Editorials

Charging for NHS care and its impact on maternal health

INTRODUCTION

NHS care remains chargeable for people with undocumented immigration status, despite repeated calls by health professionals for social justice and health inequalities now highlighted by unequal COVID-19 outcomes.[1,2] We describe the devastating consequences of charging for undocumented pregnant women, compounded by misinformation, xenophobia, and institutional racism. These are well-documented,[3] but lack recognition in everyday practice.

Feldman[4] reports that government policy, purposefully creating a *'hostile environment'* for immigration, means maternity care is often de facto unavailable for undocumented women. The policy[5] claims to *'reduce inequalities relating to the health service'* and *'ensure the needs and interests of vulnerable or disadvantaged patients are protected'*. We contend that it does the opposite: widening existing inequalities in maternal health and contributing to maternal deaths. While government legitimises this policy as necessary for a sustainable NHS, the evidence contradicts any fiscal gain as costs are not wholly recoverable and care becomes delayed.[6]

MBBRACE-UK report that women born outside the UK represent nearly a quarter of maternal deaths.[7] Refugee and asylum-seeking women, despite contributing 0.29% of the population,[8] make up 6% of this group. This is reflected across Europe where refugee and asylum-seeker outcomes include a 45% increase in low birth weight, 24% increase in pre-term delivery, and 50% increase in perinatal mortality.[9] Under-representation in research is recognised in marginalised groups,[10] and there is specifically a dearth of data for undocumented women, but the intersectional nature of their disadvantage clearly includes race, sex, limited English proficiency, poverty, and destitution. Consequently, the National Institute for Health and Care Excellence identify pregnant women in these groups as high risk and call for improved access to maternity services.[11]

> *"... government policy, purposefully creating a 'hostile environment' for immigration, means maternity care is often de facto unavailable for undocumented women."*

CHARGES

Undocumented migrants are not deemed 'ordinarily resident'. They are chargeable unless covered by complex exemptions.[12] Unlike most secondary care, maternity care is deemed urgent and immediately necessary and should not be refused if upfront payment is impossible. However, charges are set at 150% of cost,[13] for example, £7373.42 compared to £4915.61 charged to clinical commissioning groups for the same services.[14] Abortion charges are £1426.67. NHS debts of over £500, not repaid within 2 months, or without a repayment plan, are reported to the Home Office[13] and can be used negatively in determining immigration applications. There are many reported incidents of erroneous charging. Overseas visitors officers seem ill-informed of what constitutes a realistic repayment plan for women who have no permission to work nor entitlement to benefits.[4] It can take years to challenge charges, during which time women are pursued aggressively by debt collection agencies, generating high levels of anxiety.

RISKS

Undocumented migrant women are superdiverse, initially entering the UK with visitor visas, seeking asylum, or with other entitlements. A woman's status may change before or during pregnancy, can remain *'complex and fluid'*,[4] and is hard to track without legal training. This change may be a consequence of escape from forced or abusive relationships.[4] These circumstances often necessitate strategies such as 'survival sex'.[15] Complex social situations require material support, which is unavailable from the state, and they often rely solely on charitable means until 34 weeks' gestation when they are given shelter and a financial allowance well below the poverty line. Over-the-counter medication becomes out of reach and good nutrition difficult to achieve. Remote access to care is restricted by digital poverty and telephone interpretation misses opportunities for safeguarding.

Underlying undiagnosed or undertreated medical conditions include gestational diabetes, fibroids, haemoglobinopathies, blood-borne virus or other infections, depression, or post-traumatic stress disorder. These necessitate more frequent, specialist antenatal care; however, the prospect of incurring unaffordable charges, and fear of immigration sanctions including deportation, prevents or delays these women from accessing care. Moreover, many women eligible for free care are deterred through fear of being charged, a lack of clear information using professional language interpretation, and sometimes false identification of ineligibility.[4,12]

> *"It can take years to challenge charges, during which time women are pursued aggressively by debt collection agencies, generating high levels of anxiety."*

RECOMMENDATIONS

While we have focussed on NHS maternity care, we recognise the wider impact of healthcare charging and call on the UK government to urgently abolish charging policy, unless it can publish good-quality and transparent data to affirm its claims of no harm.

