

# Duty of Care?

The impact on midwives of NHS charging for maternity care



**maternity action**

Ten years of fighting for better maternity rights

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## Foreword

The role of the midwife has always been to be 'with woman'. The bedrock of quality, safe care is recognition that women's health is affected by many different forces, not just physiological processes but how she lives, how she is able to realise her ambitions and make choices that are right for her. The Code of Practice for midwives in the United Kingdom recognises this truth, that the midwife is an advocate as well as a competent, skilled clinical practitioner.

This report makes for sobering reading as it demonstrates the dilemma midwives in England face when caring for women who are required to pay for their maternity care. Women affected by these charges are some of the most vulnerable people in our society. But attempts to recover money from these women seem to be driving a wedge between midwives and the women who desperately need their care.

Cost Recovery in the NHS is not new, but recent legislative changes in England have made the NHS part of what is known as the 'hostile environment'. This report has found that midwives resent being made part of Cost Recovery architecture, finding it an anathema to the professional ethics of midwifery. Women are being discouraged from accessing maternity care for fear of being charged, even when they may be eligible for free care but may not realise that. Destitute women are frightened of bills they cannot pay. Midwives in this report are never far from the realisation that a woman's social situation – the people in her life, where she lives, how she gets by – is a major driver of her health, and this report shows the lengths midwives are going to as they try to limit the damage that Cost Recovery can do. Building on previous research by Maternity Action with migrant women themselves, this report gets to the heart of the special relationship between women and midwives, and what a transformational moment that can be for women as they begin their lives as new mothers. Anything that prevents the midwife from being an advocate, and supporting a woman to access the care she needs, is not in the spirit of our NHS.

The RCM has been a vocal critic of measures within Cost Recovery which put our members in a difficult position and jeopardise their ability to care for women. There is scant evidence that Cost Recovery actually helps the NHS. We need to recognise that vulnerable migrant women are not responsible for pressures in maternity services or the NHS generally; the government has a duty to give the NHS the resources it needs and should not be using NHS clinicians, including midwives, to patrol our borders and demonise some service users.

The RCM is committed to supporting our members to deliver the best care they can, and Cost Recovery is a barrier to this. We believe that maternity care should be exempt from NHS charging altogether to protect and promote maternal and newborn health. The current charging regime needs to be suspended until the government can prove this policy is not doing any harm and jeopardising our shared ambition to make England the safest place in the world to have a baby.

The recommendations from this report, if implemented, will absolutely improve the situation for vulnerable migrant women and the midwives who care for them, and begin to right the wrongs of Cost Recovery. We recommend NHS Trusts, commissioners and most of all, the government, listen to the voices of midwives in this report and do the right thing.



Gill Walton, Chief Executive of the Royal College of Midwives (RCM)

# Contents

Report summary

1. Introduction

2. Methodology

3. The impact of charging on Midwives' ability to address migrant women's health needs

4. Issues charging raises in Midwives' role and professional practice

5. Midwives' knowledge of and attitude towards the challenges posed by charging

6. Conclusions

7. Recommendations

Glossary

## Report summary

### *Background*

Strict government regulations for charging some migrants for NHS care have introduced new concerns for midwives in caring for women who are charged. In particular they raise questions about midwives' professional duty of care, their responsibilities to try to reduce health inequalities, and their role in advocating for the women in their care.

NHS charging is especially damaging for undocumented migrant women, many of whom are socially and economically marginalised and vulnerable. Lacking the right to work or claim benefits, there is evidence that they are being deterred from accessing maternity care. Independently of problems arising from charging, migrant women have been found to have a higher risk of maternal death and adverse pregnancy outcomes than native born women.

Long-standing maternity care policy has recognised inequalities faced by migrant and minority ethnic women. Inequality reduction in health has long been part of midwifery goals and standards, including in the government's recent review of maternity services, *Better Births*, and in the Midwifery Code. It has also been recognised by the National Institute for Health and Care Excellence (NICE) in its *Guidance on Antenatal Care for Women with Complex Social Factors*.

### *The Study*

This is the first study to investigate the impact on midwives of the policy of charging 'overseas visitors' for NHS care. There is little or no systematic evidence of how midwives address the practical and ethical problems introduced by charging a subset of their patients. This study aimed to understand how midwives perceive the consequences of charging, how charging impacts upon their capacity to give optimal care to women in pregnancy and beyond, and how individual midwives respond to the new conditions in which they work.

Fifteen midwives were interviewed by phone. They comprised 6 Specialist midwives, 2 Clinic or Birth Centre midwives, and 7 Community midwives. No midwives or women are identified in the report.

### *Issues in providing appropriate care*

Midwives recognised that they needed to address both health and social issues facing women who were charged. They were aware of the barriers to good care facing such women, including poverty and destitution, domestic abuse, poor and inadequate housing, and a poor command of English, and recognised how these factors increased women's vulnerabilities. They were also concerned about the women's mental health.

Midwives were especially worried about the health impact of late booking by women who were charged. Persuading women to attend for care regardless of their fears of charging took considerable time, effort and commitment, meaning increasingly stressful and overstretched workloads for midwives having to find women who have been deterred from attending appointments.

