

What Price Safe Motherhood?

Charging for NHS Maternity Care in England and its Impact on Migrant Women




maternity action

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Project team:

Rosalind Bragg, Rayah Feldman, Johanna Hardwick, Renata Cleaver Malzoni, Annah Psarros

The report was written by Rayah Feldman

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Foreword

By believing passionately in something that still does not exist, we create it. The nonexistent is whatever we have not sufficiently desired.” Franz Kafka

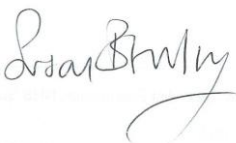
This well researched report from Maternity Action achieves a great deal in exposing institutional flaws and indifference to the problems of charging pregnant women for their maternity care. The absurdities and adverse impacts on the lives of some of the more marginalized women are vividly described. As an academic and clinician involved in assisting women birth safely for over 40 years, I know how lucky we are in the UK to have a system of universal health care.

It’s surely a basic human instinct to want to protect children and help them flourish. Additionally, women have a right to access all NHS maternity care whether or not they are able to pay for their care. Good quality services led to improvements in maternal and child health but it appears those gains were fragile. What was taken for granted is now not afforded to all who live here. Systems in place in the UK seem designed to grind down the spirit, resilience and resources of pregnant women and new mothers who need them most. Safety needs vigilance and clinicians must not be drawn in as unwilling bystanders to a loss of safe care. The National Institute of Health and Social Care Excellence has special guidance for pregnancy with complex social factors. Although specific groups of poverty and migrants are not spelled out, these undoubtedly are high risk pregnancies. The women described in the report are migrants, and mostly destitute. When NICE guidance for maternity care is undermined by charging, there will inevitably be poor health outcomes for mothers and babies. These are real people, not pawns in a game of political point scoring.

It is difficult to see in the UK’s deliberately ‘hostile environment’ anything other than the inhumanity of bureaucracy flagged by Kafka. Charging guidance is deeply problematic, implementation is woeful and the research that informed these policies was flawed. Billing pregnant women at 150% of tariff can’t generate income from the destitute.

Reading this report could lead to despair, or be a call to action. I believe it is possible to get away from the cruelty of the charging system, and simply return to basic decency. While we wait for the groundswell of support to make charging history, health professionals should be vigilant to migrant women’s needs. Trusts must take note of the findings and treat chargeable women with respect, particularly by adopting clear and transparent charging procedures. Face-to-face meetings, use of interpreters, early discussion of options, repayment plans, waiving of odious unpayable old debts and a ban on debt collectors appearing immediately post birth would go a long way to reduce unnecessary stress. Being harassed for money just after having a baby doesn’t help women’s mental health. Written information about the charges, payment options and how to appeal are vital. GPs too will find recommendations for good practice.

Of course, the most straightforward and effective recommendation is for a fundamental change to charging policies with immediate suspension of charging for NHS maternity care.



Susan Bewley MA MD FRCOG
Department of Women and Children’s Health, King’s College London

Acronyms

CEMACH	Confidential Enquiry into Maternal and Child Health
CMACE	Centre for Maternal and Child Enquiries
FGM	Female Genital Mutilation
EEA	European Economic Area
EU	European Union
GP	General Practitioner
HIV	Human Immunodeficiency Virus
NHS	National Health Service
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
NICE	National Institute for Health and Care Excellence
OVM	Overseas Visitor Manager
UK	United Kingdom
UKBA	United Kingdom Border Agency

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Executive summary

Background

The study

This is the report of a study by Maternity Action to explore the impact on migrant women who faced charges for NHS maternity care during and after their pregnancies. It was carried out in response to growing concerns that women at risk of being charged for maternity care are delaying or avoiding care. It is based on in-depth interviews with sixteen women from eleven countries in north and sub-Saharan Africa, Latin America, south-east Asia and the Caribbean who were charged, or expected to be charged for their NHS maternity care. It also draws upon case summaries from Maternity Action's Maternity Care Access Advice Service.

Charging rules and entitlements for maternity care

Only people deemed ordinarily resident in the UK, or who belong to an exempted group are entitled to free secondary (hospital) care in the UK. Non-EEA citizens who have Indefinite Leave to Remain in the UK are deemed ordinarily resident but since 2015 all other longer-term visa holders are required to pay an Immigration Health Surcharge which entitles them to free use of all NHS services for the duration of their visa. Overseas visitors are charged 150% of the normal tariff and Clinical Commissioning Groups and hospitals have a duty to report to the Home Office any patients who owe £500 or more for two months who have not negotiated a repayment plan.

Some migrants who are not ordinarily resident are exempted from NHS charges, including refugees, asylum seekers awaiting a decision, and refused asylum seekers supported by the Home Office, as well as victims of modern slavery. Holders of visitor visas and undocumented migrants are the main chargeable groups under current rules.

Some conditions, notably infectious diseases are exempt from charging but all non-exempt conditions are chargeable. Any non-urgent care must be paid in advance, but 'urgent' or 'immediately necessary' care must be provided whether or not a person can pay in advance. Department of Health guidance and recent statutory regulations regard all maternity care as immediately necessary. This means it must not be refused or delayed if a woman is unable to pay in advance though women will still be charged for their maternity care.

Undocumented migrants and social exclusion

Undocumented migrants are mainly visa overstayers or people in breach of their visa conditions. Refused asylum seekers are also regarded as undocumented unless they receive Home Office support. Undocumented migrants are among the most excluded and vulnerable people living in the UK today. As well as being subject to charges for NHS care, they have no right to work or to claim benefits and cannot rent from private landlords.

Undocumented women are especially vulnerable. They are often destitute as a result of domestic violence or relationship breakdown. Many are asylum seekers whose applications were refused, but who are unable or afraid to return to their country of origin. Fees for immigration applications have increased year on year, making it virtually impossible for many people to regularise their immigration status without assistance.

Migrant women and high risk pregnancies

Confidential Enquiries into maternal mortality show that minority ethnic women, particularly black African and Caribbean women have significantly higher risks of maternal mortality than white British women although Caribbean women were less likely to be migrants. They also highlighted an association between maternal deaths and lack of antenatal care which resulted in underlying health conditions not being identified during pregnancy. Non-white ethnicity is also associated with increased stillbirth and neonatal death.

The National Institute for Health and Care Excellence (NICE) has drawn attention to ways in which social disadvantage and social problems can adversely affect maternal health and pregnancy outcomes. It identified recent migrants, refugees and asylum seekers, and women who spoke or read little or no English as a distinctive group with 'complex social factors' as having high risk pregnancies, and advocated special efforts to improve access and engagement with maternity services.

Poor or destitute undocumented migrant women also have complex social factors as well as being likely to suffer from underlying health conditions which require regular antenatal care to provide the best chance of maintaining their own health and achieving good pregnancy outcomes.

Women's personal circumstances while pregnant

Most women interviewed had lived in the UK for several years. The immigration history of almost all the women interviewed was complex and their immigration status changed over time. Three women interviewed had British citizen or EU national spouses and one of them was also herself an EU citizen. Two women had come to the UK as asylum seekers but their applications had been refused. One woman came as a domestic servant but applied for asylum while she was pregnant. Others were overstayers from student or visitor visas.

Most of the women had no entitlement to any kind of benefit or financial support during their pregnancies because of their irregular immigration status, and so were often very poor, and even destitute. Undocumented women who were single or whose partners were also undocumented found themselves in very precarious situations. Often their irregular immigration status was a result of the breakdown of relationships with men on whom their status had depended.

Such women had limited survival strategies. These included transactional sex or domestic work in exchange for shelter, dependence on family, friends, churches and charities or working illegally, often in domestic work for very little cash in hand with no employment protection. However, pregnancy can cause the breakdown of any of these strategies and leave women completely destitute especially if they are also abandoned by their partner.

Of the sixteen women interviewed, when they became pregnant five were married or in long-term relationships, five were abandoned by their partners when they became pregnant, and three were in unstable or abusive relationships. Three women did not disclose any information about their former partner, six of the women were homeless and destitute during all or part of their pregnancies.

Almost all the participants in this study reported suffering from anxiety and stress during their pregnancies. Several women also had physical health problems during their pregnancies or had histories of poor pregnancy outcomes. Several women had children with health or developmental problems.

Charging Practices and procedures

Determining chargeability

The study found that it is more difficult for hospitals to determine eligibility for NHS care than the Department of Health guidance acknowledges. In practice, individuals' immigration statuses are both complex and fluid

with people moving from one immigration status to another, as their personal circumstances change. Moreover, even without changes to their immigration status, eligibility for free maternity care (and other NHS secondary care) can change in the course of a pregnancy, for example, when a refused asylum seeker obtains Home Office support and so becomes eligible for free NHS care.

Hospitals accepted women's immigration situation without investigation into their history or circumstances, and charged them according to their perception of their immigration status at that moment. However, where women did obtain immigration advice, some were able to change their status. One woman interviewed, applied for asylum after receiving advice while she was pregnant, and was ultimately not charged. However, access to good advocacy is essential for this to occur.

Similarly, hospitals' Overseas Visitor Managers often failed to probe women's immigration status appropriately and made errors, charging women who should have been exempt with no change to their status. Two women with EEA entitlements were incorrectly charged. Both women successfully challenged the charges, but only after intervention from legal advisers.

The scale of charges

The women were often confused by the bills they received since they were often not itemised, and even if they were, they referred to the department in which treatment took place rather than to treatment procedures. As a result it is often impossible to tell which procedure was being charged for or, where there are multiple bills, whether a bigger bill incorporates earlier ones or is for another procedure. Recently women have also been charged for previous maternity care and other treatments that took place often several years earlier which were not billed at the time.

Bills varied widely in size and at what stage during or after their care they were issued to the women. Five women in the study received invoices while they were pregnant. The remaining ten women who were charged were billed after they gave birth or miscarried, from one day to nearly a year postnatally.

Over half the women reported charges of over £4000. Charges ranged as follows:

Size of bills by women charged

Size of bill reported	Number of women
Over £6000	5
£5000-£5999	3
£4000-£4999	3
£3000-£3999	1
£2000-£3999	3
No charge	1
Total	16

Hospital charging practices

How they were charged or approached about charges affected women as much as did the size of the bills. They often received letters requesting payment together with invoices demanding payment on receipt of the invoice, never having been informed before that they were going to be charged. Letters frequently contained threats that they would be reported to the Home Office, to debt collection agencies, or to fraud investigators.

Many letters came directly from debt collection services. Women described being besieged by telephone calls demanding payment as well as by letters. The callers often threatened that if the woman did not pay she would be reported to the Home Office. One woman, billed the day after she gave birth, was told she could make a repayment plan of £100 per month. It was clear that the caller, almost certainly a debt collection agency, had no notion that she had no right to work or benefits.

Only one of the women interviewed managed to pay the full bill by means of her British citizen partner working overtime for a year. Another woman who had obtained leave to remain after her baby was born, entered a monthly repayment plan of £10 per month, which would take her 45 years to repay.

One woman was not charged because she claimed asylum and received asylum support during her pregnancy. Another had her charges waived after a request from the homelessness charity where she was living. Two women, wrongfully charged, had their bills cancelled following legal representations but received no letter of explanation or apology from the hospitals concerned. None of the other study participants had even begun to make repayments at the time of their interviews or had any expectation of being able to do so.

Refusal of care

In spite of clear guidelines that all maternity care must be treated as immediately necessary and not be withheld if a woman is unable to pay, one woman was informed in writing half way through her pregnancy that her future appointments would be cancelled if she failed to pay the bill. Maternity Action's advice service has reported several similar cases where both hospitals and GP practices have incorrectly refused treatment or GP registration because of a woman's lack of immigration status.

The impact of charging on women

The impact of being charged for their maternity care has to be seen in the context of the women's situation of social exclusion, destitution and stressful lives. All the women interviewed described their initial reactions to receiving bills for their maternity care in terms of shock and bewilderment, especially as most of them had been unaware they had to pay, and none were in a position to do so.

It was always a blow for women to receive demands for payment, especially for sums which they knew they had no chance of paying. This was the case as much for women who believed (rightly) that they were eligible for free care as for those who were chargeable under current rules.

Three women said that had they known earlier that they would be charged they would have had an abortion though in the event, did not do so. However, for most women, the invoices, accompanied by letters and phone calls requesting money and threatening to report them to the Home Office, or even telling them that they would never be able to regularise their stay, induced very high levels of anxiety and fear, affecting their physical as well as mental health. Some women spoke constantly of their fears of what might happen because they could not pay the bills they had received. Whether or not women were billed during or after their pregnancy, the demands for payment affected their willingness to see a midwife or doctor when they were not well, or even for routine appointments after they had given birth.

Cases from the Maternity Action advice service also provide strong evidence of how NHS charging acts as a deterrent against women accessing maternity care. Many of the cases reaching the advice service also involve women who avoided accessing maternity care both because they were afraid of being billed for care, and of the Home Office being notified, putting in jeopardy their immigration applications. However, few participants in the study were able to get advice and support about charging. They did not know whom to ask; generalist migrant advice charities whom they approached with housing and financial support needs are unlikely to have either expertise or capacity to help negotiate with hospitals about patients' entitlements to NHS care.

Only one woman said that an Overseas Visitor Manager was sympathetic, but even he could not give her any advice other than to offer to make a repayment plan. In spite of the recommendations in the Overseas Visitors

Charging Guidance on charging vulnerable people, no woman interviewed reported having been given any information from the hospitals about support organisations they might contact for help with repayment or advice about their entitlements.

Analysis and conclusion - Charging for NHS maternity care in a wider context

The NHS - a threatening or caring institution?

Classifying patients by eligibility, and imposing punitive charges on some and not others, fundamentally transforms the culture of the NHS. For people who cannot prove their eligibility for free NHS care, NHS hospitals and even GPs, can become a threat rather than a caring solution to their health needs.

The imposition of charges is incompatible with midwives' and other health professionals' ability to address sensitive issues or underlying conditions appropriately and in good time, and to put into place recommended specialist or interprofessional support for affected women and their babies. Anxiety about charges not only prevents the trust and reassurance that women should get from good maternity care but also deters some women from other NHS care even after they have given birth.

Charging also adds to the factors giving rise to stress and anxiety among migrant women who are pregnant. By deterring women from attending maternity care, it denies women access to clinical care and social support with possible long-term adverse consequences for their own and their children's health.

Gender inequality, immigration control and NHS charging

The report has examined some ways in which gender intersects with immigration and often positions women migrants in dependent and vulnerable situations. The individual billing of NHS patients is particularly inappropriate in the case of maternity care, where women's partners are involved in creating the need for such care, but are entirely absolved from responsibility for contributing to it financially. Undocumented women migrants or visitors without long-term leave can thus find themselves particularly vulnerable to unscrupulous men.

At the same time, immigration policy and, in particular, policies on NHS charging have focused on women migrants solely in terms of their presumed reproductive intentions, denying them both legitimacy as workers, students, family members, refugees, or indeed as full human beings in their own right. This approach has led to a singular refusal to consider exempting maternity care from the Overseas Visitors charging regulations despite an acknowledgment of the greater health risks and worse pregnancy outcomes of this group.

Many of the individuals affected by charging are in the process of applying for leave to remain in the UK, but are subsequently left saddled with burdensome debts. The complexity of the rules about entitlement also mean that many people, particularly those from minority ethnic backgrounds, are caught up in the effects of charging even when they are fully entitled to free NHS services.

It is clear that most of the women interviewed in this study will never be able to pay the sums demanded, and it is likely that the costs incurred in attempting recovery, will outweigh the actual costs incurred. But the price of charging vulnerable migrant women for maternity care is much higher, undermining the ethos and principles of a national health service created to meet clinical need regardless of an individual's ability to pay and inherently discriminating against women. Above all it has an immediate and long-term negative impact on the health of the women and families and is a significant further barrier to migrant women's access to health services.

Recommendations

1 Fundamental change to charging policies

The government should immediately suspend charging for NHS maternity care.

Charging has a deterrent effect on women's access to maternity care which poses risks to their pregnancies and the health of their babies. Anxiety about charging has an adverse effect on maternal mental health with consequent effects on women's pregnancies and pregnancy outcomes. Although all maternity care is designated as immediately necessary, this does not compensate for the anxiety women feel knowing that they are unable to repay very high charges.

2 Interim measures to mitigate the harmful impact of charging

National policy changes

The government should amend the Immigration Rules to stop debt from maternity care affecting future immigration applications.

Fear of being reported to the HO affects women's engagement with maternity services.

The government should abolish the 50% surcharge on the standard tariff on any charges imposed until all charges are suspended.

The 150% overseas tariff is justified as offering a 'risk-share' arrangement between providers and commissioners in order to share 'the risk of non-payment' (1: pp107-8). This system puts additional pressure on chargeable women and thus adds to the deterrent effect of charging while in no way increasing their ability to repay.

Changes by hospital trusts

All hospital trusts should develop policy and practice guidelines on charging procedures.

This is in order to mitigate damage done to women by charging for maternity care. Such policies should be informed by, though not restricted to, the Department of Health guidance on charging vulnerable patients (1: Ch 7). The implementation and impact of such policies should be monitored and regularly evaluated.

Trusts should waive existing charges for all patients who are unable to pay.

Costs cannot be recovered from women who are unable to pay so cancelling existing charges where women are unable to pay, saves women a great deal of anguish.

No notification should be made to the Home Office for any woman with a repayment plan in place or whose charges have been waived.

It is unreasonable and unjust for migrant women to be reported to the Home Office to be penalised for non-payment or non-completion of a debt which the waiver or payment plan indicates they are unable to pay.

Trusts should establish transparent criteria for establishing inability to pay. These can be based on existing assessments of low income or destitution.

Such assessments include: women in receipt of section 17 support under the Children Act, 1989, women who hold HC2 certificates for full help with health costs, women who have obtained fee waivers from the Home Office for current immigration applications, and women who meet the destitution criteria for asylum support.

Use of recognised eligibility criteria for low income or destitution would make charging decisions comparable and transparent, recognising certain groups' inability to pay charges.

Women should be notified that they are chargeable within two weeks of their first contact with a trust's maternity services. This should include an opportunity for a face-to-face discussion about charging with the Overseas Visitor Manager.

Early notification will enable women to make informed choices about further action which they consider appropriate. A face-to-face meeting enables issues to be clarified.

All invoices or other demands for payment should be initiated before the end of a woman's maternity care.

Unnecessary late billing creates avoidable additional anxiety for women.

No belated demand for payment should ever be made for maternity care for previous pregnancies which were not billed at the time. Any such debts should be waived.

It is unreasonable and unjust for women to be charged years after receiving care for which they were not charged at the time.

Under no circumstances should a trust pass a request for payment to a debt collection agency less than three months after a woman has given birth.

This would help to reduce stress on a woman with a newborn baby and give women time to consider their payment options after giving birth.

All trusts should ensure that no maternity booking appointment or further maternity care be refused or delayed for any reason relating to charging.

As long as charges for NHS maternity care continue to be imposed, it is incumbent on hospital trusts to develop implementation policies which follow Department of Health guidelines. They should also ensure that they are monitored and evaluated regularly to limit adverse impacts on individual women and to minimise increasing health inequalities among women and babies.

Debt recovery actions should not be initiated without first establishing that women have understood the charges, have been offered an opportunity for a realistic and affordable repayment, and been signposted to an appropriate advice service. Women should be supported in making affordable repayment plans.

