



# Maternal and infant health of vulnerable migrants

## Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: impact on the maternal and infant health of vulnerable migrants

The Home Office is currently considering proposals which would exclude vulnerable migrants from eligibility for free NHS GP and other primary care services.

This briefing examines the impact of these proposals on maternal and infant health. More detailed information about the proposed changes and their health impacts can be found in the Medact briefing paper, *Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: impact on vulnerable migrant groups*, which is available at [www.medact.org](http://www.medact.org).

### Summary

In 2004, the Government made regulations making groups considered not to be 'lawfully resident' in the UK liable for National Health Service (NHS) hospital charges. Subject to some exceptions, NHS trusts may insist on pre-payment and may refuse care to individuals who are unable to pay.

This briefing is a response to a Home Office document, *Enforcing the Rules*, which suggests that charging for primary care, including GP services, be brought into line with hospital services.

This briefing examines the impact of the proposed changes on maternal and infant health. Women affected include those whose asylum claim and appeals have been rejected ('failed asylum seekers'), trafficked women and undocumented migrants. The briefing also considers implications for women who have a current visa but 'no recourse to public funds'.

These women are at particular risk of poor maternal and child health. Maternal deaths amongst Black African women in the UK are six times higher than for White women. Many women do not have the right to work or to receive state benefits. Many are destitute and dependent on churches and charities to survive. Others are at risk of destitution if they leave an abusive relationship.

The 2004 regulations have resulted in vulnerable women being denied maternity care. This is despite guidance stating that antenatal, birth and postnatal care are considered 'immediate and necessary' and to be provided whether or not the woman can pay. Excluding vulnerable migrants from eligibility for free GP services is likely to result in more women missing out on care. It is likely to lead to delays in commencement of antenatal care, which increases the risks to the health of pregnant women and their babies.

Charging vulnerable migrant women for GP services will make it difficult for these women to access advice about sexual health, including contraception. It will create further barriers to women obtaining a termination. It removes an important source of health care and support for women experiencing domestic abuse. As children are not exempt from charging, many vulnerable migrant children will lose access to GP services.

**Definitions:**

Overseas visitor: someone who is “not ordinarily resident in the United Kingdom”

Health tourist: someone coming to the UK with the sole purpose of accessing free NHS treatment

Asylum seeker: someone who has applied for asylum in the UK

Refugee: someone who has been granted asylum in the UK

Failed asylum seeker: an asylum seeker who has had their asylum application rejected and has also been refused on appeal

Undocumented migrant: a foreign national worker who has not been granted permission to enter employment

**What is the current situation?**

In 2004, the Government made regulations making groups considered not to be ‘lawfully resident’ in the UK liable for National Health Service (NHS) hospital charges. Subject to some exceptions, NHS trusts may insist on pre-payment and may refuse care to individuals who are unable to pay.

GPs have the discretion to register individuals who are considered not to be ‘lawfully resident’ in the UK.

Some forms of treatment are excluded from charging, including:

- Emergency care provided in Accident and Emergency
- Treatment for communicable diseases including tuberculosis and sexually transmitted infections. HIV testing is free but treatment is chargeable.
- Compulsory mental health treatment

Care which is classed as ‘immediate and necessary’ must be provided without delay or prepayment however it remains chargeable (except where provided in Accident and Emergency).

Department of Health guidance states that all antenatal, birth and postnatal care is to be considered immediate and necessary and therefore to be provided irrespective of the ability to pay (NHS 2004). This does not mean that maternity care is free but instead that women should not be denied care if they cannot pay the charges. There is evidence that the arrangements for levying charges has led to the denial of antenatal care to vulnerable women (Joint Committee on Human Rights 2007).

Children are not exempt from charging.

**What are the proposed changes?**

In 2004, the Department of Health released a consultation document which proposed to extend charging to primary care, including GP services. The response to the consultation was not published, leaving a sense of uncertainty.

In 2006, the Home Office report, *Enforcing the Rules*, announced a further review of the rules governing free NHS services for foreign nationals (Home Office 2006). The review was due to be completed before October 2007 but had not been released as at 31 December 2007. The report suggests that further restrictions will be placed on access to free NHS services for foreign nationals, including eligibility for free GP services.

Also in 2006, the then Minister of State at the Home Office, Liam Byrne MP, outlined a joint Department of Health and Home Office review of access to the NHS by foreign nationals. He stated: “The aim of the review in relation to primary medical services will be to establish clear rules which are, wherever possible, consistent with the rules governing secondary care. Any new rules will take into account the key preventative and public health role of NHS primary medical care as well as international laws and humanitarian principles.”