All the midwives stressed the importance of establishing trusting relationships with women under their care, especially if the women had social vulnerabilities. The erosion of trust caused by charging

undermined the quality of the care midwives could give as women were less likely to disclose sensitive issues and information to them because of fears of repercussions.

#### *The impact of charging on midwives' professional practice*

Midwives described numerous situations where they experienced contradictions between professional standards in midwifery and the requirements of the charging regulations. These included the requirements to advocate for vulnerable women and to understand and work to mitigate health inequalities.

Such contradictions were especially evident in the booking appointment. Midwives felt that information gathered in the booking appointment which is relevant to developing an individual care plan, is also useful in establishing whether or not a woman is chargeable. As a result, questions asked in the booking appointment can give rise to suspicion on the part of women, and prevent the development of trust between women and their midwives.

Several midwives were concerned about racial profiling and discrimination in assessing women's eligibility for care. Some midwives were also concerned that women were approached disrespectfully by Overseas Visitor Managers, undermining how women should be treated.

#### *Dilemmas and pressures on midwives from charging*

Midwives were very anxious to separate their role from the charging system although it sometimes fell to them to inform women that they would be charged. However, it was not satisfactory for midwives just to avoid being involved in the implementation of charging as they also needed to know about how the regulations worked in practice, to enable them to advocate for a woman who might have been wrongly charged, or who might be exempt. They experienced this as an ongoing tension.

How midwives worked with Overseas Visitor Managers varied, with some midwives more able than others to influence Overseas Visitor Managers' decisions. Good engagement with Overseas Visitor Managers was easier in trusts where there were specialist midwives.

#### *Midwives' knowledge of and attitudes towards charging*

Midwives had had little or no training about the charging regulations and guidance. Specialist midwives were the best informed. Any training was very limited and did not give information about exemptions to charging relevant to maternity care. It also did not cover the implications for women of incurring debts to the NHS, or relevant information to enable midwives to advocate for women. Midwives had variable knowledge about local services which might help women who were charged.

**Overall, midwives' considered that charging had an adverse impact on their professional practice, increasing barriers to good relationships between midwives and women. Moreover, they felt that charges target the most vulnerable, affecting particularly women's mental health and public health. Overall midwives felt that the burdensome impact of charges on the women they cared for, as well as on their own professional practice, outweighed any justification that was made for them.**

# 1. Introduction

## ***Aim of the Study***

Since NHS charging was introduced, and particularly since the charging regime for NHS care changed in 2015, some women from abroad have been charged for their NHS maternity care. A small number of studies have investigated the impact of these charges on women, with women who are unable to pay the fees describing their fears of attending hospital, and of seeing a midwife.<sup>1,2,3,4</sup> Yet there has been no research into how charging for NHS maternity care has impinged on the way midwives look at and look after women who are charged.

This report by Maternity Action is the first attempt to fill this gap. Maternity Action conducted research to find out from midwives themselves how charging affects their capacity to look after the women for whose maternity care they are responsible. It explores the impact of charging on midwives' professional practice in terms both of their workload and also in relation to their professional ethos and principles.

This section contextualises the findings of the study by exploring current charging policy for 'overseas visitors' in England and changes in approaches to mitigating health inequality in maternity services.<sup>5</sup> The section also describes the precarious situations of the mainly undocumented migrant women who are most affected by charging for maternity care. Lastly, it presents the methodology used in the study.

## ***NHS Charging rules for 'overseas visitors'***

NHS charging for secondary care was introduced on a national scale in the UK in 2004. Charges were to be levied on 'overseas visitors' - people who were not 'ordinarily resident' in the UK. Since then there have been numerous changes to charging regulations, affecting a wider range of people.

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 been required to ask for advance

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<sup>1</sup> Feldman R. 2018, *What Price Safe Motherhood? Charging for NHS Maternity Care in England and its Impact on Migrant Women*, London, Maternity Action.

<sup>2</sup> Feldman R. 2017, *The Impact on Health Inequalities of Charging Migrant Women for NHS Maternity Care: A scoping study*, London, Maternity Action.

<sup>3</sup> Shortall, C. et al., 2015, Experiences of Pregnant Migrant Women receiving Ante/Peri and Postnatal Care in the UK: A Doctors of the World Report on the Experiences of Attendees at their London Drop-In Clinic. London, Doctors of the World.

<sup>4</sup> Nellums, L et al., 2018, *Access to healthcare for people seeking and refused asylum in Great Britain a review of evidence*. Manchester, Equality and Human Rights Commission.