Meanwhile, a unified voice from the medical professions is essential.[16] Advocating for reform, exclusions, or revisions to charging is insufficient for a truly universal NHS. We urge the Royal College of General Practitioners and other representative organisations, including

"... a unified voice from the medical professions is essential. Advocating for reform, exclusions, or revisions to charging is insufficient for a truly universal NHS."

the British Medical Association and Royal College of Midwives, to extend their position to include the blanket removal of all charges. Representation from people with lived experience and systematic case identification by experts from non-governmental organisations, such as Maternity Action, Doctors of the World, Asylum Matters, Medact, and Patients Not Passports, is essential.

Primary care remains accessible to all, irrespective of immigration status or ability to pay. GPs can equip undocumented migrants, and service providers, with accurate information on NHS entitlements. There is first an imperative to ensure timely GP registration, without demanding proof of address or immigration status; second, to undertake non-judgemental consultations, using independent professional interpretation; and third, to undertake positive action to protect undocumented migrants and their children through care that emphasises continuity and advocacy.

CONCLUSION

The situation we describe for undocumented pregnant women highlights harms brought about by government policy. Developed without adequate clinical consultation, it is morally fraught and undermines the philosophy of the NHS.

If we are serious about tackling health inequalities and protecting vulnerable people, this should include safeguarding the rights of undocumented migrants. The policy of charging for NHS care must be scrapped in its entirety.

Camilla Walker,
Foundation Year 1 Doctor, Dorchester County Hospital NHS Foundation Trust, Dorchester.

Rebecca Farrington,
GP Senior Clinical Lecturer, Faculty of Biology, Medicine, and Health, Division of Medical Education, University of Manchester; GP with Special Interest in Asylum Seeker Mental Health, Specialist Asylum Seeker Service, Greater Manchester Mental Health NHS Foundation Trust, Manchester.

Provenance
Freely submitted; externally peer reviewed.

Competing interests
The authors have declared no competing interests.

DOI: https://doi.org/10.3399/bjgp21X715337

ADDRESS FOR CORRESPONDENCE

Camilla Walker
Dorset County Hospital, Williams Ave, Dorchester DT1 2JY, UK.
Email: camilla.walker@dchft.nhs.uk

REFERENCES

1. Paremoer L, Nandi S, Serag H, Baum F. Covid-19 pandemic and the social determinants of health. *BMJ* 2021; **372:** n129.
2. Razai MS, Kankam HKN, Majeed A, *et al.* Mitigating ethnic disparities in covid-19 and beyond. *BMJ* 2021; **372:** m4921.
3. Feldman RA, Bewley S, Bragg R, Beeks M. Hostile environment prevents women from accessing maternal care. *BMJ* 2020; **368:** m968.
4. Feldman R. NHS charging for maternity care in England: its impact on migrant women. *Crit Soc Policy* 2020; DOI: 10.1177/0261018320950168.
5. Department of Health. *Making a fair contribution: government response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England.* London: UK Government, 2017.
6. Bozorgmehr K, Razum O. Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: a quasi-experimental study in Germany, 1994–2013. *PLoS One* 2015; **10(7):** e0131483.
7. MBRRACE-UK. *Saving lives, improving mothers' care. Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015–2017.* Oxford: University of Oxford, 2019.
8. United Nations High Commissioner for Refugees (UNHCR). *Global trends: forced displacement in 2019.* Copenhagen: UNHCR, 2020.
9. Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. *Soc Sci Med* 2009; **68(3):** 452–461.
10. Henrich J, Heine SJ, Norenzayan A. The weirdest people in the world? *Behav Brain Sci* 2010; **33(2–3):** 61–83.
11. National Institute for Heath and Care Excellence (NICE). *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. CG110.* London: NICE, 2010.
12. Maternity Action. *Duty of care? The impact on midwives of NHS charging for maternity care.* London: Maternity Action, 2019.
13. Department of Health and Social Care. *Guidance on implementing the overseas visitor charging regulations.* London: UK Government, 2018.
14. NHS Improvement. *Overseas patient upfront tariff.* London: NHS Improvement, 2019.
15. Watson J. Understanding survival sex: young women, homelessness and intimate relationships. *J Youth Stud* 2011; **14(6):** 639–655.
16. Medact. *Patients Not Passports: challenging healthcare charging in the NHS.* London: Medact, 2020.