Improving access to maternity services for refugees and asylum seekers in Hackney

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Glossary of terms

Abbreviations

A&E  Accident and Emergency Department  
CEMACH  Confidential Enquiry into Maternal and Child Health  
CHiPCT  City and Hackney Teaching Primary Care Trust  
DH  Department of Health (UK)  
GLA  Greater London Authority  
GP  General Practitioner  
NASS  National Asylum Support Service  
NHS  National Health Service (UK)  
NICE  National Institute of Clinical Excellence  
NRF  Neighbourhood Renewal Fund  
PCT  Primary Care Trust  
R&AS  Refugees and Asylum Seekers  
UN  United Nations  
UNHCR  United Nations High Commissioner for Refugees

Asylum definitions

Asylum seeker: a person who seeks to gain recognition as a refugee, has submitted an application for protection under the 1951 United Nation Convention relating to the Status of Refugees, and the 1967 Protocol relating to the Status of Refugees and is waiting for their claim for asylum to be decided by the Home Office. This includes people who have made an initial application, or who have had an initial application refused and are awaiting an appeal or a decision from an appeal.

Refugee: Under the 1951 United Nation Convention relating to the Status of Refugees and the 1967 Protocol relating to the Status of Refugees, a refugee is a person who has fled or is unable to return to their home country due to a well-founded fear of being persecuted for reasons of: race, religion, nationality, membership of a particular social group, or political opinion. If an individual can demonstrate the above, their asylum claim will be accepted and they will be granted indefinite leave to remain.

Humanitarian protection (post 2002): If a person fails their asylum claim but can demonstrate, that if they return to their home country, they would face serious threat to themselves from the death penalty, unlawful killing, torture, inhumane or degrading treatment or punishment, they may be granted humanitarian protection, granted for three years.

Discretionary leave to remain (Post 2003): This is granted to individuals who claim asylum based on keeping their family united; on medical grounds or severe humanitarian reasons; or is an unaccompanied
asylum seeking child; or can demonstrate with compelling reasons why removal would be inappropriate. Granted for three years initially. Following review, may be granted for a further three years after which indefinite leave to remain may be granted.

**Exceptional leave to remain** (Pre 2003): Was granted to individuals who could demonstrate compelling compassionate or humanitarian reasons why they shouldn’t be removed from the UK. This was replaced by the Humanitarian Protection status and discretionary leave to remain in 2003. Granted for up to four years.

**Failed asylum seeker:** A person whose asylum application has been refused and who is deemed to have exhausted all available channels for appeal.

**Visa overstayer:** An individual who entered the UK on a valid visa (working, tourist or student visa) and has remained in the UK beyond the time limit of their visa. An individual who has overstayed their visa is not entitled to free services, right of employment or social supports.

**Uncertain immigration status:** An individual who has entered the country and whose immigration status is unknown. This may include individuals who have been trafficked or entered the UK without a visa or permission to do so.

**National Asylum Support Service (NASS):** A Home Office department set up to provide accommodation and/or financial support to destitute asylum seekers.

**Hard cases:** These are cases where an individual has failed their asylum claim, they were previously supported by NASS and are now destitute. Hard case individuals must be unable to leave the country due to a physical impediment to travel (e.g. illness, pregnancy); unable to leave because there is not a safe route for their return; or they are complying with obtaining their travel documents; or there are exceptional or compassionate circumstances; or have applied for a judicial review of their failed asylum claim and have permission to proceed. Hard cases are supported by NASS.
Throughout this document, unless otherwise stated, refugees and asylum seekers (R&AS) will include failed asylum seekers, visa overstayers and those with an uncertain immigration status, as several of the barriers to access to maternity care affect all groups similarly. However, there are special issues related to entitlement to free healthcare for failed asylum seekers, visa overstayers and those with uncertain immigration status, which affects their access to maternity care and will be discussed in the report.

It should also be noted, that despite the grouped classification of refugee and asylum seeker in this report, the author appreciates that vast differences, such as diverse cultural and language backgrounds, exist amongst this population group and that, as succinctly stated by Burnett and Fassil (2002):

"...refugees and asylum seekers are not a homogenous group and their healthcare needs cannot be generalised".

However, similarities related to access to healthcare do exist for this population group and for ease of presentation on this issue, they have been grouped together.

This review supports the report "Improving access to maternity services for refugees and asylum seeker in Hackney: Project Report", which outlines activities and results of the one year Refugee and Asylum Seeker Maternity Access Project. This review provided the necessary background upon which the project’s strategy and activities were developed. “Improving access to maternity services for refugees and asylum seeker in Hackney: Project Report” can be found on www.homerton.nhs.uk.
1. Summary

Access to maternity services for refugees and asylum seekers (R&AS) is an important issue in the UK. As a result of the government's long and complicated asylum process, many women may be missing out on accessing maternity services in a timely manner. The consequences of accessing maternity services late may not only have detrimental effects on the well-being of the mother and child, but it also puts undue stress on staff who must support women late in their pregnancy with possibly little or no background medical information.

The Refugee and Asylum Seeker Maternity Access Project, a year long pilot project, began in April 2006 to look at access to Homerton University Hospital's maternity services for R&AS. This document is a literature review looking at the issues that may affect women accessing services and to inform the development of a project plan. Information on the asylum process and entitlements to health services is outlined in this review and potentially provides a background to explaining some of the barriers to accessing maternity care in a timely manner.

It is difficult to quantify the problem of R&AS women accessing services late, as even basic demographic data on this population group is incredibly poor across the wide spectrum of possible data sets, both locally and nationally. There is very little possibility of determining the local R&AS population in Hackney, let alone, consider those who have failed their asylum claim, overstayed their visa or entered the UK without a valid visa.

Research indicates, in more general terms, the barriers to R&AS accessing mainstream maternity services. These include difficulty registering with a GP; lack of knowledge of their entitlements to healthcare and how to access maternity services; and a fear of deportation or lack of respect if they were to access services. At the same time, healthcare staff may consider R&AS health and social needs too complex and may not have knowledge about how to refer onto other services. Interpreter services may also not be developed to cater for this diverse, multilingual and multicultural population group.

Suggested good practice when increasing access to maternity services for R&AS is the development of appropriate resources and interpreter and advocacy services. Continuity of care is important to this group, who may be fearful of accessing mainstream services. The development of an outreach midwifery model of care is recommended and collaboration with local community groups may assist services to gain access to this often hard-to-reach population. However, for sustainability, cost-effectiveness and to possibly lessen segregation of this already often socially isolated group, it is important that refugees are assisted to access mainstream maternity services. This could be made possible after training and assistance is provided to mainstream maternity staff so they may know how best to support this particular population group.
2. Introduction

In 2005, local Neighbourhood Renewal Funding was obtained to conduct a scoping exercise to assess refugees and asylum seekers’ (R&AS) access to maternity services, what barriers may be affecting their access and recommendations for service delivery for Homerton’s maternity service that address these issues. Anecdotal evidence suggested that R&AS women were accessing maternity care late in pregnancy and that this may be contributing to health inequalities in what is considered a vulnerable population group. This exercise aims to help inform the current work being developed by Team Hackney to deliver on the House of Commons Health Committee (2003) public service agreement that:

"...by 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth".

This report outlines the results of a literature review conducted from April to June 2006 at Homerton to explore issues regarding access to maternity services for R&AS. It also provides general information regarding the asylum process and entitlements to free healthcare.

Access to maternity care throughout pregnancy and during the early postnatal period has been shown to have a significant effect on children's healthy development and resilience to health problems later in life (DH, 2004b), with a concomitant effect on infant mortality and life expectancy. Care of women during the antenatal period has been highlighted as particularly important for the building of trust and empowering individuals to make decisions about the welfare of their baby and themselves (Bentham, 2003). The National Service Framework for Maternity Services specifically outlines as one of its standards that:

"Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies" (p.4, DH, 2004).