<sup>5</sup> Charging policy differs in other parts of the UK.

payment giving 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.<sup>6</sup>

Maternity care is charged in the same way although all maternity care is designated as *immediately necessary*. This means that it must not be delayed or refused because of a woman’s inability to pay in advance. Nevertheless, any woman ineligible for free NHS care remains chargeable, and failure to either repay within two months of an invoice being received or to set up an agreed repayment plan within this time, will result in a woman being reported to the Home Office. The Home Office may then refuse further immigration applications or re-entry to the UK.<sup>7</sup> In addition, most chargeable patients are also charged 150% of the standard tariff applied to normal commissioning.<sup>8</sup>

Only people deemed ‘ordinarily resident’ in the UK, or who belong to an exempted group are entitled to free secondary care in the UK. To be ordinarily resident anyone from outside the European Economic Area (EEA) has to have indefinite leave to remain (ILR) and be “in the UK for settled purposes as part of the regular order of their life for the time-being.” Since 2015 all other longer-term visa holders from outside the EEA have been required to pay an Immigration Health Surcharge (IHS), recently doubled to £400 per year (£300 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. British citizens who are not ordinarily resident are also required to pay for NHS care.<sup>9</sup>

Some migrants who are not ordinarily resident are exempted from NHS charges. Exempted groups include refugees, asylum seekers awaiting a decision, refused asylum seekers supported by the Home Office and victims of modern slavery. 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.<sup>10</sup>

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. This means that many women who are partners or spouses of men with ordinary residence, but who are themselves in the UK on a visitor visa or have overstayed an earlier visa, will be chargeable for their NHS maternity care. This applies even if they have already submitted an application for leave to remain.

Certain services including infectious diseases such as tuberculosis, HIV and other sexually transmitted diseases are exempted from charging. Family planning services are exempted, although terminations are chargeable. Charges for treatment for any condition caused by domestic and sexual

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<sup>6</sup> Department of Health and Social Care, 2019, *Guidance on implementing the overseas visitor charging regulations*. Leeds, Visitor & Migrant NHS Cost Recovery Programme

<sup>7</sup> The Platform for International Cooperation on Undocumented Migrants (PICUM) has filed a formal complaint to the European Commission against the UK for flouting the EU’s regulation on data protection (General Data Protection Regulation, GDPR) by including a broad immigration control exemption in the Data Protection Act, 2018. <https://picum.org/press-release-advocates-bring-first-gdpr-complaint-to-eu-against-uk-data-protection-law-for-violating-data-rights-of-foreigners/>

<sup>8</sup> *Ibid.*

<sup>9</sup> Maternity Action, 2017, *NHS maternity care for women from abroad (England only)*. Information sheet. <https://maternityaction.org.uk/wp-content/uploads/NHS-maternity-care-England-2017.pdf>

<sup>10</sup> Maternity Action, 2018, *Refused asylum seekers-financial support and housing*. Information sheet. <https://maternityaction.org.uk/wp-content/uploads/Refused-asylum-seekers-support-and-housing-2018.pdf>



violence, torture and female genital mutilation are also exempted, as is emergency care provided in Accident and Emergency departments.<sup>11</sup>

### ***Vulnerable Migrant women and high risk pregnancies***

The migrants in the most vulnerable situations are those who are in the UK without official authorisation - undocumented migrants. They are mainly visa overstayers which means that an earlier residence permit has expired. This is increasingly common as the fees for renewing residence permits have been raised to prohibitive levels, far beyond the rate of inflation.<sup>12</sup> At the time of writing, each individual (adult or child) renewing residence permits is charged £1033 plus £1000 Immigration Health Surcharge. Thus the cost of renewal for a family of 4 is £8132. Some 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. Others may have entered on student or work visas. In some cases undocumented migrants may have entered the UK without valid documents. In England refused (“failed”) asylum seekers are also regarded as undocumented unless they receive Home Office support.

Not only are undocumented migrants subject to charges for NHS care, they have no right to work or to claim benefits, they cannot rent from private landlords, and they are unable to obtain a UK driving licence. This situation leaves undocumented migrant women especially vulnerable. They are often destitute, perhaps as a result of leaving a relationship in which they were financially dependent on a male partner due to domestic violence or relationship breakdown. Many asylum seekers whose applications were refused, are unable or afraid to return to their country of origin but meanwhile are not eligible for financial support and are unable to work. Many undocumented women have children from relationships in the UK, some of whom may be British citizens. Some women have been trafficked into the UK, but are unaware of their rights to services because of this.<sup>13,14,15</sup>

Such women are also more likely to suffer mental health disorders than the rest of the population. This may be due to traumatic experiences from conflict or crisis situations before their arrival in the UK, or experiences of sexual or labour exploitation.<sup>16</sup> Migrant women in vulnerable situations are at particular risk for developing perinatal mental health problems due to emotional stress, exacerbated by the financial burden of charging, low socio-economic status, unemployment and social marginalisation.

They face multiple and overlapping barriers to healthcare, including language difficulties and a lack of understanding about how the NHS works, discrimination and demands for documentation when

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<sup>11</sup> Department of Health and Social Care, 2019, *op.cit.*

<sup>12</sup> C. Yeo, 2019, *Most immigration and nationality fees frozen for 2019/20.*

<https://www.freemovement.org.uk/immigration-nationality-application-fees-2019-20/>

<sup>13</sup> Price, J, and Spencer, S. 2015. *Safeguarding Children from Destitution: Local Authority Responses to Families.* Compass, Oxford.

<sup>14</sup> Petch, H, Perry, J and Lukes, S. 2015. *How to Improve Support and Services for Destitute Migrants.* Joseph Rowntree Foundation.

