THE IMPACT ON HEALTH INEQUALITIES OF CHARGING MIGRANT WOMEN FOR NHS MATERNITY CARE

A SCOPING STUDY

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WHEC Women's Health & Equality Consortium

maternity action
challenging inequality: promoting wellbeing

Maternity Action

Maternity Action is a national charity working to challenge inequality and promote the health and wellbeing of all pregnant women, new mothers and their families.

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Women's Health and Equality Consortium (WHEC)

Women's Health and Equality Consortium (WHEC) is a partnership of women's charity organisations working towards common goals of health and equality for girls and women. WHEC members are FORWARD UK, Imkaan, Maternity Action, Positively UK, Rape Crisis (England & Wales), Women's Resource Centre (WRC).

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1. Introduction – Charging and social exclusion

The introduction of charging for overseas visitors in 2004, followed by further restrictions after new immigration legislation in 2014 has led to widespread concerns about their impact on individual and public health. There have also been concerns about the procedures through which charges have come to be implemented, given that the NHS has not had pre-existing mechanisms for charging. A further major concern about charging policy, recognised by government both in consultation documents and in impact assessments, has been about its impact on health and other inequalities (Department of Health, 2013a; Department of Health, 2013b).

However, although the government has considered its policy of charging some migrants for healthcare from the point of view of equalities legislation, there has been little or no investigation of how the charging policy works in practice, and in particular, of its impact on health and health inequalities. To this end the Women's Health and Equality Consortium commissioned Maternity Action to carry out a study of the impact on ill health and health inequalities of charging migrants in England. This is a report of that study which focused on the impact on health and health inequalities of charging some migrants for maternity care.

Maternity care is a useful baseline through which to evaluate the impact of charging because it has a unique status under charging regulations as care that is *always* classified as 'immediately necessary', which means that care must never be refused even if the patient is unable to pay at the time of needing it (Department of Health, 2015). In addition, several legally binding instruments, including both the Conventions on the Rights of the Child (CRC) and on the Elimination of All Forms of Discrimination against Women (CEDAW), to which the UK is a signatory, oblige states to provide appropriate antenatal and postnatal health care for women. CEDAW specifically requires states to 'ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation' (United Nations, 1989; United Nations, 1999).

Charging the most excluded groups

The system of charging for NHS secondary care which was introduced in 2015, is designed to enable all long-term non-EEA visa holders, and people with Limited Leave to Remain, as well as all EEA qualified citizens and their families, refugees and asylum seekers, to access free NHS care. Short-term visitors (less than six months) and irregular or undocumented migrants are therefore the main groups now liable to charging.

Undocumented migrants include refused asylum seekers not supported by the Home Office (in England and Northern Ireland only), visa overstayers, and migrants in breach of their visa conditions. This may mean that their residence or work permit is invalidated or expired, often due to breakdown of the relationship on which it was dependent, or they are residing on a tourist visa. Undocumented migrants in receipt of financial support from local authorities are also not exempted

from charges, including families with children in need who are supported by local authorities under section 17 of the Children Act, 1989 (No Recourse to Public Funds Network, 2015).[1]

Undocumented migrants are among the most excluded and vulnerable people living in the UK today. They have no right to work or to claim benefits; they cannot rent from private landlords, obtain a UK driving licence or open a bank account. They therefore mainly live at the margins of society.

Undocumented women are especially vulnerable. They are often destitute as a result of domestic violence or relationship breakdown. Many are asylum seekers whose applications have been refused, but who feel unable to return to their country of origin. Many have children from relationships in the UK. Some may have been trafficked into the UK, but are unaware of their rights to services because of this. The links between migration control and public services is exacerbated by gender discrimination so that women who have experienced violence or abuse are often afraid to report it in case they will face arrest or deportation. (Platform for International Cooperation on Undocumented Migrants, n.d.).

Growing numbers of vulnerable and destitute families are accessing advice services to seek help to regularise their immigration status (Price and Spencer, 2015; Petch, Perry and Lukes, 2015). Such services report increasing instances of women presenting bills for maternity care and child treatment charges which they have no hope of paying, but which they fear will jeopardize their efforts to regularise their immigration status in the UK. Recent reports also show how undocumented women are particularly vulnerable to violence and abuse in relationships because they are told they have no rights to be here other than as their husband/ partner's dependent, and so fear to seek redress from authorities (Geddie, 2009; Safety4Sisters, 2016).

[1] Section 17 of the Children Act 1989 (s17) is the duty of local authorities in England and Wales to safeguard and promote the welfare of children in their area who are 'in need' and to promote the upbringing of such children by their families. S17 can include the provision of accommodation and financial support where families with dependent children are destitute and can be given, in certain circumstances, to undocumented migrant families with children and to migrants with limited leave to remain with the condition of No Recourse to Public Funds. There is considerable variability between local authorities in the level of subsistence payments to families, but payments are below Section4 asylum support rates for refused asylum seekers of £35.39 per person per week (Price and Spencer, 2015).

2. The policy context

Non-UK citizens' eligibility for free NHS care

For over 50 years after the establishment of the NHS there were few or no restrictions on entitlements of non-British citizens to NHS care. Regulations for charging overseas visitors were introduced in 1982 but were not rigorously or consistently enforced (Department of Health and Social Security, 1982). In 2004, however, entitlement to free NHS care was, for the first time in Britain, legally linked to immigration status. Since then, hospital Trusts have had a statutory duty to determine the eligibility to health care of an 'overseas visitor' (National Health Service, 2004).

