

# Maternity Action response to the Department of Health review of access to the NHS for foreign nationals June 2010

## Consultation Questions

Please mark your answers with an "x" as necessary.

### Chapter 2: The Charging Regulations and Guidance

Q1- Do you agree that the draft new consolidated Regulations provide a clearer, accurate and more succinct reflection of the existing Regulations?

 Yes No  
X

#### Comments

The current regulations clearly state responsibilities for deciding who must pay and for recovering charges. The new regulations broaden responsibility across the NHS, resulting in confusion about who has legal responsibility to make and recover charges.

Assessing chargeability requires detailed knowledge of the regulations, guidance, immigration law and European law. Dispersing responsibility for assessing chargeability within the NHS increases the likelihood of unskilled staff making this assessment, resulting in increased rates of wrong decisions which will deter people from accessing services.

Q2- Do you agree that the consolidated Regulations do not imply any material change in policy?

 Yes No  
X

#### Comments

The consolidated regulations embody material changes in policy in that responsibility for deciding who must pay and for recovering charges is dispersed across the NHS. This is likely to result in confusion, an increase in wrong decisions, and to deter people from accessing services.

Q3- Does the new draft guidance clearly and comprehensively explain how the consolidated regulations should be interpreted and applied?

Yes

No  
X

#### Comments

The guidance does not address inconsistencies between the regulations and both international law and a clinician's ethical obligations.

Restrictions on refused asylum seekers' access to free health care violates their rights to the highest attainable standard of health, which is guaranteed by Articles 2 and 12 of the International Covenant on Economic, Social and Cultural Rights. Where the state denies healthcare to an individual which is available to the population and thereby puts that individual's life at risk, an issue may arise under Article 2 of the European Convention on Human Rights and Fundamental Freedoms.

The guidance states (at 3.32) that costs should play a role in the choice of treatment to chargeable overseas visitors who cannot pay, subject to certain conditions. This aspect of the guidance suggests that those who are unable to pay may receive a lower standard of care than the rest of the population. We do not support a two-tiered system. This aspect of the guidance is at odds with a clinician's ethical obligations to make the care of their patients their first concern and also opens clinicians to charges of negligence.

The guidance does not explicitly address the chargeability of children who are age disputed or who turn 18 during the course of medical treatment.

Q4- Does Chapter 3 of the new Guidance document fully and clearly explain the NHS's obligations and requisite processes to ensure the provision of immediately necessary and urgent treatment to chargeable patients who are unable to pay prior to the treatment needing to be provided?

Yes

No  
X

#### Comments

Maternity Action strongly recommends that maternity care be exempt from charging. This is discussed at 'Other comments'. If the Department of Health decides not to offer an exemption for maternity care, then significant changes to the guidance are required in order to address the poor record of compliance and to reduce the deterrent effect of the charging regime (discussed at 'Other comments').

The draft guidance in relation to maternity care (at 3.7) is a significant improvement on previous guidance. We welcome the explicit statement that 'No woman must ever be denied, or have delayed, maternity services due to charging issues'. We also welcome the requirement that OVMs and clinicians inform women that care will not be withheld, irrespective of their ability to pay.

Maternity Action recommends that the following be incorporated into the draft guidance:

- *All women are provided with written and verbal information on their rights,*

*including their right to obtain maternity care whether or not they can pay in advance. This information should provide advice on where they can go for help in negotiating access and in resolving debts, for example Citizens Advice Bureau, PALS, relevant local voluntary organizations. This information is also disseminated to voluntary and community organizations, including migrant groups, women's groups and advice services.* Many women subject to charging will face language and cultural barriers to understanding information about their rights. Provision of written information and signposting to support agencies will increase the likelihood that women will understand and exercise their rights. It is imperative that voluntary and community organizations have accurate information on women's entitlements to encourage early engagement with services.