<sup>15</sup> C. Thriepland, 2015, *A place to call home: A report into the standard of housing provided to children in need in London.*

<sup>16</sup> Collins, C., Zimmerman, C. and Howard, L., 2010, “Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors” *Arch Womens Ment Health* DOI 10.1007/s00737-010-0198-7

registering with GPs.<sup>17</sup> Previous negative experiences with health services can also mean that migrant women can be reluctant to engage with care again.<sup>18</sup> Women also fear being reported to immigration enforcement and being charged for NHS care.<sup>19,20</sup> Women seeking asylum reported having been ‘blocked’ or refused by reception staff acting as gatekeepers, often in conjunction with expectations or experiences of prejudice and discrimination.<sup>21</sup> Similar gatekeeping is also experienced by undocumented migrants. For all these reasons, vulnerable migrant women’s access to maternity care is likely to be more limited and to start later than for the rest of the population.<sup>22</sup>

International evidence of worse maternal health and pregnancy outcomes among migrant women is inconsistent because studies often fail to disaggregate migrant populations according to immigration status or ethnicity.<sup>23,24,25</sup> However studies regularly indicate that some migrant groups face higher risks of maternal mortality and other poor pregnancy outcomes, especially where they are less integrated within the host society.<sup>26,27,28,29</sup> A meta-analysis of maternal mortality in western Europe found that migrant women had twice the risk of maternal death compared with native born women leading to an absolute additional risk of 9 additional maternal deaths per 100,000 deliveries per year.<sup>30</sup> Undocumented women, who are among the most socially excluded, would therefore be especially susceptible to such risks.

In Britain, data on migrant women’s pregnancy outcomes is sparse, with population classifications more commonly based on ethnicity than migration history. In spite of this limitation, for over ten years, a series of Confidential Enquiries into maternal mortality have found that minority ethnic

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<sup>17</sup> National Collaborating Centre for Women’s and Children’s Health, 2010, *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors*. London, Royal College of Obstetricians and Gynaecologists

<sup>18</sup> Jayaweera, H. 2014 "Health of Migrants in the UK: What Do We Know?" *Migration Observatory Briefing*, Oxford, COMPAS.

<sup>19</sup> Feldman, R, 2017, *op.cit.*

<sup>20</sup> Shortall, C. et al., 2015, *op.cit.*

<sup>21</sup> Maternity Action, 2014, *Women’s Voices on Health*.

<sup>22</sup> Lewis, G (ed.) 2007, *The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers’ Lives: reviewing maternal deaths to make motherhood safer - 2003-2005. The Seventh Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*. London: CEMACH.

<sup>23</sup> Gissler, M. et al. 2009, “Stillbirths and infant deaths among migrants in industrialized countries” *Acta Obstetrica et Gynecologica*, 88: 134–148 DOI: 10.1080/00016340802603805

<sup>24</sup> Bollini, P. et al. 2009, “Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature” *Social Science & Medicine* 68, 452–461

<sup>25</sup> Minsart, A-F et al. 2012, “Naturalization of immigrants and perinatal mortality” *European Journal of Public Health*, 23:2, 269–274

<sup>26</sup> Urquaiia, M. et al. 2010, “International migration and adverse birth outcomes: role of ethnicity, region of origin and destination” *J Epidemiol Community Health* 64:243e251. doi:10.1136/jech.2008.083535

<sup>27</sup> Gagnon, A. et al. 2009, “Migration to western industrialised countries and perinatal health: A systematic review” *Social Science & Medicine* 69, 934–946 doi:10.1016/j.socscimed.2009.06.027

<sup>28</sup> Essen, B. et al. 2000, Increased perinatal mortality among sub-Saharan immigrants in a city-population in Sweden” *Acta Obstet Gynecol Scand* 2000; 79: 737–743

<sup>29</sup> Zanonato, G. et al. 2011, “Pregnancy Outcome of Migrant Women Delivering in a Public Institution in Northern Italy”, *Gynecol Obstet Invest*, 72:157–162 DOI: 10.1159/000328318

<sup>30</sup> Pedersen, G et al. 2014, “Maternal Mortality Among Migrants in Western Europe: A Meta-Analysis” *Matern Child Health J* 18:1628–1638 DOI 10.1007/s10995-013-1403-x

women had substantially higher risks of death than white women.<sup>31,32,33,34</sup> The most recent Confidential Enquiry covering 2014 to 2016 also found that a quarter of women who died in this period were born outside the UK, and 11 % were not UK citizens.<sup>35</sup>

The 2007 report, *Saving Mothers' Lives* showed that vulnerable women with 'socially complex lives' who died were less likely to have booked early for maternity care or to attend antenatal appointments regularly. They included recent migrants who were also more likely to "have poor overall health status, underlying and possible unrecognised medical conditions."<sup>36</sup> The most recent Confidential Enquiry went further than previous reports in defining "vulnerable pregnant women as 'pregnant women who experience a distance in accessing maternal healthcare, as refugees/ migrants/ ethnic minorities/ second or third generation immigrants, due to problems in speaking the language and/ or understanding the culture, and/ or due to lack of income, housing or social support.'"<sup>37</sup>