This responsibility was extended in 2011 when government acquired the right to refuse further immigration applications from overseas visitors with debts to the NHS of over £1000, and NHS bodies were "strongly encouraged to... improve the recovery of their debts by providing relevant information to the Home Office" (Department of Health, 2014, p.3) The threshold for reporting debt to the NHS was reduced to £500 in 2016. Treatment for chargeable overseas visitors is charged at 150% of the standard commissioning tariff to NHS Clinical Commissioning Groups (National Health Service England, 2015).

Charging overseas visitors for NHS care only applies to secondary care. Primary care is currently not chargeable. The Charging Regulations which underpin the discussion in this report refer to England only as there are different regulations in other parts of the UK. There are certain services which are exempted from charging. These include infectious diseases such as tuberculosis and sexually transmitted diseases, including HIV. Charges for treatment for any condition caused by domestic and sexual violence, torture and female genital mutilation are also exempted, as is emergency care provided in Accident and Emergency departments.

Since 2004, only people ordinarily resident or who belong to an exempted group have been entitled to free secondary care in the UK. Until April 2015 'ordinarily resident' meant living in the UK on a 'lawful, voluntary and properly settled basis for the time being' (Department of Health, 2015). This also included the dependants of settled individuals. However, the Immigration Act 2014 redefined ordinary residence for the purposes of access to NHS healthcare, restricting it to people with Indefinite Leave to Remain in the UK. This applies to far fewer people than formerly. All other visitors with stays of 6 months or more must now pay a health surcharge of £200 per year (£150 for student visas) on top of their visa application fee, after which they are entitled to free use of all NHS services for the duration of their visa.

Settled EEA and Swiss nationals are deemed to be ordinarily resident if they are exercising treaty rights in the UK. Family members of qualified EEA Citizens can also be considered ordinarily resident whether or not they themselves are EEA Citizens, or if they or their family members are exercising EU treaty rights in the UK (Maternity Action, 2017).

Some migrants who are not ordinarily resident are exempted from NHS charges, including refugees, asylum seekers awaiting a decision, refused asylum seekers supported by the Home Office and most nationals of the EEA states and Switzerland who have an EHIC card (National Health Service England, 2015). In England, support for refused asylum seekers is subject to stringent conditions, and pregnant women who have been refused asylum can only obtain it on health and destitution grounds at 34 weeks' gestation. In Scotland and Wales, anyone who has submitted a claim for asylum, whether or not it has been successful, is entitled to free NHS secondary care (Maternity Action, 2015; Maternity Action, 2017).

Maternity care policy and inequality

Reducing inequalities in health has been a goal of NHS policy for many years. (Department of Health, 2000; Health and Social Care Act, 2012). The Marmot Review was developed in order to identify evidence based strategies to reduce health inequalities (Marmot, 2010).

Policies to reduce maternal and infant mortality have been part of efforts to reduce health inequalities. The Department of Health's National Service Framework for Children, Young People and Maternity Services (NSF), and Maternity Matters, proposed specific improvements to maternity services as a means of reducing social inequalities in pregnancy outcomes (Department of Health, 2004; Department of Health, 2007a).

Particular attention has been focused on the most excluded groups. Ethnic inequalities in maternal mortality were highlighted in 'Why Mothers Die', the 2004 Confidential Enquiries into Maternal Deaths in the United Kingdom (CEMACH) report (Lewis, 2004).

CEMACH's next report addressed the disproportionate numbers of maternal deaths among migrant women more specifically (Lewis, 2007). In the UK, recent migrants, refugees and asylum seekers, and women who have difficulty reading or speaking English have been identified as being at especially high risk of pregnancy related deaths (Lewis, 2007; Centre for Maternal and Child Enquiries (CMACE), 2011). The CEMACH report covering 2003-2005, found that black African women had a maternal mortality rate nearly six times that of white women in England (Lewis, 2007). Despite a downward trend in overall maternal mortality in the subsequent triennium, the risk is still almost three times higher for African women than for white women (Knight, 2014).

These reports highlighted the association between maternal death and lack of antenatal care. Many of the migrant women who died had underlying health conditions which were not identified because they had not accessed routine antenatal care. Successive Confidential Enquiries have shown that women who died received disproportionately insufficient or no antenatal care, and that migrant women were particularly likely to receive less than the level of care recommended by the National Institute for Health and Care Excellence (NICE) (Lewis, 2007; Knight, 2014).

NICE guidance on antenatal care for women with 'complex social factors' - "women whose social situation may impact adversely on the outcomes of pregnancy for them and their baby," developed as a response to the Confidential Enquiries. This terminology identifies social problems or disadvantage in distinction to additional health problems which could complicate a pregnancy (National Collaborating Centre for Women's and Children's Health, 2010; Scottish Government, 2011). It singles out recent migrants, refugees, asylum seekers, and women with little or no English as a distinctive risk group.

NICE guidance and other policies have been concerned to meet the needs of disadvantaged and vulnerable pregnant women. They consistently emphasise the need for special efforts and/ or service provision to identify and reach disadvantaged women in order to facilitate early booking, continuity of midwifery care throughout pregnancy, birth and postnatally, inter-professional and inter-agency collaboration, and provision of language and translation services, including extra time at antenatal appointments.

However, in spite of these efforts, more women with underlying medical conditions or complex social needs are giving birth, and funding cuts and staff shortages are placing greater demands on maternity services (Plotkin, 2017).

Migrant women and high risk pregnancies

Whilst there is no universally recognised definition of 'high risk pregnancies, it is now accepted that both medical and social factors are likely to affect pregnancy outcomes (National Institute for Health and Care Excellence, 2010; NHS Scotland, 2010; Maternity Action and ASAP, 2015).