Department of Health Guidance recognises that OVMs should take steps to understand the needs and circumstances of vulnerable patients and help them to get advice and information to enable them to make informed choices regarding payment (1: p53). If women are having difficulty maintaining repayments they should be signposted to independent debt advice services. In such circumstances, no notification about the debt should be made to the Home Office until women have received advice and modifications to their repayment have been considered, or the charges waived. Women's circumstances can easily change during the course of instalment payments. With proper advice, such a plan can be adapted in response to a woman's new situation.

All trusts should ensure that all communications and actions relating to charging treat women respectfully and show an understanding of their vulnerabilities in line with the trusts' responsibilities as health providers. This will include the following basic considerations:

- Face-to-face information about charging should be provided within two weeks of a woman's contact with maternity services, and with an interpreter, if needed.
- Communications must *highlight* a woman's right to access *all* NHS maternity care whether or not she is able to pay for her care.
- All communications relating to charging should be written in clear and comprehensible language. Any communications sent to a woman with limited English should be translated into a language which she can understand.
- Any requests for payment should include a written statement which explains the decision to charge the woman receiving the request. It should also include an estimate of the final bill, and clear payment options, including genuinely affordable repayment plans. Such a request should also provide information about how to appeal the decision to charge and/ or the amount charged.
- Hospital trusts should ensure that communications with women from debt collection agencies be sensitively worded, and that such agencies do not harass women with telephone calls. Such agencies should also be informed if women cannot understand English.

Insensitive and officious communications from trusts and debt agencies have been shown to have harmful effects on the mental health and health seeking behaviour of women receiving maternity care. Consideration of the function and purpose of communications and how any communication impacts on the recipients should inform and underlie all communication about charging. The central concern should be to **not** deter women from seeking maternity care, and to enable them to retain trust in their treating midwives and other clinicians.

Clinical Commissioning Groups should ensure that GP practices in the local area be informed about NHS charging policies especially in relation to maternity care, and about where women can get advice locally. Wherever possible, GPs should inform any practice patients who become pregnant that they may be charged for maternity care and where they can receive further advice and information.

GP practices are a key element in most women's initiation to maternity care. It is essential that GPs are themselves familiar with national and local charging policies in order to be able to help women better understand the system and obtain appropriate assistance.

3 Good practice in maternity care for vulnerable migrant women

Charging for NHS maternity care undermines efforts to optimise care for disadvantaged migrant women. Nonetheless, trusts should continue to follow NICE guidance on women with complex social factors and other national policies in order to reach such women and enable them to access the maternity care they need (2,3).

Vulnerable migrant women face many other barriers to healthy pregnancies and to accessing good maternity care besides NHS charging. While NHS charging undermines many of these good intentions, they should remain the goals of maternity care for all migrant women. Concerns about entitlement to free NHS care should never take priority over trusts' responsibilities to meet the health needs of migrant women and their babies.

Trusts should make efforts to provide outreach to recent migrants and women with little or no English via local organisations and GP practices to encourage early booking and help to develop trust and confidence in maternity services.

Reducing inequalities in health has been repeatedly restated as an aim of policies to improve maternity care. Such policies consistently emphasise the need for special efforts and/or service provision to identify and reach disadvantaged women.

Interpreting services should be provided routinely if a woman is unable to communicate satisfactorily with midwives or other clinicians.

Good mutual comprehension is fundamental to midwives' ability to identify women's health needs and to establish trust between themselves and the women they are looking after.

Trusts should audit clinic attendance and pregnancy outcomes of all migrant women, noting whether or not they were charged.

While it is known that migrant women face higher risks of maternal mortality, such audits would provide more information about factors affecting women's participation in maternity care and broader pregnancy outcomes of migrant women. It would also contribute to a better understanding impact of charging for maternity care.

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Chapter 1 Introduction

Background to charging for NHS maternity care

Charging for NHS healthcare is part of a range of policies administered by public and private bodies intended to deter irregular migration to the UK. Such policies have been encouraged by successive governments and have culminated in the ‘hostile environment’ initiated under Theresa May when she was Home Secretary. NHS charging, widely introduced in hospitals in 2004, was initially rationalised as a deterrent against ‘health tourism’ but is now unashamedly used to exclude undocumented and other temporary migrants from access to NHS healthcare (1-3). Unpaid debts incurred as a consequence of charging can be used as a sanction to reject new or further immigration applications.

Evidence from a growing number of studies and reports from migrant advice organisations show that women at risk of charging for maternity care are more likely to delay or avoid care. This is due to fears of incurring large debts and of being reported to the Home Office, so jeopardizing the success of future immigration applications (4-8). Many of the women affected are poor or destitute, and are likely to have underlying health conditions which require regular antenatal care to provide the best chance of maintaining their own health and achieving good pregnancy outcomes. However, maternity care has never been exempted since charging for “Overseas Visitors” became a statutory obligation on NHS hospitals.

The UK has signed legally binding international conventions which require the provision by signatories of appropriate antenatal and postnatal care (9-10). Since charges were introduced campaigning organisations have also made efforts to exempt maternity care from charges but without success.

Department of Health guidance, and more recently, statutory regulations, have deemed all maternity care to be “immediately necessary” (11,12). This means it must not be refused or delayed if a woman is unable to pay in advance. However, this policy is often not followed and there is long-term as well as recent evidence women that have been refused care if upfront payment is not forthcoming. (13,4-6). More importantly, the prospect of large debts as well as the fear of immigration sanctions can deter women from accessing maternity care at the recommended time or from attending the recommended number of appointments.

Charging rules and entitlements¹

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 (14). In 2004, hospital trusts acquired a statutory duty to determine the eligibility to health care of an ‘overseas visitor’ (15). For the first time in NHS history, it represented a deliberate policy by governments to restrict access to NHS services to particular, though not easily definable groups of non-citizens. Since then this policy has continued and been intensified.

Charging overseas visitors for NHS care only applies to secondary care and some community services but does not include primary care. Since 2017 hospital trusts have become required to ask for advance payment for an estimated charge for treatment, unless care is urgent or immediately necessary, and to identify on a patient’s record whether the patient is chargeable or exempt (12).

¹ 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.

Only people deemed ordinarily resident in the UK, or who belong to an exempted group are entitled to free secondary care in the UK. Non-EEA citizens can only be considered as ordinarily resident once they have Indefinite Leave to Remain in the UK. 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 (16).

Since 2015 all other longer-term visa holders are required to pay an Immigration Health Surcharge (IHS) of £200 per year (£150 for student visas) on top of their visa application fee. This then entitles them to free use of all NHS services for the duration of their visa (11).

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 victims of modern slavery. Most nationals of the EEA states and Switzerland who have an EHIC card are also exempt from charging (34). Home Office 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 (17).²

Holders of visitor visas are not eligible for the IHS so it is they and undocumented migrants who are the main chargeable groups under current rules. In relation to maternity care this means that many women who are partners or spouses of men with ordinary residence, but who are in the UK on a visitor visa or are overstayers and have not obtained longer term leave, will be chargeable for their NHS care. This applies even if they have already submitted an application for leave to remain.

There are also certain services which are exempted from charging. These include infectious diseases such as tuberculosis, HIV and other sexually transmitted diseases. 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 (11).

Treatment for chargeable non-EEA overseas visitors is charged at 150% of the standard commissioning tariff to NHS Clinical Commissioning Groups (19). Hospital trusts and any other chargeable services are required to report to the Home Office any debts of £500 or more which remain unpaid after two months, or for which plan for repayment has not been made (20).

The complex eligibility criteria for free NHS care have given rise to Department of Health charging guidance which now runs to 118 pages and to the presence of Overseas Visitor Offices in all hospitals. Overseas Visitor Managers (OVMs) are responsible for the accurate identification of the immigration status of patients. The guidance, in trying to address the eligibility for free NHS care of all possible immigration statuses, ignores a central issue - that individuals' immigration statuses are both contested and changeable. It is therefore extremely difficult to ensure that all patients are charged appropriately. Moreover OVMs are not required to have qualifications in immigration law which can lead to errors in determining eligibility and wrongful charging.

Undocumented migrants and social exclusion

Many earlier reports and guidance dealing with migrant health have traditionally focussed on refugees and asylum seekers as the archetypes of vulnerable migrant groups (21,22). In the last two decades, however, changes both in patterns of immigration and in immigration policy point to unaddressed needs of undocumented migrants who are at the crux of the 'hostile environment' and charging policies. Asylum seekers are entitled to a minimum level of support from the Home Office until all their appeal rights are

² In Scotland and Wales, anyone who has submitted a claim for asylum is entitled to free NHS secondary care whether or not it has been successful, and regardless of whether they receive Home Office support (18).

exhausted, and refugees have the same rights to work and to benefits as British citizens. Both groups are entitled to all NHS care without any payments.

Although errors are frequent, and there is often ambiguity about a person's immigration status and hence their eligibility for NHS care, as has been seen in the recent scandal of the 'Windrush generation', the groups who routinely face the worst barriers to healthcare are undocumented migrants who are required to pay for almost all hospital care.

Undocumented migrants are mainly visa overstayers or people in breach of their visa conditions. This may mean that their residence or work permit is invalidated or expired, for example because of the breakdown of a relationship on which it was dependent. Some undocumented migrants may have entered the UK without valid documents. Refused asylum seekers are also regarded as undocumented unless they receive Home Office support. Other undocumented migrants, especially women, may have entered on a short-term visitor visa to join their partner, but have not been able to obtain longer term leave.

Undocumented migrants are among the most excluded and vulnerable people living in the UK today. As well as being subject to charges for NHS care, they have no right to work or to claim benefits; they cannot rent from private landlords or obtain a UK driving licence. Although immigration checks on migrants' bank accounts were suspended in the wake of the "Windrush" scandal, undocumented migrants still mainly live at the margins of society. Even families with children who are supported by local authorities under the Children Act 1989³ are not exempted from NHS charges (23).

Undocumented women are especially vulnerable. They are often destitute as a result of domestic violence or relationship breakdown. They are frequently asylum seekers whose applications were refused, but who are unable or afraid to return to their country of origin. Many have children from relationships in the UK, who may be British citizens. 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 (24).

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 (25,26). The current study shows that because of their extreme dependence on partners for support, undocumented women are also at high risk of destitution in the event of relationship breakdown.

As well as undocumented migrants' prohibitions from work and benefits, fees for immigration applications have increased year on year, making it virtually impossible for many people to regularise their immigration status without assistance. Growing numbers of vulnerable and destitute families are therefore accessing advice services to seek help to apply for leave to remain (27, 28). Such services report increasing instances of women presenting bills for maternity care and child treatment which they have no hope of paying, but which they fear will jeopardize their efforts to regularise their immigration status in the UK.

³ 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 Section 4 asylum support rates for refused asylum seekers of £35.39 per person per week (20).

Migrant women and high risk pregnancies

Concern about migrant women's access to maternity care stems from a long-standing recognition of significant ethnic inequalities in maternal mortality and poor pregnancy outcomes identified in successive Confidential Enquiries which investigated the causes of maternal mortality in the UK. Most collected data on ethnicity rather than on migration, though the 2007 report did draw attention to the fact that Black African women included asylum seekers and newly arrived refugees (29).

The Confidential Enquiries and related studies show that minority ethnic women, particularly black African and Caribbean women have significantly higher risks of maternal mortality than white British women although Caribbean women were less likely to be migrants. They also highlighted an association between maternal deaths and lack of antenatal care which resulted in underlying health conditions not being identified during pregnancy (29-32). Non-white ethnicity is also associated with increased stillbirth and neonatal death (33-35).

In 2010 the National Institute for Health and Care Excellence (NICE) issued guidelines on antenatal care for women with 'complex social factors'. NICE's aim was to find ways of improving access and overcoming barriers to services and to facilitate maintaining contact throughout pregnancy for such women. This was to be achieved by identifying and, if necessary, providing additional care "over and above that described in the NICE guideline 'Antenatal care: routine care for the healthy pregnant woman: clinical guideline 62'" (36).

NICE Clinical Guideline 110, 'Pregnancy and Complex Social Factors' drew attention to ways in which social disadvantage and social problems could also adversely affect maternal health and pregnancy outcomes. NICE identified recent migrants, refugees and asylum seekers, and women who spoke or read little or no English as a distinctive group at high risk, and advocated special efforts to improve access and engagement with maternity services. NICE also noted poverty and homelessness as key examples of 'complex social factors'. (36)

High risk or complex pregnancies can stem from medical complications or social risk factors or a combination of both. Both social and medical risk factors are particularly likely to be present among undocumented migrant women (37). Medical complications can be due to existing health conditions such as diabetes, heart disease, HIV or hepatitis infections, or to conditions arising in pregnancy, especially gestational diabetes or high blood pressure. Social risk factors include poverty, homelessness or precarious housing, domestic abuse, violence or exploitation in their home countries, during travel or in the UK, inability to speak English, or poor mental health. Often these circumstances are interlinked.

Women in these situations 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. But as this study shows, in practice such women face additional barriers to accessing appropriate maternity care. Difficulty registering with GPs, ignorance of how the NHS works and limited knowledge of English can often make it difficult for women to obtain timely maternity care. In addition, migrant women often have had negative experiences with the health system, which may make them reluctant to engage with services (38). To this can be added, more recently, fear of receiving large bills and of being reported to the immigration authorities because of an inability to pay.

The current study

This report follows a scoping study by Maternity Action carried out for the Women's Health and Equality Forum which investigated the impact on health inequalities of charging undocumented migrant women for maternity care (5). It is based on interviews with women who were charged or had concerns about being charged for maternity care. It also draws upon case summaries from Maternity Action's Maternity Care Access Advice Service (referred to throughout as Maternity Action's advice service) which is dealing with an increasing

number of requests for advice relating to the manner, appropriateness and impact of NHS charging for maternity care.

Methodology

The study sought to investigate how NHS charging rules operate in practice, and how women who are affected, respond to and manage to deal with their impact. We also sought to obtain information from as wide a range of women as possible in order to see whether different backgrounds, including country of origin, relationships and immigration history in the UK might affect women’s experiences of charging.

Women were recruited who had been or had expected to be charged for their maternity care within the five years prior to the interview. We deliberately endeavoured to recruit women from a range of nationalities and regions, in the expectation that their circumstances might vary somewhat depending on where they came from. Table 1.1 shows the regions of origin of participants in the study. Other demographic details about the women are given in the course of the report.

Table 1.1 Participants’ regions of origin

Woman’s region of origin	Number of women	Countries of origin
North Africa	1	Algeria
Latin America	3	Brazil, Colombia, Ecuador (EU citizen)
South east Asia	2	China, Philippines
West Africa	9	Ghana, Guinea, Nigeria (6 participants), Togo
Caribbean	1	Jamaica
Total	16	

Women were reached after referral from various agencies after we had put out a call for participants, and we visited some agencies to try to meet women who might fit our selection criteria. 16 women of 11 nationalities were recruited. Ten women were recruited via migrant advice agencies, one after an invitation from the Maternity Action advice service to some clients, three from a migrant women’s group, and one from a Latin American mother and baby group. One woman was recruited who works for a migrant women’s rights service.

One woman had EU citizenship besides her original nationality; one was a dependant of an EU citizen and two were married to British citizens. Women’s immigration statuses only emerged in the course of the interviews and were not a basis for recruitment. However, as their immigration statuses proved to be more fluid and changeable than we had anticipated, where possible we re-contacted as many participants as possible some months after their first interview to try to find out what had happened to them in the interim.

In-depth semi-structured interviews were carried out with the women who had been recruited. All the interview participants lived in or near London. Most were interviewed in their homes, but one woman who lived outside London was interviewed by phone and five women were interviewed in a quiet room at the Maternity Action offices. Two interviews were conducted with interpreters, two in the woman’s own language, and the remainder were carried out in English.

An advisory group was appointed whose members commented on the interview topic guide and the final report. Formal ethical approval was not sought but standard ethical guidelines were followed, including a commitment to confidentiality and an assurance that all recordings of interviews would be destroyed. All participants were given verbal and written information about the project and signed consent forms before

the interviews. Where appropriate they were referred to the Maternity Action advice service for advice about their situation. They were reimbursed £15 for their expenses and in recognition of the time and effort involved in participation.

The interviews were carried out by two members of Maternity Action staff, including the lead researcher, Rayah Feldman and two experienced volunteers who were later employed by Maternity Action. All the interviewers were trained in qualitative interviewing and dealing with sensitive issues and the specific issues surrounding charging for maternity care by the lead researcher. All interviews were recorded and transcribed by the interviewers. Recordings were destroyed after transcriptions were checked. Interview transcripts were analysed thematically using standard word processing software.

In addition to the interviews, we were given brief anonymised vignettes of some cases dealt with by advisers at the Maternity Action advice service. We have used some of these to provide further evidence of charging procedures and the impact of charging on women and families.

The study participants were also asked to allow us to photograph examples of invoices and letters received, some of which are reproduced in this report. In order to fulfil our commitment to their confidentiality, where hospitals are identified in these letters, details of names, dates, and invoice references have been obscured. Exact sums invoiced have also been concealed so that the woman whose invoice has been reproduced cannot be identified. Similarly, all participants have been given pseudonyms and their actual country of origin is not given.

Limitations of the study

Despite strenuous efforts we failed to recruit any eastern European or south Asian women, although we have reports of women from these regions being charged for maternity care, and the Maternity Action advice service has received requests for advice from women and couples from these regions.

The interviews required probing into sensitive personal issues that women might not have expected to have to talk about when asked to participate in a study about NHS charging. It was not possible to investigate in as much depth as we would have liked in a single interview, and we did not have the capacity to carry out multiple interviews. As a result, some aspects of women's lives relating to their pregnancies such as their relationships with their child's father, their experiences of domestic violence were not as fully addressed as we would have liked.

The study may have understated the medical conditions affecting the participants. None of the interviewers have medical training, and we depended on women's own accounts of their health and their pregnancies which were described more in terms of symptoms than of conditions.

The report

In the remainder of this report, Chapter 2 describes the personal histories and current family circumstances of the interview participants. Chapter 3 examines the charging procedures operated by the hospitals, and explores the different types of charging practice. It also looks at how hospitals dealt with women who were unable to pay or who claimed they were wrongly charged. In Chapter 4 we look at the impact on the participants of being charged for their maternity care, and how they responded to requests for payment. Chapter 5 discusses the implications of the study's findings. It explores how charging affects the culture of the NHS the effect this has on people affected by charging, especially on pregnant women's use of the service and on their health. It also considers gender issues raised by charging for maternity care. Finally the report sets out recommendations developed in the light of the study.

Chapter 2 Women’s personal circumstances and background

Circumstances before and during pregnancy

The study explored women’s personal history and migration history before the pregnancy under discussion. There was wide variation in the length of time women had lived in the UK. All but one of the participants had lived in the UK for several years before their last pregnancy as shown in Table 2.1. Only one woman interviewed entered the UK when she was already pregnant. She came to join her British citizen husband who was living in the UK.

Table 2.1 Participants length of residence in the UK before the most recent pregnancy

Length of residence in the UK	Number of Participants (n=16)
Less than one year	1
1-3 years	2
3-5 years	4
5-10 years	5
10-15 years	2
15-16 years	2
Total	16

The mean length of residence in the UK before their last pregnancy was 6 years and 5 months and the median was 3.8 years. This compares with a mean length of residence of 4.6 years before delivery of women seen in a Doctors of the World clinic and show wide variability (1).