This report also shows that the relative risk of maternal mortality is still nearly five times higher for black women than for white women.<sup>38</sup> Non-white ethnicity is also associated with increased stillbirth and neonatal death.<sup>39,40,41</sup>

The Confidential Enquiries showed an association between ethnicity and lack of antenatal care due to late booking or sub-optimal care (attendance at fewer than four antenatal appointments) which resulted in underlying health conditions such as diabetes or HIV, or conditions related to the pregnancy such as high blood pressure or mental health issues not being identified during pregnancy.<sup>42,43,44,45</sup>

The Confidential Enquiries were not alone in highlighting significant inequalities in pregnancy care

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<sup>31</sup> Lewis, G (ed.) 2007, *op.cit.*

<sup>32</sup> Centre for Maternal and Child Enquiries (CMACE), 2011; *Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*. BJOG 118 (Suppl. 1):1–203

<sup>33</sup> Knight M. et al. (eds.) on behalf of MBRRACE-UK, 2015, *Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13*. Oxford: National Perinatal Epidemiology Unit, University of Oxford

<sup>34</sup> Knight M. et al. (eds.) on behalf of MBRRACE-UK, 2017, *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15*. Oxford: National Perinatal Epidemiology Unit, University of Oxford

<sup>35</sup> Knight M, et al. (eds.) on behalf of MBRRACE-UK, 2018 *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16*. Oxford: National Perinatal Epidemiology Unit, University of Oxford

<sup>36</sup> Lewis, G (ed.) 2007, *op.cit.*

<sup>37</sup> Knight M. et al. (eds.) 2018, *op.cit.* pp 61-2, citing Women Political Leaders Global Forum, 2018, "Improving maternal healthcare for vulnerable women in the EU."

<sup>38</sup> *Ibid.* p1

<sup>39</sup> Manktelow, B, et al. on behalf of the MBRRACE-UK Collaboration. 2016. MBRRACE-UK *Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2014*. Leicester, University of Leicester.

<sup>40</sup> Centre for Maternal and Child Enquiries (CMACE). 2011. *Perinatal Mortality 2009: United Kingdom*. CMACE, London.

<sup>41</sup> Toleikyte, L. and Salway, S. 2018, *Local action on health inequalities: Understanding and reducing ethnic inequalities in health*. London, PHE England.

<sup>42</sup> Lewis, G (ed.) 2007, *op.cit.*

<sup>43</sup> Knight M. et al. (eds.) 2015, *op.cit.*

<sup>44</sup> Knight M. et al. (eds.) 2017, *op.cit.*

<sup>45</sup> Nair M et.al. 2014, "Ethnic Variations in Severe Maternal Morbidity in the UK– A Case Control Study" *PLoS ONE* 9(4): e95086. doi:10.1371/journal.pone.0095086

and outcomes between minority ethnic and white women. Although many studies focused exclusively on ethnicity,<sup>46,47,48</sup> there were some that addressed the distinctive issues facing migrant women.<sup>49,50</sup>

There has also been growing recognition of the role of NHS charging in exacerbating already existing health vulnerabilities of migrant women. In 2016, the Royal College of Midwives (RCM) surveyed all Heads of Midwifery in England to ask them their views on the impact of charging for secondary care on vulnerable groups. Many were concerned about the way in which charges for maternity care acted as a barrier to vulnerable women accessing care at all or in a timely manner. Respondents to the survey also reported that some trusts were refusing “to let international women who are not entitled to free NHS care, book in to their services.”<sup>51</sup> Some respondents were worried that hard to reach or vulnerable women “would be deterred from accessing care which could potentially affect their safety and ultimate clinical outcomes.”<sup>52</sup>

### ***Maternity care policies, disadvantage and inequality***

The RCM’s 2016 consultation response to the Department of Health was unequivocal in insisting that maternity care should never be denied on the basis of ability to pay and that individual entitlements to healthcare must be designed to maintain the wider public’s health and reduce inequalities. This position is in line with long-standing maternity care policy that recognises the inequalities faced by minority ethnic and migrant women, and how these affect what is professionally expected of midwives.

*Changing Childbirth* published in 1993, widely considered to have been a landmark in maternity care policy, had shifted the direction of maternity care to both an emphasis on ‘woman-centred care’, and to a more significant role for midwives.<sup>53</sup> The report set out a vision of midwives becoming autonomous practitioners exercising a full range of professional skills.<sup>54,55</sup> Indeed *Changing Childbirth* proposed that midwives should play a lead role in 30% of maternity cases.

As well as addressing the changing role and standing of midwives, the emphasis on woman-centred care also enabled maternity care policy to take a tentative step towards recognising the diversity of

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<sup>46</sup> Raleigh et al. 2010, “Ethnic and social inequalities in women’s experience of maternity care in England: results of a national survey” *J R Soc Med* 103: 188–198. DOI 10.1258/jrsm.2010.090460

<sup>47</sup> Bharj, K. and Salway, S. 2008, *Addressing ethnic inequalities in maternity service experiences and outcomes*, London, Race Equality Foundation

<sup>48</sup> Henderson J. et al. 2013, “Experiencing maternity care: the care received and perceptions of women from different ethnic groups” *BMC Pregnancy and Childbirth*, 13:196.