Medical complications can be due to existing medical conditions such as diabetes, heart disease, HIV or hepatitis infections, or to conditions arising in pregnancy such as gestational diabetes or high blood pressure. Social risk factors in pregnancy include poverty, homelessness or precarious housing, domestic abuse, experience of asylum seeking, recent migration, inability to speak English, or poor mental health. Often these circumstances may be interlinked.

Almost all undocumented migrant women, including refused asylum seekers can be deemed to have high risk pregnancies due to a combination of social and health risks. These include destitution and homelessness, sub-optimal (less than recommended) antenatal care, stress stemming from their past experiences and current circumstances. As a result such women have additional health and social care needs during their pregnancies and in the post-partum period. Such care involves early booking with good history taking at first booking, more frequent antenatal appointments, and continuity of care with a particular midwife.

In practice, however, such women face additional barriers to accessing appropriate maternity care, particularly when they fear they may be charged. Other well-documented barriers include difficulty registering with GPs, ignorance of how the NHS works, limited knowledge of English, fear of being reported to immigration authorities, and more recently, fear of high charges and inability to pay. In addition, migrant women often have had negative experiences with the heath system, which may make them reluctant to engage with services (Jayaweera, 2010). The Royal College of Midwives together with Maternity Action have set up a Vulnerable Migrant Women's Network specifically to raise awareness of such women's needs and to improve methods of meeting them within maternity care.

There has been a great deal of anecdotal evidence that even when women know where and how to access maternity care, some are reluctant to do so because of fears of being charged, and of the immigration sanctions these may lead to. This study has attempted to provide an overview of the impact of charging on the most vulnerable and socially excluded migrant women.

3. Methodology

The study was conceived as part of the Department of Health Strategic Partner Programme (Department of Health, 2011) to investigate the impact of NHS charging for migrants on ill health and health inequalities. We have focused on charging vulnerable women migrants for maternity care as an example of charging practice and the impact on patients in a very particular situation, where care is automatically deemed immediately necessary and cannot be refused, and so should be free of ambiguity about any woman's right to access care.

The focus of the study was to find out from professionals with knowledge of the circumstances of vulnerable migrant women whether charging for maternity care had affected the women in any way. Where possible, we also interviewed women affected who were referred to the study by generic professionals who knew about their situation.

In the absence of other background data on this issue, in order to get as broad a coverage as possible we designed the study as a scoping exercise and cast a very broad net to gather stories of migrant women's experiences of being charged for maternity care. We obtained information from 32 professionals working with migrant women and interviewed 19 women who had been charged for maternity care.

Table 1 Types of professionals interviewed

Type of professional	**Number**
Generic advisers at migrant advocacy services	18
Legal advisers	7
Midwives and nurses	7
Total	32

Table 2 Sources of case examples

Sources of case examples	**Number**
Interviews with professionals	29
Cases collected from Doctors of the World	3
Cases from MCAAS	4
Interviews with women charged for maternity care	19
Total	55

Professionals were consulted by email, telephone and in person. A few professionals also responded to an online request for case examples, which were followed up where possible. Professionals contributed a total of 32 case examples of women who had been charged. These included three already anonymised case studies from Doctors of the World clinics. We also drew on four anonymised cases from Maternity Action's Maternity Access Advice Service (MCAAS). Health professionals in the NHS also contributed examples of policies and practices from their workplaces, and all professionals reported general concerns relating to NHS charging for maternity care that had come to their attention.

Nineteen women accessed via advocacy organisations to which they had turned for help with their financial situation and homelessness were also interviewed. These women were given written and verbal information about the project and signed consent forms before the interviews. They were given store vouchers of £10 in appreciation of their time and effort in participating.

All cases examples in the report have been anonymised. Where specific case examples are used in the report we have indicated how the information was obtained.

All the empirical material is qualitative collected through semi-structured interviews with both professionals and women, designed to elicit information about women's experiences of being charged, the procedures that were followed as the women or professionals perceived them, and the circumstances in which women found themselves when they were charged. Some cases involve women's experience of being charged for the birth of more than one child.

All the data collected, whether from professionals' reports or directly from women who had been charged for their maternity care, were analysed thematically. The remainder of this report discusses the findings under a number of overarching themes.

4. The findings

4.1. Women's economic and social vulnerability

Poverty and Destitution

Chargeable women are typically either visitors to the UK who may or may not be able to pay NHS charges, or, as we have indicated, undocumented migrants, typically overstayers, who have no rights to work or to benefits. However, these immigration statuses do not indicate the circumstances in which they arrived, the degree of independent control they have or have had over their lives, or the connections and roots they have either in their countries of origin or in the UK.

Most of destitute women in our cases had been in the UK for several years, in some cases over 10 years, and had found themselves in financial hardship or destitute after failure of immigration applications meant that they were no longer able to work. Others were brought to the UK by abusive partners or traffickers on whom they were completely dependent, but from whom they have since fled or been abandoned. Some women in our case examples still live with husbands or partners with whom they came, or whom they met in the UK.

Our cases show that many women often already faced serious financial problems before any charging took place, which meant that they had little or no realistic expectation of repayment. One midwife described how she saw women who were sofa-surfing before they gave birth but their friends were not willing to take them back after they had had the baby.

Beatrice, like many women, was able to support her family by working until she was sacked when her employer discovered she did not have permission to work, after which she slid into destitution. She is still awaiting the outcome of an immigration decision, so has no access to any benefits, or a right to work.