- *Women who require language support receive this support during their meeting with the OVM.* The draft guidance is not explicit on this point.
- *Women who are referred to the OVM and do not return for appointments are followed up by midwives. These midwives should have an excellent understanding of women's entitlement to care irrespective of their ability to pay and be able to clarify any confusion. The follow-up process should recognize that many women who are chargeable are extremely vulnerable.* While many maternity services have follow-up arrangements, these vary widely. Many midwives are uncertain about the entitlement to care of women who are subject to charging and some are misinformed. This affects their ability to address any confusion and act as an effective advocate for the women within the trust.
- *Women are provided with the bill for their treatment after maternity care has finished. Under no circumstances should the woman receive a bill prior to giving birth.* The guidance states that women should be informed if charges apply to her treatment but must not be discouraged from obtaining treatment. Receipt of a bill discourages many women from continuing with care, particularly when this is followed by active pursuit of payment.
- *Where a woman is unable to pay the bill, the trust will write off the debt.* This should be explicitly stated to ensure that trusts are confident in writing off a debt. At present, trusts are required to take reasonable steps to pursue a bill and many implement this by not writing off any debts.
- *Debts for maternity care are not transferred to a debt collection agency.* Trusts have no control over the behavior of debt collection agencies and aggressive pursuit of a debt is likely to cause the woman and her baby to drop out of the healthcare system and to deter other vulnerable women from seeking maternity care. It is preferable that any debt collection activities are undertaken by the trust.
- *The trust audits these processes on a regular basis to ensure that they are being followed.* As discussed under 'Other comments', there is strong evidence of widespread failure to comply with current guidance. The trusts have strong financial disincentives to comply with the current guidance and this is unchanged under the draft guidance. Stronger formal accountability requirements are necessary to address lack of compliance.

Maternity Action has concerns about asking clinicians to sign the form at Appendix 2. This

is an administrative form and includes elements which are not appropriate for clinicians to sign. For example, it is not appropriate to ask clinicians to sign up to the statement: "I do not intend to provide treatment unless payment is made in advance, since the patient's need is non-urgent and it can wait until they return home." It is essential that clinician views are accurately documented, however this form is not the appropriate mechanism for doing so. To sign the form is at odds with a clinician's ethical obligations to make the care of their patients their first concern and also opens clinicians to charges of negligence.

We recognize that forms will be used in the administration of the charging regulations. We recommend that these forms explicitly state that immediately necessary care includes all maternity care. This will assist in addressing the confusion about the entitlement to maternity care and in reducing non-compliance.

We recommend that the estimated date of return be extended to 12 months where date of return is unclear. This better reflects the extended delays in removal faced by refused asylum seekers.

The guidance recommends that posters on entitlement to care be displayed and patients be encouraged to approach receptionists for further information. We are concerned that warnings that patients may be chargeable will deter vulnerable women from seeking maternity care and we recommend that the posters not be used. We are concerned that reception staff commonly lack the detailed knowledge of the regulations, guidance, immigration law and European law. This advice should only provided by trained staff.

### Chapter 3: Proposals for Change to the Charging Regulations.

Q5- Do you agree with the proposal to exempt Section 4 and Section 95 failed asylum seekers from charges for NHS hospital treatment?

<b>Yes</b> X
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<b>No</b>
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#### Comments

We strongly support proposals to stop charging refused asylum seekers in receipt of section 4 and section 95 for secondary healthcare and we urge the Government to cease charging all refused asylum seekers for care.

Refugee and asylum seeking women have some of the worst maternal health outcomes of any group in the community. Refugee and asylum seeking women make up 12% of all maternal deaths (CEMACH 2007) and only 0.3% of the population.

Asylum seeking women commonly have poor general health when they arrive in the UK and their health commonly declines in the years following arrival (BMA 2002). One in six refugees has a physical health problem serious enough to affect their life, and that two out of three have experienced significant anxiety or depression (BMA 2002). Asylum seeking women are less likely than their UK counterparts to have received vaccinations against common communicable diseases, and may have spent time during transit in overcrowded and unsanitary conditions. They are therefore more likely to present with diseases such as tuberculosis, and hepatitis. They may also come from countries of origin where HIV infection is a widespread problem (McLeish 2002). Poor healthcare in their country of origin may also mean that women arrive with a host of other undetected or untreated problems such as congenital or rheumatic heart disease, sickle cell anaemia or beta thalassaemia (CEMACH 2007). Many will still bear the physical and mental scars of the

oppression and violence meted out to them in the country they have fled, such as injuries sustained through torture, imprisonment, rape or female genital cutting (FGC) (BMA 2002; McLeish 2002; CEMACH 2007). These complex health profiles may have been compounded by a lifetime of poor nutrition, as well as by long and arduous journeys to the UK (Dunkley-Bent 2005).