At the time they became pregnant over half the women were visa overstayers (undocumented) or people with visitor visas who are chargeable under current immigration rules. The immigration history of almost all the women interviewed was complex and their immigration status changed over time. Three women interviewed had British citizen or EU national spouses and one of them was also herself an EU citizen. Two women had come to the UK as asylum seekers but their applications had been refused. One woman had entered the UK on a visa as a domestic servant for a family but her visa became invalid once she left her job because she was badly treated. Two women entered on visitor visas but were spouses of British citizens and obtained spouse visas after the birth of their baby. Figures 2.1 to 2.3 show the changes that took place in participants’ immigration status by illustrating the distribution of their immigration statuses when they entered the UK, when they became pregnant, and when they were interviewed for this study.

Changes in women's immigration statuses over time

FIGURE 2.1 IMMIGRATION STATUS WHEN ENTERED THE UK (n=16)



FIGURE 2.2 IMMIGRATION STATUS WHEN PREGNANT (n=16)

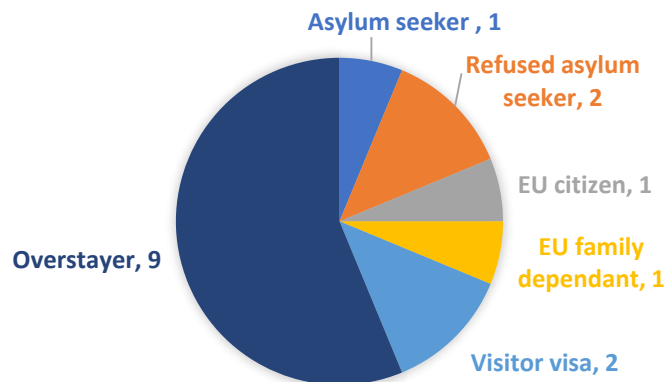
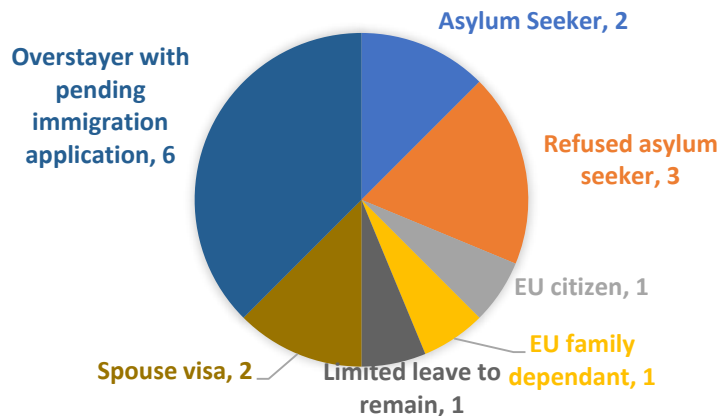


FIGURE 2.3 IMMIGRATION STATUS AT TIME OF INTERVIEW (n=16)



The irregular immigration status of most of the women when they were pregnant meant that they had no entitlement to any kind of benefit or financial support during their pregnancies and so were often very poor, and even destitute. Only one of the participants, who was an EU citizen, was eligible for maternity benefits during her pregnancy. The following case shows in more detail how one woman's immigration status changed before and during her pregnancy.

Helena came to the UK as a domestic servant (nanny) for a family but fled from their home because she was severely exploited. She found a job as a non-resident nanny but was ineligible for maternity or any other benefits. She became destitute when she had to leave her job because of her pregnancy. Later, after receiving legal advice, she submitted an asylum and trafficking claim and was able to receive asylum support from the Home Office. As a result she was not charged for her maternity care.

Only one of the two participants who were refused asylum seekers was able to obtain Home Office support during her pregnancy. Refused asylum seekers who are pregnant and destitute can normally obtain cashless support and accommodation from the Home Office from the 34th week of pregnancy. This is commonly known as Section 4 support.

Three women were supported by their working British and EU partners. Undocumented women who were single or whose partners were also undocumented found themselves in very precarious situations, dependent on friends for financial support and accommodation. Six of the eight single women interviewed had become homeless during their pregnancies because they were unable to pay rent. Several who had no income had been financially dependent on their partners, family or friends and had to leave their accommodation when they lost that support. One woman had to stop working but was not eligible for any benefits, and two were asked leave households where they were staying rent-free when their pregnancies became known.

Undocumented women's economic precariousness was a consequence of their exclusion from access to mainstream economic life, whether work or benefits, because of their irregular immigration status. Their immigration status was often closely linked with their personal situation, especially their relationships with the men to whom they were married or with whom they had sexual relationships both in the UK and in their home countries.

The example of Ayesha illustrates how women migrants can find themselves with irregular immigration status as a result of their dependence on men with whom they have formed relationships.

Ayesha

Ayesha came to the UK in 2011 from West Africa to an arranged marriage. She had not met her future husband but he was 'nice and caring' when she spoke to him on the phone. They stayed together for about 4 months but she fled from him because he turned out to be violent and abusive. At that time she could not speak English and knew nothing about the UK. She survived by helping out different women she met in her mosque who offered her shelter in return for help with housework and childcare. When she became pregnant a family took her in for a longer period but made it clear she would not be able to continue to stay once she had her child. She was afraid to go back to her country because she had run away from her husband, and she was also worried that her family would force her daughter to have FGM. She applied for asylum just before she was due to give birth.

Ayesha's story shows how a woman's undocumented status can stem from her dependence on a partner and how she is treated by him. If her husband had been British or with settled status, and had not been abusive to her, she might have obtained leave on the basis of her marriage, but she had come on a visitor visa which was not extended or changed.

During the six years she had been in the UK her immigration status changed from 'visitor' to 'overstayer' and then to 'asylum seeker'. She was awaiting the outcome of an asylum appeal when we met her. Having been duped into entering into an abusive marriage she fled into near destitution dependent on random short-term

accommodation in exchange for housework and childcare from women she knew. At times such support may have been interspersed with sex in exchange for money or accommodation.

'Staying with friends' is often a code for sleeping with men in exchange for a bed. Many women reported that to support themselves they had moved from place living with 'friends'. This is also often referred to as 'sofa-surfing'. These terms may be euphemisms for transactional sexual relationships or domestic work in exchange for shelter (2-4). Such sexual relationships have also been characterised as 'survival sex' – "the exchange of sex for accommodation and/or other material support," and may involve considerable complexity and range of relationships (5). Such relationships may involve not only financial support and shelter, but also emotional attachment and a hope of stability.

Ayesha did not disclose any information about the father of her baby but was no longer in a relationship with him at the time of her interview. It is possible that her pregnancy and some other women's pregnancies in this study were a consequence of their using 'survival sex' strategies to manage their lives when they were homeless and without income.

Survival sex is one of only a few limited strategies available to help women survive. Other strategies include dependence on family, friends, churches and charities or working illegally, often in domestic work for very little cash in hand. Such work carries no employment protections such as maternity leave or pay. Pregnancy can cause the breakdown of any of these strategies and leave women completely destitute especially if they are also abandoned by their partner.

Personal relationships are important factors in people's decisions to migrate and subsequently whether to remain, move elsewhere, or return home. But women are more frequently the dependants in immigration decisions, whether they are dependants of male asylum seekers, follow partners who have settled, or come, as Ayesha, to form a new marriage. This means that women's immigration status or income is more likely than men's to be dependent on a spouse or partner so they are especially vulnerable to coercion or physical violence. If the relationship breaks down or their partner abandons them, they may not only lose their material support but can also slip into irregular immigration status.

Table 2.2 indicates how unstable the relationships of the study participants were. It sets out a summary of the personal circumstances and relationships of the participants in our study at the time they were pregnant, and their situation at the time of the interview or, where that was possible, after a follow up some months later.

Table 2.2

Immigration status, accommodation and relationships during and after pregnancy

'Name'	Immigration status when pregnant	Situation when pregnant	Partner	Last known immigration situation
Anna	Undocumented	Lived in rented flat with 2 children. Was helped by friends and family but owed rent.	No information about partner	Undocumented
Ayesha	Undocumented Overstayed visitor visa	Came to arranged marriage from which fled because of abuse by husband. Sofa surfed with women she met at mosque but unable to stay when baby was born. Sought asylum the day before she gave birth. Then moved to section 4 accommodation.	No information about child's father	Asylum appeal rejected
Beatrice	Undocumented Overstayed student visa	Her father stopped sending money when she got pregnant so she left rented room. Partner left her and she lived with a woman in exchange for childcare. Thrown out when this woman discovered she was pregnant. Moved in with second man who was abusive. Church members helped her with rent for room so she could leave partner.	Partner denied paternity and disappeared. 2 nd partner abusive	Claiming asylum
Fatima	Visitor visa	Came to join British citizen husband. Lived with sister-in-law and then husband obtained a flat from the council.	Husband tried to abandon her in home country. She returned to the UK separately with her British child born here.	Limited leave to remain
Helena	Undocumented overstayer. Applied for asylum and trafficking claim	Working as living-out nanny but had to leave because of pregnancy and could no longer pay rent. Went to stay with friend, then applied for asylum and went to Home Office accommodation.	Discovered partner was married. Separated	Seeking asylum and trafficking claim
Isabella	Visitor visa	She became pregnant while on visitor visa to join British citizen partner working in UK. Applied for spouse visa which was initially refused. She appealed successfully but did not receive the visa before her baby was born.	Had lived with partner in own country and in his country of origin. Partner is British citizen and working in UK so I. accompanied him when he came back to UK.	Obtained spouse visa one month after child born.
Josephine	EU citizen exercising treaty rights	Working as cleaner. Living with partner in rented flat.	Long term relationship with partner	EU citizen exercising treaty rights
Julia	Undocumented Overstayed after divorce from marriage to EU citizen	Living with with 2 other children in friend's accommodation. Friend mostly away from home.	In unstable and abusive relationship (undocumented) father of children	Pending application for family leave

'Name'	Immigration status when pregnant	Situation when pregnant	Partner	Last known immigration situation
Leah	Undocumented - Overstayed visitor visa	Living with partner in room in shared house but unable to pay rent when he left. Migrant charity then helped her moved into homeless shelter.	Partner left when she became pregnant	New immigration application
Mariam	Undocumented - Refused asylum seeker	Living with friend who paid rent. Friend left UK so she stayed with various friends and finally housed by charity for homeless. Was refused s4 support in pregnancy. Obtained s4 support 5 weeks after birth.	Partner left when became pregnant	Making fresh asylum claim. In s4 accommodation
Mary	Undocumented - Overstayed visitor visa	Did not have fixed address. Lived with different people throughout her pregnancy.	No information about partner	New immigration application
Mei	Undocumented - Refused asylum seeker	Lived with husband whom she met in UK and his relatives. They then separated and she moved to Home Office accommodation.	Married but separated before child was born	Refused asylum seeker in Home Office accommodation
Natasha	Undocumented - Overstayed student visa	Living with extended family.	Partner left when she became pregnant	Making new immigration claim
Nina	Undocumented - Overstayed student visa	Renting room with husband and 2 children. Landlord evicted them. Family moved to social services accommodation 3 weeks after baby born.	Still married	Pending application for family leave
Olivia	Undocumented - Overstayed student visa	Stayed in rented room with partner and 2 children. Supported by Kids Company until they closed. Left to stay with relative after giving birth.	Remains with partner but they now live separately because of accommodation problem.	Pending application for family leave
Rosa	Dependant (wife) of EU citizen exercising treaty rights	Returned to UK with new partner but without proof of residency as wife of EU citizen. Lived with partner in rented room.	Still with new partner who is also EU citizen exercising treaty rights	Dependant of EU citizen exercising treaty rights

- Deserted by child's father when he knew the woman was pregnant
- No information about child's father
- Married or long-term problematic/ abusive relationship ended during or after pregnancy
- Married or in durable relationship

The women who were abandoned by their partners or who had never been in a stable relationship with the father of the child were most likely to have been precariously housed while they were pregnant and were sometimes actually or at risk of street homelessness as in the following case.

Helena

When Helena became pregnant she discovered that her partner was already married with a family and they separated. She was not eligible for any maternity pay or benefits and had to leave her rented room in shared accommodation as she was not allowed to have a baby there. She would have become homeless had not a friend in another city offered her a place to stay.

Helena's experience mirrored that of several participants in this study. Five of the women interviewed were abandoned by their partners when they became pregnant. Three others were separated from marriages or long-term relationships with the father of the child. Three women seem to have been in very brief relationships and were unwilling to talk about the father of their child. Only five women were still married or in long-term relationships. Two of these had residence rights under EU legislation. Only two undocumented women remained in longer-term relationships with partners who were also undocumented. They were the only undocumented women who were able to count on emotional support from their partners despite both couples still awaiting decisions about immigration applications.

Even where couples have established relationships, the pressures of poverty and insecure housing, coupled with anxieties about immigration, can contribute to domestic violence and relationship breakdown (6,7). When women with precarious immigration status become pregnant their partners may become more controlling, and there are also few or no constraints to stop them abandoning their partners and taking no responsibility for any child they have fathered. Alternatively, women may feel trapped in a violent relationship with no option but to stay, as Beatrice's experience illustrates. Despite a lack of uniformity in definitions, studies suggest that domestic violence may increase or be exacerbated during pregnancy (8,9).

Beatrice

Beatrice had overstayed her student visa. When she became pregnant she was living with a man who refused to accept paternity of her child and threw her out. She then moved in with another man who turned out to be violent and abusive but she did not leave him because she had no other income and nowhere to go. Her father had been supporting her from her home country but disowned her because of the pregnancy. She was afraid to approach any authorities because "I was scared of being deported." She told her story to some "church people" who eventually paid a deposit for a room and she managed to leave her violent partner three weeks before her due date.

Undocumented women like Beatrice would be unlikely to claim child maintenance from the father of any children born in a relationship with them, for fear of being reported to the Home Office. Beatrice also had no claim to financial support from the father for the payment of hospital charges.

Women's health in pregnancy

The women's accounts show that destitute pregnant women may already be very depressed as a result of their difficult personal circumstances. Almost all the participants in this study reported suffering from anxiety and stress during their pregnancies.

Mariam

Mariam was a refused asylum seeker from West Africa who came to London after leaving asylum accommodation when her claim was refused. She came from a conservative background and had herself experienced FGM. The relationship in which she became pregnant was her first sexual relationship but her partner abandoned her as soon as she told him she was pregnant and she later discovered that he was in another relationship and already had two children. When Mariam became

pregnant she was living with a friend who was working but who then left the country, leaving Mariam unable to pay rent for the room and dependant on the kindness of other tenants. She later moved from place to place during much of the rest of her pregnancy.

She was also desperately unhappy, unable to eat and crying all the time, and had thought of killing herself during her pregnancy. At the time of her interview her child was almost two but she had still not told her mother that she had a child because of the stigma that would attach to her. Hospital charges of nearly £3000 were yet another blow, as Mariam believed that this debt would prevent her from making any successful immigration claim.

'I lost 13kg (while I was pregnant) because I was sick. I couldn't eat, and I have no one... I am on my own. It's very hard... I was one week in hospital, on my own, no one visited me, no one helped me. Even the social (worker) was saying, this girl has been here one week today, but no one has come. Can you imagine?

I was sharing (a room) with one lady, she's the one who knows how I cried, all those nights, crying. 'Stop crying' she said. I cried night and day, night and day. She always told me, "Listen, if you don't stop it, they will take your child away." If you cry here, they say you don't want the baby, or that you may hurt the baby. The midwife used to come in and say, "Do you think to hurt your baby, or something?" I say, "No. It's not about that. What's happened already has happened, there's nothing I can do about that. It's just sad. It's still sad when you have a child that none of your family can know about."

Maternal mental health problems have become recognised as representing serious health risks for women. The Confidential Enquiries into Maternal Deaths and Morbidity 2009-13 in the UK and Ireland found that 23% of women who died between six weeks and one year after pregnancy died from mental-health related causes, and noted the poor availability of specialist perinatal mental health care (10). A World Health Organization global review of the literature on mental health aspects of women's reproductive health noted that "Summary reviews have found that suicide in pregnancy is not common; however, when it happens, it is primarily associated with unwanted pregnancy or entrapment in situations of sexual or physical abuse or poverty" (11).

In their interviews participants overwhelmingly reported stress, depression and extreme anxiety. We shall show later how receiving bills for their maternity care caused a significant increase in stress. One woman attributed her headaches in pregnancy to her 'situation':

"I always had a headache and was always throwing up. I always felt tired, thinking... Because of the situation I am in, whenever I think about that I get that headache. Yeah whenever I think I always have a headache."

Several women also had physical health problems during their pregnancies or had histories of poor pregnancy outcomes. Four women had very high blood pressure, including one who had been hospitalised for several months during an earlier pregnancy. Other underlying health conditions including diabetes, asthma and sickle cell disease but mostly women's health concerns were specific to their pregnancies. Pregnancy related conditions women reported were gestational diabetes, Strep B infection, H. pylori, low iron, and fibroids. One woman had had two miscarriages, including one in her most recent pregnancy and two other women also had a history of previous miscarriages or a stillbirth. At least four women were delivered by caesarean section in their last pregnancies, three as emergencies.

Children's and family health and welfare

As well as their own health problems some women also had to cope with problems in their children's health. One woman had a child diagnosed with autism, and another, Julia, had three children, all of whom had health or developmental problems. Her first child, born very prematurely suffers from severe asthma, her second

child has delayed reading and speech, and her third child has been on medication since birth for a kidney disease.

Julia

Julia was charged for her third pregnancy and then billed for the earlier ones as well. When asked about how charging affected her, she said:

'When they told me (about charging) I was so panicked. I was so afraid they were going to stop attending to my children, especially P (with asthma) because she needs the help. And G. (the last child with kidney disease). I was so afraid because I didn't know anything about it....If I can't afford the money and they won't attend to my children what was I going to do? I was afraid to lose my children.'

Julia's anxiety about her children also affected her own health, raising her blood pressure, until her solicitor assured her that her children would not be removed from her care, and she then calmed down. So far she has not been charged for her children's medical care.

Isabella

Isabella and her partner were able to pay their bill over the period of year but nevertheless she felt that the bills she received affected her whole family.

'I don't think my whole family needs to be treated like that. It is not just a bill to me, or not even the bill, the harassment I had to endure all those months because I couldn't pay. So I was very stressed, and that affected the way I look after my children, it affected how confident I was to be able to have a different role in society, like work or study and other things, I basically stopped for a year or so, so I could pay this debt. I felt like I was in debt with the whole country! Maybe it was a big deal for me, and it won't be for other people but I was there, pretty much 10 hours a day with two small children while my husband was working extra hours a day to be able to pay this bill. Because we didn't prepare for that.'

Conclusion

This chapter has provided an overview of the types of situation which faced women who were charged for their maternity care. Many of them were socially and psychologically extremely vulnerable and suffered from significant health problems during their pregnancies. Some also had children with serious long-term health issues. But even a woman like Isabella who was living in a stable situation, found that the charges for her maternity care had a negative impact on her family life.

Many of the women were undocumented migrants at the time they were pregnant and were struggling to regularise their immigration situation. Our interviews show that pregnant women who are undocumented migrants are economically dependent and often socially very excluded. They are therefore particularly vulnerable to casual and abusive treatment by men, and to finding themselves alone when they become pregnant. Three women did not disclose anything about the man responsible for their pregnancy, suggesting either that they were afraid or ashamed or that they did not know who the father was. All three, at the time they were pregnant, were homeless and destitute.