<sup>49</sup> McLeish, J. 2005, “Maternity experiences of asylum seekers in England” *British Journal Of Midwifery*, 13: 12

<sup>50</sup> Taylor, B. and Newall, D. 2008, *Maternity, mortality and migration: the impact of new communities*. Birmingham: West Midlands Strategic Migration Partnership.

<sup>51</sup> Royal College of Midwives, 2016, *Response to DH Consultation on ‘Making a fair contribution: A consultation on the extension of charging overseas visitors and migrants using the NHS in England’* London, Royal College of Midwives

<sup>52</sup> *Ibid.*

<sup>53</sup> Department of Health, 1993, *Report of the Expert Maternity Group: Changing Childbirth (Cumberlege Report)*. HMSO, London

<sup>54</sup> *Ibid.*

<sup>55</sup> McIntosh, T, 2013, “Changing childbirth: consigned to the ‘shelf of history’?” *MIDIRS Midwifery Digest* 23:4 415–420

women and their needs. The report acknowledged the special needs of women with disabilities and recognised the importance of understanding local health, cultural and social conditions.<sup>56</sup> Indeed, in spite of limitations imposed by a model of care which focussed on individual difference and need rather than on any structural inequalities, *Changing Childbirth* did open up the possibility of maternity services addressing disadvantage among women.

This became all the more relevant as it was followed by a large number of more explicit policy reports and initiatives which made inequality reduction in health a specific remit, reflecting the focus on social exclusion of the Labour government from 1997.<sup>57,58,59</sup> One of these policy documents, *Maternity Matters*, proposed a major new strategy to modernise maternity services.<sup>60</sup> It gave particular emphasis to improving access and uptake of care to women from “vulnerable and disadvantaged backgrounds” and proposed that consultant midwives, among other aspects of their role, could take responsibility for reducing inequalities.<sup>61</sup>

None of these reports explored migration as a determining factor in health inequalities although the Marmot report did mention additional health needs of refugees and asylum seekers.<sup>62</sup> However, *Saving Mothers’ Lives* (2007), the then most recent Confidential Enquiry into Maternal Mortality showed that socially excluded women were at higher risk of death during or after pregnancy than other women and that significant among these were migrant women.<sup>63</sup>

As a result of the Confidential Enquiry, National Institute for Health and Care Excellence commissioned the National Collaborating Centre for Women’s and Children’s Health to review evidence to provide a model for antenatal care for women with “complex social factors”. This review, *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors* identified migrant women as one of several disadvantaged groups facing barriers to optimal maternity care and led to specific guidelines to improve antenatal care for them.<sup>64</sup>

By the end of the Labour government, trying to reduce inequalities and redress disadvantage had become an accepted principle of good healthcare practice. For midwives a “clear imperative to target ‘disadvantaged clients’” rapidly became one of the fundamental assumptions of good midwifery care though how this was to be done was not always clear.<sup>65</sup>

This emphasis on inequality is still present as a key goal of modern maternity care. Although there is no specificity about how particular inequalities should be addressed, *Better Births*, the National

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<sup>56</sup> Department of Health, 1993, *op.cit.*

<sup>57</sup> Department of Health, 1999, *Making a Difference Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. London, Department of Health

<sup>58</sup> NHS, 2000, *The NHS Plan*, Cm 4818-I London, HMSO

<sup>59</sup> Marmot, M. et al. 2010, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post-2010*. London The Marmot Review

<sup>60</sup> Department of Health, 2007, *Maternity Matters: Choice, access and continuity of care in a safe service* London, Department of Health

<sup>61</sup> *Ibid.* p43

<sup>62</sup> Marmot, M. et al. 2010, *op.cit.* p141

<sup>63</sup> Lewis, G (ed.) 2007, *op.cit.*

<sup>64</sup> National Collaborating Centre for Women’s and Children’s Health, 2010, *op.cit.*

<sup>65</sup> Hart, A. and Lockey, R. 2001, “Inequalities in health care provision: the relationship between contemporary policy and contemporary practice in maternity services in England” *Journal of Advanced Nursing*, 37:5 485-493

Maternity Review, nevertheless sees a ‘modern maternity service’ as one “that delivers safer, more personalised care for all women and every baby, improves outcomes and reduces inequalities.”<sup>66</sup> In addition, the NHS Long Term Plan commits to reducing maternal and neonatal mortality and to providing better care for vulnerable groups, with an emphasis on prevention and access. It pledges that 75% of women from minority ethnic communities and a similar percentage of women from the most deprived groups will receive continuity of care from their midwife.”<sup>67</sup>

Further clarification of midwives’ responsibilities in relation to social and health inequalities has come from the Nursing and Midwifery Council (NMC) Code which sets out professional standards for nurses and midwives.<sup>68</sup> At the time of writing, the NMC is in the process of reviewing standards of proficiency for midwives which more explicitly address expectations of midwives’ responsibilities towards women and babies in their care. Some of these have specifically social reference points. For example they refer to midwives’ role in “enabling and advocating for the human rights ... of women, partners and families,” and their responsibility in “understanding and mitigating health and social inequalities.”<sup>69</sup> They also explicitly require midwives to “challenge discriminatory behaviour to promote equity and inclusion for all.”<sup>70</sup>

### ***Addressing health inequalities for migrants***

These new draft standards of proficiency for midwifery illustrate how much thinking about social aspects of health and healthcare has developed since 2007 when *Maternity Matters* made reducing inequalities one of its primary concerns, or since 2010 when NICE published its Guideline on Antenatal Care for Women with Complex Social Factors.<sup>71</sup> However, midwives now face a very different environment for providing maternity care to migrant women.