Promoting early engagement with maternity services for these women is of the highest importance in improving the health outcomes for this group. Providing free NHS care to all refused asylum seekers will remove a significant barrier to access. While maternity care is immediately necessary treatment and should not be refused irrespective of the woman's ability to pay, we are aware of the deterrent effect of charging. This is particularly important amongst women with insecure immigration status who are anxious to avoid any action which would reduce their chances of obtaining leave to remain.

Retaining charging for some refused asylum seekers renders the rules more complex. Confusion about entitlement to free care can prevent asylum seeking women from seeking care. This can result in women who are entitled to free NHS care failing to obtain essential maternity care.

We note that Wales and Scotland provide free NHS care to all refused asylum seekers and this has not resulted in an additional burden on health services.

Q6- Do you agree with the proposal that any unaccompanied non-resident Children should be exempted from NHS treatment charges?

Yes  
X

No

#### Comments

We support proposals to exempt unaccompanied minors from charging for NHS secondary care. We argue that this exemption should be extended to all children present in the UK, regardless of status.

- The UK has an obligation under the UN Convention on the Rights of the Child to ensure that no child is deprived of access to healthcare.
- Both the NHS and UKBA have legal duties to have regard to the need to safeguard and promote the welfare of children.
- Improving the health of all children is an essential element of the 'Every Child Matters: Change for Children' reforms. Local authorities and PCTs have duties to work in partnership to pursue these reforms.
- Providing children with appropriate health services is vital for their future health, mental health and protection. Early intervention, including secondary care, prevents later health problems. Failure to provide access to the full range of health services can result in avoidable illness and disability.

Q7- Do you agree that UK residents may be absent from the UK for up to six months in a year before potentially being liable for charges for NHS treatment under the Charging Regulations?

Yes No

**Comments**

Q8- In respect of the proposals referred to in Questions 5-7 are you able to provide any additional data that may inform the calculations of costs and benefits?

 Yes No  
X

**Comments**

The Impact Assessment wrongly states that there is an overall social cost when the summary analysis shows there is a net social benefit. The Impact Assessment shows there is a net annual benefit from the proposals of £12 million.

**Chapter 4: Tackling NHS Debt and Misuse**

Q9- Do you agree with the proposal to require an overseas visitor receiving chargeable NHS treatment to provide personal information to aid subsequent recovery of charges?

 Yes No  
X

**Comments**

There should be no obligation to provide any personal information which is not essential for the person to receive adequate healthcare. An obligation to provide personal information to pursue charges is likely to deter pregnant women from accessing antenatal care and negatively impact on Government initiatives to reduce maternal deaths and infant mortality. Many individuals are unable to provide additional information as they do not have a permanent home address.

Q10- Do you agree with the proposal that NHS organisations must provide information relating to outstanding debt for NHS treatment to the Department of Health or to an appointed agency?

Yes

No  
X

#### Comments

There should be no obligation for a NHS Trust to pass on any information relating to outstanding debts to the Department of Health or any other agency.

Maternity Action strongly opposes the use of debt collection agencies to pursue debts for maternity care. Debt collection agencies operate independently of the Trust and are not subject to the same scrutiny and accountability. Front line service providers report that the practice of using debt collection agencies deters vulnerable women from making initial contact with maternity services. Active pursuit of debts prior to the birth is likely to result in women 'disappearing' from services.

Maternity Action opposes transfer of information relating to outstanding debt to the Department of Health. Many women will not wish to accrue a debt they cannot pay and the knowledge that a record of this debt will be communicated to the Department of Health will further deter them from engaging with maternity services.

NHS Trusts should not pass information about individual patients to GPs. Regulations governing entitlement to primary care and secondary care are different and it should be left up to each service to determine entitlement. We are aware of instances where Overseas Visitor Managers at NHS trusts have informed GPs that individuals are not entitled to free healthcare. This is an incorrect application of the regulations as everyone in the UK is entitled to free primary care at the GP's discretion.

Q11- What safeguards on the protection of personal information are needed beyond those described?

#### Comments

Personal information should not be passed on to any private companies, including debt collection agencies. Any transfer or access to any personal information held by the NHS Counter Fraud Service, should be logged and accountable to demonstrate good practice and no breaches of confidentiality.

Q12- Do you agree that the NHS Counter Fraud Service should transfer the data from the Department of Health's appointed agency to the UK Border Agency to support recovery and implement any agreed immigration sanctions under rules approved by parliament?