> Beatrice came to the UK in 2005 on a visitor visa and worked until 2014 as a care worker with a national care agency until she lost her job because of her irregular immigration status. In 2009 Beatrice submitted an immigration application based on family life. This has gone through several appeals and is still ongoing.
>
> She had three children in the UK, all by caesarean section. The first child, born in 2009, died when he was 3 weeks old. A second child was born a year later. Beatrice was not charged for her maternity care for either of these births, and had no knowledge of charging. She gave birth to her third child in 2015 after she lost her job.
>
> This time she was told that she was liable to be charged, so she missed some appointments in order to save money. Since she had her last baby, she and her children have been destitute, supported by a local authority for some of the time under s17 of the Children Act, or sofa-surfing. All this time she has been reporting regularly to the Home Office.
>
> Less than 2 months after birth of her third child, she received a bill for around £11,000, backdated to include the previous births. She received numerous reminder letters saying she would be taken to court so she called them to say she couldn't pay, but was told that she must. (Interview with woman)

Yvonne's story is typical of the most vulnerable migrant women, who may have been trafficked here, or brought and then abandoned by a partner. They can be left in almost total destitution when their immigration applications are refused (if they have submitted any at all).

> Yvonne came to the UK in 2013 with her first child who had been born in Nigeria. She had another child in 2014 but was sleeping in a church at the time she gave birth and was completely destitute and reliant on charity. She spoke little English and gave her pastor's wife's name as next of kin as she had no other relatives. Some months after she gave birth Yvonne received a bill of nearly £4000. The pastor rang the hospital to try to get them to withdraw the charge, but they refused. Yvonne is totally unable to pay. (Interview with woman)

Dependence on men

The stories told by and about the women in this study testified to their economic and social vulnerability. Chargeable women by definition have no access to benefits as all migrant women not entitled to free NHS either have irregular status or visitor visas neither of which confer rights to mainstream benefits. Some chargeable women whose cases we collected had working partners, but without the right to work themselves, were dependent on those male partners.

> Violet was presented with a bill at her first scan in a London hospital. Her British partner agreed to pay £50 per month in a repayment plan. However it emerged that her partner was actually married to another woman, and Violet lost contact with him and he stopped paying. Fortunately her son's godfather continued to make the instalment payments. (Interview with woman)

In another case, a woman avoided all antenatal care because her partner would not take on the charges.

> Diana is an undocumented woman aged 22 who did not access any antenatal care because her 45-50 year old partner had said he didn't want to have to pay. The woman was referred to a domestic violence advocate, but the midwife did not know whether she had received follow-up care. (Interview with Safeguarding midwife)

In this case, the much older male partner was clearly able to control the young mother by means of his total financial control, recognised now as a form of domestic violence. This led to the woman 'choosing' to avoid antenatal care for fear of incurring bills which she was unable to meet.

Vulnerable women are particularly likely to be dependent not just on their partners, but are also at greater risk of sexual or other exploitation in order to try and make their repayments. One woman interviewed said that a male 'friend' was meeting her repayments of £50 per month, but she did not indicate what her friend wanted in return.

Domestic violence and pregnancy

Several of the case examples involved women who had experienced domestic violence. Domestic violence is more prevalent among vulnerable migrant women than among women generally, and such abuse increases during pregnancy. Studies have highlighted the prevalence in pregnancy of domestic violence and the risks of adverse pregnancy outcomes as a result of such violence, as well as the even higher risk of post-partum violence and the impact of domestic violence on post-partum depression (Bacchus, 2001; Jasinski, 2004).

Vulnerable migrant women including refused asylum seekers are at heightened risk of domestic violence. A study of 46 asylum seekers in Scotland found that 19% had experienced domestic violence in the past 12 months (Zimmerman, 2009). Women with other types of immigration status, especially if it is insecure, may be at equal or greater risk. However, in order to benefit from the exemption from charging for victims of domestic violence, women need to provide evidence of violence which may only be obtained after establishing relationships of trust with midwives or GPs. Women with no recourse to public funds or state benefits, suffering from domestic violence, are often not able to get places in refuges, and may not be able to access antenatal and postnatal care because of actual or threatened violence (Safety4Sisters, 2016).

> Helen was trafficked to the UK in 2011 and entered into an arranged marriage where she suffered severe domestic abuse from her husband and his family, but she was afraid to seek help. She gave birth very prematurely (26 weeks) in 2012 and her baby needed additional care both immediately after birth and subsequently. She was billed for her maternity care and for her child's care but her husband's family, instead of helping her pay, laughed at her and used the bills as further pressure to make her stay with them. She was afraid to continue taking her child to the hospital as she knew she could not pay.
>
> Helen finally left her husband and his family when she felt that the child was being threatened and she feared for her life. She was referred to the National Referral Mechanism in July 2015 and currently has a pending asylum application. (Interview with woman)

This case illustrates the added anxiety that charging adds to an already vulnerable women during pregnancy and postnatally, to a woman who was already statistically more likely to have an adverse pregnancy outcome. Furthermore, although, in principle, she might have been exempt from charging because of the domestic abuse she was experiencing, she feared to disclose this at the time of the pregnancy so was just viewed as another chargeable patient. Her case shows that it is not always possible for an Overseas Visitor Manager to identify the circumstances which would qualify a patient for a charging exemption. The complex process in which a person may be recognised by the Home Office as a victim of trafficking or domestic violence can just as easily follow NHS hospital care as precede it, but meanwhile women at risk such as Helen may be placed in an even more vulnerable position.