Midwives are now working in a context where, from the moment women book for maternity care, they are identified as eligible or (often incorrectly) ineligible for free NHS care and therefore as chargeable. Recent studies have shown that migrant women are being deterred from accessing maternity care and that the bills they receive - up to £7000 or more, are causing many severe mental distress.<sup>72,73</sup> Whatever the structures in place for good care, non-attendance for antenatal care makes continuity both of care and carer impossible, and makes it increasingly difficult for midwives to carry out the quality of professional care required of them. The RCM’s response in 2016 to the Department of Health’s Consultation on extending charging stated that “the DH has a responsibility to NHS staff to ensure that they can implement policies whilst adhering to their respective Codes of

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<sup>66</sup> National Maternity Review, 2016, *Better Births, Improving outcomes of maternity services in England*, p4.

<sup>67</sup> NHS, 2019, *NHS Long Term Plan*. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf>

<sup>68</sup> Nursing and Midwifery Council, 2015, *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*, London, The nursing and midwifery regulator for England, Wales, Scotland and Northern Ireland

<sup>69</sup> Nursing and Midwifery Council, 2019, *Future midwife: Standards of proficiency for midwives: Draft*, p5

<sup>70</sup> *Ibid.* p9

<sup>71</sup> National Institute for Health and Care Excellence, 2010, *Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors*. Clinical Guideline 110.

<sup>72</sup> Feldman, R. 2018, *op. cit.*

<sup>73</sup> Nellums, L. et al. 2018, *The lived experiences of access to healthcare for people seeking and refused asylum*. Equality and Human Rights Commission Research report 122.

Practice.”<sup>74</sup>

There is very little systematic evidence of how midwives resolve both the practical and ethical problems introduced by charging a subset of their patients. This study is an attempt to respond to concerns from midwives about these issues and to understand better how midwives perceive the consequences of charging, how charging impacts upon their capacity to give optimal care to women in pregnancy and beyond, and how individual midwives respond to the new conditions in which they work.

### ***The Report***

The following section of the report presents the study methodology (Section 2). Section 3 explores midwives’ concerns about how NHS charging impacts on their ability to perform their role. This is explored further in Section 4 which considers the contradictions and professional dilemmas which arise for midwives in managing the care of women who have been charged. Section 5 discusses midwives’ knowledge of and attitudes towards the charging regulations, while sections 6 and 7 present the conclusions and recommendations from the study.

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<sup>74</sup> Royal College of Midwives, *op.cit.* 2016, p7

## **2. Methodology**

In order to capture detail and understand better how the charging regulations and guidance work in practice we carried out a qualitative study involving in-depth telephone interviews with midwives.

### ***Selection criteria***

We sought to interview midwives in England who had experience of caring for women who had been charged for their maternity care, with a distribution between those based in London, in other high migration areas and in low migration areas. We limited our geographic scope to England, as Northern Ireland, Wales and Scotland have different regulations regarding NHS charges. We aimed to interview approximately 20 midwives.

### ***Recruitment***

Midwives were recruited from existing contacts, by 'snowballing' and by seeking out specialist midwives for refugees, asylum seekers, migrants, and/ or vulnerable and homeless women in trusts which met our geographic selection criteria. In two areas, we also contacted voluntary sector organisations supporting migrant women to see if they had contact details of local midwives they could share.

It proved difficult to recruit our target number of midwives, with some midwives only contactable via hospital phone numbers or emails. We often found that midwives were keen to speak to us, but struggled to find the time.

### ***The participants***

Fifteen midwives from 13 different hospital Trusts participated in the study. They had been in their current posts for between 1 and 30 years, with an average of 7.8 years. Seven were graded at Band 6 and eight at Band 7. Six midwives were based in London, two in the North West, two in Yorkshire and the Humber, two in the East Midlands, one in the West Midlands, one in the East of England and one in the South East. All but two Trusts saw significant numbers of migrant women, but midwives varied in their experience of looking after women who had been charged.

Of the fifteen midwives who participated in the study, 7 described themselves as Community midwives, 6 as Specialist midwives and 2 as Maternity Clinic or Birth Centre midwives. Both the Community and Specialist midwives carried caseloads, indicating that they worked particularly with women who needed some kind of extra support.



## ***Data collection***

We conducted semi-structured telephone interviews with the midwives. Telephone interviews were chosen due to resource constraints as the study had no independent funding and it was not possible to travel to midwives' workplaces, especially those outside London. They also enabled greater flexibility as pressure of work on midwives meant that they were often not sure when they could be available.