Yes No  
X

**Comments**

Personal information should not be transferred to the UKBA or any immigration body. Health services should remain independent of immigration controls and sanctions. The consultation states that the Department of Health is committed to protecting the health of pregnant women and their children. Vulnerable women are unlikely to engage with maternity services if data relating to them can be transferred to an immigration body.

Q13- Do you agree that the Secretary of State Directions to the NHS Business Services Authority should be amended to enable the NHS Counter Fraud Service to lawfully carry out the data transfer process?

 Yes No  
X

**Comments**

The NHS Counter Fraud Service should not be involved in the data transfer process. Increasing the number of agencies in the process is likely to lead to a breach of confidentiality.

**Chapter 5: Health Insurance for Overseas Visitors**

Q14- Do you support the principle that a requirement for chargeable overseas visitors to have health insurance should be introduced to cover the costs of any NHS treatment they may require during their stay?

 Yes No  
X

**Comments**

See answer to Q15.

Q15- What issues may arise from a system of either strongly recommended or mandatory health insurance for chargeable overseas visitors? How might these be overcome?

**Comments**

Many individuals are unable to obtain health insurance. It may not be provided in their home country, they may not be eligible as a result of a pre-existing conditions or age, or it may be prohibitively expensive.

The requirement is unlikely to address the situation of pregnant, vulnerable women with insecure immigration status who are residing in the UK. These women are commonly on very low incomes and would not have sufficient funds to maintain an insurance policy.

Q16- Do you support the principle that some overseas visitors who are currently exempted from charges should instead fund their treatment costs through health insurance?

Yes

No  
x

**Comments**

See answer to Q15.

Q17- What practical issues may arise if particular categories of overseas visitors or temporary residents were required to cover or insure their own healthcare costs rather than be entitled to free NHS treatment? How might these be overcome?

**Comments**

See answer to Q15.

**Please feel free to submit any further comments on these draft regulations below.**

## **Further comments**

### **Maternity care**

Maternity Action strongly recommends that maternity care be exempt from charging. If maternity care is not made exempt, we recommend significant changes to the guidance to better protect pregnant women and their children. These are discussed at Q4.

### **The effect of current arrangements**

A significant proportion of the women affected by the charging arrangements are from groups which have poor maternal and infant health outcomes. New migrants tend to have worse maternal health outcomes than settled populations due to poor overall health and unrecognized medical conditions such as congenital heart disease, HIV/AIDS and TB (CEMACH 2007). Refugees and asylum seekers (including refused asylum seekers who are subject to charging) comprise 12% of all maternal deaths (CEMACH 2007) despite making up 0.3% of the population. Specific ethnic groups have significantly worse maternal mortality risks than White women: Black African women 5.6 times higher; Black Caribbean 3.7 times higher; Middle Eastern 2.9 times higher; Bangladeshi 2.1 times higher; Indian 1.9 times higher; Chinese and Other Asian 1.3 times higher (CEMACH 2007).

The women affected by the charging arrangements extend beyond those who are not entitled to free NHS care. It includes women who are uncertain about their entitlements. This may be a large group as the charging arrangements are complex and information spread through community networks may not be accurate.

Promoting early engagement with maternity services has been a priority for the NHS and was embodied in the 2007 PSA targets. Through the Department of Health policy document, *Maternity Matters* (2007), maternity services have been required to investigate and address barriers to early engagement with services.

Charging women for maternity care has the effect of deterring women from accessing care, irrespective of formal rules requiring care to be provided even if the woman cannot pay in advance. Many women with limited resources are not prepared to take on a debt which they are unable to pay. To avoid the debt, they do not access services until they go into labour or something goes wrong. For example:

Maternity Action received a call from a foreign national who was in the UK on a student visa. His wife had joined him in the UK and had become pregnant. They attended a maternity service early in her pregnancy and he was required to sign a form stating that he would pay for her care. They did not have the money so decided not to return for care. He contacted Maternity Action when his wife was eight months pregnant in order to find out how to obtain care during labour. This man spoke fluent English and was well able to advocate for himself and his wife.

There is widespread non-compliance with the current charging arrangements for maternity care. The Joint Parliamentary Committee on Human Rights inquiry into the treatment of asylum seekers (2007) documented women wrongly required to pay in advance before care was provided. This has also been documented by Project London (2007, 2009), National AIDS Trust (2006), Medact (2006) and the Refugee Council (2006). There is also evidence of payments being pursued in such a way that women feel intimidated and unable to receive necessary maternity care (Joint Parliamentary Committee 2007).