### **What is the rationale for the proposals?**

The reason given for the 2004 regulations on charging for hospital care was to reduce abuse of NHS services by ‘health tourists’. This was also the rationale for the 2004 consultation on entitlement to free primary care services.

Health tourists are individuals who have come to the UK with the sole purpose of obtaining health care. In 2005, the then Minister for Health, John Hutton, stated that the NHS has not been required to keep figures on this question and so it was not possible to give a definitive assessment of the scale of health tourism.

The 2006 Home Office paper focuses on deterrence for groups of people who are deemed to be living in the UK without legal residence, rather than visiting. It states its aim as “to ensure that living illegally becomes ever more uncomfortable and constrained until they leave or are removed.” The paper makes only passing reference to health tourism.

### **How will charging for GP services work in practice?**

The 2004 consultation outlined two options for charging for GP services.

- Option 1: GPs would hold a separate list for overseas visitors. The charges made would be NHS charges and would be considered to be NHS income. The practice would account for them as such.
- Option 2: Any services provided to Overseas Visitors would be provided on a private basis by GPs. In this case the practice would be responsible for agreeing and recovering charges from individuals.

It is expected that payment would be requested in advance except where treatment is deemed to be immediate and necessary in which case it would be requested after treatment.

### **Who are vulnerable migrants?**

Health tourists are defined as people coming to the UK specifically to avail themselves of free NHS treatment. We have almost no information on who makes up these groups and what numbers are involved. We can presume however that they include expatriates returning to the UK for health care in the mistaken belief that they are entitled to do so and family members of settled migrant communities (Hargreaves 2006). There will also be some other people who can afford to make the trip specifically to obtain NHS care.

To date the Government has not provided any reliable data to show that this is an issue of significance. The following is a quote from evidence given by then Health Minister, Melanie Johnson, to the Health Select Committee:

‘It is very difficult to produce figures. Historically, figures have not been collected by the Health Service over decades - never, basically - about levels of people using the service who are not resident or normally resident in the UK. That is partly because, obviously, some of the people who use those services are genuine tourists - and I am not talking about HIV/AIDS here; I am talking more generally, because it is quite difficult, again, to make distinctions between this and a number of other things for which people need treatment. It is impossible therefore to disaggregate data as to whether a tourist came over and broke their foot and received treatment through an A&E department of whether somebody came in and received another service as a so-called health tourist.’ (Health Select Committee, February 2005)

Whether intentionally or not, the legislation has the most profound impact on groups who are not health tourists but are instead the most vulnerable of migrant groups. These include failed asylum seekers, trafficked people and undocumented migrants. Project London provides care to undocumented migrants at its London clinic. Their first end of year report on this service found that the majority of their clients had lived in the UK for just under three years, on average, and presented with only routine minor complaints (Medecins du Monde 2007).

Asylum seekers are entitled to full access to free NHS care during the period their asylum claim is being reviewed. If health care was a major consideration in coming to the UK they would seek treatment during this initial period and not wait until after their claim has been refused. Asylum claims even today take time to process and appeals will further extend this period. If, as John Reid claims in *Enforcing the Rules*, that 15 women a month enter the UK in the late stages of pregnancy solely with the intention of obtaining free NHS care, these women are not failed asylum seekers.

#### **Why don't we simply send people home?**

The arrival of and removal of migrants from the UK is beyond the scope of this brief. We simply look to the responsibility of the state for the welfare of those who live in the UK no matter their legal status. We believe immigration should be managed at borders and not hospital doors.

The Immigration and Nationality Directorate recognizes that some failed asylum seekers are unable to return home due to factors beyond their control and for medical reasons. Short term support under section 4 of the Immigration and Asylum Act is in place to provide subsistence support. At the end of 2006, there were a total of 6,555 people in receipt of section 4 support (Home Office 2006). These individuals do not have access to free secondary health services. Perversely, this includes those who are unable to return home for medical reasons, the proposed changes would also make this same group ineligible for primary care.

#### **What is the health impact of the current policy?**

The 2004 regulations and ensuing confusion have resulted in desperate cases of people unable to access health care for serious or life-threatening illness. This is sometimes because they are unable to find the funds required to pay for treatment or because they are so scared of the possibility of debt they choose to remain outside the health care system. Examples of this can be seen in the report, *First*

*do no harm: denying health care to people whose asylum claims have failed* (Kelley & Stevenson 2006). The impact of a potential debt of hundred or thousands of pounds on people who have nothing cannot be overestimated.