4.2 Health problems

Complex pregnancies

The chargeable women whose cases we collected also appeared to have a high frequency of medically complex pregnancies and poor pregnancy outcomes. Our case examples included one woman who had a stillbirth and another whose baby died three weeks after birth. Several women had emergency caesarean sections. Three women gave birth prematurely, two to twins, and one to a singleton. At least two women suffered from hypertension during their pregnancies.

Information on women's health during pregnancy and any underlying conditions was not uniformly available from informants as the study focused particularly on the experience of charging. It is likely that a more in-depth study would have actually found more health problems among women and their families.

It is obviously not possible on the basis of this scoping study to attribute poor pregnancy outcomes to sub-optimal care but the study does show that a significant number of the women whose cases were collected had medically complex pregnancies but nevertheless were minded to, or actually did avoid care because they were afraid of receiving bills that they could not pay. Such avoidance of

care may have had the unintended effect of increasing the size of the bills which women received because of a later need for more complex care, and subsequent health problems among babies born after inadequate antenatal or postnatal care.

Children and family health problems

In addition to women's own pregnancy problems, a surprising number of the children born to women in the case examples had serious health problems too. These included two babies with Down's Syndrome, one of whom also had a heart condition, another baby with a heart condition - both of these required heart surgery, a child with a rare congenital eye condition, and another woman who had two very sick children. All of these needed extensive hospital treatment, as did the babies born very prematurely. In one case, not only was one child very sick and requiring treatment; the woman's husband was suffering from Lymphoma and waiting for a bone-marrow transplant.

One woman's adviser described the situation of one of her clients.

> I do know of a family who are being billed for health care. The little one (aged 2) has Down's Syndrome, and has had to have operations for her heart since birth and is being monitored. The husband has non-Hodgkin Lymphoma and is on a waiting list for a bone marrow transplant and the hospital have started pressing him about the cost of his chemotherapy. The health bill for the family must run to tens of thousands and it is just another stress on them. (Interview with Law Centre immigration adviser)

4.3 Impact of charging

Charging for maternity care has a very different impact if women are expecting to be charged or not. Several women in this study were presented with bills unexpectedly after having had more than one baby in the UK and with no idea that they were likely to be charged.

Lack of awareness of charging

> Olivia came to the UK in 2008 on a student visa which expired in 2011. She had two children whilst her visa was still valid and was correctly not charged at the time. An application for leave to remain in 2012 was refused. Having no experience of charging, when she had a third child in 2015 she was shocked to be presented with an invoice for £4,000 soon after her first scan. (Interview with woman)

Midwives reported that often women are not warned that they will be charged, so that the first they hear about it is when they receive a letter or invoice from the hospital. One woman was reported by her midwife as having been very upset that she did not know she would be charged at the beginning of her care as she did not have the choice to *not* attend antenatal care including scans so she would not be billed.

One woman's immigration status actually changed as a result of her pregnancy, making her chargeable when she had not expected it or been aware of charging.

> Katherine came to the UK in 2012 on a student visa. She was studying accountancy and finance full-time, and working part-time. She became pregnant in 2015 and as a result, suspended her studies. The university then informed the Home Office who wrote to her to

tell her that her visa was therefore now invalid. This made her chargeable for her maternity care.

She was billed less than one week after she gave birth in July 2016. This was the first time she had ever heard of the idea of charging for healthcare. Katherine is very concerned about the impact of the debt on the renewal of her visa. As a result of the cancellation of her student visa she has no immigration status and is now destitute. Asked what she would have done if she'd found out about the charges in advance, she stated without hesitation that she would have had an abortion. "Of course, how am I going to pay that?" (Interview with woman)

In some cases women have been in and out of the asylum system, both in the course of a single pregnancy, or over several pregnancies, so they are likely not to be aware that they are chargeable. Moreover, there are numerous examples of women asylum seekers having their invoices cancelled after representations to the hospital, because they should not have been charged at all.

Women are also not informed that they have to pay 150% of the tariff. This makes a difference for women who have the means to pay. A specialist midwife said that some women say they will seek private healthcare once they discover this, while others say that they would have gone privately if they had been told earlier.

Charging procedures and practice

The case examples we collected, together with reports of local practice and experience from midwives and advocacy organisations indicate that there is no consistent practice on charging between hospital trusts. Sometimes women only hear about charges several months after they have given birth when an invoice is issued; one woman who was not informed that she might be charged received a letter five months after giving birth saying that she owed nearly £700 for maternity care and needed to take action within a week. Other women reported that they were told in the hospital that they were chargeable, but invoices were only received several months after they gave birth.

In some cases women were billed for full maternity care prior to giving birth, so it is not clear how the costs are determined and what would happen if a woman did not attend all appointments. One migration specialist interviewed commented on the reluctance of trusts to publish their charging policies.

Department of Health Guidance states that 'Where an invoice is particularly large, or where the patient is genuinely willing to provide payment for services provided but cannot meet repayment in full, then trusts should agree with the patient, at the earliest opportunity, a meaningful repayment plan' (Department of Health, 2016). In spite of a degree of flexibility in what constitutes such a plan, there seems to be wide variation between trusts, and over time within trusts. Repayment plan levels appear to be at a hospitals' discretion. A midwife at a London hospital said that formerly her hospital used to accept 'reasonable' payment plans, but recently they have started refusing any payment plan under £50 per week, which is outside the reach of many poor or destitute women.

In at least one case, a hospital's refusal to accept a modest repayment plan resulted in an immigration application being refused. The following case was reported by an immigration lawyer, and at the time of the study remained unresolved.

