

Money and Maternity: charging vulnerable pregnant women for NHS care

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Abstract:

Women not considered 'ordinarily resident' in the UK may be asked to pay for antenatal, birth and postnatal care. These women include refused (failed) asylum seekers, trafficked women and undocumented migrants. Charging practices also negatively impact on engagement with maternity services by other vulnerable migrant women.

Late booking and non-attendance for care are key risk factors for maternal mortality (Lewis 2007). Internationally, financial barriers to access are associated with late booking and non-attendance (Rowe and Garcia 2003) and recent evidence of their impact in the UK will be presented. Charging practices are likely to impact on initiatives to meet PSA targets to reduce inequalities in infant mortality and to increase attendance for booking appointment before 12 weeks gestation.

Practical strategies can promote access to maternity care for vulnerable migrant women. Project London provides basic health care and assistance to access NHS care. Maternity Action and Medact provide information and training to promote awareness of health care entitlements amongst health and community workers. At local level, maternity services can institute policies and practices that help minimise barriers to access. Health professionals are well-placed to participate in the debate about future directions for charging for healthcare.

1. Late booking and poor attendance

The Confidential Enquiry into Maternal and Child Health (CEMACH) has consistently identified suboptimal antenatal care as a major risk factor for maternal death. Women who booked after 22 weeks gestation, missed over four routine antenatal visits, who did not seek care or who concealed their pregnancy made up 17% of maternal deaths in the period 2003-2005 (Lewis 2007) and 20% in the period 2000-2002 (Lewis 2004).

In a 2006 survey of women with recent experience of maternity care, 96% reported that they had made a 'booking' appointment by 18 weeks gestation (Redshaw et al 2007). Data from NHS trusts indicates that the rate of suboptimal care is much higher than this study suggests. In 2007, the Department of Health estimated that around 16% of all pregnant women book after 20 weeks gestation (Department of Health 2007a).

Of the maternal deaths reviewed in the CEMACH report, those from Black and minority ethnic women and from socially excluded women were disproportionately likely to have involved suboptimal antenatal care. Suboptimal antenatal care was experienced by 35% of women who did not

speak English, 40% of Black African women, 57% of Black Caribbean women and 25% of Middle Eastern women, compared to 17% of White women (Lewis 2007). Suboptimal antenatal care was evident for 56% of single, unemployed women and 47% of women with partners where both were unemployed, compared to 5% of women with a partner where at least one was in employment (Lewis 2007).

A disproportionate number of the women who died were from vulnerable or more excluded groups. Refugee and asylum seeker women accounted for 26 of the 295 maternal deaths in 2003-05, or 12% (Lewis 2007). Women whose partner was unemployed were 7.4 times more likely to die than women whose partner was employed (Lewis 2007). Women from a number of Black and minority ethnic groups had significantly higher rates of maternal mortality with rates for Black African women 5.6 times higher than for White women and 2.9 times higher for Middle Eastern women (Lewis 2007).

The importance of women attending early for maternity care and maintaining regular contact is noted in the Department of Health National Service Framework for Children, Young People and Maternity Services (Department of Health 2004) and in National Institute of Clinical Excellence guidelines (National Institute for Clinical Excellence 2003). The Department of Health framework document, *Maternity Matters*, calls for local commissioners to investigate barriers to access which inhibit early booking (Department of Health 2007a)

The UK Government has prioritised action to reduce rates of suboptimal care. A 2007 Public Service Agreement indicator is the percentage of women who have booking appointments before 12 weeks gestation (HM Treasury 2007). The 2003 Public Service Agreement target of reducing inequalities in infant mortality also prompted action to increase the number of women making early contact with maternity services (Department of Health 2007).

2. Charging regulations

Historically, the NHS has been free at the point of delivery, however this principle has eroded over time. The introduction of charges is associated with claims that 'health tourists' are costing the NHS considerable sums (Bragg and Feldman 2008). A 'health tourist' is a person who has come to the UK for the specific purpose of obtaining healthcare. The Department of Health has not provided data on the extent of health tourism and has stated that this information is not collected in any systematic form (Bragg and Feldman 2008).

Individuals who are not considered to be 'ordinarily resident' are liable for charges for NHS secondary care under 2004 amendments to *The NHS (Charges to overseas visitors) Regulations* 1989. To be 'ordinarily resident', an individual must have a legal right to reside in the UK and they must be 'settled' in the UK. NHS guidance suggests that six months residence indicates that an individual is 'settled' in the UK however this figure is not fixed in law (NHS 2004). This is a complex text and a source of ongoing confusion.