Chapter 3 Charging Practices and procedures

Determining chargeability

Since the introduction of the Immigration Health Surcharge (IHS) in 2015, anyone entering the UK on a visa for more than six months has access to free NHS care. Consequently, most chargeable individuals in England are either undocumented migrants, including refused asylum seekers not supported by the Home Office, or people with short-term visitor visas.

The *Guidance on implementing the overseas visitor charging regulations* presents criteria for chargeability as unproblematic, with eligibility for free NHS hospital care a simple consequence of unambiguous immigration statuses and exemptions (1). Yet both this study, and evidence from the Maternity Action advice service show that in practice, an individual's immigration status is both complex and fluid. People move from one immigration status to another as their personal circumstances change over time, making it difficult to determine eligibility. Moreover, even without changes to their immigration status, eligibility for free maternity (and other NHS secondary care) care can change in the course of a pregnancy.

For example, the Department of Health's rules exempt refused asylum seekers from charges when they are receiving Home Office accommodation and cashless financial support (widely referred to as section 4 support), but such support is only given under very stringent conditions. In England, in most cases destitute pregnant women who have been refused asylum can only receive section 4 support after 34 weeks gestation.⁴ So even if they are destitute when they are receiving maternity care earlier in pregnancy, that care will be chargeable until they qualify for section 4 support later.

Mei

Mei was a refused asylum seeker who moved to Home Office accommodation on section 4 support during her first pregnancy. A year after she gave birth she received bills for her maternity care. She went to the Red Cross for help and they asked the hospital to waive the charge and referred her to a debt advice service. The hospital agreed a small reduction in the bill from the date that the application for section 4 support was submitted. It also offered a six month suspension of 'recovery action' for payment. When we interviewed her Mei was still in section 4 accommodation and had had another child and had not been charged for maternity care for the maternity care for her second child. The debt recovery suspension for the first pregnancy was still operative at the time of the interview but the debt had not been cancelled.

(See Appendix Figure 1)

The success or failure of section 4 applications illustrates how apparently random external circumstances can determine whether a person is deemed chargeable by the NHS.

Mariam

Mariam (see Chapter 2) applied for section 4 support to which she should have been entitled. However, due to an error by the adviser making the application, it was submitted as a section 95

⁴ An applicant for s4 support must show that they are destitute or are likely to become destitute within 14 days. A person is "destitute" if they do not have adequate accommodation or do not have enough money to meet essential living expenses for themselves and any dependants.(2) Section 4 recipients receive accommodation and a prepayment card useable in certain shops.

application for which Mariam was not eligible.⁵ So her application was refused, with the result that she was denied accommodation and financial support from the Home Office in the last weeks of her pregnancy. But, without being a recipient of section 4 support, Mariam was also not exempt from charges for that part of her maternity care that it could have covered. After she gave birth, she received further advice from a migrant support charity and was granted the section 4 support to which she should have been entitled earlier. At the time of her interview her maternity care charges had not been cancelled.

Irregular immigration status can be challenged and changed when someone understands their entitlements, but this is also significantly dependent on access to legal advice as shown in the following example from Maternity Action's advice service.

Advice case A - The role of advocacy in clarifying patients' immigration status

A, a non-EEA national who had overstayed her visa, contacted the Maternity Action advice service when she was 37 weeks pregnant. She was at risk of violence from her husband and his family if she returned to her home country and had not sought maternity care as she was afraid she would be deported. Following intervention from Maternity Action's solicitor she was accepted by a GP and a hospital. She was also referred to an immigration adviser who helped her to claim asylum and she was granted refugee status a year later.

Similarly, Helena, the domestic worker, described in Chapter 2, was not aware that that she might be considered a victim of trafficking under modern slavery legislation, until, at more than 30 weeks pregnant, she contacted the Maternity Action advice service for advice about being charged for maternity care. She was referred to an immigration lawyer who submitted a claim for asylum and trafficking on her behalf. As a result she became exempt from NHS charges.

The difficulties in accurately ascertaining a person's immigration status can lead to mistakes in identifying whether an individual is chargeable. For example, for EEA nationals or their dependants, eligibility to NHS care is an *entitlement* which may not be visible on the documents requested by an Overseas Visitor Manager, as is shown in the following case.

Rosa

Rosa is a Latin American woman who was married to an EU citizen working in the UK, and who had a five-year UK residence card on that basis. She and her husband later separated but were not divorced. She then started a relationship with another EU citizen who had been working in the UK, and they went together to her home country for a year. When they returned she was stopped at the airport because her residence card had expired. The immigration authorities at the airport contacted her husband to verify that she really was the wife of an EU citizen, and then (unnecessarily) issued her with a tourist visa to re-enter the UK.

Soon after her return to the UK Rosa discovered that she was pregnant. Although she told the hospital where she booked for maternity care that she was married to an EU citizen, she was informed that she had to pay as she had a tourist visa in her passport. It took numerous letters from Maternity Action's legal adviser and a threat of legal action before the hospital cancelled the charges.

Establishing entitlements becomes even more difficult if past medical treatments are deemed chargeable, as present immigration status (and hence liability to charging) is not necessarily the same as immigration status at a previous time when liability charging might have been different. This is shown in the following case from the Maternity Action advice service.

⁵ Only people still awaiting the outcome of an asylum claim or appeal are eligible for Section 95 support (see Glossary).

Advice Case B - Impact of changed immigration status

B. is a non-EEA national who came to the UK and married an EEA national who was working here. They were married for more than 5 years and had two children. The marriage broke down but they did not divorce. B. became entitled to permanent residence after 5 years and was later granted leave to remain as the parent of a British child. When applying for accommodation through social services, an immigration officer who was present asked her if she paid for her maternity care. The following day she received a call from the hospital and was sent a bill for £5000 for the maternity care for her first child.

As the family member of a qualified EEA national she was not chargeable when she received that care but she needs proof that her husband was working or looking for work at that time. This is difficult and may be impossible as she does not know his whereabouts now. Even if she was in contact with her former husband he would have to have kept the relevant documentation and have to be willing to assist her.

This case highlights how data is shared between hospital trusts, the Home Office and local authority social services departments. Similar data sharing also affected Julia who was interviewed in this study (see below). It also raises questions of whether trusts always conducted 'reasonable enquiries' into a patient's liability for charging as required by the Regulations, or simply relied on the word of the Home Office (1, 3).

The scale of charges

With one exception, all the women interviewed were at some time billed for their maternity care. Not all were able to give us exact information about the bills they received as some women had given their bills to their solicitors, and others could not find all the documentation at the time of their interview. However, most women who received a bill were able to show us copies of some demands for payment.

The women were often confused by the bills they showed to us since, even when they were itemised, they did not refer to procedures but rather to the department in which treatment took place. As a result it is often impossible to tell which procedure was being charged for. Moreover, where there are multiple bills it is often not clear whether the largest one incorporates earlier ones or is for another procedure.

Recently women have also been charged for previous maternity care and other treatments that were not billed at the time - historic or late billing.

Julia

Julia has had three children in the UK since 2008 and was never billed. After her last child was born in 2017 she separated from the children's father and became homeless. She sought accommodation and financial support (section 17 support) from her local social services when her baby was about five months old. An official from the Home Office was present at her social services assessment. She was contacted the following day by the hospital where she had given birth and told that the Home Office had contacted them and told them that she owed money for her maternity care, and soon after she received a bill for about £6000. The following week she received a bill for about £13000 that included her two previous births. Julia had not been billed for any of her three periods of maternity care.

Table 3.1 shows the size of bills for each woman's most recent charges for maternity care, as stated on relevant invoices shown to our interviewers where they were available, and repayment outcomes by the time of our interview. In some cases we were able to contact women some months after the interview to find out about changes in their circumstances.

Table 3.1 Hospital charging practices and repayment outcomes

'Name'	Time of first billing	Description of bills and letters and phone calls	Amount in £ Charged (to nearest £100)	Notes on repayment arrangements	Further comment
Anna	Antenatal (20 weeks)	1. Invoice for planned charges. Itemised by antenatal care, inpatient (normal delivery), postnatal outpatient. (repeat invoice after 2 months) 2. Letter - Final demand for payment: Demands payment in 7 days and threatens litigation. Threatens reporting to HO.	6900	Not known. A. obtained s17 support and unable to repay.	A. sought advice about repayment but had difficulties obtaining it. NB Final demand for payment received at 20 weeks gestation.
Aysha	Postnatal (5 days)	1. Combined invoice maternity outpatients and dermatology from May 2016 (dermatology) & from Feb onwards (maternity). Sent to previous address. 2. Phone calls after had baby. Hospital asked her to send them a 'NHS something' letter. No invitation to discuss repayment plan	2100	A. was receiving Home Office s4 support (cashless) in the last 6 weeks of pregnancy. Unable to repay.	A. could not always understand what was said on the phone when debt agency demanded payment.
Beatrice	Postnatal (1 day)	1. Itemised invoice: for scans, obstetrics, and oral surgery 2. 2 nd bill not available 3. Phone calls up to 2-3 months after birth which offered £100 pm instalments.	1300 5000 [E] ¹	Undocumented with no financial support so unable to repay	Did not know where to get help.
Fatima	Antenatal - she did not know when as her husband controlled all mail.	1. Bills not available. 2. Letter from debt collection agency after husband had failed to pay bill	5400	Following legal advice F. emailed the hospital and explained her situation. Hospital deferred repayment for two months. Later made repayment plan £10 per month	Repayment at £10 per month will take 45 years to repay.
Helena	Not billed	No bill received.		Was never billed because she claimed asylum during her pregnancy.	Before claiming asylum H. received misleading information about charging from lawyer and midwife so thought she would be charged.
Isabella	Postnatal - some months after birth	1. Received about 10 letters including demands for immediate payment. 2. Frequent phone calls and emails demanding payment.	3000 (E)	Charges paid in full over one year.	I. was given no information about charging despite repeated requests during her pregnancy. Bill sent several months after baby's birth
Josephine (EU citizen)	Antenatal (1 month)	1. Bill received not itemized. 2. Received letter 4 months before birth requesting evidence of having worked. 3. Hospital or debt agency called her 3-4 times after birth and told her she had a big debt. Last call said she had 24 hours to pay.	4000	Charges were cancelled after lengthy intervention from adviser.	After intervention from the adviser no further demands received but J. was not informed that the charges were cancelled.

'Name'	Time of first billing	Description of bills and letters and phone calls	Amount in £ Charged (to nearest £100)	Notes on repayment arrangements	Further comment
Julia	Postnatal (c.3 months)	Bills not seen (with lawyer). J. was first billed after meeting social services with embedded Home Office officer. £6000 charge for last child but £13000 seems to be for all 3 children. Offered repayment plan of £10 per month.	6000 (E) (13000) ²	J. obtained s17 support and unable to pay .	J. said she would pay £3 month if she could afford it.
Leah	Antenatal (32 weeks)	L. was given a list of Overseas Visitor Patient tariffs with 'Delivery' circled at an appointment with midwife. Told to bring half the payment to her next appointment.	4600	Charges cancelled after intervention by homelessness charity where L. was living during her pregnancy.	Maternity Action phoned hospital and received reassurance that care would continue.
Mariam	Postnatal	Letter from debt recovery agency collected from previous address some time after she gave birth.	2900	Received s4 support (cashless) after she gave birth so unable to pay	Demands for payment did not continue. Not known if bill cancelled.
Mary	Postnatal (7 months after birth)	1. Invoice 2. Letter with invoice suggested instalment plan. 3. Demand for overdue payment within 14 days. 4. Letter and bank mandate form from debt agency.	5800	Obtained s17 support and unable to pay	Received no information on charging before was discharged from hospital.
Mei	Postnatal (1 year)	Received letter requesting payment when child 1 year old. Letter not available.	2100 (reduced charge)	Hospital sent response to debt advice agency and reduced bill by £240 because Mei granted s4 support during the pregnancy. As M. was on Home Office s4 (cashless support) she was unable to pay	
Natasha	Post miscarriage at 18+ weeks	1. Invoice 2. Letter requesting payment within 7 days. 3. Letter from debt collection agency	4900	Dependent on elderly aunt whom she looks after and 'pocket money' from cousin. Paid a few instalments of £10 before was detained. Unable to pay	Letter to attend clinic for support after miscarriage was received two weeks after letter from debt collection agency.
Nina	Postnatal (2 weeks)	1. Letter and invoice re. in-patient (delivery) care. 2. Phone calls offer her instalments. Told she should call them to say how will pay. Each call say they will call HO.	6000	Obtained s17 support and unable to pay	Letter states that there may be additional charges for postnatal care.
Olivia	Antenatal (c. 15 weeks)	1. Letter and invoice. Letter re AN care package 2. Invoice - not specified - inpatient episode. 3. Letter re. invoice 4. Phone call said they would tell HO and they will never give her papers.	5800	Supported and accommodated by friends. Unable to pay	Separate bills for antenatal care and delivery.

'Name'	Time of first billing	Description of bills and letters and phone calls	Amount in £ Charged (to nearest £100)	Notes on repayment arrangements	Further comment
Rosa (EU dependant)	Antenatal (20 weeks)	<ol style="list-style-type: none"> 1. Letter insisting R. was chargeable following meeting and request for deposit. Threatened cancellation of appointments if deposit not paid. 2. Invoice: Payment terms - immediate. Threat of reporting. Invoice referred to maternity care but no detailed itemisation. 3. Letter with final demand for payment including threats that further immigration applications could be refused. 4. Statement/ invoice 5. Credit memo - reason - incorrect debtor/ not liable 	6500	Charges cancelled after intervention by legal adviser.	

1. We used the woman's own estimate if we did not see any bill, indicated by (E).
2. Further charges which may be for earlier treatments (historic or late billing) or for other parts of the same maternity care are shown in brackets.

The table shows that all but one of the invoices were for more than two thousand pounds, the highest being a bill of almost £6900. Half of the bills were for sums over £5000. In view of the financial background and circumstances of the participants in this study, it is not surprising that most of them were unable to repay the costs of their maternity care, even for one child. Yet the bills continued to be issued relentlessly with no advice to women being charged or opportunity to discuss their situation.

Anna

Anna's bill was issued in advance when she was just under 20 weeks pregnant, and was for all standard maternity services, including antenatal, delivery, and postnatal care.

Anna did not have a partner, and she and her three children, including her month old baby, were facing destitution and eviction from their accommodation. She had turned to an advice agency for help. There was no prospect of Anna ever being able to pay for her maternity care.

At another hospital Rosa was billed £6500 in advance for her maternity care. It is not clear why bills for the same standard care should vary widely. However, hospitals often refuse to provide a breakdown of costs.

Repayment of bills of this size from the chargeable group of women who are mainly undocumented migrants is plainly unrealistic. In fact, not a single undocumented migrant woman in the sample was able to maintain a repayment plan for any length of time. Most women did not even attempt one, though Natasha, who had a miscarriage, paid three instalments, but was then detained for 10 weeks, and after her release, did not continue her repayments.

Only two women out of the 16 interviewed had managed to pay either the full bill or had engaged in an ongoing repayment plan. Both had British partners and spouse visas. Isabella repaid the whole of her bill for £3000 over the course of a year by her British citizen partner working overtime.

Fatima had an ongoing repayment plan at the time of her interview. She had been granted a spouse visa soon after her baby was born though she later separated from her husband. She had also been billed approximately £5400. She began monthly repayments of £10 when the No Recourse to Public Funds (NRPF) condition on her visa was lifted and she was able to claim benefits. This made her repayment feasible despite her situation as a single parent of two young children. However, the 45 years it will take to repay this debt is plainly risible in terms of the cost of its administration and benefit to the hospital or the NHS.

None of the other study participants had even begun to make repayments at the time of their interviews or had any expectation of being able to do so.

Charging practices

The Department of Health delegates specific arrangements for identifying and charging 'overseas visitors' to individual hospital trusts, so there is considerable variation in the procedures by which women received notification that they would be charged for their maternity care. None of the women received accurate information about charging policies prior to being billed for it, or any information at any time about where they might get advice about chargeability or repayment. Moreover they were not given details about which procedures attracted which charges, so were not in a position to make an informed decision about what care they wanted and what they might safely avoid.

They were told about charging in a variety of ways, mainly by letter or invoice, but also in person. Twelve of the women billed were not told anything in the hospital prior to receiving a letter or an

invoice either during their pregnancy or after giving birth. Only four women had any expectation that they would be charged before they received an invoice.

Isabella

Isabella repeatedly asked the midwife for information about what documentation she needed as the Home Office had all her documents, but was just told not to worry. After the baby was born the Overseas Visitor Manager (OVM) asked Isabella for her passport for the discharge paperwork and when she explained again that it was with the Home Office, the OVM said, "OK. You are going to receive some information." However she received nothing until, some months later she received a demand for about £3000 followed by a stream of "menacing" letters and phone calls.

Other women received formal invoices or standard letters requesting payment, and in many case repeat demands. In some cases the invoices were itemised in detail, while in others there was just a reference to a charge.

Letters from a number of hospitals demanded almost immediate payments of very large bills. The following examples illustrate the ways in which demands for payment were issued.

Payment demand Hospital 1 - Maternity care received in the same hospital in 2015 and 2017 (Olivia and Nina)

Both women were overstayers with 2 other children, all born in UK. Figures 2 and 3 show invoices and accompanying letters relating to charges for delivery but both women had already received invoices for substantial sums during their antenatal care. The invoices and letters demanded payment *on receipt* of the invoice for sums of approximately £6000 and c.£4000 respectively for each woman relating to an "inpatient episode" on particular dates referring to the dates on which their babies were delivered.

The letters state that "Failure to pay by return may require the involvement of external debt agencies and/or the relevant official bodies such as our Local Counter Fraud specialists, UK Border Agency (UKBA) and embassies." They make no reference to the possibility of paying by instalment, or to what the patients might do if they believed they have not been appropriately charged. Both letters explicitly stated, "Unlike specialised Private Hospitals we are not in a position to provide a cost per procedure or cost per service itemised charges" but they did not explain why this was so. The letters claim that "charged NHS patients" unlike private patients "usually but not always, incur charges as a result of an emergency admission." This is clearly incorrect in relation to maternity care. [See Appendix Figures 2 and 3]

Payment demand Hospital 2 - Maternity care received in 2017 (Anna).

Anna's invoice for c. £6800 was issued when she was 5 months pregnant. Under 'Payment Terms on the invoice, it stated 'IMMEDIATE' (capitalised in original). She also received a letter dated one day after the invoice which was headed FINAL DEMAND FOR PAYMENT (*capitalised in original*). The letter demanded full settlement within 7 days to avoid referral to a debt collection agency or the possibility of litigation. It stated that if the bill was not paid in full the hospital would provide information to the UK Border Agency (UKBA). [See Appendix Figure 4]

There is nothing in the letter to say that all maternity care is immediately necessary and will not be refused whether or not the patient can pay. There is no offer to discuss with the woman the possibility of paying by instalment, or what she should do if she believes she was incorrectly charged.