The woman and her British citizen child were accommodated and supported under Section 17 of the Children Act, 1989 as they were destitute. She applied for leave on the basis of family life with her British citizen child. However, this was refused because of her debt to the NHS from maternity care but it was suggested that her application might be accepted if she

had a repayment plan in place. She tried to make an arrangement with the hospital to repay the debt, but could only offer £5-10 per week from her s17 allowance. The hospital rejected her offer and said she needed to pay £70 per month. (Interview with lawyer)

It would be difficult for the Home Office to remove this mother because her child is a British citizen, but until this is resolved, the family is dependent on minimal social services support, and the mother not entitled to work.

Procedures to identify eligibility for NHS care may also create further barriers to access maternity care for vulnerable migrant women. This is illustrated by reference to the widely publicised pilot project introduced at St George's Hospital in London, ostensibly intended to recover costs more effectively from "overseas patients not eligible for free UK Healthcare" (St. George's Hospital NHS Foundation Trust, 2016).

The background document presented at St. George's public Trust Board meeting indicated that the Trust had identified a procedural problem of recovering costs from non-eligible patients, and had developed a pilot study for overcoming this in maternity care. This involved a procedure for identifying 'non-eligible women *before* receiving care' requiring photo ID and a current utility bill (ibid. *This author's emphasis)*.

However, the pilot study procedure raises a number of serious concerns about the impact on access to maternity care for vulnerable migrant women. Firstly, neither photo ID nor a current utility bill (even if all women had both) would provide evidence of a woman's eligibility for free NHS care. Secondly, the report of the pilot proposal makes no reference at all to the possible deterrent effect on access of requiring such prior documentation. Finally and most importantly, the Department of Health's own guidance that maternity care does not need to be paid for in advance as it is always regarded as immediately necessary and must never be delayed on account of a woman's inability to pay, appears to have been wholly disregarded in the pilot study. It is curious that the site of the pilot should be the very specialism in which all care must always be regarded as immediately necessary.

Attitudes to repayment

This study focused particularly on vulnerable migrant women who were unlikely to be able to pay for their maternity and other health care. It is striking, therefore, that, in spite of their poverty, many women were very anxious to make arrangements for payment of their bills by means of repayment plans. An advocate who works exclusively with destitute families, felt that women were afraid of getting into debt as well as being on the wrong side of authority. She told of a woman who faced a bill of £3500, but her sole income was from her two British children's Child Benefit of £132 per month. Nevertheless, she negotiated a payment plan with the hospital of £25 per month, nearly 20% of her income.

Some women have accrued credit card debts in order to pay their hospital bills while others borrow from friends and promise to pay back the money. In some cases, this is a sensible solution, but in others it can leave women with no backup if the friend or partner refuses or is unable to continue paying. This author has personal experience of a woman asking for help from an advocacy organisation as she was being threatened by someone who had lent her money which she was unable to repay. Choosing to move the debt because of fear of authority and of being reported to the Home Office and having future leave refused, is likely to leave women vulnerable to threats and exploitation.

We found no evidence that women who could afford to pay, or who were able to make a feasible payment plan were unwilling to do so. What happened more commonly was that payment plans

were too high in relation to women's incomes, or became too high if the women lost support from local authorities or from their child's father. Some women tried to pay irregularly. However if no payment plan had been made and women were receiving letters demanding payment, they often ignored the letters.

> Anna received a bill for over £4000 a few months after she gave birth in 2012. This was the first time she'd heard about charging. Her partner was working at this point, so she paid what he could afford, about 3 instalments of £100. He lost his job, so was then unable to carry on paying. They left it. (Interview with woman)

Families facing destitution and homelessness as well as significant health problems are, unsurprisingly, very anxious about having to face bills which they know they cannot afford. This is of particular concern to families with sick children or other family members suffering from serious conditions who came to advocates with cumulative bills of, in one case, £68,000 (for a child's heart operation), £16,000 for maternity, special care for the baby and follow up appointments. One family which had a child with Down's Syndrome had a cumulative bill of £17,000.

A specialist refugee midwife at a London hospital commented that people were so scared of charging that they ignored bills and letters from the hospital. But it is also the case that families who are homeless or precariously housed, or dependant on housing from local authorities, are likely to live in multiple occupancy residences and to move frequently. This means that they will often not receive bills and letters, and thus, like Anna, not think about it.

One woman received a bill of £40,000 after the premature birth of twins.

> She initially ignored the letters and bills, and only brought it to the attention of support workers when everything was written in red, with court summons etc. She'd also started getting phone calls from the hospital. (Interview with advice worker)

Anxiety

Women's fear of facing unrepayable bills as well as of being reported to the Home Office results in high levels of anxiety and stress, reported by midwives and advocates as well as by the interviewed women themselves. This is in addition to the daily stress experienced by these vulnerable women as a result of poverty, destitution, or precarious housing. Indeed anxiety about charging and repayment was the most commonly reported effect of charging on the vulnerable migrant women in this study.

This is of particular concern as there is a growing body of evidence that stress levels in pregnant women can have long term effects on their children's emotional or cognitive development, including an increased risk of attentional deficit/hyperactivity, anxiety, and language delay (Talge, 2007; Glover, 2014; Kinsella, 2009).

A specialist midwife commented that there were regular reports by midwives of women saying that the charging and bills caused them significant stress and anxiety in pregnancy, so much so that the issue has been raised in routine departmental meetings. One woman described her experience of being charged for two pregnancies as follows:

> "Childbirth and being a mum is trauma and stress. I don't know the joy of giving birth and having a child. I would need counselling before having another child." Yet she has saved every single letter so that she can pay off her debt once she regularises her immigration status. (Interview with woman)

A lawyer described how one case showing how a trafficked woman's access to social support was affected by fear of charging.