The importance of easy access to maternity services was highlighted in the CEMACH enquiry into the deaths of women related to pregnancy (directly and indirectly) during the years 2000-2002. It noted that:

"Many women who died, particularly the vulnerable and socially excluded, found it difficult to access or maintain access with services, and follow-up for those who failed to attend was poor". (p.4, CEMACH, 2004).

Greater difficulties accessing maternity services have been noted in ethnic minority groups. City and Hackney Teaching Primary Care Trust reviewed infant deaths and still births in Hackney between 1999 and 2001 and stated that:

"Mothers from ethnic minority groups tend to use antenatal services less intensively" (CHTPCT, 2005).
Gasserud (2001) also states that unequal access to antenatal and midwifery care is a problem for women of an ethnic minority, and he goes further to say that R&AS women may be an even more vulnerable group of the ethnic minority population. The Greater London Authority's research into R&AS in London supports these comments stating that R&AS, as a whole, are:

"More insecure, vulnerable and socially excluded, arguably, than any other category of London's population except the street homeless" (p. 67, GLA, 2001).

There are many reasons for this high vulnerability amongst R&AS including huge changes and a lack of control over their lives affecting their mental and physical well being, as well as specific health affects related to their experiences in their home country and their travel to the UK (BMA, 2002; Jones & Gill, 1998). However, many of the health problems of R&AS have been linked to poverty and are therefore shared amongst other deprived and socially excluded groups (BMA, 2002) and that the health needs of R&AS have:

"more similarities than dissimilarities" in the "multi-ethnic population of Britain today…" (p. 47, Heptinstall et al, 2004).

In consideration of the above statements, is there a case for providing a bespoke maternity service for R&AS? What is the population of R&AS in Hackney? And what are the general barriers for R&AS in accessing maternity services and how might these barriers be overcome?

The purpose of this literature review is to provide staff at Homerton University Hospital, City and Hackney Teaching Primary Care Trust, and local community and voluntary organisations with a background to the issues related to R&AS accessing maternity care. This report:

- describes some of the pertinent definitions related to R&AS
- provides a short summary of the asylum process and healthcare entitlements
- presents R&AS demographics and data for the UK as a whole and locally in Hackney
- outline the main issues affecting R&AS’ access to maternity services
- provides recommendations for action to improve their access.

In particular, the review aims to increase knowledge and awareness amongst Homerton staff about the issues affecting R&AS and to provide a rationale for the recommended actions to improve access to the hospital’s maternity services for this population group.
3. Literature review methodology

The literature search was carried out through electronic databases of MEDLINE and CINAHL for the last 10 years using the following keywords: refugee; asylum seeker; maternity; access; hard-to-reach; and community engagement. Research papers, published journals and professional and non-professionally reviewed papers were examined for the literature review, which included literature based on data analysis from a wide range of data sets, at national and local levels, focus group research and qualitative research. The review also included national health frameworks, guidelines, and policies obtained via the internet from relevant sites. Also unpublished data and personal correspondences via face-to-face interviews were used to provide an overall picture of the current situation.

4. The asylum process

The asylum process in the United Kingdom (UK) is currently a long, complicated and often confusing process, not only for those seeking asylum but also for individuals caring for R&AS. Multiple changes to the legislation relating to the asylum process over the past few years only serves to increase the amount of confusion for those health staff who may be in direct contact with R&AS, but who may have limited knowledge of the legal framework or the process for obtaining refugee status that asylum seekers must go through. Likewise, the media may also contribute to the confusion; often sensationalised reporting that often bears limited resemblance to the main issues facing the majority of R&AS each day.

Dumper (2005) outlines the three pieces of legislation that an asylum claim is assessed against:

1) **1951 UN Convention Relating to the Status of Refugees and the Protocol Relating to the Status of Refugees 1967 (Refugee Convention)** defines someone with a well-founded fear of persecution for reasons of race, religion, nationality, membership to a particular group or political opinion.

2) **The Asylum and Immigration Act 2004** and its associated statutory instruments, guidelines and instructions.

3) **Human Rights Act 1998** implements the **Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (European Convention on Human Rights)**. This ensures that all decision made by immigrant officers comply with the Human Rights Act.

Figure 1 is a simplified version of the process for individuals who enter the UK and claim asylum:
On entry into the UK, a person claims asylum by completing an asylum application. They are then known as an asylum seeker. If their application for refugee status is returned positive they are considered a refugee. If a person’s initial application for refugee status is rejected, they may appeal the decision. If following the appeal process their claim is again rejected and all avenues of appeal are exhausted, then the individual is a failed asylum seeker.

The “target” time frames for providing results for applications submitted have been outlined by the Home Office with the development of a policy for managing immigration and asylum claims. The aim is to increase...
the processing speed from 22 months to 2 months for 80% of initial decisions (Home Office, 2005).

Another, and rather controversial, recent change states that asylum seekers given a positive decision on their asylum claim and thus given refugee status will be granted temporary leave rather than a permanent status (which they were previously given). A grant of permanent residency status will be given if the situation in the individual’s country of origin has not improved within five years (Home Office, 2005). This does not affect the individual’s rights to access free healthcare, however, it does greatly impact on their ability to integrate into society when there is continued doubt for a further five years as to whether or not they will be granted permanent status.

**NASS support process and dispersal**

When an asylum seeker claims asylum they have the option to obtain their own accommodation and to financially support themselves, or they may apply for accommodation and/or financial support from the National Asylum Support Service (NASS). This Home Office department, set up in April 2000, assesses applications for NASS support from asylum seekers who are destitute (GLA, 2004).

Under Section 55 of the National, Immigration and Asylum Act 1999, asylum seekers are expected to claim for NASS support as soon as reasonably practicable (often considered within three days of arrival) otherwise the Secretary of State is able to refuse to provide or to arrange for the provision of support to an individual (GLA, 2004). However, in 2005 this was overturned by the House of Lords on a Human Rights basis (House of Lords, 2005) and there is no time limit when a claim should be lodged. Entitlement for support is assessed by NASS and should take no longer than seven days, during which time the claimant may be housed in emergency accommodation.

At the end of September 2003 there were 3,804 asylum seekers living in emergency accommodation in London (GLA, 2004). Table A outlines the weekly subsistence allowance provided to each individual currently collecting NASS support. The approximate amount of £40 per week is not a large sum of money upon which to live, particularly in London.
If an asylum seeker is considered destitute and is assessed as eligible for receiving accommodation, they are “dispersed” and provided accommodation in dispersal areas. Dispersal was introduced in 2000 to alleviate the burden of new arrivals for local authorities in the south-east of the UK as, according to Heptinstall et al (2004), until the late 1990s, most new asylum seekers settled in Greater London. Under the dispersal system, all asylum seekers with no specific reason to stay in London or the south-east will be dispersed.

The areas of the UK with the greatest number of people being supported with accommodation by NASS in the first three months of 2006 (in descending order) were: Yorkshire and the Humber; North West; Wales; West Midlands; North East; Wales; East Midlands (Home Office, 2006). If an individual voluntarily leaves their dispersal accommodation they forfeit the support they received from NASS.

Burnett and Peel (2001) state the possible dilemma this situation may cause by stating:

“…many asylum seekers will leave the outlying areas to which they have been sent to come to London, where there are established support networks, thereby being removed from the asylum support system and adding to the number of destitute people in the capital” (p. 487).

Appendix A outlines an individual’s eligibility for NASS support during the various stages of their asylum process.