The Department of Health guidance makes it clear that measures should always be taken to pursue debt, including where the individual leaves the country, and trusts are strongly recommended to use the services of debt recovery agencies to do so. The guidance also makes clear that it is unacceptable not to raise an invoice for treatment because the person is unable to pay (National Health Service 2004).

#### **What would be the impacts on maternal and infant health of the proposals for charging for primary care?**

- Health status of vulnerable migrants

The social and economic circumstances of many vulnerable migrants are not conducive to good health. Some failed asylum seekers receive section 4 support, which consists of full board accommodation or a combination of accommodation and vouchers. The vouchers are £32.80 for those aged 18-24 and £41.41 for those 25 and over. Other undocumented migrants and the vast majority of failed asylum seekers are not entitled to state benefits and are not permitted to work. Many are homeless and survive on assistance from church groups and charities (Refugee Action 2006).

Vulnerable migrants are at particular risk of poor maternal and infant health. Social disadvantage, living in poor communities and minority ethnic status are associated with significantly higher maternal mortality rates (Lewis 2007). The maternal mortality rate for Black African women is six times that of White women and the rate for Middle Eastern women is three times that of White women (Lewis 2007). Infant mortality is closely associated with socio-economic status and babies born to the most socially disadvantaged group (NS-SEC Other) have infant mortality rates almost twice that of the population as a whole (Department of Health 2007).

A major factor in poor maternal health outcomes for vulnerable migrants is poor general health (Lewis 2007). Women may arrive in the UK with unrecognised conditions such as congenital cardiac disease, HIV/AIDS or TB, or have undergone genital mutilation/cutting (FGM). Some women have experienced the psychological and medical effects of fleeing war torn countries, including rape, while others have been trafficked into the country and forced to work as prostitutes.

The Confidential Enquiry into Child and Maternity Health report (CEMACH report) recommended a full medical examination be undertaken for all pregnant women new to the UK, including a cardio-vascular examination (Lewis 2007). This should be undertaken by a suitably trained doctor, such as the woman's GP.

- Maternity care

Department of Health guidance states that all antenatal, birth and postnatal care is to be considered immediate and necessary and therefore to be provided irrespective of the ability to pay. This does not mean that maternity is free but instead that women should not be denied care if they cannot pay the charges.

There is evidence that the arrangements for levying charges has led to the denial of antenatal care to vulnerable women (Joint Committee on Human Rights 2007, Medecins du Monde 2007, Kelley & Stevenson 2006, Citizens Advice 2006). The Joint Committee on Human Rights found that women have been deterred from

obtaining care by the treatment received from the Overseas Visitor Managers and hospital finance departments. This consists of rude, and in some cases, abusive treatment in meeting with Overseas Visitor Managers; repeated phone calls, often very aggressive in character; and threats to bring in debt collectors prior to the birth. In some cases, the Overseas Visitor Manager has rung the woman's GP during the meeting and advised the GP that the woman is not entitled to free care. For some women this has resulted in loss of access to primary health care services.

This evidence raises questions about the efficacy of creating exemptions from charging for individuals with particular conditions. It is evident that many health care professionals are uncertain about the rules governing entitlement to maternity care, despite Department of Health circulars providing clarification. These rules are complex and many health professionals encounter an undocumented migrant only on rare occasions, giving them little reason to gain a detailed understanding of the regulations. Many vulnerable women are not aware of their entitlement to maternity care and even where they do, they are not well-placed to enforce them. It seems likely that many women are not seeking care that they are entitled to because they are not aware of their entitlement, are not prepared to incur a debt they cannot pay, or fear being reported to the authorities. It is questionable whether exempting maternity care from the proposed primary care charging proposals would ensure access to GP services for vulnerable, pregnant migrants.

Poor attendance or non-attendance for antenatal care places the health of the mother and her baby at risk. In around 20% of maternal deaths, the woman booked for maternity after 20 weeks gestation, missed more than four antenatal visits, or did not seek care for various reasons (Lewis 2007). At Project London, a health service for undocumented migrants, women who were more than 23 weeks pregnant made up 44% of the pregnant women who sought care in 2006 and for whom this information was recorded (Medecins du Monde 2006). Many women who are HIV positive discover their status through antenatal screening (National AIDS Trust 2006). Delays in commencing HIV treatment increase the risk of mother-to-child HIV transmission.

