTION 16: If you disagree or strongly disagree with the proposals in question 15, do you agree that charging should cover care given within an NHS A&E setting if an individual is subsequently admitted to hospital, or referred to an outpatient appointment?

8.1 No

QUESTION 20: Do you agree that the Government should charge individuals who receive care by air ambulance?

9.1 No

QUESTION 22: Our proposal for assisted reproduction is to create a new mandatory residency requirement across England for access to fertility treatments where both partners will need to demonstrate they are ordinarily resident (in the case of non-EEA citizens this includes having Indefinite Leave to Remain in the UK) in order for any treatment to begin.

Do you agree?

10.1 No.

QUESTION 23: We propose removing the right to access NHS funded fertility treatment from those who have paid the health surcharge. This will not affect any other care given by the NHS.

Do you agree?

11.1 No.

QUESTION 24: Are there any other services that you think we should consider removing access to for those who have paid the health surcharge?

12.1 No

QUESTION 25: Are there any groups of individuals who you believe should continue to have the right to access NHS funded fertility treatment, even if they are not ordinarily resident, and (in the case of non-EEA citizens), do not have Indefinite Leave to Remain in the UK?

13.1 We do not believe any group of migrants should be charged to receive NHS funded fertility treatment.

QUESTION 26: Our proposal for non-NHS providers and out-of-hospital care is to standardise the rules so that NHS funded care is chargeable to non-exempt overseas visitors wherever, and by whomever, it is provided.

QUESTION 27: Are there any non-NHS providers that should be exempt from a requirement to apply the Charging Regulations?

QUESTION 28: Are there any NHS-funded services provided outside hospital that should be exempt from a requirement to apply the Charging Regulations (e.g. on public protection grounds)?

14.1 The TUC does not believe charges should be extended to care provided in non-NHS providers such as community health care clinics. These clinics are often the primary source of treatment for communicable diseases, such as STIs and TB.

QUESTION 34: Do you have any evidence on the impact of this proposal on NHS cost recovery or any comments on the implementation of such a proposal?

15.1 The TUC believes the health charges that have already been introduced are creating burdens on NHS finances that are negatively impacting on its ability to function, particularly in the context of the NHS being mandated to make billions of pounds of savings to meet Government austerity plans.

15.2 We are concerned this system of checks creates additional costs in terms of staff time, introducing inefficiencies as each patient would need to be checked each time they used a health service. This causes increased delays to services that are already stretched.

15.3 The impact assessment accompanying this consultation estimates that 'an increased administrative burden for Overseas Visitor Meetings (OVMs) and new burdens for administrative staff in other settings (e.g. GP receptionists)' entailed in these proposals will cost £63.6 million over five years. It also estimates the development of a new IT system will cost a further £5 million.[9]

15.4 The TUC does not believe such costs will be adequately covered by funds raised by the health charge as there is considerable uncertainty that migrants covered by these charges will be able to pay them. As outlined above, many of the new groups

9 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482648/Impact_Assessment.pdf

liable to pay will not have the means to do so. There is also uncertainty that debts will be effectively collected.

15.5 We also believe creating new categories of people eligible for prescription charges would add to the complexity of the system, and make it less efficient and more expensive to operate.

15.6 Furthermore, the new charging system means the NHS will more regularly have to provide more costly emergency treatment as it compels migrants not able to pay the charges to wait until their conditions become critical before seeking medical care. For example, identifying and treating a urinary tract infection during standard antenatal care can prevent a woman developing a kidney infection which may result in premature birth. Such a minor intervention could avoid over £50 000 in costs associated with treating a very premature baby.[10]

QUESTION 35: Our proposal for overseas visitors working on UK-registered ships is to remove their exemption from NHS charges.

16.1 The TUC believes that the proposals are in breach of the ILO's Maritime Labour Convention, 2006 (MLC) which came into force in the UK in 2014.

16.2 Due to the international nature of their work, moving in and out of various jurisdictions, seafarers are recognised by the ILO as 'needing special protection' and must be able to access medical care in UK ports at no cost to themselves.

16.3 Although the consultation document states that it will be employers of overseas visitors employed on ships that are liable for the cost of NHS treatment in England, regardless of where the ship is registered, the TUC is concerned about what will happen if the employer does not pay.

16.4 Seafarers on temporary visas are often employed by overseas employers, which is likely to give rise to difficulties in the recovery of NHS charges in many cases. This may mean that workers will be compelled to cover the cost of their treatment themselves which they may not be able to afford. This means they may not be able to access vital care.

16.5 These proposals also appear to contravene the non-regression recital in the MLC which states: 'Recalling paragraph 8 of article 19 of the Constitution of the International Labour Organisation which provides that in no case shall the adoption of any Convention or Recommendation by the Conference or the ratification of any Convention by any Member be deemed to affect any law, award, custom or agreement which ensures more favourable conditions to the workers concerned than those provided for in the Convention or Recommendation.'

[10] L. Mangham, S. Petrou , L. Doyle et al.2009,The cost of preterm birth throughout childhood in England and Wales. *Pediatrics* 123(2): e312-27.

16.6 These proposals would, furthermore, breach the ILO's Work in Fishing Convention, 2007 that the UK may be likely to ratify which states:

'(e) fishers have the right to medical treatment ashore and the right to be taken ashore in a timely manner for treatment in the event of serious injury or illness. Therefore, any changes to the system should not impede this right.'

16.7 The TUC is concerned that these proposals represent a step backwards on seafarers' rights and calls for them to be dropped.