It is also noteworthy that the UKBA closed in 2013 and was replaced by UK Visas and Immigration but the hospital had not updated its own information. The letter has also not updated the rules about the requirements to report to the Home Office, but in any case, the claim that if the debt is not paid in full

the woman will be reported, is inconsistent with the (incorrect at the time) statement that this will happen only if there is a debt of over £1000 *three months after* the invoice.

Payment demand Hospital 3 - Maternity care received in 2012 (Mary)

Mary received an invoice for almost £6000 seven months after giving birth by caesarean section. The payment terms were given as 30 days. The invoice was clearly itemised and covered frequent obstetric episodes, including delivery by C-section and inpatient care, and two episodes in haematology several months after delivery.

She also received a letter dated the same day as the invoice. The letter explained clearly the (then) terms of debt to NHS in relation to immigration applications and offered an opportunity to Mary to discuss a repayment plan.

However, it stresses that the outstanding debt would not be cancelled and placed on her the responsibility of demonstrating that the hospital was wrong about her immigration status, should that be the case. "If you feel that _____ Hospital has the wrong information about your immigration status and you are, in fact, eligible for free NHS care, then please do contact the relevant authorities directly so that they can further review your files and advise us accordingly." [See Appendix Figure 5]

This letter is less threatening than the previous examples. However, it fails to explain on what basis it considers Mary chargeable and requires her to contact "the relevant authorities" should she feel she was wrongly charged. This suggests that the hospital's default position is to assume chargeability, rather than to justify that it has, as required in the regulations, made reasonable enquiries to ensure this. It does not offer her the option of discussing this with them.

Payment demand Hospital 4 - Woman in shelter for homeless women 2017 (Leah)

Leah's first communication about charging was a list of the *Overseas NHS Charged Patient Tariff (Overseas Visitors) 2015/16* which she was given when she attended an antenatal appointment at 32 weeks. The list included a charge for 'Delivery (including 2 night stay)' for £4600. She was told to bring half the amount to her next appointment or bring her immigration documents with her. At the time Leah was living in a hostel for homeless and destitute women. [See Appendix Figure 6]

During our interview with her, Leah asked us to advise her what to do about this demand as she had no money. As a result, Maternity Action phoned the hospital and received an assurance that they would not stop Leah's maternity care because she was unable to pay.

Payment demand Hospital 5 - EEA dependant - wrongly charged 2016 (Rosa)

Rosa, a non-EEA national married to an EEA national working in the UK, was asked to bring documentation to establish her eligibility for free NHS care, and met with the Overseas Visitors Officer early in her pregnancy. When she was four months pregnant she received an invoice for over £6000 with 'IMMEDIATE' (capitalised in original) payment terms. A letter dated the following day told her that they had determined that she was not eligible for free maternity care though no reason was given [See Appendix Figure 7]. She was not offered any suggestion as to how to challenge this decision should she disagree with it.

The letter stated that all treatment was therefore chargeable "compliant with the Department of Health's regulations for Overseas Visitors using the NHS for healthcare" and that an invoice would be sent to her. The letter also said, "Please be aware failure to pay this invoice may result in your future appointments being cancelled."

Eventually, in the last month of her pregnancy, following multiple representations from Maternity Action's legal adviser, the hospital conceded that it had been in error. This time it sent Rosa a Credit Memo cancelling the charges. Underneath the description of the transaction - "4450-Overseas Visitor Maternity Care in _____ Hospital" and the full amount credited, it stated simply, "Credit reason- Incorrect Debtor/ Not Liable." In her collection of documents there is no letter of apology, and no recognition of the psychological harm that this debt caused.

Apart from the fact that Rosa later successfully challenged the OVM's decision as to her eligibility, nowhere did the letter inform her that maternity care is immediately necessary and that Department of Health Guidance states that it must not be denied or delayed because of inability to pay (1:p66). Indeed, the invoice with "Immediate' payment terms, and the letter informing her that she could have her appointments cancelled, were contrary to the Department of Health's own guidance. Insistence on upfront payment also precluded an offer of repayment within a payment plan.

In the next chapter we discuss the impact this debt had on Rosa before it was cancelled, and the impact of charging on the other women who participated in the study.

Communicating about hospital charges and debts

The hospital's communication with Rosa about the cancellation of her debt speaks as much about hospitals' communications generally about the debts as do the letters themselves. They ranged from the extremely intimidating, involving, threats to refer women to external debt agencies, local Counter Fraud specialists, the UK Border Agency (UKBA) and even embassies, to the merely formal. They might have been demands for repayment of gas or electricity bills or for hire purchase payments. Were the invoices and letters not headed with NHS Trust logos, it would be hard to believe they were sent from health providers to woman who were socially excluded, often destitute and vulnerable to exploitation.

Many of the women interviewed described receiving frequent phone calls, which they found intimidating. All the calls described were in English, even when women told the caller they could not understand.

Beatrice

Beatrice was called by phone nearly every week after her baby was born until he was two or three months old. She had left an abusive partner three weeks before giving birth and was not allowed to work. The caller suggested that she should pay £100 every month when she started working.

Women received both letters and phone calls from debt collection agencies.

Josephine

Josephine had already given the hospital a copy of her passport and informed them that she was legally working as an EU citizen but received a letter while she was pregnant telling her that she had to pay. She was also phoned three or four times after she had given birth, and told that she had a big debt.

"They told me that I had a very big debt with them. And I said, what debt? I haven't taken out any loans. So they told me - I don't remember where they said they were from, but they said that I owe the health organisation and I have to pay £4000."

She went to a legal adviser who wrote to the hospital explaining that Josephine was an EU citizen who had been working and was not required to pay. Nevertheless, before the calls stopped she received one more, when the caller said they were giving her 24 hours to pay the full debt. Josephine never received any acknowledgement that the hospital had cancelled the charges, but she was not troubled by requests for payment after that.

Other women described receiving phone calls where the caller threatened to call the Home Office. One woman said that the caller said that “they” would tell the Home Office which would never give her leave to stay. Another woman said that nobody in the hospital told her anything about being charged, but after she gave birth she started to receive phone calls, but didn’t always understand what was said on the phone. Understandably the women found such phone calls extremely threatening.

Some women were offered the opportunity of paying by instalments, but all the women who reported this had no right to work or benefits. At the time they were either living on help from friends or charities, or were accommodated by local authority social services departments with minimal financial support. None of them was able to make more than a minimal repayment, if any.

Mary

Mary was homeless and sleeping in a church for a year before she and her son, then aged 5, obtained accommodation from social services. She received a standing order mandate from a debt agency to make repayments for her maternity care bill of nearly £6000. She also received a 14 page form to set up a personal budget plan to repay her debt.

Nina

Nina said the hospital told her ***“to call them to tell them how she would pay, weekly or monthly. But I don’t know how I’m going to pay. I’m not working, I don’t know what to do.”*** ***Nina has had three children in the UK and was first charged after her second child was born. She said, “I remember the phone calls. I didn’t know what to do. It’s an unknown number when they call and say they are from the NHS and that if I don’t pay they will call the Home Office. Every time they will call the Home Office.”***

None of these communications about repayment reflect the Department of Health’s own guidance on “operating the charging rules” where it states that “it is very important to consider the position of vulnerable overseas visitors, including those unlawfully resident in our communities, both those who are exempt from charge and those who are chargeable”(1:p54). This includes helping patients understand the charges they face as “working together with organisations and agencies supporting these patients helps to ensure that they receive the support they need, and are fully informed about how to access support services, including any entitlement to free NHS hospital services”(1:p54). The Guidance also states that such support “can also improve a person’s understanding of the charges they face and the choices they have (including the consequences of incurring NHS debts), and facilitate discussions about the possibility of payment plans being agreed for those having difficulty paying for the cost of their treatment” (1:p54).

Refusal of care

Charging practices not only involve harsh approaches to billing as well as mistakes in incorrectly identifying chargeable patients. In some cases hospitals also wrongfully threaten to refuse care to maternity patients despite the unequivocal guidance since 2004 that “because of the severe health risks associated with conditions such as eclampsia and pre-eclampsia, maternity services should not be withheld if the woman is unable to pay in advance.” (4:p42).

In 2011 revised Department of Health Guidance strengthened this view by saying that “all maternity services, including routine antenatal treatment, *must be treated as being immediately necessary*. No woman must ever be denied, or have delayed, maternity services due to charging issues.” (5:p44) (Our emphasis.) The amended statutory regulations in 2017 explicitly specified that “immediately necessary service” means antenatal services provided in respect of a person who is pregnant; intrapartum and postnatal services provided in respect of (i) a person who is pregnant; (b) a person

who has recently given birth” (3:p3). This means that refusal of care to maternity patients if they are unable to pay upfront is now illegal.

We have noted above that Rosa was threatened with cancellation of her future appointments if she failed to pay the bill she received for maternity care half way through her pregnancy. Similar cases have been reported to the Maternity Action advice service as shown in the following examples.

Advice Case C - Woman asked for advance payment before initiating maternity care
C. came to UK on four year student visa. Her husband came as her dependant. Both overstayed their original visas. The hospital asked for upfront payment before starting maternity care and at 6 months C. had not yet received any care. She was also refused GP registration as they (wrongly) asked for proof of immigration status.

Advice Case D - Woman refused maternity care
D. is non-EEA national who came to the UK on a Tier 2 skilled worker visa. She is married to an EEA national who is working. They have both been here since 2011 and have one child. She became pregnant again and was refused NHS care and told she must pay for it.

As a family member of an EEA national, D. was entitled to care and is exempt from charges. However, even if she had not been exempt, she should not have been refused maternity care because of an inability to pay.

Refusal of GP registration

Since most women access maternity care after seeing a GP, refusal of NHS treatment by GPs creates a serious barrier to women being able to access care at the appropriate time. “GPs have a duty to provide free of charge treatment which they consider to be immediately necessary or emergency, regardless of whether that person is an overseas visitor or registered with that practice” (1: p.97). Although they also have discretion to accept any patient regardless of their immigration status, GPs routinely refuse to see or register patients (6).

The following cases from the Maternity Action advice service show how the refusal of GP registration prevents onward referral to hospital maternity units, whether or not women are actually eligible for free NHS care.

Advice Case E - Refusal of GP registration as barrier to maternity care.
E. is a non-EEA national with a British partner who is working but on a low income. She overstayed her visa. She came to the Maternity Action advice service because she was pregnant and had been refused GP registration. After numerous phone calls and emails from Maternity Action the GP registered her and referred her for maternity care.

Advice Case F - Refusal of GP registration and incorrect information about charging for maternity care.
F. is an EU national who moved to the UK to work. When she became pregnant she was wrongly refused GP registration because she had not been here for 6 months. She was also told she was not entitled to free NHS maternity care.

Refusal of maternity care by both GPs and hospitals is not surprising given the complexity of rules and guidance relating to different categories of migrants and to different kinds of care. But while wrongful refusal of GP care may be perceived as just an administrative error, it is actually a serious barrier to women’s ability to access timely and necessary maternity care and may be in breach of statutory regulations.

Conclusion

This chapter has shown that there is little or no likelihood of recouping the costs of maternity care from the women described in this study. In our sample of 16 women, selected only for their actual or perceived chargeability, not for their ability to repay, just one woman was able to pay the maternity care charges incurred, and that only with great difficulty. Only one other woman had any prospect of maintaining small regular repayments which at present levels will take her 45 years to complete. For all the others, charges were either wrongfully imposed, withdrawn, or not levied because of some women's changed immigration status or interventions made on their behalf.

The study has highlighted the errors that can be made by hospitals and GPs in determining chargeability, and how the changeability of immigration statuses affects whether a woman will be charged or not. Among the participants in this study alone, there were two women with EEA rights of residence who were eligible for free NHS care but who were wrongly charged.

There was a baffling opacity to the bills which rarely showed which procedures women were being charged for, and did not explain to women who were billed in advance that the bills might be adjusted later - either up or down. Women were not informed that they were being charged 150% of the standard tariff to Clinical Commissioning Groups. It is also puzzling that charges based on standard tariffs gave rise to so much variability between hospitals. It was, however, outside the remit of this study to explore the consistency of charging.

The study was nevertheless able to demonstrate the contrast between actual hospital charging procedures which are aggressive, impenetrable and threatening, and the requirements in the Department of Health's own Guidance to take account of the situation of vulnerable migrants. Whether or not they are chargeable, OVMs and other frontline staff are "strongly encouraged" to work with migrant and other support organisations to help them understand the charges and deal with the costs of their treatment (1: p53).

Unfortunately not only is this guidance not followed, but an examination of the scale of the charges themselves, beyond the normal means of all the participants in this study, shows that even with the best of intentions, support organisations cannot significantly mitigate their impact or facilitate repayment. Yet the financial return to the NHS from charging these women for maternity care is paltry at best, and it is probable that the costs of administering the charges far outweigh anything recovered. There are no beneficiaries in the cruel practice of sending out invoices for unfeasibly large payments to the most marginalised people.

The real consequence of charging poor migrant women for maternity care is that a fear of huge and unrepayable bills increasingly casts a shadow over their pregnancies and experiences of childbirth. Indeed, whether or not a woman is 'chargeable' for maternity care in terms of current regulations, whether she is mistakenly charged, or even if she has simply heard about charging and is worried that she might be affected, she will face the anxiety of how to pay what is for her, *de facto*, an impossible bill. How women are affected by and respond to this situation is the subject of the next chapter.

Chapter 4 The impact of charging on women

The impact of being charged for their maternity care has to be seen in the context of women's whole life situation. Many chargeable women, as we have seen, are socially excluded and destitute and already struggling with extraordinarily stressful lives. Almost one third of our sample were abandoned by the baby's father as soon as the woman told him she was pregnant. Only five of the sixteen women lived with or were still in a relationship with their baby's father at the time of interview. In two of these cases the partner was also undocumented and so also without an income.

Whatever their circumstances it was always a blow for women to receive demands for payment, especially for sums which they knew they had no chance of paying. This was the case as much for women who believed (rightly) that they were eligible for free care as for those who were chargeable under current rules but had no idea that they would be charged.

Only five of the women interviewed had heard about charging, or expected to be charged before they were actually billed. This meant that for most of them, the bills came as a complete shock. Ten women were charged after they gave birth, or in one case, after having a miscarriage, while five were billed during their pregnancies.

We explored their reactions to being charged, how the bills affected both their health and wellbeing, and what decisions they took as a result of charging. These responses were interrelated, the emotional responses both affecting their health and shaping their decisions. This could mean in some cases, deciding to avoid antenatal or postnatal care altogether, having a further knock-on effect on their own and their babies' health.

Emotional impact on women

All the women we interviewed described their initial reactions to receiving bills for their maternity care in terms of shock and bewilderment, especially as most of them had been unaware they had to pay, and none were in a position to do so. The demand for payment of thousands of pounds was like the miller's daughter in Grimm's fairy tale *Rumpelstiltskin* being asked to spin straw into gold, and created overwhelming anxiety.

Women who were not charged until after giving birth reacted in different ways. Ayesha was grimly pleased that she had not known before her baby was born.

"Maybe, in my view it's better that they don't tell you (before you give birth). If they tell you, what will you do? You will be thinking...how will you find that kind of money? You're not working. You're not doing anything. You will be thinking about it till it's maybe going to be worse. (Laughs). Maybe it's a little bit safer that you don't know and then they tell you (later)."

On the other hand, Julia was very angry that she was not told before any of her children were born that she would be charged. The hospital apologised to her for not having informed her. She said:

"They should have told me. Normally they should tell you or give you a letter saying, when you deliver you need to pay this amount. Even if you don't have it. This way you will be aware of it. It's good to say it."

Two participants said they had previously heard that women were billed for maternity care but they did not know how much. This did not reduce their anxieties and created real fears for them.

Reaction to the charges often only added to existing anxieties, as illustrated by Beatrice's reaction to requests for payment, even though she was not charged until after the baby was born.

Beatrice

Beatrice found herself pregnant and giving birth with no immigration status, and no family member or close friend to support her.

"It's just me alone with my child. And they're telling me you have to pay, when my child was four months. I almost went mad. I almost went crazy. It's my first child. I've got no experience. And so the guy's calling me, you have to pay, you have to do this, when you start working, they take £100 every month. ... And I'm like, so you don't know what I'm going through! ... And I told him, stop calling me! There's no way I'm going to get the money. It's not just that I'm alone with a child. The Home office is on my back [Crying] I can't deal with it. It's just crazy actually. It's just really crazy....because I'm still trying to get over the nightmare that this is happening and I have to deal with it all alone..."

...When they were calling me and saying I have to pay, I have to do this, there was a point I felt like just dying. And my son was crying, I'm like, shut up! You know what I mean? I just screamed at him like, shut up! It's just... It does have an impact (on the child) because I shouted at him when I wasn't meant to. Because he was just a baby then, he was a crying baby. So the whole thing was just too much for me."

Like Beatrice, most of the women interviewed were already living in a distressed state during their pregnancies. (See also the example of Mariam in Chapter 2). Helena considered adoption because she didn't have a job or a place to live and worried how she would be able to support her baby. But the assurances from the midwife that she would not be charged for the care, and that the baby was healthy, encouraged her to continue with the pregnancy and to keep the baby.

Three women said that had they known earlier that they would be charged they would have had an abortion.

Leah

Leah had previously heard about charging but she had no idea how much it would cost. It was not her most immediate problem as her circumstances were desperate. She was abandoned by her partner when she became pregnant and had nowhere to live and no money, so that a vague notion of having to pay for her care loomed less large than the immediate reality of destitution. The actual implications of charging seemed only to have hit her when the midwife told her to bring over £2000 to her next appointment when she was 32 weeks pregnant, at which point she said she just cried.

The midwife told her to contact social services but they said they couldn't help her.⁶ Leah had no idea what to do next as she would not be able to stay in the shelter after the baby was born. Leah was interviewed when she was about 34 weeks pregnant. She said:

⁶ As a healthy pregnant woman without another child and no current immigration application, social services had no obligation to support Leah.

“I feel lost right now. Right now I’m still confused I don’t have any documents. Then, with the charging (I feel) bad... If I hadn’t been 33 weeks (pregnant) I could have aborted it.”

Deterrence from care

None of the women we interviewed either terminated their pregnancies or gave up their babies for adoption after the pregnancies discussed. Nevertheless, for some, the invoices, accompanied by letters and phone calls requesting money and threatening to report them to the Home Office, or even telling them that they would never be able to regularise their stay, induced very high levels of anxiety and fear, affecting their physical as well as mental health. Whether or not women were billed during or after their pregnancy, the demands for payment affected their willingness to see a midwife or doctor when they were not well, or even for routine appointments.

Some women spoke constantly of their fears of what might happen because they could not pay the bills they had received: fear just of being in debt, of debt “spoiling my name”, of being taken to court, having their children taken away, and being further charged for their sick children’s medical treatment, and the additional fear that the Home Office would be told and refuse their immigration applications.

Women who knew they would be charged when they were pregnant, whether or not they were actually billed, could be deterred from attending appointments. This was partly because they might incur more charges, partly because they thought they would be denied treatment, and partly because it seemed that the hospital was where the authorities would find them and detain or deport them.

Helena:

“I am afraid that if I go to the hospital they will charge me and I’m so afraid what’s gonna happen to me if I say that I don’t have money to pay for that. If they will detain me, or if ... after I have delivered the baby if I’m gonna stay at the hospital or in a detention centre or something like that.”