One of the important issues to consider for asylum seekers is their right to obtain employment. It is only once an asylum seeker gains refugee status (temporary or permanent) that they are then entitled to seek employment, or if their asylum claim takes longer than one year. This lack of ability to earn money has great bearing on not only their ability to improve their financial situation, but also on their mental well being, potential sense of isolation, independence on a day-to-day basis and their integration into society.
5. Refugee and asylum seeker demographics

Currently there is very limited data available at national, regional and local levels on the R&AS population in the UK; and for more specific groups there is no data at all (e.g. for failed asylum seekers and people who overstay their visas, let alone specific data on R&AS women of child bearing age). This issue has been described by various studies where:

“...The scarcity of accurate figures on the numbers of asylum seekers and refugees was noted as a serious impediment to the research process” (ICAR, 2003, p. 7).

In 2001, the GLA stated that there was no possible way to estimate the demographic make-up of London’s cumulative R&AS population (GLA, 2001).

With the introduction of the dispersal system for those on NASS accommodation support in 2000, it was anticipated that absolute figures of new arrival into London would decrease, but as cited by several researchers, many asylum seekers leave their dispersal areas, which are often not equipped to support the diversity of languages and cultures of new arrivals, and move back to their cultural and ethnic communities, which are often broadly based in London (Burnett & Peel, 2001; Heptinstall et al, 2004).

A review of the available data on R&AS shows new asylum requests in the UK fell during 2005 by 25%, compared to the previous year, to a total of 30,500 applications; and fell by 50% compared to 2003, this from a high of 103,100 applications in 2002 (UNHCR, 2006). This is possibly due to several changes in UK immigration laws in the last five to six years. Despite this, the UK remained the third largest asylum-seeker receiving country in 2005, accounting for 9% of all asylum requests in the industrialised world (UNHCR, 2006). To consider the UK figures against the global picture, at the start of 2003, UNHCR were responsible for approximately 20.6 million people across the globe, of which 10.4 million were refugees, 1 million were asylum seekers, 2.4 million were returned refugees and over 6.5 million were internally displaced or stateless persons (UNHCR, 2003). Most people claiming asylum seek it in nearby countries, with the majority of refugees in Africa and Asia (UNHCR, 2001).

Home Office figures for the first quarter of 2006 (January to March) showed 8% fewer applications for asylum in the UK compared to the same quarter in 2005 (Home Office, 2006). The top five nationalities claiming asylum in the first quarter of 2006 were, in descending order: Zimbabwean; Eritrean; Iranian; Somali; Afghani (Home Office, 2006).

The population of asylum seekers on entry into the UK is quite young. In 2005, 83% of asylum applicants were less than 35 years of age and 29% of principal applicants were female. Over three-quarters of both male and female applicants were less than 35 years of age which is similar to 2003 and 2004 figures (Heath et al, 2006). The average age of those entering the UK as asylum seekers is less than the average age of the UK
population, so you would expect them to use the health service less, particularly as it is thought that the general physical health status of asylum seekers on arrival is not particularly poor (Aldous et al., 1999). However, of relevance to maternity services is the proportion of asylum seeker women who would be of childbearing age and the potential use of maternity services.

Despite a lack of systematic collection and tracking of movement of R&AS, estimates have been made regarding possible population numbers in London. The Greater London Authority (GLA) estimated that from 250,000 asylum applications nationally between 1996 to 2000, 217,000 applicants would have opted to live in London based on the Home Office estimation that 85% of asylum applicants live in the capital (GLA, 2001). The GLA surmised that R&AS make up approximately 5% of the resident population in London (GLA, 2001). The GLA in 2004 estimated 47,000 asylum seekers were living in publicly funded temporary accommodation in London and that approximately half of these are likely to be accepted as refugees and go on to become long-term residents in the UK (GLA, 2004).

Bardsley and Storkey (2000), when finding no routine data source at the local level, set up a calculation methodology using national level data and various other data sets. They estimated that in 2000, measured using figures since 1983, the estimated number of R&AS in Hackney was approximately 14,200 to 16,500 equating to 74-86 R&AS per 1000 residents. Assumptions used on the data sets were that 25-50% of failed asylum seekers left the country and that those given successful asylum in the preceding 15 years did not die or leave the UK. Their figures did not account for any illegal immigrants (e.g. visa overstayers) and those who entered the country without a valid visa and did not claim asylum.

At the end of March 2006, 48,190 people in the UK received NASS support. 405 of these people (applicants and dependants) were living in Hackney and were receiving subsistence-only support and 35 were living in Hackney with accommodation support (Home Office, 2006). This compared to 865 and 690 people receiving subsistence only support in Newham and Ealing, respectively, and 350 and 220 people receiving accommodation support from NASS in Harringey and Enfield, respectively, in 2005 (Home Office, 2006). These figures are generally similar to those found in the London Asylum Seeker Consortium datasets, which state that in March 2006 there were 398 individuals (adults and their dependents) in receipt of subsistence-only support from NASS in Hackney (LASC, 2006). However, these figures only indicate those on official support through NASS and does not account for those asylum seekers who did not accept NASS support or those who were dispersed and decided to move to London and thus forfeit their NASS support. Also, these figures give no indication of the numbers of people with overstayed visas or those who entered the country without a valid visa.
6. Entitlements to healthcare

The DH and Refugee Council (2003) produced a document called “Caring for Dispersed Asylum Seekers: A Resource Pack”. It outlines the entitlements for primary and secondary healthcare for individuals through the various stages of their asylum process. Appendix B provides a web address for this information (correct as of March 2006) in a table format (DH, 2006).

In general, an asylum seeker with a current claim for asylum (including during the appeal process) and those given a positive claim for refugee status are eligible for free NHS primary and secondary care. For individuals with a failed asylum claim they are not generally considered eligible for free NHS care. The DH has stated that failed asylum seekers should not be registered for primary care, however, it is at the discretion of the GP practice if they wish to register the person or not. Secondary care is generally considered chargeable for failed asylum seekers, except for treatment commenced prior to the final decision regarding their asylum claim. All emergency and immediately necessary treatment (including maternity care) should be given without delay in both primary and secondary care settings and should be provided free at the primary care level.

The DH advises hospital trusts to actively pursue payment of secondary care treatment given to failed asylum seekers (DH, 2006). However, the DH and Refugee Council (2003) document does state that failed asylum seekers are chargeable for secondary hospital treatment from the date their asylum claim failed unless they have been in the UK for more than 12 months (whereby a 12 months residency exemption comes into effect).

The DH document “Implementing the Overseas Visitors Hospital Charging Regulations” (DH, 2004a) provides guidance to frontline staff about how to determine an individuals’ eligibility to free NHS treatment by asking the following questions:

1. Where have you lived for the last 12 months? followed by:
2. Can you show you have the right to live here?

If the patient has not lived in the UK for 12 months or there is any doubt, the staff member should refer the patient to the overseas visitor team (known as the patient initiatives officer at Homerton) for further questioning and investigation.

The DH and Refugee Council (2003) provide further advice for R&AS stating that if an individual has any difficulties registering with a GP they should contact their local primary care trust for assistance. The document also states that if an asylum seeker is not supported by NASS, they should fill out a HC1 form which provides them assistance with health costs under the NHS Low Income Scheme. Finally, the DH and Refugee Council (2003) outlines additional payments a pregnant woman may receive. She may receive an additional payment of £3 towards health foods and may apply for a maternity payment of £300. Then from 0-1 year of age of her child, she receives an additional £5 payment.
Dumper (2005) describes changes in legislation on 1 April 2004 when Statutory Instrument Number 614 was implemented stating those not “lawfully resident” in the UK were liable for NHS charges. This created confusion about ‘entitlements’ with those that fit the legal criteria being denied treatment. For example, pregnant women at the end of their asylum process may end up being charged in advance of delivery which is against the guidance.