While government policy supports direct access to midwives, 83% of women first seek pregnancy care from their GP (Redshaw 2006). This rises to 86% for women having their first child. Charging for GP services may result in vulnerable migrants delaying the commencement of maternity care or not seeking it at all. Given evidence that vulnerable women are already being deterred from obtaining maternity care by requests for payment by maternity services, charging for GP appointment is likely to increase the proportion of women who do not obtain satisfactory antenatal care.

The recent CEMACH report emphasised the importance of identifying any underlying health problems early in pregnancy, and recommended that women who are new to the UK undergo a full medical examination by a suitably trained doctor, such as the woman's GP. It is unclear whether this would be considered part of maternity care and therefore 'immediate and necessary' care. If this is not the case, then vulnerable migrants may be unable to obtain this examination unless they can pay. This places an already vulnerable group of women at further risk.

- Health care for infants

The 2004 regulations on charging for NHS hospital care do not exempt children from the obligation to pay. Hospital care can be refused if the child or their parents is unable to pay, subject to the same exceptions that apply to adults.

Extending the 2004 charging regime into primary care would result in children being denied GP services unless they or their parents could pay.

There is evidence to suggest that introducing exemptions for children may not result in children obtaining care. In Sweden, children of failed asylum seekers are treated free of charge. Despite this, there is evidence of parents not attending for care for their children for fear of being reported to the immigration authorities (Medecins Sans Frontiers 2006).

- Advice about sexual health, including contraception

Free NHS GP services are an important source of advice about sexual health, including contraception. If vulnerable migrant women are required to pay for a GP visit they may not seek this advice because they cannot afford it, or may delay doing so. This places them at risk of unwanted pregnancy and sexually transmitted infections.

- Termination of pregnancy

Many women seek a termination through their GP. The earlier in pregnancy that the termination occurs, the safer it is. If vulnerable migrant women are required to pay for GP care they may not seek this advice because they cannot afford it, or may delay doing so.

Women who are not entitled to free NHS care are required to pay for terminations. Charges at one private clinic range from around £450 to £1650, depending on the method used and the stage of pregnancy.

The 2007 CEMACH report included the first recorded death from unsafe (illegal) abortion in twenty years (Lewis 2007). The woman who died was a new arrival in the UK and had initially sought care from the NHS. Charging for GP services and ongoing charging for secondary care increases the risk of unsafe abortions amongst vulnerable migrants.

- Domestic abuse

Each year, an estimated 600 women who have insecure immigration status are subject to domestic violence from their spouse (Southall Black Sisters & Women's Resource Centre 2005). Women who are pregnant are at particular risk of domestic abuse. In approximately 30% of domestic violence cases, the abuse began during pregnancy (Department of Health 2005). Of the 295 maternal deaths examined in the CEMACH report, 19 of these deaths were of women murdered by abusive partners (Lewis 2007). 70 of the 295 women who died had features of domestic abuse (Lewis 2007).

Women who are vulnerable migrants have particular difficulties in leaving an abusive partner. Women who are failed asylum seekers or undocumented migrants are not entitled to access emergency accommodation or receive welfare benefits. As a result, leaving an abusive partner may leave them destitute.

For women experiencing domestic abuse, GPs provide an important source of health care and may assist in linking her to sources of support. Vulnerable migrants who are experiencing domestic abuse may not be able to obtain money from their partner or family to pay for GP appointments and so may lose this source of support.

For many women who are legally resident in the UK, their right to remain in the country is dependent upon their husband. If they leave the relationship, they face deportation. For some women, deportation back to their countries of origin may mean violence and persecution for being divorced or separated. Many new migrants have, as a condition of their visa, 'no recourse to public funds'. Women with 'no recourse to public funds' are not entitled to access emergency accommodation and are not entitled to receive welfare benefits (Southall Black Sisters & Women's Resource Centre 2005). They face destitution if they leave the relationship.

Women with 'no recourse to public funds' who are escaping an abusive relationship may gain the right to remain in the country if they can provide evidence of the abuse. A letter from a GP is one of the few forms of evidence which is acceptable to the Home Office. Currently, most women with 'no recourse to public funds' are entitled to free GP appointments. If these women were to be charged to attend a GP appointment, they may not be able to obtain the necessary medical report for the Home Office.