Anna

Anna’s fears almost drove her to avoid her antenatal care altogether. She was charged in mid-pregnancy, and was very worried about where she would find nearly £7000. She became very afraid to see the midwife at the hospital, despite suffering from constant headaches and other symptoms. She was even afraid to collect her maternity exemption certificate.

“I just filled in the form but I’m scared to collect it I just filled it out and I’ve got it at home.”

She only went to her further antenatal appointments after being persuaded by a friend that she should go for the sake of the baby.

“Whenever I’m going to the midwife I’m really scared to go. I’m not happy about going there now. I’m always scared. I don’t know what’s going to happen whenever I have an appointment with the midwife. I don’t know what I’m going to hear from them. Maybe they will stop me from getting care. In the hospital I was so scared.”

Eventually the hospital did persuade her to come and have a scan but she was never again comfortable at the hospital. She eventually had her baby by C-section.

The way Anna expressed her fear of attending the hospital suggested she expected that they would refuse to treat her as a punishment for her unpaid debt rather than just being afraid of being charged more. But Anna, with two other children and facing eviction, had a high risk pregnancy, and particularly needed to form an ongoing trusting relationship with her midwife.

Natasha

Natasha felt that the overseas charging office was sympathetic to her situation, but even so, as a result of the bills she faced, she did not return for follow up care. She was afraid to go back for a check-up or to find out what had caused this miscarriage and possibly a previous one.

“My baby was buried and I couldn’t even go. I was just so scared that I was going to go and they were going to come and detain me.

I went to see my GP, I was still bleeding then. And then there was something still remaining so they had to take me to the theatre to do a D&C. And from then I haven’t had any examination to see anything, to see if it is all OK. At times my period is so painful, I feel cramps when I sit down, when I get up I can hardly walk sometimes. But the clots, a lot of clots.... I am scared to go to the hospital because I don’t know how I will be able to pay on top of this bill. So I haven’t had any exams just to see if it is OK.

Even to just to hear what caused the death of my baby, that is what I would really like to know. Just tell me what happened, so I know what caused the death, instead I am just thinking “was I stressed?”, “was I not eating well?” was it a time, that I was going on the stairs and I slipped? I don’t know what caused it. Or was it a medical problem? I don’t know.”

Natasha’s fear of incurring further charges not only prevented her getting examined to see that her physical health was alright, but also stopped her coming to terms with the loss of her pregnancy. She continues to be plagued by fears, doubt, anxiety and self-blame.

All the above vignettes show high levels of anxiety. The contrast between them and Rosa’s feelings below when the charges were dropped, provides an alternative insight into how much the women suffered under burden of charging.

Rosa:

“When (the adviser) emailed me, when the letter from the hospital saying the charges were going to be dropped, I jumped with happiness. Even though I was eight months pregnant, I just had to jump with happiness. I called my mother in _____, who had been nervous this whole time. I called my partner and I was going crazy with joy, I wanted to go running all the way to the office and hug and kiss (the adviser), and thank her thank, her thank her. I wouldn’t believe, thank you God. It was a weight off my shoulders, I could enjoy my pregnancy peacefully. I could sleep peacefully, feel my belly peacefully. I would walk into the hospital for my examinations, head held high, feeling relieved, I was no longer afraid. I knew no one could close the door on me. It was a great relief, it changed my life. That is certain.”

It is striking that Rosa could now talk about ‘enjoying’ her pregnancy, no longer being afraid, and engaging in her maternity care with dignity and peace of mind “head held high”. For some women, though the anxiety continued long after pregnancy.

Olivia

Olivia refused to attend further antenatal appointments after she received her first bill. But her blood pressure increased and she couldn’t eat or sleep, and became very depressed and upset. Eventually she was admitted to hospital a day before her due date with very high blood pressure.

At the time of the interview she said she was suffering a lot of pain all over her body and was unable to sleep, but **“I can’t go to the hospital to get it checked because I am scared of getting**

more bills. I don't have the money. My life is at risk at the moment but I just have to keep praying to God to help me."

Olivia continued to avoid care postnatally because she was afraid of getting more bills. Isabella, too, avoided further healthcare long after her baby was born even though her bills had been repaid and her spouse visa granted. She did not stop mistrusting the NHS or fearing that she might get further bills.

Isabella:

"I don't go to the GP at all, I never go to the GP. And at the moment I have been diagnosed with a degenerative illness and I struggle to make my appointments. It really left me completely, not angry, but I can't trust a place like that. Sometimes I think I prefer to be sick... I don't want to go there. My husband thinks I am crazy, but you never know. Maybe in two months' time they are going to send me another bill for something that I didn't even have any idea about."

Cases from the Maternity Action advice service also provide strong evidence of how NHS charging acts as a deterrent against women accessing maternity care. Many of the cases reaching the advice service also involve women who avoided accessing maternity care because they were afraid of being billed for care and of the Home Office being notified, putting in jeopardy their immigration applications. As a legal service, the Maternity Action cases focus more on entitlement and so illustrate very clearly the complex and ambiguous immigration statuses of women affected by charging for maternity care. Such ambiguity also applies to several cases of British citizens who had difficulty proving that they were ordinarily resident, or whose entitlement to ordinary residence was disputed.

The following examples drawn from the Maternity Action advice service show how, whatever women's immigration status, the decisions by the hospitals, frequently deter them from accessing maternity care until very late in pregnancy, if at all. In several cases women were deterred from accessing care because of wrongful refusals by hospitals to recognise their right to immediately necessary maternity care, or because of threats from these services. Women themselves are also unaware of their entitlements.

Advice Case G - Woman informed that she would be charged - but likely to be exempt
G. is thought to be a victim of trafficking and needs advice. She is three months pregnant and went to hospital for her first antenatal appointment. She was told she would be charged and did not go ahead with the appointment.

Advice Case H - British citizen unable to prove ordinary residence - might be exempt
H. is a British citizen who worked in an EU country for 6 month periods over 3 years. She returned to the UK to be with her family and have their support. Her boyfriend reacted badly to the pregnancy and they are no longer together. She is 5 months pregnant and has not yet started maternity care. She is finding it hard to prove ordinary residence as she does not have housing or bills in her name and won't be working again until some time after the birth.

Advice Case I - Woman believed she was not entitled
I. is a homeless non-EEA national aged 38. Her application for leave was refused and she is now seeking legal advice. She didn't seek maternity care until she was 24 weeks pregnant as she did not think she was entitled to it. Although I. is chargeable under current rules she is entitled to all maternity care though it is likely that the hospital would notify the Home Office if she did not pay.

These cases show that not only the bills themselves, but also difficulties proving entitlement, and women's own confusion about entitlement, create an environment in which many pregnant women, including some who are both socially and medically at high risk, do not have access to essential maternity care to which they are entitled.

Obtaining advice

Rosa:

"It was not easy to find the information that I had the right to fight the charges. It should be more visible for those who need it. Because when you are desperate, you cannot see clearly, and to find something can be harder...If it wasn't for my partner, if I was alone and scared I don't know that I would have found a way to make things right. Maybe I would, but it would have taken me longer."

Delaying or avoiding maternity care in response to charging, or inability to challenge refusals of care also reflect the difficulties women face in obtaining appropriate advice. Rosa articulated one of the main reasons why so few participants in our study were able to get advice and support about charging. They did not know whom to ask; generalist migrant advice charities whom they approached with housing and financial support needs are unlikely to have either expertise or capacity to help negotiate with hospitals about patients' entitlements to NHS care.

Rosa only reached the Maternity Action advice service through another health advice charity, Doctors of the World, which she had found online. One woman was given the advice service phone number by a generalist support service but could not get through. She was then referred to her local Healthwatch who did not come back with any advice.

Several women said they did not know whom to approach for advice about NHS charges, and very often, given the impossibility of repayment, other issues were more immediate and urgent. But failing to get advice meant that women remained more anxious than they might have been.

Few women in our sample managed to obtain legal advice about charging. Two women accessed the Maternity Action advice service, and two consulted other solicitors. Two other women were helped by charities which were also helping them with their immigration and housing situations.

Mei

Mei sought help from the Red Cross to obtain financial support from the Home Office. They also referred her to a debt advice agency which managed to get part of her bill reduced for the period during which she had been granted Home Office support.

Leah

Leah approached a migrant support charity who referred her to a shelter for homeless women. Her hospital charges were waived or cancelled after the charity running the shelter sent a letter to the hospital confirming that she was destitute.

Only one woman said that an Overseas Visitor Manager (OVM) was sympathetic, but even he could not give her any advice other than to offer to make a repayment plan. Several women said that callers, whom they thought were from the hospital but who might have been from debt collection agencies, suggested they contact the hospital to make repayment plans. However, this seems to have been said in the same breath as what were perceived as threats that the hospital would contact the Home Office. No hospitals appeared to take on board that women to whom they were sending huge invoices and payment demands were living from hand to mouth. Not only could they not start payments, but were at risk of discontinuing maternity care or avoiding other treatments that they might need.

In spite of the recommendations in the Overseas Visitors Charging Guidance on charging vulnerable people, no woman interviewed reported having been given any information from the hospitals about support organisations they might contact for help with repayment or advice about their entitlements.

Conclusion

Charging for maternity care clearly produced fear and anxiety in the women interviewed, resulting in some avoiding attending hospital and GP appointments both during and after their pregnancies. They were afraid of further charges for each attendance, and also feared the humiliation of being refused care. For some, the easier option was just not to attend. Their own accounts show that they knew this might be risky, as was indeed sometimes the case, so that some women arrived before delivery with possibly worse health than they might have had. The Maternity Action advice service cases provide further evidence of women avoiding care because of fears of charging or lack of entitlement.

Refusing to answer phone calls or not responding to demands for payment are forms of self-protection when other support and advice is not forthcoming. Hospital Overseas Visitor departments are plainly not complying with guidance to recognise and respond to needs of vulnerable patients, including women receiving maternity care. Although the study shows that advocacy is critical to enabling women to challenge wrongful charging and to refer women to appropriate immigration and debt advice, it does not address the fundamental injustice in the charging policy.

The charging regulations and guidance claim to seek to prevent any delay or denial of maternity care if a woman is unable to pay in advance. However such guidance is contradicted and undermined by women's knowledge that they will have to pay anyway and if, as will be almost inevitable, they will be unable to do so, they will be reported to the Home Office and have their further immigration applications refused.

The demand for low income or penniless women to repay enormous charges for their maternity care increases barriers to access and increases health inequalities between these women, their babies and their families and the wider population. Meanwhile, the NHS cannot recoup the inflated charges against these patients. Instead it risks spending more on administrative and debt recovery, and is likely to have to deal with health problems which could have been avoided by improving access rather than creating further barriers to health care.

Chapter 5 Analysis and conclusion - Charging for NHS maternity care in a wider context

The interviews and Maternity Action advice service case summaries in this report provide compelling evidence that charging for maternity care constitutes a major additional barrier to accessing care for migrant women with insecure immigration status. The large bills alone provide an incentive to women to limit or to try avoid maternity care altogether, and this is significantly increased by the knowledge that failure to pay their debt will result in them being reported to the Home Office, and may jeopardize ongoing immigration claims. Women are also navigating this system with little accurate information from trusts or debt collection agencies, adding to their stress.

Our examination of the study participants' experiences of being charged for maternity care raises broader implications about the impact of charging. We consider how charging affects the culture of the NHS and leads people affected by charging to perceive and experience NHS healthcare in new and disturbing ways. This in turn affects pregnant women's use of the service with ongoing impacts on their health. We also address the ways in which gender inequalities and biases are embedded in the exclusive charging of women for maternity care.

The impact of charging on the NHS and its effect on women's health

The NHS - threat or caring service?

Classifying patients by eligibility, and imposing punitive charges on some and not others, fundamentally transforms the culture of the NHS. Indeed it is now an explicit goal of government policy that charging "overseas visitors and migrants not eligible for free NHS care" should "drive a culture change in the NHS" (1). However it appears that the government has neglected the effect of such a culture change on the capacity of the NHS to deliver appropriate healthcare or how it might impact on some groups' health seeking behaviours.

For people who cannot prove their eligibility for free NHS care, NHS hospitals and even GPs, can become a menacing threat rather than a caring solution to their health needs. Women receiving maternity care are not only in the hands of midwives and clinicians, but also have to deal with the Overseas Visitor Managers (OVMs) and subsequently with the whole apparatus of debt recovery which hospitals put in place.

There is no evidence from our study that hospital OVMs follow Department of Health guidance on the charging of vulnerable patients and consider the welfare of vulnerable migrants or consulting migrant support organisations when hospitals are aware that patients are not in a position to pay the charges (2: pp.53ff). Instead, debt recovery appears to be their single priority. The operation of NHS debts is outsourced to debt recovery agencies which harass women by phone and letter, and threats to report non-payers to the Home Office are made from the moment a patient is invoiced.

Ignoring the vulnerability and social needs of patients is incompatible with principles of good care and the establishment of trust between patients and practitioners. It is also incompatible with the principles of the NHS which is still the body providing the care, even when the patients are chargeable (3). The threatening letters and invoices sent by Overseas Visitors departments to women who participated in this study, without regard for their situation, highlight the contradiction between

ostensibly patient-focussed medical care, and the use of such care for increased state control of immigration.

The purpose of the NHS charging regime for non-EEA residents is to identify and exclude the 'unentitled' from its comprehensive coverage. The expected gross income from charging non-EEA 'overseas visitors' who had not paid the immigration health surcharge in 2017-18 was £100 million, representing approximately 0.08% of the Department of Health planned spending for that year (4, 5). Moreover, the National Audit Office report estimated that "on average, the cash recovered is around half of the amounts charged" (4: p11).

In the context of the 'hostile environment', the success would appear to demonstrate not in 'cost recovery' but rather in the stigmatisation and self-stigmatisation of those who are so identified. Several women in our study were reluctant to attend the hospital not just because they were afraid of the cost, or of being reported to the Home Office, but because they felt criminalized or perceived as in some way illegitimate. Such feelings inevitably undermine patients' relationship with the health service and its staff, and limit their capacity to benefit from the healthcare that might be available to them.

From this perspective the imposition of charges is incompatible with midwives' and other health professionals' ability to address sensitive issues or underlying conditions appropriately and in good time, and to put into place recommended interprofessional or specialist support for affected women and their babies (6,7). Some women limited their attendance or avoided appointments altogether, thus possibly missing out on specialist referrals or other potential support. Our study shows how anxiety about charges not only prevents the trust and reassurance that women should get from good maternity care but also deters some women from other NHS care even after they have given birth.

Identifying entitlements

As well as failing to investigate and consider the social needs of chargeable patients who are vulnerable, hospitals also often fall short in correctly identifying eligible and ineligible patients, frequently demanding inappropriate proofs to determine eligibility. Many migrants have entitlements under EU and EEA rules which do not require Home Office documentation in their passports; the entitlement is intrinsic to their situation.

For example, 'Zambrano carers' are migrants who have an EU derivative right to reside in the UK as the primary carer of a British citizen or non-British EEA national residing in the UK if the person being cared for would have to leave the UK or EEA if the primary carer were forced to do so (8). This right to reside arises as soon as a non-EEA national becomes the primary carer of an EEA citizen. There is no requirement to obtain an EEA Derivative Residence Card for a derivative right to be acquired, and it is not indicated in a passport.

Such entitlements are often not recognised without advocacy. Two participants in this study with unexceptional EEA entitlements were wrongly charged, and needed robust legal representation to challenge the hospitals' decisions and to get the charges cancelled. They both had clear rights to NHS care under EU law. In one case the woman was the wife of an EU citizen exercising his treaty rights; in another, the woman failed to prove to the satisfaction of the Overseas Visitor Manager (OVM), that she herself was exercising treaty rights even though she was working. Both women needed determined advocacy to get inappropriate charges cancelled.

There are other rights and exemptions which may emerge as advisers or health professionals learn more about a woman's situation, but which are impossible for anyone to identify by just checking a person's passport (if they have one). One participant in this study had contacted Maternity Action's advice service in the course of her pregnancy. The adviser considered that there were reasonable grounds to consider her a victim of human trafficking and referred her to an immigration adviser who made claims for trafficking and asylum on her behalf. As a result she was not liable for charges for her

maternity care. This woman was especially vulnerable and had absolutely no means of paying NHS charges.

But there is no mechanism for an OVM to identify a patient as a trafficked person or as an asylum seeker if they do not already carry this 'label', unless the OVM deliberately seeks the assistance of a qualified advocate to evaluate each case. OVMs are not qualified immigration advisers and so cannot take on this role. But nor can such judgments only be the responsibility of the patient, particularly where patients are very vulnerable, may not speak English, and have little or no grasp of how the NHS or charging regulations work.

This has serious implications for healthcare which should be concerned with the whole patient, rather than with the immigration label he or she bears. Yet the role of the OVM is explicitly to ignore the individual and to focus only on the person's 'visible' immigration status. Where people do not have the right documents to which they might be entitled, or are not aware of entitlements they might have, it is not within the remit or competences of the OVM to investigate beyond what is presented at a particular moment. The consequences of this approach to migrants has recently been brought to public attention in the Windrush scandal, where people have been denied healthcare and even their right to reside in the UK just for not having certain documents deemed to 'prove' their entitlements.

There is no mechanism within the healthcare system to identify patients who might have an alternative immigration status which would make them eligible for NHS care. Indeed, even though there are exemptions for chargeable patients who have experienced violence or abuse which has given rise to the need for the medical treatment, there is nothing in the Department of Health guidance to identify who has responsibility for transmitting such information to an OVM.

Department of Health guidance on the implementation of overseas visitor charges explicitly encourages OVMs to seek 'advice and information from local agencies which support people in various types of need, or to seek advice and information from relevant national agencies and organisations' 'if in the course of their work they are concerned about the welfare of any patient (2: p53). Throughout this report we have drawn attention to hospitals' failure to do this, resulting in severe anxiety for vulnerable women. On the contrary, reports from Maternity Action's Maternity Care Access advice service that hospitals frequently resist advocacy from precisely such recommended agencies.

Moreover, it is disingenuous for government departments to suggest that NHS bodies should depend on what are, often, very small, cash-strapped charities, to ensure that vulnerable patients are adequately supported and advised, especially when the charging policy itself is intended to de-incentivise ineligible patients from seeking care. There are no established procedures within hospitals for identifying the complex needs of chargeable patients, suggesting the low priority hospitals attach to protecting vulnerable patients who may be chargeable.

This is particularly detrimental to the maternity care of vulnerable migrant women as maternity can be a key period in which to identify background issues of trafficking, violence and other forms of abuse which can affect immigration status, as well as chargeability.

The impact of charging on women's health in pregnancy

In this study we found that women's reaction not only to the fact of charging, but also to the size of bills and the ways in which they were issued and demanded, was almost uniformly one of enormous stress. For some women this endured long after they gave birth, having a negative effect on their own health and on how well they were able to care for their children. A review of the long-term impact of postnatal depression concluded that its "impact is likely to be more pernicious where the depressive

episode is severe and prolonged, and where it occurs in the context of personal and social adversity” (9). This was exactly the situation faced by several participants in this study.

There is already evidence of high rates of postnatal depression among migrant women (10). However, while studies acknowledge the impact of discrimination and racism as causative factors within the broader experience of migration, the specific impact of charging and indebtedness for maternity care has not yet been addressed. This study suggests that charging might be considered a significant factor in exacerbating postnatal depression among migrant women.