Hull and Boomla (2006) state that the consequences of restricting access to secondary care hasn’t been properly scrutinised by the government, but concerns have been raised about how maternity care is affected. There are several proposed consequences of denying free care to individuals including reluctance to obtain care for minor ailments, which may develop into a more serious condition, which may then lead to greater use of A&E or highly specialised units. This scenario could be much more expensive than if a health promotion and prevention approach were able to be pursued. Naaz Coker, Chair of the Refugee Council and of St Georges Healthcare NHS Trust, succinctly stated:

"...current procedures might well give the message that some people were not welcome.” (p. 6)
(Refugee Council, 2005)

This may lead to greater health inequity amongst the population.

7. Barriers to access to maternity services for refugees and asylum seekers

Easy access to maternity services is noted as one of the Standards in the National Service Framework for Maternity Services (DH, 2004b). However, for many women from minority groups, a review of evidence suggests they have poorer access to maternity care (D’Souza, 2003). R&AS have been described as some of the most vulnerable women in society (McLeish, 2002) making up a very “hard-to-reach” minority group. Doherty et al (2004) describes hard-to-reach groups in three categories:

- Minority groups traditionally under-represented groups, marginalised, disadvantaged or socially exclude
- Slipping through the net invisible or those 'unable to articulate their needs', includes those who fall outside statutory or usual remit
- Services resistant unwilling to engage, those suspicious, over targeted, or disaffected.

It would be possible to say that R&AS fit into all three categories in various ways. They often fall within minority groups who are particularly marginalised and socially excluded, often accentuated by unfavourable or biased media reports. R&AS often have language difficulties and as such have difficulty expressing their needs. At the same time they may be concerned about accessing services due to fear of reprisal on their asylum claim and therefore do not actively pursue access to services.

Of the greatest concern, for those probably classed as the most hard-to-reach, would be those not entitled to services. These would include those who have overstayed their visas, who have failed their asylum claim and all appeals, and those who have entered the UK without a visa, including those people trafficked into the country. Without any legal right to access free services, and with possibly the least access to available finances, they may be considered the most vulnerable sub-group of all the marginalised groups in our society. The financial and legal implications of this group accessing care is beyond the outline of this report, but it should be noted that based on anecdotal evidence from midwives, they are a very real user group of maternity services at Homerton and consideration should be given regarding their access to maternity services.

**Late bookers**

Time of booking for antenatal care is seen as a good indicator of a woman’s accessibility to maternity services. Early antenatal care is considered an important part in the provision of a comprehensive maternity service and is vital in providing education to a woman about her pregnancy and the scanning and monitoring of various conditions for both the mother and the baby.

The 2000-2002 Confidential Enquiry into Maternal and Child Health found that 20% of women who had died from direct or indirect causes, booked for maternity care after 22 weeks gestation and had missed over four routine antenatal visits (CEMACH, 2004). The National Service Framework for Maternity Services states that women living in disadvantaged or minority groups and communities are significantly less likely to access services early or maintain contact throughout their pregnancies (DH, 2004b). The 1997-1999 Confidential Enquiries into Maternal Deaths found that women from ethnic minority groups were twice as likely to book later than 20 weeks than white women (CEMD, 2001).

Rowe and Garcia (2003) reviewed four studies reporting on antenatal attendance and ethnicity for women with low incomes. They found that women of Asian origin were more likely to book late for antenatal care than White British women.

Although much data is anecdotal, several studies have been conducted to determine the level of late booking amongst R&AS. In 2001 City University sent a postal survey to 33 maternity units in the London region (Macfarlane, 2005). With all 33 units responding, it was suggested by respondents that:

> “women who are refugees and asylum seekers are disproportionately represented within unbooked births” (p.42, Macfarlane, 2005).
An Irish study by Kennedy and Murphy-Lawless (2001) showed nearly two-thirds of R&AS women had their first antenatal appointment at 22 weeks+ gestation. They explained that many of these women were in their second or third trimester when they arrived into the country. A study of refugees in Dublin found the average time of booking was 33 weeks gestation (Lalchandani, 2001). And Ukoko (2005) describes the setting up of an onsite antenatal service for pregnant asylum seekers (set up in 2003) with a dedicated Sure Start midwife. She states of the total number of 29 bookings between March and September 2003, 65% booked late with the average gestation of 24 weeks at time of booking.

**Barriers to accessing maternity services**

There has been a great deal of research conducted reviewing access to maternity services for R&AS in the UK. This has predominately concentrated on the barriers to access of which are outlined in Figure 2. These barriers include those issues related to R&AS women not accessing services themselves, due to reasons such as lack of knowledge or awareness about available services or fear of deportation, but equally maternity services may present barriers which prevent a women feeling able to access services, for example, lack of appropriate interpreting services or lack of understanding of R&AS specific health needs.

**Figure 2: Barriers for R&AS women accessing maternity services**

- Don’t know entitlements to services
- Are not aware of services
- Don’t know how to access services
- Fearful to access services (e.g. fear of deportation or lack of respect and prejudice)
- Cannot get registered with a GP
- Lack of one-to-one care and poor continuity of care (poor relationship development and trust building)

* R&AS = Refugees and Asylum Seekers
Cultural influences
As complex and diverse as the nationalities are that make up the R&AS population in the UK, so are the cultural reasons why some R&AS do not access maternity services early in pregnancy, and possibly for some, do not access services at all. As stated by the BMA (2002):

“The most important barriers to healthcare are language and cultural differences“ (p. 11).

For some women, the Western model of maternity care may be quite unfamiliar, particularly for attending antenatal care, and that:

“prevention medicine and individual health promotion are new concepts to some migrant communities” (p. 22, Maharaj et al, 1996).

Cultural background and societal influences have a major impact on whether women access maternity services early or late. According to research conducted by Dartnall et al (2005) there did not appear to be a typical time when asylum seekers accessed maternity services, but that there did seem to be an influence from their cultural beliefs. The research found that most Asian and Somali women engaged with services by mid-stage pregnancy. Those with westernised values accessed when their first scan was due (approximately at three months), and those with traditional beliefs accessing by scan two because the women saw it as fatalistic to go to a doctor early when there was no apparent reason to do so.

For some women, practices in their home country may influence them utilising services early. In 2001, McLeish (2002) interviewed 25 asylum seekers and 8 refugees and found:

“For some women, antenatal care was in great contrast to the little or nothing available in their home countries” (p. 35).

As such, antenatal care may be a foreign concept and unless they are informed of its existence, they would not seek out their closest antenatal clinic.

Another cultural issue may be related to the rigidity of time for maternity appointments. As expressed by the DH and Refugee Council (2003), some asylum seekers may not have experience of making appointments to see a doctor and are more familiar with a ‘walk-in’ type service. As such, they may feel hesitant to make an appointment or have difficulty doing so.

And finally, some cultures may not have experience of non-hospital based health services provided by health professionals who are not medical practitioners. As such, they may feel being attended by a midwife as a strange experience. Alternatively, some community groups may be used to local health workers in their home country and would be very accepting of midwives and their role.
Communication and interpretation

Language is considered a crucial aspect in the delivery of health care and is possibly the major issue affecting access to maternity services for R&AS women. Ali and Burchett (2004) in their small scale qualitative research study explored Muslim women’s experience of maternity services. Health professionals who participated in the focus groups identified communication as the most important barrier to providing effective maternity care. In research conducted in an east Kent asylum seeker midwifery team by Harris et al (2006), it was found that 70% of the asylum seeking caseload did not speak English as a first language. Gammell et al (1993) found that:

“Female asylum seekers are less likely than males to speak English or to be literate” (p.8).