> When she was charged she decided to cease treatment. The lawyer managed to persuade the trust to withdraw the charges. However she had also wanted to move to another area to be nearer her support network but chose not to because she feared that the new trust would again charge. (Interview with immigration solicitor)

Avoidance of care

Late booking and inadequate use of antenatal care have been highlighted as significant factors associated with maternal mortality (Knight *et al.,* 2015) and perinatal mortality (Taylor, 2008; Department of Health, 2007b).

Yet the most frequently reported consequence of women's anxiety and panic about being charged is that many avoid care, either through late booking, or even not booking at all for antenatal care, or avoiding aftercare. They may do this in spite of underlying or pregnancy related health problems, thus putting themselves and their babies at risk, as the following cases illustrate.

> Olivia was found to have very high blood pressure and was booked to see a consultant. However, she did not attend the appointment for fear of being charged. She was admitted before her due date with severe pains and was in hospital for three days before she gave birth, in an attempt to reduce her blood pressure. (Interview with woman)

> Nadia had her asylum application refused a few days before she gave birth to twins prematurely by emergency c-section. She and one of the twins required ongoing care after the birth. At times, the hospital refused to treat them without up-front payment because the care was not seen as immediately necessary. She was billed over £40,000 after she had given birth while receiving ongoing outpatient treatment for herself and one of the twins. Her immediate response was to cease further treatment. However, her advice workers persuaded her to continue and also continued to assist her with her asylum claim. (Interview with advocate)

A midwife gave the following example of a woman with medical problems who booked late because she was afraid of facing a large bill.

> She booked at over 30 weeks gestation at a London hospital with her second pregnancy. She had hypertension and would ideally have had more frequent antenatal visits. She had her first child at the same hospital and had been charged. She defaulted from antenatal care, attended in labour, and although she was 'quite unwell' on the postnatal ward, she was desperate to go home so she would not run up a bigger bill. (Interview with midwife)

Some women also described missing 'some appointments' in order to minimise the cost. A welfare advocate said that she had encountered several women who presented late for care, and had heard anecdotally of a woman who chose to give birth at home in order to avoid charges. This respondent stated that the issue of charging and avoiding care was becoming more prevalent, especially in the last year.

Another consequence of charging is that confusion about charging rules actually serves to deter women who might be eligible for free care from accessing services. This can apply to asylum seekers, trafficked women, women fleeing from domestic violence if they are eligible for the Domestic Violence Concession or women with other forms of eligibility.

> A woman who had been in the UK for over 2 years was detained when she was 7 months pregnant. She had not accessed any healthcare, including maternity care, prior to being detained because she had heard that she would be charged. An advocacy organisation helped her to get released from detention and to claim asylum. Because of this she was exempt from charges and was able to access free NHS maternity care. (Interview with advocate)

Women may also avoid care not just because they cannot afford the charges, but also because they are afraid of being reported to the Home Office and of having future immigration applications refused. There is previous evidence that this was an important source of anxiety for women (Aston, 2014). In this study a midwife reported that one woman's NHS debt was listed as among reasons for the Home Office's refusal of her immigration application. Another woman was refused Indefinite Leave to Remain and granted more limited Discretionary Leave despite being otherwise eligible for the Domestic Violence Concession, because she had a debt for maternity care to the NHS.

Midwives and advocates expressed concern about the ethical dilemma they face as to whether to tell women that they would be charged, at the risk that they would avoid maternity care, or not telling them so that they do access the service, but become indebted or seriously shocked when they receive large bills. In one hospital women are only informed about charging after their 22 week anomaly scan but this policy means that women who are chargeable do not have a choice not to access care or to seek care privately.

Role of advocacy

The women interviewed in this study were all reached via people working in advocacy organisations. Here we raise advocacy as a significant issue in the context of charging, having seen how women became desperate and stressed by receiving bills, often without forewarning and without understanding what the bills were for, and how they could be expected to pay apparently overwhelming bills.

In a number of cases advocates were able to identify that women had been wrongly charged, for example because they were asylum seekers or 'Zambrano carers'[2], neither of which group is chargeable for maternity care. Nevertheless, it often took a great deal of professional effort to challenge the Overseas Visitor Managers (OVM) in the hospital trusts. Without advocacy, vulnerable migrant women are unable to afford legal advice to challenge charges which may have been wrongly applied because OVM's lack the necessary knowledge of immigration legislation.

Maternity Action has set up a *Maternity Care Access Advice Service* in response to frequent requests for information from women and their families or professionals about whether women are chargeable, anxieties about NHS debts for maternity care, and concerns about inappropriate charging. The service provides advice and casework to support women who wish to challenge charges that have been imposed.

In the following example, Maternity Action was contacted by another service which was assisting a woman who had approached them.

> Essie had overstayed her visa but had made an application under Article 3 European Convention of Human Rights prior to giving birth. Maternity Action advised that she was not chargeable as she had a current Article 3 claim. However, it was difficult to provide

[2] 'Zambrano' status applies to any non-EEA national who is the primary carer of a British (or EEA national) child or dependent adult who is residing in the UK, if that child or dependent adult would be unable to reside in the UK or in another EEA State if the primary carer were required to leave (NRPF Network, 2016).

> evidence of her Article 3 claim as the Home Office provided no confirmatory documentation so Essie had to provide her own copy of her claim to the OVM. An OVM would not necessarily recognise the grounds of her claim as an Article 3 claim and thus the basis of an exemption from charging. (Maternity Action Advice service)

In another case Maternity Action was contacted by a British citizen who had arrived in the UK as a refugee.