Anxiety and stress are recognised as having an adverse effect on immediate pregnancy outcomes such as preterm birth and low birth weight (11, 12). They also affect the health of babies who are born following stressful pregnancies, through childhood into adulthood (13). Migrant women who are pregnant already face more causes of stress than the mainstream population, including, as this report illustrates, poverty, insecurity, unstable relationships and domestic abuse, as well as uncertainty about their immigration status. Many participants in this study also suffered from a range of underlying or pregnancy related health problems during their pregnancies. In spite of this many women delayed or avoided maternity care because of fears of incurring charges.

The requirement that maternity care must not be delayed or deferred if women cannot pay in advance is little consolation to those who know they will be indebted and reported to the Home Office, and so still acts as a strong deterrent to accessing care. In practice, charging women for NHS maternity care exacerbates inevitable anxieties which might arise from being pregnant in challenging situations. It thus actually reduces the NHS’ capacity to provide even the most basic care to the women who might need it most, let alone the holistic care recommended for women with ‘complex social factors’.

Who is charged for maternity care? Women, maternity care and gender discrimination

Gender inequality and migrant women

This report has highlighted how the intersection of gender with immigration controls can increase some women’s subordination and vulnerability. Gendered patterns of migration can create different risks and vulnerabilities for men and women migrants (14). In cases where women’s routes to regularised immigration status are dependent on their relationship to a man, men can exercise greater control over them. As irregular migrants, women without the right to work or benefits, are also particularly at risk of sexual exploitation.

Our study includes a woman who was persuaded to come to marry a man already here, only to find her new husband violent and abusive. There were several cases of women in partnerships with men which they believed were enduring relationships, only to find that they were abandoned as soon as they became pregnant. One married woman found that her husband was even trying to use the system of immigration sanctions for NHS debt to abandon her and prevent her from re-entering the UK.

Women may have come to join a partner on a visitor visas and so do not have the right to work or claim benefit; they may have a spouse or partner visa but if the relationship breaks down, they can end up with no immigration status unless they qualify for Indefinite Leave to Remain (ILR) under the Domestic Violence Rule. This entitles women whose relationship has broken down because of domestic violence, to ILR, subject to various conditions, if they are in the UK on a spouse or partner visa. However, fees for ILR, including under the Domestic Violence Rule are almost £2400.

The Domestic Violence Rule is restricted to women with spouse or partner visas. Women with visitor or student visas, or with other types of leave, cannot benefit from this regulation (15). Women who

have experienced domestic violence but who do not qualify under the Domestic Violence rule may have great difficulty obtaining leave in their own right. Without permission to work or claim benefits they will not be able to pay the application fee and Immigration Health Surcharge totalling over £1500.

Only a regulated immigration adviser can apply for a fee waiver for an immigration application. There is no legal aid for such applications though in some cases exceptional case funding can be granted by the Legal Aid Agency. But there is a serious shortage of immigration legal aid providers and so many women may not be able to get the good legal help they need. As a result, many migrant women who leave violent relationships are left with irregular immigration status, while others may remain trapped in abusive relationships to avoid that outcome.

Gender neutral charging and gender inequality

The widespread dependence of migrant women is not acknowledged in charging for maternity care. Although their pregnancies are a consequence of the actions of *both* a man *and* a woman, only women are regarded by the NHS and the Home Office as being responsible for repayments. Only they are charged; only their immigration status is considered relevant to their eligibility for free NHS care and only they face immigration sanctions if they are unable to pay. A dependent woman within a relationship is rendered more dependent if she alone is deemed responsible for a debt of thousands of pounds. Whether or not the father or her child is violent, controlling, or has deceived her, it is only the woman who will bear the costs of maternity care. If she is undocumented and separated from the child's father she is unlikely to request help from government-run Child Maintenance Service and would be at risk of becoming destitute.

There has been no attempt to ensure that fathers take responsibility for any share of the charges for maternity care. This is because charging for health care is carried out on an individual per-patient basis, the reverse of the collective responsibility for health provision, the principle that has underpinned the NHS. The individualisation of responsibility for charging is 'gender blind'. But gender blindness or gender neutrality where there is gender discrimination or gender inequality, increases and perpetuates such inequality. As a result, women who are chargeable for maternity care, whatever the extent of their disadvantage or vulnerability are left with sole responsibility for the bill.

Maternity care charging as a policy priority

Given the risks to both mothers and infants during pregnancy and birth, it is also worth asking why maternity care has not been included as an exemption to the charging regime on public health grounds. The government response to the 2013 consultation on migrant access and financial contribution to NHS provision in England recognised that "There was particular concern expressed around maternity, where there is evidence of the poor outcomes experienced in disadvantaged communities" (16: p34). It also noted that children and maternity care were the most frequently cited categories for which respondents to the consultation sought exemptions from charging (16: p43).

Nevertheless, it held firm on both these categories, exempting only 'looked after' children. Some new exemptions for charging were introduced including "treatment required for a physical or mental condition caused by torture, female genital mutilation, domestic violence, or sexual violence" (2: p10). Such exemptions are extremely restrictive. In relation to maternity care, they are hard to prove and would almost certainly be unknown to the woman seeking care. Identifying conditions which could be considered as exemptions are likely to depend on a trusting relationship being established between a woman and a midwife. As we have seen, this is made more difficult if women have already been billed or are expecting a bill in future. Almost all women whose immigration status disqualifies them for free NHS care are likely to be charged, regardless of the exemptions or whether their spouse or partner is a British citizen or settled in the UK.

This raises the question why, given the government's own acknowledgement of poor maternity outcomes in "disadvantaged communities", has it been so resistant to exempting maternity care from

charging? The answer would seem to lie in racial or national targeting of some pregnant women's use of health care as a form of border control (17). This approach was very visible in a series of Department of Health internal and external studies about the cost of overseas visitors to the NHS which preceded a Department of Health consultation on changes to charging regulations

In a 2012 Overseas Visitors Charging Review, only maternity was singled out for attention, Furthermore Nigeria was the only source country singled out, and again, only in the context of maternity. "Anecdotal evidence from Trusts points to a strong inflow of women from Nigeria to receive maternity services and some tentative evidence from our survey supports this." (18: p16). However, much more nuanced data from the Department of Health's Internal Review collected from eight trusts, found that only 4% of both chargeable and exempt "overseas visitors" obtaining maternity care were from Nigeria compared with 38% from the EEA and 18% British expatriates. There was no investigation of how long the non-British users of maternity or other services had lived in the UK, or whether any had actually deliberately come to use maternity services (19: p70).

The internal review was followed by a quantitative report commissioned by the Department. This was hedged with qualifications about the lack of certainty about the data used (20) but focused significantly on estimated costs of maternity care for women born outside the UK.

At the same time as the Quantitative Assessment, a complementary Qualitative Assessment sampled trusts based on a set of seven 'variables' including a focus on cancer, renal and maternity specialisms on the basis of "anecdotal evidence suggest(ing) that higher numbers of migrants and overseas visitors may be accessing these types of services" (21: p7). However, maternity was referred to on seventeen further occasions in this report, while cancer and renal treatment not at all.

Not only did the slant of the discourse around NHS maternity charging focus on non-white, especially Nigerian, women but it also denied legitimacy to family creation by mixed couples of British men (presumed white) and non-British women (presumed non-white). The following extract from the Qualitative Assessment illustrates this:

"There were also examples of British men bringing non-British girlfriends/wives into the UK expecting to be able to access treatment, such as maternity.

'What we have had quite a few of lately I would say, is men who have married women from abroad, bringing them here thinking that they will get free treatment and they don't and then the men get very stropy'" (Midwife) (21: p21).

There is a long history of a range of UK immigration control measures relating to marriage, for example the Primary Purpose rule, which denied entry to spouses whose 'primary purpose' was supposed to be immigration, but which was used to prevent husbands joining wives in arranged marriages from 1980 until it was abolished in 1997 (22). In the 1970s and 1980s South Asian wives and children were unable to join husbands and parents because they could not meet unrealistic demands for proof that they were related (23,24). Wray has suggested that "immigration controls over marriage" are really used "to restrict the admission of those whose deficit is... not only or even mainly their gender, but their race or nationality, their immigration status or their socio-economic position" (25). In the same way, the idea that foreign wives of British citizens or men settled in the UK, should not be able to have the same expectations of health care or other services as a UK born wife is to perceive such women and their relationships as deficient.

So, for instance, if a woman follows a partner on a visitor visa either when pregnant or if she becomes pregnant while on this visa, it is implied that she is only here to sponge off 'our' system.

"So you'll get somebody coming to Maternity, this is a good example, this happens quite frequently, so they'll say 'oh yeah, I'm living here' and we'll say 'how long have you been in the country?' They'll say, 'oh six weeks'. And we'll go then and check them out and they're

here on a visit visa, so they're here on a six month visit visa, no recourse to public funds, no right to NHS treatment. And then we'll go back and if the treatment hasn't started we'll bill them upfront, before their treatment starts they'll have to pay that bill" (OVM) (21: pp39-40).

It should be noted that at the time the above interview was carried out, earlier Department of Health guidance already stated explicitly that maternity care was immediately necessary and should not be delayed or denied because a woman was unable to pay upfront (26: pp44,82). It is striking that the government's own commissioned researchers should not have noted or commented on the disjuncture between this OVM's statement and government policy. Yet these statements were presented as evidence for deliberate 'misuse' of the NHS for maternity care.

Given widespread gendered norms in marriage and immigration, it is common for men to migrate first, or for a man to seek to bring his partner to join him on a visitor visa, and then seek to regularise her status. This pattern is further encouraged by the high income requirements since 2012 for bringing family members to the UK, as well as delays and errors in processing visa applications (27, 28). As a result spouses and partners often first come to the UK on visit visas to demonstrate that they have a genuine relationship with their sponsor. Maternity Action's advice service receives numerous requests for advice about charging from established couples where the woman is in the UK on a visitor visa.

But given the prejudicial assumptions about these foreign women's motives, it doesn't really matter whether the woman is in a persisting relationship or not. She is clearly playing the system.

"I think there're a number of people coming on student visas who aren't actually a student. And if we asked them to provide evidence that they are actually studying, regardless of the NHS number, if we were doing it legitimately and properly, I think you would find there is a lot of people using maternity services while on a student visa and aren't actually studying. So they've used the visa to get over here and the entitlement for free treatment, but the reality is they've come to have the child." (OVM) (21: p40).

The above quotations in the government commissioned research on charging were used uncritically as 'evidence' of how non-eligible women used immigration routes such as visitor and student visas for health tourism. With no investigation of the background behind these stories, it was possible to present the motives of many foreign born women seeking maternity care as duplicitous and manipulative. Above all, this research which formed part of the 'evidence base' for legislation, implicitly denied women the possibility of migrating for the same reasons as men - to seek work, to flee persecution, to study, or to join families, reducing women to simply childbearing bodies.

The present study has provided evidence to support a re-appraisal of this negative view of migrant women's needs for maternity services. Our more holistic picture of the histories and circumstances of women who were charged, shows that far from "women cheating their way into UK for free birth care" (29), migrant women live in the UK for a variety of reasons and seek maternity services when they are pregnant with the same intentions as other women - to safeguard their own and their babies' health.

Conclusion

The focus of this study has been the individual experiences of a wide range of women who faced charges for maternity care under the Overseas Visitor charging regulations operating in recent years. We have shown the very negative effects of charging on all the participants in the study. Most of the participants were socially and economically vulnerable but even others, in more stable situations

faced anxiety and for most, unrepayable debts in the face of bills which they were sent from the NHS. The bills they were issued remain unpaid, rendering the debt recovery activity useless.

This chapter has explored in more detail the major implications of the study, addressing the contradictions between NHS charging linked to immigration control, and a caring and compassionate health service. Charging adds to the already myriad factors giving rise to stress and anxiety among migrant women who are pregnant. Deterrence from attending maternity care denies women access to clinical care and social support which could have possible long-term consequences for their own and their children's health.

We have also examined some ways in which gender intersects with immigration and often positions women migrants in dependent and vulnerable situations. The individual billing of NHS patients is particularly inappropriate in the case of maternity care, where women's partners are involved in creating the need for such care, but are entirely absolved from responsibility for contributing to it financially. Undocumented women migrants or visitors without long-term leave can thus find themselves particularly vulnerable to unscrupulous men.

At the same time, immigration policy and in particular, policies on NHS charging have focused on women migrants solely in terms of their presumed reproductive intentions, denying them both legitimacy as workers, students, family members, refugees, or indeed as full human beings in their own right. This approach has led to a singular refusal to consider exempting maternity care from the Overseas Visitors charging regulations despite an acknowledgment of the greater health risks and worse pregnancy outcomes of this group.

Many of the individuals affected by charging are in the process of applying for leave to remain in the UK, but are subsequently left saddled with burdensome debts. The complexity of the rules about entitlement also mean that many people, particularly those from minority ethnic backgrounds, are caught up in the effects of charging even when they are fully entitled to free NHS services.

It is clear that most of the women interviewed in this study will never be able to pay the sums demanded, and it is likely that the costs incurred in attempting recovery, will outweigh the actual costs incurred. But the price of charging vulnerable migrant women for maternity care is much higher, undermining the ethos and principles of a national health service created to meet clinical need regardless of an individual's ability to pay and inherently discriminating against women. Above all it has an immediate and long-term negative impact on the health of the women and families and is a significant further barrier to migrant women's access to health services.

Recommendations

1 Fundamental change to charging policies

The government should immediately suspend charging for NHS maternity care.

Charging has a deterrent effect on women's access to maternity care which poses risks to their pregnancies and the health of their babies. Anxiety about charging has an adverse effect on maternal mental health with consequent effects on women's pregnancies and pregnancy outcomes. Although all maternity care is designated as immediately necessary, this does not compensate for the anxiety women feel knowing that they are unable to repay very high charges.

2 Interim measures to mitigate the harmful impact of charging

National policy changes

The government should amend the Immigration Rules to stop debt from maternity care affecting future immigration applications.

Fear of being reported to the HO affects women's engagement with maternity services.

The government should abolish the 50% surcharge on the standard tariff on any charges imposed until all charges are suspended.

The 150% overseas tariff is justified as offering a 'risk-share' arrangement between providers and commissioners in order to share 'the risk of non-payment' (1: pp107-8). This system puts additional pressure on chargeable women and thus adds to the deterrent effect of charging while in no way increasing their ability to repay.

Changes by hospital trusts

All hospital trusts should develop policy and practice guidelines on charging procedures.

This is in order to mitigate damage done to women by charging for maternity care. Such policies should be informed by, though not restricted to, the Department of Health guidance on charging vulnerable patients (1: Ch 7). The implementation and impact of such policies should be monitored and regularly evaluated.

Trusts should waive existing charges for all patients who are unable to pay.

Costs cannot be recovered from women who are unable to pay so cancelling existing charges where women are unable to pay, saves women a great deal of anguish.

No notification should be made to the Home Office for any woman with a repayment plan in place or whose charges have been waived.

It is unreasonable and unjust for migrant women to be reported to the Home Office to be penalised for non-payment or non-completion of a debt which the waiver or payment plan indicates they are unable to pay.

Trusts should establish transparent criteria for establishing inability to pay. These can be based on existing assessments of low income or destitution.

Such assessments include: women in receipt of section 17 support under the Children Act, 1989, women who hold HC2 certificates for full help with health costs, women who have obtained fee waivers from the Home Office for current immigration applications, and women who meet the destitution criteria for asylum support.

Use of recognised eligibility criteria for low income or destitution would make charging decisions comparable and transparent, recognising certain groups' inability to pay charges.

Women should be notified that they are chargeable within two weeks of their first contact with a trust's maternity services. This should include an opportunity for a face-to-face discussion about charging with the Overseas Visitor Manager.

Early notification will enable women to make informed choices about further action which they consider appropriate. A face-to-face meeting enables issues to be clarified.

All invoices or other demands for payment should be initiated before the end of a woman's maternity care.

Unnecessary late billing creates avoidable additional anxiety for women.

No belated demand for payment should ever be made for maternity care for previous pregnancies which were not billed at the time. Any such debts should be waived.

It is unreasonable and unjust for women to be charged years after receiving care for which they were not charged at the time.

Under no circumstances should a trust pass a request for payment to a debt collection agency less than three months after a woman has given birth.

This would help to reduce stress on a woman with a newborn baby and give women time to consider their payment options after giving birth.

All trusts should ensure that no maternity booking appointment or further maternity care be refused or delayed for any reason relating to charging.

As long as charges for NHS maternity care continue to be imposed, it is incumbent on hospital trusts to develop implementation policies which follow Department of Health guidelines. They should also ensure that they are monitored and evaluated regularly to limit adverse impacts on individual women and to minimise increasing health inequalities among women and babies.

Debt recovery actions should not be initiated without first establishing that women have understood the charges, have been offered an opportunity for a realistic and affordable repayment, and been signposted to an appropriate advice service. Women should be supported in making affordable repayment plans.

Department of Health Guidance recognises that OVMs should take steps to understand the needs and circumstances of vulnerable patients and help them to get advice and information to enable them to make informed choices regarding payment (1: p53). If women are having difficulty maintaining repayments they should be signposted to independent debt advice services. In such circumstances, no notification about the debt should be made to the Home Office until women have received advice and modifications to their repayment have been considered, or the charges waived. Women's circumstances can easily change during the course of instalment payments. With proper advice, such a plan can be adapted in response to a woman's new situation.

All trusts should ensure that all communications and actions relating to charging treat women respectfully and show an understanding of their vulnerabilities in line with the trusts' responsibilities as health providers. This will include the following basic considerations:

- Face-to-face information about charging should be provided within two weeks of a woman's contact with maternity services, and with an interpreter, if needed.
- Communications must *highlight* a woman's right to access *all* NHS maternity care whether or not she is able to pay for her care.
- All communications relating to charging should be written in clear and comprehensible language. Any communications sent to a woman with limited English should be translated into a language which she can understand.
- Any requests for payment should include a written statement which explains the decision to charge the woman receiving the request. It should also include an estimate of the final bill, and clear payment options, including genuinely affordable repayment plans. Such a request should also provide information about how to appeal the decision to charge and/ or the amount charged.
- Hospital trusts should ensure that communications with women from debt collection agencies be sensitively worded, and that such agencies do not harass women with telephone calls. Such agencies should also be informed if women cannot understand English.

Insensitive and officious communications from trusts and debt agencies have been shown to have harmful effects on the mental health and health seeking behaviour of women receiving maternity care. Consideration of the function and purpose of communications and how any communication impacts on the recipients should inform and underlie all communication about charging. The central concern should be to **not** deter women from seeking maternity care, and to enable them to retain trust in their treating midwives and other clinicians.

Clinical Commissioning Groups should ensure that GP practices in the local area be informed about NHS charging policies especially in relation to maternity care, and about where women can get advice locally. Wherever possible, GPs should inform any practice patients who become pregnant that they may be charged for maternity care and where they can receive further advice and information.

GP practices are a key element in most women's initiation to maternity care. It is essential that GPs are themselves familiar with national and local charging policies in order to be able to help women better understand the system and obtain appropriate assistance.

3 Good practice in maternity care for vulnerable migrant women

Charging for NHS maternity care undermines efforts to optimise care for disadvantaged migrant women. Nonetheless, trusts should continue to follow NICE guidance on women with complex social factors and other national policies in order to reach such women and enable them to access the maternity care they need (2,3).