### Conclusions

- A full health and equality impact assessment should be carried out before any further changes in NHS regulations
- Who enters and who leaves or is removed as long as it is done legally and humanely is outside our remit however we believe that a duty of care exists for all who live within our borders without discrimination
- Any change in regulation must ensure that no one is excluded from accessing health care simply because they are unable to pay
- Health care workers must remain clearly and visibly separate from government immigration policy

### Further information

For information on about the campaign, see [www.medact.org](http://www.medact.org) or contact Rosalind Bragg at [rosbragg@medact.org](mailto:rosbragg@medact.org) or 020 7324 4739

The Reaching Out Project at Medact aims to improve access to maternity care for marginalised women from Black and minority ethnic communities.

The Reaching Out Project, Medact  
The Grayston Centre  
28 Charles Square  
London N1 6HT  
W: [www.medact.org](http://www.medact.org)

## References

- British Medical Association, 2002, *Asylum seekers: meeting their healthcare needs* Available online: [www.bma.org.uk](http://www.bma.org.uk)
- Citizens Advice Bureau, 2006, *Shaming destitution*, Citizens Advice Bureau: London Available online: [www.citizensadvice.org.uk](http://www.citizensadvice.org.uk)
- Department of Health, 2005, *Responding to domestic abuse: a handbook for health professionals* Available online: [www.dh.gov.uk](http://www.dh.gov.uk)
- Department of Health, 2007, Review of the health inequalities infant mortality PSA target, COI: London Available online: [www.dh.gov.uk](http://www.dh.gov.uk)
- S. Hargreaves, J.S. Friedland, A. Holmes, & S. Saxena, 2006, *The identification and charging of Overseas Visitors at NHS services in Newham: a Consultation*, Newham Primary Care Trust & Imperial College: London
- Home Office, 2006, *Asylum statistics, Fourth quarter 2006, United Kingdom*
- Home Office, 2007, *Enforcing the rules: a strategy to ensure and enforce compliance with our immigration laws*
- Joint Committee on Human Rights, House of Lords and House of Commons, (2007), *The treatment of asylum seekers: tenth report*, HMSO: London Available online: [www.publications.parliament.uk](http://www.publications.parliament.uk)
- N. Kelley & Stevenson, 2006, *First do no harm: denying health care to people whose asylum claims have failed* Available online: [www.refugeecouncil.org.uk](http://www.refugeecouncil.org.uk)
- G. Lewis (ed), 2007, *The Confidential Enquiry into Maternity and Child Health (CEMACH) Savings Mothers' Lives: reviewing maternal deaths to make motherhood safer 2003-2005 The Seventh Report on Confidential Enquiries into Maternity Deaths in the United Kingdom*, London: CEMACH Available online: [www.cemach.org](http://www.cemach.org)
- Medact, 2007, *Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: impact on vulnerable migrant groups* Available online: [www.medact.org](http://www.medact.org)
- Medecins Du Monde, 2007, *Project London: Report 2006* Available online: [www.medecinsdumonde.org.uk](http://www.medecinsdumonde.org.uk)
- Medecins Sans Frontiers, 2006, *Experiences of Gomda in Sweden: Exclusions from health care for immigrants living without legal status* Available online: [www.lakareutangranser.se/gomda](http://www.lakareutangranser.se/gomda)
- National AIDS Trust, 2006, 'The treatment of asylum seekers: the National AIDS Trust submission to the Joint Committee on Human Rights' Available online: [www.nat.org.uk](http://www.nat.org.uk)
- National Health Service (NHS), 2004, *Implementing the Overseas Visitors Hospital Charging Regulations: Guidance for NHS Trust Hospitals in England*, COI: London Available online: [www.dh.gov.uk](http://www.dh.gov.uk)
- M. Redshaw, R. Rowe, C. Hockley, & P. Brocklehurst, *Recorded delivery: a national survey of women's experience of maternity care 2006*, National Perinatal Epidemiology Unit Available online: [www.npeu.ox.ac.uk](http://www.npeu.ox.ac.uk)
- Refugee Action, 2006, *The Destitution Trap: Asylum's untold story* Available online: [www.refugee-action.org.uk](http://www.refugee-action.org.uk)
- Southall Black Sisters & Women's Resource Centre, 2005, *How can I support her? Domestic violence, immigration and women with no recourse to public funds* Available online: [www.southallblacksisters.org.uk](http://www.southallblacksisters.org.uk)