Women who are not considered to be 'ordinarily resident' in the UK include

visa overstayers and trafficked women. It includes women who have entered the UK on a spouse visa and whose partner hasn't regularised their status and women who have entered the country on a work visa and have been unable to renew their visa under the new points-based system.

There is uncertainty about the entitlement of asylum seekers whose claim has been refused and who have exhausted the appeal process. These 'refused' asylum seekers were originally thought not to be 'ordinarily resident' however a 2008 court case concluded that they can also be ordinarily resident if they are 'settled' in the UK (Medact 2008a). This decision was reversed on appeal in March 2009 and a further appeal is in progress.

Many of the women affected by charging arrangements are vulnerable. Many have no right to work and no access to the benefits system. Some are at risk of deportation. For those who are in abusive relationships, there are few options for housing and support if they leave the relationship. These women are not 'health tourists' as they did not come to the UK for the purpose of accessing health services.

3. Impact of charging regulations on engagement with maternity services

There is evidence that the policy of charging for maternity care has the effect of deterring vulnerable migrant women from obtaining care. Many women are intimidated by the prospect of incurring a substantial debt which they have no capacity to repay (Medact 2006). Many have chosen not to receive care they cannot afford, and disappear from maternity services (Joint Committee on Human Rights 2007, Gaudion, McLeish & Homeyard 2007, Kelley & Stevenson 2006, Citizens Advice Bureau 2006). Some women are able to raise part of the sum but feel that they have no option but to discontinue the care when the money runs out (Project London 2007, Kelly & Stevenson 2006).

There is evidence of a lack of compliance with the policy which impacts on access to care. Compliance with the regulations varies across health services and between individual staff (Medact 2006). The Joint Committee on Human Rights inquiry into the treatment of asylum seekers 2006-7 concluded:

It is clear to us that there is considerable confusion. Pregnant women are denied, or fail to access, essential care as a result. The evidence shows that additional [Department of Health] guidance has not removed the confusion. (Joint Committee for Human Rights 2007)

The Refugee Council identified eight cases of women refused care unless payment was made in advance (Joint Committee on Human Rights 2007). The Refugee Council reported an instance of a pregnant woman who gave birth alone and unattended and was subsequently admitted to hospital with health problems relating to the traumatic birth (Kelly & Stevenson 2006). She had sought antenatal care on several occasions but her local NHS trust had refused care unless she could pay several thousand pounds in advance.

Project London reported several cases of women who were refused care unless they paid some or all of the charges in advance (Project London 2007). Medact has collected case studies of women refused maternity care without payment in advance, including a woman who attended hospital in labour (Medact, unpublished research). The National AIDS Trust has reported that pregnant women with HIV had been required to pay in advance of receiving care (National AIDS Trust 2006).

Advocates have reported difficulties in negotiating for individual women to obtain care in accordance with the regulations (Medact 2006). Advocates have reported unpleasant meetings and phone conversation, and lack of response to letters (Medact 2006). The consequence of difficult negotiations is substantial delays in women gaining access to antenatal care (Medact 2006).

The Department of Health has received reports of payment being pursued 'in such a way that women feel intimidated and unable to receive necessary maternity care' (Joint Committee on Human Rights 2007). Some women have experienced harassment from Overseas Visitor Managers and hospital finance departments when they were unable to pay for care (Medact 2006). This consisted of rudeness in meetings, repeated phonecalls which were aggressive in character, and threats to bring in debt collectors before the birth (Medact 2006). In some cases, the Overseas Visitor Manager rang the woman's general practitioner during the meeting and advised that the woman was not entitled to free care (Medact 2006). In addition, some women who were entitled to free NHS care were charged for care (Joint Committee on Human Rights 2007).

4. Proposals to extend charging to primary care

At the time of writing, the Home Office and Department of Health were undertaking a joint review of access to the NHS for foreign nationals. The review aims to make the rules governing access to primary medical care consistent with those governing access to secondary care (Joint Committee on Human Rights 2007a), which suggests that access to free NHS primary care services will be further restricted. The principles underpinning this review are not primarily about recovering costs from foreign nationals but about denying access to healthcare (Heath 2008).

Under current arrangements, there is no law preventing General Practitioners providing care to anyone, irrespective of their immigration status. General Practitioners have the discretion to provide care to anyone. This was confirmed in guidance issued by the British Medical Association in 2008. (BMA 2008: *Access to health care for asylum seekers and refused asylum seekers: guidance from the BMA's Medical Ethics Department*) Despite this, many PCTs are issuing guidance to restrict access to primary care and many GP practices are refusing to provide care to individuals with insecure immigration status.