Vulnerable migrant women face many other barriers to healthy pregnancies and to accessing good maternity care besides NHS charging. While NHS charging undermines many of these good intentions, they should remain the goals of maternity care for all migrant women. Concerns about entitlement to free NHS care should never take priority over trusts' responsibilities to meet the health needs of migrant women and their babies.

Trusts should make efforts to provide outreach to recent migrants and women with little or no English via local organisations and GP practices to encourage early booking and help to develop trust and confidence in maternity services.

Reducing inequalities in health has been repeatedly restated as an aim of policies to improve maternity care. Such policies consistently emphasise the need for special efforts and/or service provision to identify and reach disadvantaged women.

Interpreting services should be provided routinely if a woman is unable to communicate satisfactorily with midwives or other clinicians.

Good mutual comprehension is fundamental to midwives' ability to identify women's health needs and to establish trust between themselves and the women they are looking after.

Trusts should audit clinic attendance and pregnancy outcomes of all migrant women, noting whether or not they were charged.

While it is known that migrant women face higher risks of maternal mortality, such audits would provide more information about factors affecting women's participation in maternity care and broader pregnancy outcomes of migrant women. It would also contribute to a better understanding impact of charging for maternity care.



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Glossary

Asylum Seeker

An asylum seeker is a person who has made a claim for international protection under the UN Refugee Convention, 1951 or under Article 3 of the European Convention on Human Rights, 1950 or under Article 15c European Qualification Directive, 2004. Asylum seekers are entitled to support under section 95 of the Immigration and Asylum Act 1999 while their claim is being considered and during any appeal. Asylum seekers are entitled to all NHS care.

Booking (appointment)

The booking appointment is the first formal antenatal appointment following a woman's first contact with a health professional in her pregnancy, and normally takes place where a woman will receive her maternity care. Ideally it should take place by 10 weeks' pregnancy in order to carry out initial fundamental health checks and to offer and arrange important screening tests. It is regarded as the key opportunity to identify women with particular risk factors such as FGM, domestic violence, previous pregnancy problems, or underlying health or social issues which may require the woman to receive additional care. At the booking appointment women are given information about healthcare during the pregnancy and options for delivery, and have an opportunity to ask questions and discuss issues of concern to them.

Destitute

Asylum seekers or refused asylum seekers are considered destitute if they do not have access to 'adequate accommodation' or cannot meet their 'essential living needs' now or within the next 14 days. Local authorities may consider a family destitute if they are homeless or at immediate risk of homelessness and/or do not have enough funds available to meet their living needs.

Female genital mutilation (FGM)

Female genital mutilation (FGM), also known as female genital cutting or female circumcision, comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

Immediately necessary treatment

Government charging regulations define an immediately necessary service as all antenatal, intrapartum and postnatal services, i.e. all maternity services. Immediately necessary treatment also applies to any relevant service that the treating clinician determines that a person needs promptly to save their life, to prevent a condition becoming immediately life-threatening, or to prevent permanent serious damage to the recipient from occurring.

Immigration Health Surcharge (IHS)

An immigration health charge, often referred to as the 'health surcharge' must be paid as part of their immigration application by non-EEA nationals who apply for a visa to enter or remain in the UK for more than six months. People with indefinite leave to remain in the UK normally do not have pay the health surcharge. People with visas of less than six months cannot pay the surcharge and so are chargeable for NHS hospital services.

Payment of the health surcharge entitles those who have paid, to all NHS services, free at the point of use, including NHS hospital care, except for assisted conception services such as *in-vitro* fertilisation (IVF). People who have paid the surcharge must pay for all services for which people who are ordinarily resident in the UK also pay, such as prescriptions, dental treatment and eye tests. People with visas of less than six months cannot pay the surcharge and so are chargeable for NHS hospital services.

Indefinite leave to remain (ILR)

Indefinite leave to remain (ILR) or permanent residency is an immigration status granted to a person who does not hold the right of abode in the UK (the right to live or work in the UK without any immigration restrictions) but who has been admitted to the UK without any time limit on his or her stay and who is free to take up employment or study without restriction. A person who has indefinite leave to remain does not need a visa to come to the UK. Indefinite leave can lapse where the holder has stayed outside the United Kingdom for a continuous period of more than two years.

Limited Leave to Remain

A person who is subject to immigration control (who requires leave to enter or remain in the UK) may be given permission to enter for a limited period and will have to leave the UK at the end of that time, or apply for an extension to their permit *before* it expires if they wish to stay longer. People with limited leave to remain normally have permission to stay in the UK for 30 months after which they will have to renew their visa. They will have to pay the Immigration Health Surcharge, and will normally have No Recourse to Public Funds as a condition on their visa.

No Recourse to Public Funds (NRPF)

No recourse to public funds is a condition imposed on someone by the Home Office due to their immigration status. Section 115 of the Immigration and Asylum Act 1999 states that a person will have 'no recourse to public funds' if they are 'subject to immigration control'. This can include people on spouse visas, student visas, or with limited leave granted under family or private life rules.

Ordinary residence

The test of residence that the UK uses to determine entitlement to free NHS healthcare is known as 'ordinary residence'. An overseas visitor is defined in the Charging Regulations as anyone who is not ordinarily resident in the UK. The criteria of ordinary residence are whether someone is living lawfully in the United Kingdom voluntarily, and for settled purposes as part of the regular order of their life for the time being, whether of short or long duration.

Ordinary residence is not transferable to other family members. Therefore, if a spouse or civil partner of someone who is ordinarily resident here normally lives overseas and requires treatment during a visit to the UK, they will not be ordinarily resident or automatically entitled to free NHS treatment. Even if a person is a British Citizen or has Indefinite Leave to Remain, if they normally live overseas and have not returned to 'resume properly settled residence', they will not be considered ordinarily resident.

Overseas visitors

An overseas visitor is defined in the Charging Regulations as anyone who is not ordinarily resident in the UK.

Refused Asylum Seeker

Refused asylum seekers, often referred to as 'failed' asylum seekers, are those who have exhausted their appeal rights in the asylum process. They are expected to leave the UK voluntarily, or can be removed if they do not leave of their own accord. Many refused asylum seekers fear that they will be in danger if they return. Refused asylum seekers are more likely to be destitute than other asylum seekers as they often have no access to government support or permission to work. Destitute refused asylum seekers can, under certain conditions, apply to the Home Office for section 4 support.

Section 4 support

Section 4 support is the support granted by the Home Office to destitute refused asylum seekers under certain conditions. It is cashless support is only provided in conjunction with accommodation in a no-choice location.

Section 95 support

Section 95 is support granted by the Home Office to asylum seekers in the process of making their asylum claim, including during an appeal process. Support is provided in two ways, on a cash only basis at 70% of income support levels, or with cash and accommodation on a no-choice basis.

Undocumented migrants

An undocumented or irregular migrant is someone who does not have permission to live in the country in which they are residing. In the UK undocumented migrants include refused asylum seekers, visa overstayers, people who have entered without required documentation, and migrants in breach of their visa conditions. This may mean that their residence or work permit is invalidated or expired. Such migrants may be prohibited from accessing certain public services, from working, or from receiving benefits. Apart from refused asylum seekers in Wales and Scotland, in the UK undocumented migrants are chargeable for most NHS hospital care.

United Kingdom Border Agency (UKBA)

The United Kingdom Border Agency (UKBA) was until 2013 the border control agency of the British government and an Executive Agency of the Home Office. It had responsibility for asylum support. Its functions have been replaced by UK Visas and Immigration (UKVI).

Appendix - Anonymised scans and transcripts of communications from hospital trusts and debt agencies to participants in the study

Figure 1 – Letter to debt advice agency from hospital trust reducing ‘Mei’’s bill by approximately 10%

Figure 2 – Letter from hospital trust charging ‘Olivia’ for in-patient care for delivery

Figure 3 – Letter from hospital trust charging ‘Nina’ for in-patient care for delivery

Figure 4 – Final demand for payment from hospital trust to ‘Anna’

Figure 5 – Overdue demand for payment from hospital trust to ‘Mary’

Figure 6 – Charges sheet with amount payable circled given by hospital trust to ‘Leah’

Figure 7 – Demand for payment from hospital trust to ‘Rosa’

Notes

1. The exact sums referred to have been modified to protect confidentiality but reflect their approximate amount.
2. Where dates are given to show length of hospital stays, these have been modified to protect confidentiality.
3. Transcripts are based on single pages scanned which are not necessarily complete documents.

Figure 1 – Letter to debt advice agency from hospital trust re. research participant ‘Mei’

**Name of NHS Trust
NHS Overseas Visitors Team**

___ October 2017

Our ref: ____

Debt Team Leader

Name and address of debt advice agency

Dear _____,

Re: Mrs M, DOB _____ – attendance at _____ Trust

Thank you for your email dated ___ October 2017. I am writing to you in my capacity as Overseas Visitors Communications and Regulations Manager at _____ Trust ('Trust').

You kindly provided copies of the correspondence Mrs M received from the Home Office confirming her application for support under Section 4 of the immigration and Asylum Act 1999. I have further investigated the circumstances of Mrs M's case and these are summarised, as follows: an application for asylum was made by Mrs M and was acknowledged by the Section 4 National Team ("SNT") at the Home Office on ___ September 2015. As of this date Mrs M was deemed NHS entitled. On ___ October 2015 the SNT wrote back to confirm Mrs M's application was successful.

Unfortunately, my investigation confirms Mrs M's non-entitlement to NHS care without incurring NHS charges, which have been acknowledged by the British Red Cross in their correspondence letters of ___ July and ___ August 2017. This decision has been made in conjunction with the supporting documents you have provided on behalf of your client, as well as information received from the Home Office. This is also in-line with Department of Health guidelines, which _____ Trust strictly adheres to.

After reviewing the date of application and acceptance by SNT, I can confirm that invoice number _____ will be reduced by £240. This means that the total billed, in the amount of £2300 has been reduced and the revised outstanding debt owed at _____ Trust now stands at £2060.

Whilst I understand your client is not able to pay the monies owed at this time, as a Public Accountable Body we are responsible to the authorities to ensure that we capture and get reimbursement of any tax-payers money that is expended on non-NHS entitled patients. Mrs M is not covered for her NHS care, under the Department of Health exemption category.

I thank you again for providing Mrs M's papers, it assisted us when deliberating the issue of her exemption to NHS charges for the period billed.

Due to the financial position Mrs M currently finds herself in, _____ Trust will suspend all further recovery action for a period of 6 months. The review date for Mrs M will be ___ April 2018. At this time we will expect an update on Mrs M's circumstances. This will avoid this department from contacting her unnecessarily, which may cause her unwarranted stress and anxiety.

If Mrs M's wish is to discuss a payment plan for this outstanding debt owed to the NHS, please contact our Credit Control team on telephone number _____ to arrange a meeting and / or to discuss this matter further. _____ Trust is willing to discuss the implementation of an instalment plan, thereby recouping monies owed to the Trust.

Please do not hesitate to contact me or a member of the NHS Overseas Visitors Team on telephone number _____ should you have further queries.

Yours sincerely,

NHS Overseas Visitor Manager

Figure 2 – Letter from hospital trust charging ‘Olivia’ for in-patient care for delivery

Name of NHS Trust

NHS Overseas Visitors Team
Team address and contact details

_____ 2015

Acc No: _____

Dear Ms O,

Under the current Department of Health regulations (NHS Charges to Overseas Visitors, 1989) National Health Service (NHS) Hospitals have a legal responsibility to invoice all overseas visitors liable to charges. An overseas visitor is someone who is not ordinarily resident in United Kingdom.

Persons charged under these regulations are “charged NHS patients” and not private patients. Unlike private patients who sign an agreement based on private charges and are aware of the cost beforehand, overseas patients usually incur charges as a result of an emergency admission.

You were admitted to _____ Trust on 28.03 2015 and you were discharged on 01.04.2015.

A total charge of £4200 was made for this episode.

This charge is inclusive of your delivery care only. Please note additional charges would be incurred for your postnatal care and any stays in intensive care or high dependency units.

Please make arrangements to pay this outstanding amount on receipt of this invoice. Failure to pay by return may require the involvement of external debt agencies and/or the relevant official bodies such as our Local Counter Fraud specialists, UK border agency and Embassies.

This final charge is inclusive of all elements of medical care. A separate consultant fee is not charged in accordance with Department Of Health Regulations.

Unlike specialised Private Hospitals, we are not in a position to provide a cost per procedure or cost per service itemised charges.

Important, please read the following information:-

Please note that if you fail to pay for NHS treatment for which the charges have been levied, it may result in a future immigration application to enter or remain in the UK being denied. Necessary personal information may be passed via the Department of Health to the UK Border Agency for this purpose.

Figure 3 – Letter from hospital trust charging ‘Nina’ for care for delivery

Name of NHS Trust

Our ref: _____

NHS Overseas Visitors Team
Team address and contact details

_____ 2017

Acc No: _____

Dear Mrs N,

The current Department of Health regulations (NHS Charges to Overseas Visitors) place a legal obligation on NHS hospital trusts to make and recover charges from the person liable to pay for the NHS services provided to the overseas visitor. An overseas visitor is any person who is not ordinarily resident in the United Kingdom. A person will be “ordinarily resident” in the UK when that residence is lawful and for settled purposes.

Persons charged under the Regulations are “charged NHS patients” and not private patients. Unlike private patients who sign an agreement based on private charges and are aware of the cost beforehand, overseas patients usually but not always incur charges as a result of an emergency admission.

You were admitted to _____ Trust on 01.03 2017 and you were discharged on 04.03 2017.

A total charge of £6000 was made for this episode.

This charge is inclusive of your delivery care only. Please note additional charges would be incurred for your postnatal care and any stays in intensive care or high dependency units.

Please make arrangements to pay this outstanding amount on receipt of this invoice. Failure to pay by return may require the involvement of external debt agencies and/or the relevant official bodies such as our Local Counter Fraud specialists, Home Office (HO) and Embassies.

This final charge is inclusive of all elements of medical care. A separate consultant fee is not charged in accordance with Department Of Health Regulations.

Unlike specialised Private Hospitals, we are not in a position to provide a cost per procedure or cost per service itemised charges.

Figure 4 – Final demand for payment from hospital trust to ‘Anna’

Customer No [number]	Document Date [day.month].17
--------------------------------	--

[Patient name and address]

Send Payment To [Name of trust and address of debt management office]

FINAL DEMAND FOR PAYMENT
Dear Sir/Madam

We wish to notify you that if this account is not settled within 7 days of this letter it will be referred to a debt collection agency and you may face litigation.

Furthermore, under immigration rules 320, 321, 321A and 322, a person with outstanding debts of over £1,000 for NHS treatment which are not paid within three months of invoicing, may be denied a further immigration application to enter / remain in the UK. If full settlement is not made, information relating to this debt will be provided to the UK Border Agency and may be used by them to apply the above immigration rules. This information will remain active for the purpose of the above rules until the debt is settled: a record of the settlement will also be retained, subject to normal limitation periods. In the event that you may seek entry to the UK or make an advance immigration application, after settling an NHS debt in the previous three months, please retain and carry evidence of payment for potential examination by UK Border Agency officials.

If you believe you are exempt from paying for NHS treatment costs, evidence is required to support your claim. For exemption guidance, please refer to <https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations>

Yours faithfully

Debt Management Team (Overseas)
NHS Shared Business Services

Send Payment to [Name of trust and address of debt management office]

Remittance Slip
NHS

Customer No [number]
Document Date [date]

Please enter the amount to be paid into the box provided
Total Amount Remitted

Please Make Cheques Payable to: [Name of trust]

BACS/CHAPS/Book Transfers: [Sort code and account number]

For Payment and Credit Card enquires please contact: Opening Hours: 09:00 to 17:30 Monday - Friday

CONTACT NAME Accounts Receivables Team **CONTACT** [Telephone number]

CONTACT EMAIL [Email address] **TELEPHONE** **CONTACT FAX** [Fax number]

Figure 5 – Overdue demand for payment from hospital trust to ‘Mary’

Overseas Visitors Team
Our Ref: [REDACTED]

[REDACTED] 2013

Miss [REDACTED]
[REDACTED]
[REDACTED]
LONDON
[REDACTED]

Dear [REDACTED]

Outstanding Balance: £6,000.00

As we have not received any response with regards to our previous requests for payments to be made in respect of the above outstanding balance, I write to inform you that this amount is now overdue. Please forward the amount due within the **NEXT 14 DAYS**, thus enabling full settlement of your account.

This can be done by forwarding a cheque made payable to [REDACTED] to the address listed below. Alternatively, if you wish to make a credit/Debit card payment please call our cashier on [REDACTED].

However, [REDACTED] is willing to discuss the implementation of an instalment plan, thereby recouping monies owed to the Trust over an agreed period of time. If you wish to discuss a repayment plan, do contact me to arrange a meeting.

If we do not hear from you within the next 14 days we are obliged to forward your details to CCI Legal, our debt collection agency. Once your details have been passed to CCI Legal all future correspondence pertaining to your outstanding debt will be dealt with by CCI Legal and therefore our Trust will no longer have any involvement in your case. I must also advise you that any additional costs incurred for the collection of the monies owed to our Trust will be payable by you.

In accordance with Regulations that first came into effect on 1st October 1982, visitors to the United Kingdom may be liable to be charged for NHS hospital treatment. A visitor is someone not ordinarily resident in the UK

Non-EEA: - The UK Border Agency has published an equality analysis on its amendment to the immigration rules to allow an outstanding debt to the NHS of £1000 or more to be reason normally to refuse a new visa or extension of stay to those subject to immigration control. Details can be found on:
<http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/consultations/nhs-debtors/>.

Figure 6 – Charges sheet with amount payable circled given by hospital trust to ‘Leah’

[Name of NHS trust]

Overseas NHS Charged Patient Tariff (Overseas Visitors)

2015/16

In England overseas visitors who are admitted through Accident and Emergency departments are billed according to the Department of Health regulations. These regulations state that we charge all emergency admissions at a set rate per night, inclusive of all treatment they receive whilst they are an inpatient. These charges include surgery, blood tests, x-rays and inpatient medication. Outpatient’s consultations will incur additional charges.

Tariff for Overseas Visitors 2015/2016

	£
Inpatient Stay	
Charge per night on a general ward	798.00
Charge per night in ITU (Intensive Care Unit)	2,126.00
Charge per night in HDU Or CCU	1,433.00
Day Case charge	545.00
Angioplasty	1,296.00
Angioplasty plus one night Coronary Care Unit	2,614.00
Cardiac repro drug	1,772.00
Per angioplasty stent	1,022
Per angioplasty coated stent	2,006
Outpatient	£
Outpatient per attendance	151.00
Dressing Clinic (per visit)	77.00
Scans/x-rays/ultrasound	Charged at private patient tariff
Hire or crutches/walker	32
Maternity	£
Maternity Booking	632.00
Delivery (including 2 night stay)	4,581.00
NICU	2,125.00
SCUB	1,434.00
PICU	2,687.00

Please note: Unfortunately we do not have a direct debit settlement arrangement with any overseas insurance companies and we require that you pay your medical account in full and then submit your invoice to your insurance company for reimbursement.

If you have any further enquiries regarding the above please do not hesitate to contact the hospital overseas officer via the hospital switchboard [telephone number]

Note

Leah was told to bring half the amount circled to her next antenatal appointment.

Figure 7 – Demand for payment from hospital trust to ‘Rosa’