However, it appears a common theme that interpreter services are required but that there they are limited in some areas. Johnson (2003) studied healthcare provision for asylum seekers in dispersal areas under NASS and found there to be a lack of interpreters, particularly those who are medically trained. The Confidential Enquiry into Maternal and Child Health (The Sixth Report) noted:

“Inadequate translation services for those who could not speak English was…a recurring theme” (p.4, CEMACH, 2004).


Often families or friends are used as substitutes to professionally trained interpreters. This is not recommended due to possible breaches of confidentiality and of the possibility that women may not disclose pertinent information in front of their family or friends, as well as incorrect information being translated regarding medical needs and treatment (CEMD, 2001). The use of children as interpreters has been highlighted as a particular concern due to the content of information being discussed when a woman attends maternity services, including sensitive situations which a woman may have experienced, e.g. rape or torture. Gaaserud (2001), in his review of maternity services for newly arrived R&AS women in Hackney, found:

“All health providers felt it was inappropriate to ask men or children in a woman’s family to translate, however sometimes they are left no option” (p.20).

He also found that the availability of advocates was:

“…specifically problematic for the midwives because of difficulty with scheduling” (p.21. Gaaserud, 2001).

Overall, language and access to translated information is considered one of the most important issues in ensuring good access to services for the diverse multilingual population of R&AS. As Le Feuvre (2005) states:
“Unless you have access to a good interpreter service, your patient does not have access to medical care”.

Staff knowledge and attitudes
Staff attitudes play a major role in women accessing maternity services. R&AS women have reported experiencing, racism leading to underlying fear and suspicion amongst this group (Collard, 2005), and discrimination and negative attitudes all of which may make R&AS women reluctant to access a particular maternity service again or only when absolutely necessary (i.e. for delivery of their baby). Much of this may lie with a lack of knowledge and understanding amongst health staff of the specific situations and issues experienced by R&AS. Also of great influence is the often distorted and sensationalised news regarding R&AS, which currently features prominently in popular media. It is only natural that such news would influence the public’s perception of R&AS. However it highlights a need to dispel distorted or biased information.

The Greater London Authority and the Refugee Council noted that NHS health professional staff lacked knowledge and understanding of refugee issues (GLA, 2001) and more specifically lacked knowledge about other services and supports which could help asylum seekers (Levenson & Sharma, 1999). The asylum process system is quite complex and with multiple changes in legislation in the past few years, it requires constant updating for staff. It is therefore not surprising that staff find the legal status of asylum seekers as variable, complex and confusing (Johnson, 2003) and there is a level of uncertainty amongst health professionals about the rights of particular groups (including asylum seekers) to access health care in the UK (Barer et al, 2004).

Burnett and Peel (2001) describe the difficulties facing health workers when working with R&AS and state that R&AS have been seen as time demanding. Health workers have cited language difficulties, lack of understanding of cultures, and lack of expertise and knowledge about issues outside of health (e.g. housing, welfare, and immigration issues) as reasons for more time required to work with R&AS. Despite the enormous value to the woman and the staff member in providing more time for translations and connecting women to appropriate social service or other agencies, health workers may have limited time to do this in their. Further research is necessary to determine the knowledge and attitudes of staff at Homerton’s maternity services, regarding R&AS. However, anecdotally, evidence suggests it would appear useful for staff to be regularly updated on issues regarding this population groups and to dispel common misconceptions.

Recouping money for healthcare
There has recently been much debate about what groups are entitled to free NHS services and the recouping of money for those who are not entitled. The Department of Health (2004a) has issued guidance to NHS trusts as to how to recover money from those not entitled to free NHS services. Unfortunately, it is most likely that women who have overstayed their visas, or are failed asylum seekers, will be most affected by this policy. These women are probably least likely to be able to afford to pay for maternity services and when served with
a letter outlining the charges that have been incurred by their use of maternity services, it is highly likely they will be reluctant to attend maternity services again. As news spreads amongst communities about hospitals recouping money for health services provided, misinformation may also spread and confusion within communities about who has access to care and who must pay for care may occur. This is potentially a large barrier to encouraging women to access maternity services early and appears contradictory to the DH’s National Service Framework’s maternity standard to provide easy access to maternity services.

**General practitioner registration**

Registering with a General Practitioner (GP) was often cited in the literature as a major difficulty for R&AS. Registration with a GP is considered important to enable access to a range of NHS services. According to a study conducted in Islington, 48% of refugees encountered problems registering with a GP (Islington Refugee Working Party, 1992). The Greater London Authority also noted the difficulty this population group has in registering with a GP (GLA, 2001) and Collard (2005) found R&AS seekers had difficulties accessing healthcare (particularly registering with a GP) in the Hackney area.

The 2004 Health in London Report found that closed GP waiting lists are a problem for highly mobile and vulnerable groups (Barer et al, 2004), as R&AS are often described. It has been found that GPs are reluctant to register an individual if they are to move in a short period of time, which can often be the case when asylum seekers are moved from place to place by NASS (Johnson, 2003). GPs may also be reluctant to register R&AS due to perceived or real increased costs in caring for this population group (e.g. cost of interpreter fees, additional time to deal with social issues) (Jones & Gill, 1998; Johnson, 2003). Dumper (2005) reviewed evidence that indicates GP receptionists deny R&AS access to care because they think they are not entitled to primary care.

Under the current guidance by the DH, all R&AS with a valid and current claim (including during appeals) are eligible for free primary care and it is at the discretion of the GP if they will register failed asylum seekers, visa overstayers or those with no known status. In effect, unless a GP practice has been formally closed from registering new people via the local PCT protocol, the GP cannot refuse to register a R&AS who has a current asylum claim and who fills the general local criteria for registration (e.g. location of residence etc) for the GP surgery (Jugdeese, 2006).

**R&AS knowledge regarding health services**

An important issue related to the access of health services, is the R&AS’ knowledge about how to access such services. The Greater London Authority found in 2001, that R&AS had a lack of familiarity with the UK health services (GLA, 2001).

This is hardly surprising for new arrivals entering a foreign country and health system, but the paper did not go into detail about those individuals who had resided in the UK for some time (either because they have had a prolonged asylum claim or had been given refugee status). It is of concern that both groups would lack
information about health services available to them, but the reasons for the lack of knowledge may be vastly
different. For example, a recently arrived asylum seeker may not have been given appropriate information
about local services at the time they claimed asylum or may not have support locally to be given such
information. Such issues may be easily rectified by ensuring information is easily at hand and assistance given
to access care. However, for long-term asylum seekers or those given refugee status, the reasons behind
their lack of knowledge in how to access healthcare may be more complex and may relate to such issues as
isolation and possibly segregation from the general local community, with a concomitant lack of local support,
or because of continued language difficulties and the inability to search and obtain local information.

The GLA found that there was limited translated information for such issues as confidentiality and entitlements
to treatment (GLA, 2001). This may lead R&AS to think that information about their health will be given to
those assessing their asylum claim and may jeopardise their chances of a successful asylum claim. Dartnall et
al (2005) found that usage of health services by asylum seekers was limited and infrequent mainly because
they were unaware that they were eligible or thought they had to pay. If R&AS do not believe they are entitled
to health services, they may not actively search for information about locally available health services, thus
contributing to their lack of knowledge about health services. BMA (2002) found asylum seekers had difficulty
finding information on health services and knowing the correct forms to fill. For example the HC2 Certificate
may exempt individuals from charges for healthcare, however the form is lengthy and only available in English
and Welsh. If an individual does not have support from individuals or local groups, they may find such forms
impossible to complete.