Difficulties in accessing primary care impact on women's access to maternity care. 82.5% of pregnant women first seek maternity care from a General Practitioner. Fewer than 13% contact a midwife directly (Redshaw 2007).

There is some data available on barriers to accessing primary care and commencement of maternity care. Project London provides free clinics in London targeting migrants, the homeless and sex workers who are having difficulty in accessing healthcare. Project London worked with 118 pregnant women in 2006 and 2007, 68% of whom had not accessed care prior to coming to Project London. Nearly 25% of those attending were more than 18 weeks pregnant and had received no antenatal care.

The reasons given for not yet accessing antenatal care were varied and included:

- Care refused by professionals (including frontline administrative staff)
- Lack of knowledge about whether or not she would be entitled to access care
- A lack of knowledge about where to go to access care
- Administrative difficulties which prevented her registering with a GP or accessing antenatal care
- Fear of being deported which made her afraid of contact with health services
- Financial difficulties
- Not having tried to access care yet, or
- Wanting to terminate the pregnancy. (Project London 2007).

In 2008, Project London conducted research on access to General Practice for pregnant women. The unpublished research involved phonecalls to five General Practice surgeries in each of the 31 Primary Care Trusts in the Greater London area. The caller inquired about registration for a fictitious, pregnant woman who was 15 weeks pregnant and a visa overstayer. Only 6.5% of practices contacted agreed to register the woman and 56% of practices contacted refused to register the woman. 6.5% said that the decision would be at the General Practitioner's discretion, and the remainder asked the woman to complete the documentation before they would state whether or not they would register her.

5. Human rights issues

There are a number of human rights instruments which are relevant to charging for maternity care. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides that states must ensure the rights of access to health facilities, goods and services on a non-discriminatory basis. They must have special regard to vulnerable or marginalised groups. Under General Comment 14, States are obliged to refrain from denying or limiting equal access to minorities, asylum seekers and illegal immigrants to preventative, curative and palliative health services. They are also obliged to abstain from enforcing discriminatory practices as State policy and abstain from imposing discriminatory practice relating to women's health status and needs.

In 2007, the UK submitted their Fifth Periodic Report to the Committee on Economic, Social and Cultural Rights. The People's Health Movement (UK) prepared a parallel submission which comments on the UK Government report (PHM-UK 2009). The PHM submission states that the UK Government failed to acknowledge evidence of poorer maternity outcomes for women from ethnic minority and marginalised groups. It further states that the UK violates the ICESCR by failing to ensure the right of access to health facilities and services on a non-discriminatory basis with regard to vulnerable and marginalised pregnant women, in particular, asylum seekers and those with insecure immigration status. The submission recommends that the UK Government be asked to suspend charges for maternity care.

The European Social Charter addresses entitlement to healthcare. Part 1.11 states that everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable. Article 13 states that anyone without adequate resources has the right to social and medical assistance. The Council of Europe's Committee of Social Rights has the power to assess complaints under the Charter and make recommendations to states. The Council confirmed that:

Legislation or practice that denies entitlement to medical assistance to foreign nationals, with the territory of a State Party, even if they are there illegally, is contrary to the Charter.

Committee recommendations are not enforceable.

The European Convention on Human Rights states, at Article 3, that no one shall be subjected to torture or inhuman or degrading treatment or punishment. Article 14 further states that the enjoyment of the rights and freedoms set forth in the Convention shall be secured without discrimination on any grounds such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. There is no case law on the application of these articles to access to healthcare.

The Human Rights Act 1998 incorporates most of the human rights of the European Convention on Human Rights into UK law. All public authorities must act in a manner compatible with the rights contained in the Act. It incorporates into UK law the right not to be tortured or treated in an inhuman or degrading way (Article 3 ECHR) and the right not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention (Article 14 ECHR). In order to establish discrimination under Article 14, a woman would have to firstly establish breach of Article 3. There is no case law on this question.

The Department of Health document, *Human Rights in Healthcare: a framework for local action* (2008), explains the obligations of NHS organisations under the Human Rights Act when planning and delivering healthcare. It neglects to acknowledge the obligations of the UK Government under the Covenant on Economic, Social and Cultural Rights.