The consultation document states that the Department of Health is committed to ensuring that the health of expectant mothers and their unborn children is protected, and that they have issued clear guidance that care should be provided irrespective of the woman's ability

to pay. Clear guidance has been available to trusts for several years however it is evident that this has not resulted in compliance. In 2007, the Joint Parliamentary Committee on Human Rights recommended that charging for maternity care be suspended while this problem was resolved. This did not occur. Maternity Action can find no evidence of any action taken after the 2007 report was released, apart from including reference to maternity care in the general guidance on entitlement to secondary care. This is manifestly not sufficient to address the problem identified.

A factor contributing to both deterrence and the failure of compliance is the financial arrangements. A trust must issue an invoice to a woman who is not entitled to free care, irrespective of her circumstances. Trusts are required to take reasonable steps to pursue the payment, which many interpret as sending the invoice to a debt collector. While trusts are empowered to write off a debt if the woman is unable to pay, very few trusts will do so. The active pursuit of payment deters women from engaging with services. Maternity services have strong financial disincentives to provide care to these women as there is no formal arrangement for an alternative source of payment if the woman is unable to pay. Providing further guidance will not ensure access to maternity care for pregnant women who are liable for charging. If the Government's goal is to ensure access for these women, then all maternity care should be exempt from charging.

### **Assessment of policy options**

The consultation document states that no exemption for maternity care is recommended as it would exacerbate maternity health tourism. The evidence of maternal health tourism provided is the statement that 'UKBA officials report often encountering passengers in advanced stage of pregnancy seeking entry to the UK but who evidently intend to access NHS maternity services. Over 300 such cases were identified at Gatwick between 2006 and 2008, some of whom had used the NHS for previous births and had not paid their bill.'

This is profoundly unsatisfactory evidence to justify a policy decision of this magnitude. We understand that the Gatwick figures are based on internal data collection and there is no opportunity for public scrutiny of the data collection process. It is not clear how UKBA officials distinguished between women who were visiting the UK with the intention of making use of maternity services and those did not intend to do so. It is not clear how UKBA officials determined which women intended to use the NHS and pay for their care and those who did not. No figure is given for the number of women who had used the NHS previously and not paid their bills. This detail is essential to accurately assess claims about the risk of increased costs to the NHS of exempting maternity care from charging.

We note that there is no data in the consultation document on the number of chargeable women who are using NHS maternity care at present or the proportion who are paying for their care. We understand that this data is not available. We find it surprising that the Government would seek to make policy decisions of this magnitude without this data.

A satisfactory assessment of the costs and benefits of exempting maternity care from charging would take into account the costs to the NHS of women's non-engagement or poor engagement with maternity services resulting from the charging regime. As discussed above, many of the women subject to charging are from groups with extremely poor maternal and infant health outcomes. The charging policies impact both on women who are chargeable and others within their communities who are reliant on community networks for their understanding of healthcare entitlement.

Women who have received no or poor antenatal care have significantly higher risks of maternal mortality and morbidity (CEMACH 2007) and an increased risk of infant mortality (Department of Health 2007). There are many risks faced by these women and these include avoidable premature births, avoidable transmission of HIV, and avoidable caesarean section. In the absence of research in this area, we are unable to provide accurate figures for the

numbers of women deterred from maternity services as a result of the charging regime or the precise costs of this to the NHS. We can provide some figures which indicate the magnitude of costs to be considered.

- The national tariff for a standard initial antenatal appointment is £145 and a standard delivery is £1174 (DH 2009).
- The national tariff for a caesarean with complications is £3626 which is £2452 higher than for a standard delivery (DH 2009).
- The national tariff for an antenatal admission is between £499 and £1450 (DH 2009).
- The average additional cost of a premature birth is £20 000 (Tommy's 2009). The costs vary widely according to the length of gestation. A birth at 28 weeks gestation costs, on average, £56 700 more than a child born at term.
- The lifetime cost of healthcare for a child born with HIV is estimated at £135 000 – 180 000.

These figures indicate that the cost of one avoidable antenatal admission is greater than three initial antenatal appointments; the additional cost of one avoidable caesarean is greater than two standard deliveries; the additional cost of one avoidable premature birth is greater than 17 standard deliveries; the cost of one avoidable mother to child transmission of HIV is equivalent to the cost of 153 standard deliveries.