Francoise (2004) found that newly arrived asylum seekers who were seen by the Croydon Homeless Health
Team, stated they had difficulties accessing health services. Of interest in this research was that staff often felt
that R&AS used health services inappropriately. For example, R&AS may use A&E for issues that may be
better dealt with in the community or where services have been specifically set up for such health issues.
Newly-arrived asylum seekers may not have been appropriately briefed about how to use health services in
the UK on their arrival and may utilise services which are more familiar to them from their own country (e.g. a
centralised hospital unit for addressing all health issues).

Specific research regarding asylum seekers’ maternity experiences in the UK conducted by McLeish (2002)
found many of the women interviewed were unaware of the existence of support projects and children’s
facilities, local sources of charity, social services support, the Maternity Grant or how to access health services
and advocacy support. McLeish (2002) eloquently states that the likelihood is that many women and babies
will remain in the country and then the NHS and education systems will have to deal with potentially
preventable ill-health and disability as a result of poor access to maternity services and health services in
general. It is in the best interest of the NHS, other statutory services and voluntary groups, as well as the UK
public as a whole, to ensure all people who are entitled to services are well informed about them to not only
prevent unnecessary illness, but so that there is appropriate use of limited resources and services.
8. Good practice to facilitate refugees and asylum seekers to access maternity services

Much of the research into access to maternity services for R&AS has concentrated on the barriers to their access. There is, however, some literature on good models of care for working with hard-to-reach groups and, more specifically, some examples of services set up for improving access to maternity care for R&AS.

Doherty et al (2004) in their research about how to engage hard-to-reach groups, categorises them into three groups and describes the different methods for engagement:

- Minority groups
  - identify factors why service is inaccessible
  - meet population needs
  - address barriers to access (incl. travel, language)

- Slipping through the net
  - develop new target strategies within existing system of service delivery
  - focus on groups unable to express their needs because their views were not previously sought
  - address lack of information provided to specific groups

- Service resistant
  - address previous negative experiences by service users
  - review difference of opinion between providers and services users.

Unfortunately, these methods require a good grasp of the demographics of a population so that they can be appropriately consulted on such things as their specific needs or that engagement can be centred on those whose views have not previously been examined. As outlined earlier in this report, lack of demographic data is a major drawback to ensuring equitable access to services and as stated by Gaaserud (2001) in his research on access to maternity services for R&AS in Hackney:

“Improved data is needed to assess and quantify the prevalence of need for maternity services by newly arrived refugees & asylum seekers”,

as well as those who have been here for some time:

“To aid planning and resource allocation” (p. 18, Gaaserud, 2001).

The National Service Framework for Maternity Services (DH, 2004b) suggests that all NHS maternity care providers and PCTs should improve access for disadvantaged and minority groups by determining the barriers
Improving access to maternity services for refugees and asylum seekers in Hackney

Literature review

Knowing the basic profile of the target population in regards to ethnic background, location of residence, language spoken etc, and setting up a systematic, coordinated and comprehensive approach to data collection across various agencies is the first step.

Appropriate information resources are seen as essential in increasing the profile of maternity services amongst R&AS so as to encourage this population to access such services in a timely manner. However, with the extensive diversity of the R&AS population in relation to culture, language, and previous experience with health systems in their home country and in the UK, it is difficult to identify and develop the most appropriate resource type for R&AS as a whole. Maharaj et al (1996) in their community consultative meetings for HIV prevention found:

"Refugees would not be bothered to read leaflet after leaflet but would listen to music, get involved in drama, comedy and other cultural events" (p.55).

One example included gathering people based on an interest, such as a sewing group or around food, and incorporate health training and information delivery as a secondary piece of information. Once again, the type of resource is very much dependent on literacy, language and culturally acceptable media and it may be necessary to use a range of resources to ensure as best coverage as possible. One popular method of spreading information is through word of mouth which, according to Dartnall et al (2005):

"...is the most common way of passing on information" (p.51).

For a mobile group, as asylum seekers are thought to be, it may be difficult to gather enough women in the same area to ensure a viable flow of word of mouth information. The so called “critical mass” for the effective delivery of word of mouth information may not be large enough amongst asylum seekers. As such, utilisation of local organisations and community groups may be the best method of spreading information about maternity services.

It has been found by Gaaserud (2001) when researching R&AS access to maternity services in Hackney, that health staff stated they would find it helpful to have clear referral pathways to appropriate organisations for issues not related to health matters (e.g. housing or financial issues). Simple guidelines and contact details of appropriate statutory, voluntary and community based groups would ease much of the anxiety for staff when faced with an individual for whom staff do not know how to assist.

Development of interpreter and advocacy services are seen as key in improving access to maternity services for R&AS. Of particular note is the recommendation for developing a service such that the same interpreter is used for the same patient (BMA, 2002). It is thought that this will assist in building trust amongst a group that
may be reluctant to access services in the first place. Bentham (2003) concurs with this view in relation to continuity of care for midwives saying:

“For an asylum seeker, the fewer midwives involved in her antenatal care the better” (p.76).

The recommendation of continuity of care is reiterated as a standard in the National Service Framework for maternity services (DH, 2004b), in the NICE Antenatal Guidelines (NICE, 2003), by the House of Commons Health Committee (2003) and by the DH and Refugee Council (2003) in their resource pack about caring for dispersed asylum seekers.

An outreach model of care and development of community based services has been regularly recommended within the literature. Ali and Burchett (2004) recommend community based services and cite the Children’s Centres as the way to provide such services. Pfeil and Howe (2004) in their research in Norwich PCT on reducing inequalities to access to services for vulnerable groups found clients wanted services to come to them. In the development of a community based maternity service, it is seen essential that the community directly affected is consulted. As the R&AS population can be difficult to access, Heptinstall et al (2004) states:

“…networking and active involvement where appropriate with refugee community organisation is at the centre of developing effective services…” (p.53).

Ukoko (2005), found in the set up of her local antenatal service for R&AS that collaboration with the Refugee Health Team and other voluntary organisations and the asylum team from the local authority “proved paramount” in providing seamless maternity care and support for pregnant asylum seekers.

The DH and Refugee Council (2003) encourage the development of links between statutory health services and refugee community groups as a means of assessing the particular needs of a community. Likewise, they go on to say that one of the roles of projects and organisations working with R&AS is to signpost asylum seekers to other services such as housing, health and social care, legal services, welfare benefits, education, employment and training, voluntary sector and other agencies, such as NASS and the police (DH and Refugee Council, 2003).

Despite the development of bespoke community based services for R&AS it is considered that:

“The best model of health care for asylum seekers is to facilitate integration into existing mainstream services”,

although noting that it may be beneficial to have dedicated services for those asylum seekers newly arrived to a geographical area (DH and Refugee Council, 2003). Ukoko (2005) agrees with this assumption stating that:
“Total segregation and separate services for asylum seekers may lead to marginalisation and stigmatisation” (p.778).

The integration of R&AS into mainstream services is potentially a more sustainable and cost-effective approach to service delivery and may expose staff and other members of the public to this minority group, with the potential to decrease unfounded stereotypes and misconceptions about this group.
9. Conclusion

R&AS pregnant women represent some of the most disadvantaged, marginalised and vulnerable individuals in the UK. It has been found they encounter many barriers when accessing maternity services due to such issues as language, difficulties registering with a GP, cultural issues, and a lack of knowledge of available health services, to name a few possible reasons. At the same time, few services have been developed to specifically cater for this group. It is made more difficult to justify the development of bespoke services for R&AS when data at both local and national levels is so poor.

However, it is recommended that some type of specialist R&AS midwifery service be developed for new arrivals to an area and those who continue to feel isolated and unable to access mainstream services. An outreach model of midwifery care, which connects mainstream maternity services to local refugee and community groups, may be the necessary link between the statutory services and the often difficult to reach R&AS women. This outreach model would aim to highlight the availability of maternity services to R&AS women, and local organisations, and would advise and assist women how to access mainstream services in a timely manner.