> His partner was an Albanian women who was due to give birth in three months. She had overstayed her visa and was terrified of the Home Office being notified as well as fearful of being charged for maternity care. He had met her when she was street homeless, cold, hungry and scared. It seemed very likely that she had been trafficked to the UK for forced prostitution. Maternity Action referred her to agencies providing asylum and trafficking advice. If she received a positive asylum or trafficking decision, she would not be chargeable. (Maternity Action Advice service)

An advocate in a voluntary agency assisting with refugee health issues carried out lengthy casework to assist an asylum seeking family to cancel the charges that had been levied. This involved contacting a sub-contracted debt collection agency to stop pursuing the charge.

Advocates in non-profit agencies also encouraged or assisted several women to organise repayment plans where this was possible and relevant. Although the Department of Health Guidance allows or encourages people to set up payment plans for their debt to the hospital trust, there seemed to be few instances of advocacy by the Overseas Visitor team to assist chargeable women to do this. One hospital trust appeared to try to identify women who were known or suspected of having been trafficked or subject to domestic violence, but this was more to enable such women to seek appropriate support than to waive payment.

Advocates in voluntary sector organisations not only helped women to manage their repayments, or to cancel charges when they were inappropriate. They were also often instrumental in encouraging women to attend their appointments and continue their maternity care. However, women predominantly accessed such organisations for help with regularising their immigration status or for advice about poverty or destitution, and issues about charging were not always immediately reported. In addition, voluntary organisations are overwhelmed by demand for immigration and welfare advice, and often do not have the capacity to advise or carry out casework on NHS charging.

5. Conclusion: Exacerbating health inequalities

The primary target group for this study, undocumented migrant women, are among the most marginalised and excluded in the UK and are particularly vulnerable to exploitation and violence. Their social circumstances alone, characterised by poverty, destitution, and precarious housing, signify them as having high risk pregnancies. Given the equality objectives of the NHS one would expect these women to be the target of equality enhancing policies rather than inequality promoting ones.

In spite of the fact that this study did not set out to collect systematic data on the health of the women during the pregnancies for which they were charged, or on any underlying health conditions, we nevertheless found a high number of cases where women also had current or previous medically complex pregnancies.

Most, if not all, the cases identified in this study should be considered as high risk pregnancies, and therefore treated with increased vigilance. In practice, however, we found that anxiety over charging, and of being reported to the Home Office because of consequent debts to the NHS served as powerful deterrents on women to accessing care.

Despite Department of Health Guidance states that maternity care must never be denied or delayed on account of a woman's inability to pay, fear of high bills routinely deters vulnerable migrant women from seeking timely and regular maternity care.

The consequent sub-optimal care is likely to increase the likelihood of pre-term births and other adverse pregnancy outcomes. It prevents midwives identifying safeguarding or other problems, notably domestic abuse, which might justify further interventions, regardless of whether it would enable exemptions from charging. The study suggests that charging may also have longer term effects on women's own health and that of their children, thus reinforcing already existing health inequalities.

Hospital procedures on determining eligibility to free NHS care, may be crucial in increasing or reducing barriers to care for the most vulnerable women. The requirement to produce identity and address documents in advance of treatment, long identified as a barrier to access in primary care, is wholly inappropriate in the maternity care setting. Maternity Action wrote to the Chief Executive of St. George's hospital when their pilot requiring passports or other evidence of immigration status was first announced, querying how this policy was compatible with Department of Health Guidance not to deny or delay maternity care due to charging issues. To date, there has been no reply. Of even greater concern is the government's planned requirement for passports to be presented at all new hospital admissions, without a proper prior equalities impact assessment (Donnelly, 2017).

Variability in hospital trusts' policies and practice on charging 'overseas visitors' makes it difficult for women to know in advance whether they are chargeable, and, when they receive invoices, to know whether they refer to recent or long-standing chargeable care. However, this problem is not solved by blanket, up-front demands for proof of eligibility, but rather by sensitive and informed discussion with patients about their situation, and the provision of flexible methods for payment. It is essential that demands for proof of eligibility should not deter vulnerable migrant women from accessing all recommended maternity care.

Although the study did not explore inappropriate charging as a central issue, a number of case examples reveals that this occurs regularly where OVMs make mistakes or do not acknowledge complex immigration statuses. The effect of this is to spread the adverse health impact of charging more widely than should be necessary given the existing regulations. But in the absence of advice

or advocacy on charging as part of hospital services, if women want to challenge or negotiate their bills, they need to find advocacy services elsewhere, primarily in the voluntary sector. Such services are the only ones which can give them help in challenging charging decisions, cancelling inappropriate charges, or assisting with payment plans. However, such services are currently overstretched and often unable to meet more immediate needs of their clients such as help out of destitution or assistance with immigration claims.

Given the known vulnerabilities of migrant women who are chargeable for maternity care, this study, as an initial scoping exercise, suggests that there is a need for further and more in-depth investigation of the impact of charging for maternity care on migrant women and their families.

6. Recommendations

1. The Department of Health should suspend charges for maternity care to overseas visitors pending the development of effective strategies to ensure vulnerable migrant women's access to all maternity care.
2. As long as charging continues, all hospital trusts should provide advocacy on repayment and chargeability in conjunction with expert voluntary sector organisations.
3. All hospital trusts should develop policies for charging and repayment which ensure access to care and proper safeguarding for vulnerable migrant women.
4. Further in-depth research needs to be conducted on the impact of charging for maternity care on migrant women and their families, and on effective strategies to mitigate the adverse impact of charging.
5. The Department of Health should carry out further cost-benefit analysis into charging taking the longer-term health of women and their children into account.

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