6. Practical strategies to improve access

There are a number of strategies which could be adopted by trusts to improve access to maternity services for vulnerable migrant women. These are:

- Ensure reception staff and clinicians in maternity services understand the regulations and guidance
- Ensure that reception staff and clinicians in GP practices understand the law and the scope for GP discretion
- Ensure that the Overseas Visitor Managers are subject to effective oversight
- Ensure pregnant women are seen by a midwife before referral to the Overseas Visitor Manager, and follow up if they do not return for a subsequent appointment
- Raise awareness within communities

References

R. Bragg and R. Feldman, 2008, 'An increasingly uncomfortable environment': Access to healthcare for documented and undocumented migrants in the UK', Migration and Social Protection Conference, University of Sussex, 5 November 2008

R. Bragg, 2008, 'Maternal deaths and vulnerable migrants', *The Lancet* 371:879-881

British Medical Association, 2002, *Asylum seekers: meeting their healthcare needs*. British Medical Association.

Citizens Advice Bureau, 2006, *Shaming destitution: NASS section 4 support for failed asylum seekers who are temporarily unable to leave the UK*, London: Citizens Advice

Department of Health, 2008, *Human rights in healthcare: a framework for local action*, London: Department of Health

Department of Health, 2007, *Review of the Health Inequalities Infant Mortality PSA target*, London: Department of Health

Department of Health, 2007a, *Maternity Matters: Choice, access and continuity of care in a safe service*, London: Department of Health

Department of Health, 2004, *National Service Framework for children, young people and maternity services, standard 11*, London: Department of Health

A. Gaudion, J. McLeish, C. Homeyard, 2007, 'Free care for the displaced?' *Midwives*, Vol. 10(3)

I. Heath, 2008, 'A modest thoughtfulness', *BMJ* vol 336:535

HM Treasury, 2007, *PSA Delivery Agreement 19: Ensure better care for all*, London: HMSO

Joint Committee on Human Rights, 2007, *The treatment of asylum seekers: Tenth report of session 2006-07*, London: The Stationery Office

Joint Committee on Human Rights, 2007a, *Government response to the Committee's tenth report of this session: the treatment of asylum seekers*, London: The Stationery Office

N. Kelly & J. Stevenson, 2006, *First do no harm: denying healthcare to people whose asylum claims have failed*, London: Oxfam and Refugee Council

Lewis, G. (ed) 2007, *The Confidential Enquiry into Maternity and Child Health (CEMACH) Saving Mother's Lives: reviewing maternal deaths to make*

motherhood safer 2003-2005. The seventh report on Confidential Enquiries into Maternal Deaths in the United Kingdom, London: CEMACH

Lewis, G, (ed) 2004, *Confidential Enquiry into Maternity and Child Health: Why Mothers Die 2000-2002. The sixth report of the Confidential Enquiries into Maternal Deaths in the United Kingdom*, London: RCOG

Medact, 2006, Submission to the Joint Committee on Human Rights inquiry into treatment of asylum seekers

Medact, 2007, *Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: impact on vulnerable migrant groups*, London: Medact

Medact, 2008, *Maternal and infant health of vulnerable migrants*, London: Medact

Medact, 2008a, *Maternity care and refused ('failed') asylum seekers: recent court case*, London: Medact

National AIDS Trust, 2006, 'The treatment of asylum seekers: National AIDS Trust submission to the Joint Committee on Human Rights'

National Health Service, (2004) 'Implementing the overseas visitors hospital charging regulations: Guidance for NHS trust hospitals in England,' (As amended 2007)

National Institute for Clinical Excellence, 2003, *Antenatal care: Routine care for the healthy pregnant woman: Clinical guideline 6*, London: National Institute of Clinical Excellence

PHM-UK, 2009, *Shadow submission on the right to the highest attainable standard of health in the United Kingdom for the ICESCR*

Available at: <http://www2.ohchr.org/english/bodies/cescr/cescrs42.htm>

Accessed 27.07.09

Project London, 2008, *Project London: Report and recommendations 2007*, London: Medecins du Monde

Project London, 2007, *Project London: Report 2006*, London: Medecins du Monde

M. Redshaw, R. Rowe, C. Hockley, P. Brocklehurst, (2007), *Recorded delivery: a national survey of women's experience of maternity care 2006*, Oxford: National Perinatal Epidemiology Unit

R.E. Rowe and J. Garcia, 2003, 'Social class, ethnicity and attendance for antenatal care in the United Kingdom: a systemic review', *Journal of Public Health Medicine* 25(2): 113-119