If R&AS are to access mainstream services, then further support and training for maternity staff regarding R&AS issues and a clear understanding of entitlements to healthcare is essential to ensure the transition from specialist assistance to mainstream services is as smooth as possible for this client group. This includes provision of suitable interpreter services in all areas of the maternity service. Also, staff may be faced with an individual with complex social, and/or psychological needs, and as such, clear referral pathways to other services are necessary to support staff members when working with R&AS with complex needs.

The potential adverse health outcome for a mother and child, who do not access maternity care appropriately, during and after pregnancy, is a major public health concern. No woman should be turned away from accessing services and every effort should be made to include all women in maternity care, regardless of their residency status. It is essential that we provide every opportunity for all mothers and their babies to access the best maternity health care we can provide.
## References


Appendices

APPENDIX A: NASS support during the asylum process

National Asylum Support Service (NASS): was set up under the 1999 Immigration and Asylum Act (IAA1999). It has provided the government's support to asylum seekers (AS) since April 2000.

Application Registration Cards (ARC): allows asylum seekers to obtain weekly cash entitlements through the post office.

1) Application for asylum
   - At initial screening, assessed for support by NASS. If eligible, receive accommodation and/or subsistence support (cash) [Under Section 95 of IAA1999]
   - Given emergency accommodation [Under Section 98 of IAA1999] while NASS support decision being made – target to make decision within 7 days.
   - Section 55 of Nationality Immigration Asylum Act 2002 prevents people receiving NASS support if it thought that the person claiming asylum did not do so “as soon as reasonably practicable”.

2) Initial decision
   - Applicants stay on NASS support until initial decision. Home Office previously known to take years to gain initial decision. Current aim is for an initial decision by the Home Office within two months.
   - Possible initial decisions (outcomes of claims):
     
     a) Positive decision
        - indefinite leave to remain (pre 2002)
        - exceptional leave to remain (pre 2002)
        - humanitarian protection (post 2002)
        - discretionary leave (post 2002)
        Can claim full support. Have 28 days to leave NASS support and move to mainstream support.

     b) Negative decision - appeal
        Refused status, but with right to appeal. Have 10 days to lodge an appeal or NASS support removed.

     c) Negative decision – no appeal
        Refused status and refused right to appeal. NASS support removed within 14 days (unless have a family with children).
d) Negative decision – “out-of-time” appeal
If have right to appeal, but don’t do so within 10 days, then submit an “out-of-time” appeal application to Asylum and Immigration Tribunal for permission to make an appeal. During this time NASS support is ceased, but re-instated if an appeal accepted.

3) Appeal decision
   a) Appeal accepted = full income support
   b) Appeal rejected = NASS support withdrawn in 14 days, but can apply for judicial review.

4) Judicial review and statutory review
   Lawyer to make a case because of an error in the law during the person’s claim – no entitlement to NASS support.

5) Appeal rights exhausted
   • All appeals exhausted
   • Support withdrawn within 21 days
   • May apply for voluntary repatriation or deported
   • Some cannot be returned to home country because:
     a) Home country won’t provide citizenship papers for the individual
     b) UK Government is unable to gain assurance that the receiving country will uphold Article 3 of the Human Rights Convention (i.e. security of a person).

   In this situation, a person can claim for “hard case” support – support not guaranteed and may be placed far from where they have been living.
APPENDIX B: Table of entitlement to NHS treatment

Source: DH (2006). *Table of Entitlements to NHS Treatment (Correct as of March 2006).* Accessed 18/5/06:
http://www.dh.gov.uk/assetRoot/04/13/33/33/04133333.pdf
<table>
<thead>
<tr>
<th>Status</th>
<th>Primary Care</th>
<th>Secondary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum Seeker</td>
<td>A person who has formally applied for asylum is entitled to NHS treatment without charge for as long as their application (including appeals) is under consideration. They will have to pay certain statutory NHS charges (e.g. prescription charges) unless they also qualify for exemption from these (see notes section), and will go on waiting lists. Since asylum seekers are entitled to free NHS treatment, they can apply to a general practitioner to register as a patient. Asylum seekers are exempt from charges for NHS hospital treatment.</td>
<td>A person who has formally applied for asylum is entitled to NHS treatment without charge for as long as their application (including appeals) is under consideration. They will have to pay certain statutory NHS charges (e.g. prescription charges) unless they also qualify for exemption from these (see notes section), and will go on waiting lists. Since asylum seekers are entitled to free NHS treatment, they can apply to a general practitioner to register as a patient. Asylum seekers are exempt from charges for NHS hospital treatment.</td>
</tr>
</tbody>
</table>
| Asylum Seeker refused but appealing decision. | Access to **primary care** without charge.  
As for Asylum Seeker | Access to **secondary care** without charge  
As for Asylum Seeker |
| Asylum Seeker denied support under Section 55 of the 2002 Act, but still claiming asylum. | Access to **primary care** without charge.  
As for Asylum Seeker | Access to **secondary care** without charge  
As for Asylum Seeker |
| Failed asylum seekers – including those getting NASS Section 4 (formerly “hard case”) support while awaiting departure from the UK | The Department of Health has sought to allay confusion over the entitlements of failed asylum seekers to primary care without charge. Health service Circular 1999/018 states that failed asylum seekers should not be registered, but equally, GP practices have the discretion to accept such people as registered NHS patients. Ministers wish to bring greater clarity and consistency to the rules regarding access to primary medical services and so have recently sought views on this issue as part of a consultation on the entitlement of overseas visitors to NHS primary care services. Ministers are still considering the responses and the outcome of the consultation has not yet been announced. Therefore the current situation remains unchanged -  
Emergencies or treatment which is immediately necessary should continue to be provided free of charge within primary care to anyone, where in the clinical opinion of a health care professional this is required. | For secondary care, failed asylum seekers are not generally eligible for free hospital treatment. However, immediately necessary treatment to save life or prevent a condition from becoming life-threatening should always be given to failed asylum seekers without delay, irrespective of their eligibility for free treatment or ability to pay. However if they are found to be chargeable, the charge will still apply, and recovery should be pursued as far as the trust considers reasonable.  
Any course of hospital treatment already underway at the time when the asylum seeker’s claim, including any appeals, is finally rejected should remain free of charge until completion. It will be a matter for clinical judgement as to when a particular course of treatment has been completed. Any new course of treatment, begun after the asylum claim is finally rejected, will be chargeable (unless the treatment itself is exempt under the provisions of the NHS (Charges to Overseas Visitors) Regulations 1989, as amended, e.g. TB). Trusts should refer to the document “Implementing the Overseas Visitors Hospital Charging Regulations - Guidance for NHS Trust Hospitals in England” for advice on how and when to make the charge in these cases. |
| Given Refugee Status  
(successful asylum seeker or, arriving in the country through a Government initiative, i.e. Refugee Gateway Scheme) | Access to **primary care** without charge.  
As for Asylum Seeker. | Access to **secondary care** without charge  
As for Asylum Seeker. |
| Given Discretionary Leave to Remain | Access to **primary care** without charge  
As for Asylum Seeker. | Access to **secondary care** without charge  
As for Asylum Seeker. |
| Given Humanitarian Protection | Access to **primary care** without charge  
As for Asylum Seeker. | Access to **secondary care** without charge  
As for Asylum Seeker. |
Entitlement to NHS treatment (correct at March 2006 onwards)

Certain services are exempt from charges for everyone. This includes treatment provided solely in an Accident and Emergency Department, treatment of certain specified communicable diseases (although prescription charges may be payable unless exempt) and compulsory mental health treatment. Flu immunisations are given to those who are in at risk categories. These categories include anyone over 6 months with respiratory disease (inc. asthma), chronic heart disease, renal disease, diabetes and immunosuppression or staying or living in long stay facilities – or who at the GPs’ discretion needs to have a flu jab on a clinical need basis.

**HIV/AIDS**

In the case of services which relate to HIV/AIDS only the initial test and counselling is free to all. People not eligible for free hospital treatment are required to pay the full costs, including drugs, of any HIV treatment beyond the initial test and counselling. Where a person has been identified as chargeable (not an asylum seeker) for HIV/AIDS treatment a HC2 (certificate for full help with health costs) is not applicable and the full cost of the drugs should be recovered from them. The guidelines in the table above regarding immediately necessary treatment and treatment already under way when an application for asylum is finally rejected, apply equally to HIV/AIDS treatment.

**Maternity Services**

Maternity services should always be classed as immediately necessary treatment (see above) and provided even if the pregnant woman is unable to pay in advance. As with other immediately necessary treatment, however, the patient remains chargeable and reasonable steps should be taken to recover the debt. Maternity services can include treatment to prevent transmission of HIV/AIDS from mother to child if considered clinically appropriate.

Enquiries about this table should be addressed to: Justine Osborne on 0113 2546605, or Justine.Osborne@dh.gsi.gov.uk

**Notes**

**Secondary Care**

It is the responsibility of the NHS trust or Primary Care Trust (PCT) providing secondary care to establish if a person is entitled to treatment without charge (although out-patients may have to pay charges for drugs and appliances unless they are exempt). All patients, regardless of their status or nationality are subject to the same basic screening process and should be asked the following question about their residential status as part of the hospital registration procedure:

- Where have you lived for the last 12 months?
- Can you show that you have the right to live here?

A person who has not been living in the UK for the last 12 months is subject to the NHS (Charges to Overseas Visitors) Regulations and can therefore expect to be asked further questions such as,

- On what date did you arrive in the UK?
- What is the basis for your stay in the UK?

Patients who are unable to provide answers to these questions, or whose answers indicate that they may not be eligible for free hospital treatment should be referred to the NHS trust’s Overseas Visitors Manager, who will conduct a full interview with the patient to establish whether he/she is chargeable. However, immediately necessary treatment should never be delayed or withheld because of doubts about the patient’s chargeable status or his/her ability to pay.
Help with Access to Health Services

If asylum seekers and refugees are having difficulties registering with a GP, they should contact their local PCT who will be able to provide a list of practices to which they can apply. Where a person, who is entitled to free NHS treatment, has had their application to join a practice’s list of patients refused, they can apply to the PCT, which has the power to allocate them to a GP.

PCTs will also be able to provide information on local Community Dental Services and dentists in an area treating patients under the NHS. NHS Direct, provides information on local GPs and NHS dentists. You can also find out about services in your area (including PCT contact details) by going to: http://www.nhs.uk/localnhsservices/default.asp

Help with Health Costs

Under the Immigration and Asylum Act 1999 and the Asylum and Immigration Act 1996, most asylum seekers are not entitled to welfare benefits. However they may qualify for:

- Free NHS prescriptions;
- Free NHS dental treatment;
- Free NHS wigs and fabric support;
- Necessary travel costs to and from hospital for NHS treatment;
- Free NHS sight tests;
- The full value of an NHS optical voucher towards the cost of glasses or contact lenses.

NASS will issue HC2 certificates to asylum seekers after they claim asylum and when they are being dispersed.

Asylum seekers not supported by NASS

Asylum seekers who are not supported by NASS or those supported by the Interim Arrangements and who are not otherwise entitled to free prescriptions, will need to complete form HC1 (claim for help with health costs including prescriptions through the NHS Low Income Scheme (LIS). Health practitioners who come into contact with asylum seekers should encourage them to apply. Failed asylum seekers can also apply.

Since the interim support arrangements were introduced on 6 December 1999, the Patient Services Division (PSD) (previously the Health Benefits Division) of the Prescription Pricing Authority (who run the LIS for the Department of Health) have made arrangements for claims from asylum seekers to be given priority. They have arranged for a separate postcode to be printed on white envelopes, which asylum seekers can use to send off their HC1 claim form.

HC1s are available from the PSD or in bulk from Department of Health, PO Box 777, London, SE1 6XN. Tel: 08701 555 4555 (Department of Health publications order line). Fax: 01623 724 524.

HC1 Completion Guidance Notes

This note contains guidance for case workers and health professionals who help asylum seekers to complete the HC1 form. Asylum seekers who have not received an HC2 certificate from NASS are eligible to apply for one using an HC1 form under the low-income scheme which is managed by Patient Services at the PPA. Failed asylum seekers are also able to apply for an HC2 certificate using an HC1 form.

Asylum seekers who have received an HC2 certificate should apply directly to NASS for a new certificate when their old one expires. There is no need to fill in a new HC1 form or to re-apply through Patient Services.
A system operated by Patient Services is in place that speeds up the process for asylum seeker cases. This fast-track procedure should also be adopted and followed by Social Services:

1. Order bulk supplies of HC1 forms (claim for help with health costs) from Department of Health PO Box 777, London SE1 6XN, Tel: 08701 555 4555, Fax: 01623 724 524.

2. To enable applications from asylum seekers to be fast-tracked, white envelopes (as opposed to the supplied brown ones) need to be used. To obtain these contact Patient Services on their enquiry line, 0845 850 1166.

3. Once the HC1 has been completed and signed by the claimant, post it in the white envelope to Patient Services.

4. Once received, Patient Services give claims in white envelopes priority and aim to issue a reply within 5 days.

In order for the appropriate level of support to be given and for the fast-track system to operate as intended, the HC1 form must be completed correctly. However, many assessments are delayed due to forms containing errors or being incomplete.

Common errors include:

- **Signatures** – Case workers often sign HC1s on behalf of their clients because the client cannot speak English. Patient Services is unable to accept HC1s signed by a third party, the claimant or partner must sign them or make their mark. The caseworker should ensure that this happens.

- **Income** – Often the amount of income that the applicant / their family receives is not specified on the HC1. Patient Services need to know this information, without it the HC1 will be returned as incomplete. NASS support should be recorded in section 5.2 “Do you or your partner get any other income?”. Throughout the document the ‘no’ boxes should be ticked for which do not apply.

  Where income is payable for a child, this is often paid under the Children’s Act. Income paid under sections 17, 23B 23C or 24A is fully disregarded in the assessment therefore if caseworkers could specify the act payments are made under, it will help their clients assessment.

- **Capital** – Although most asylum seekers are unlikely to have any capital or own any capital assets, the ‘no’ boxes must be ticked on the page covering property, savings and other money to indicate this.

- **Extended Families** – Under asylum laws, extended families are assessed and paid as one family unit. Low Income rules are different, assessments are made for traditional family units. Consequently it is not possible to include aunts, cousins or grandparents on a single assessment unless they are a minor for which the claimant and partner have responsibility. It is therefore necessary for separate applications to be submitted and for income details to be broken down accordingly.

- **Asylum seekers living in Hostels/Hotels** – Room numbers need to be added if the applicant lives in a hostel or hotel. In cases where asylum seekers are in temporary accommodation, it may be advisable to use Social Services’, voluntary agency or health centre addresses as large numbers of certificates are returned when asylum seekers move out.

- **Inconsistencies** – There have been cases where the asylum seeker states that they are supported by NASS, but no record appears on the database. This may be due to a delay in the data being entered onto the database. However for some cases the spelling of the name on the HC1 is different to the spelling on the NASS supplied database which is used by Patient Services. It is helpful if case workers, where possible, ensure that the spelling of names and order of names are consistent with the info which was given to NASS.