The interviews sought to explore midwives' experiences of looking after women who had been charged for their maternity care. Midwives were asked to reflect on how they felt that charging had affected the quality of care they were able to offer these women and what specific factors may have impacted on the care they could give. The interviews also explored whether charging for maternity care had affected midwives' professional practice over time, and about their personal knowledge of the charging regulations. Where possible midwives gave anonymised case examples.

## ***Data analysis***

All the data collected were analysed thematically using standard word processing software.

## ***Ethical issues***

We followed the Health Research Authority (HRA) decision tool which stated that this study did not require NHS Research Ethics Committee approval as no confidential patient data was collected.<sup>75</sup> We are confident that we have successfully maintained recognised standards of research ethics.

Standard ethical guidelines were followed for data collection and analysis. The study was explained to participating midwives who then verbally consented to the recording of the interview and subsequent transcription. Participants were also assured that all recordings of interviews would be destroyed.

No information about individual women given by midwives contained any identifiers. Midwives' identities and places of work have also been anonymised in the study so it is not possible to identify any woman from case examples given by midwives.

Unless otherwise stated all quoted extracts in the text are from midwives who participated in the study. Quotations are only attributed to a 'specialist', 'community' or 'clinic/birth centre' midwife, in order to preserve the participants' anonymity.

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<sup>75</sup> NHS Health Research Authority, 2017, *What approvals and decisions do I need?* <http://www.hra-decisiontools.org.uk/research/>

### ***Limitations of the study***

Telephone interviews sometimes made it difficult to find and interview midwives in a relaxed atmosphere. On a few occasions, interviews were postponed, interrupted or curtailed due to midwives attending to other duties.

Because participants were identified from existing contacts, by 'snowballing' and by seeking out specialist midwives, the sample may be biased towards midwives who are especially sympathetic to migrant women. However, the study is not an attempt to make generalisations about midwives' views on NHS charging for maternity care. Its intention is to understand more fully the impact of charging on midwives' professional practice where they have had experience of looking after women who have been charged for their maternity care.

### 3. The impact of charging on midwives' ability to address migrant women's health needs

Midwives are trained to have expectations of their responsibilities as health professionals both in a narrow sense of competence in managing a safe pregnancy and delivery, but also in a wider sense of addressing problematic social issues such as domestic violence or child safeguarding. This section explores how the midwives interviewed sought to address the social as well as the health needs of the women in their care. Not only did the effect of charging on women's mental health make the task of looking after these women more difficult, but midwives felt that charges led to women booking late and avoiding care. This negatively affected the women's health as well as making additional demands on midwives' time and energy.

They were particularly concerned about the effect of charging on their ability to develop a trusting relationship with women, which further affected their capacity to protect women's health and avoid pregnancy complications.

#### ***Dealing with problems faced by women***

##### *Poverty and social issues*

The first priority for midwives was to provide appropriate healthcare for the women whom they were looking after, whoever they were. They stressed the importance of being vigilant about the health needs of the women, whether it was a question of simple health needs such as following up a test, or treating iron deficiency, or more complex issues. In addition, midwives had to address the social issues which women faced. Describing the case of one woman who booked late at 34 weeks, an experienced midwife said:

*"From a midwifery point of view, it was quite simple really, in the sense, it was about recognising her immediate need in terms of the testing and the results that came back. What we needed to do then, that was clear cut. The more complex thing was trying to understand the social setting and because with having no recourse to public funds, at that point accessing our services. There was a grey area, and I think that's the thing with overseas charging that who is – it's understanding that bit."* (Specialist midwife)

All the midwives interviewed recognised that most of the women who were being charged, with whom they came into contact, lived in particularly vulnerable situations. They gave many examples of the vulnerabilities and barriers migrant women face in other aspects of their life, recognising that particular attention is required and specific care needs must be addressed.

*"They haven't got a lot of money for food, they're having to resort to food banks. They can't afford the vitamins. There's domestic abuse sometimes and they're dependent on this spouse for money, when they haven't got any access to anything themselves. So they're vulnerable women. These are the issues, really."* (Community midwife)

*“The women I see are all poor, they are all destitute. They’ve all come in to the immigration service as destitute asylum seekers. Some have partners, some don’t”* (Specialist midwife)

Midwives also reported that they looked after women who were completely dependent on friends, families and other community based support for survival, as they are not allowed to work or access benefits.

*“I’ve seen families, who have No Recourse to Public Funds, living in very unsuitable accommodation. They are often living off a friend, or a church, or something like that.”*  
(Community midwife)

Several midwives spoke with great feeling about the women in their care and personally supported women who were destitute and/or isolated during their pregnancies, far beyond their immediate professional responsibility. One midwife said:

*“I’ve actually seen ladies before who are staying in very poor accommodation. They have very little, and they have nobody to go and get any shopping for them. I know some of my colleagues have occasionally picked up some shopping for a lady because they are there with a baby. They have no transport, they have nobody to go and bring food into the house. So you go and get a few bits for them. It’s a sad situation. Some of these ladies, they don’t have anybody.”*  
(Community midwife)

Another described the case of a woman who could not speak English:

*“The woman had no idea what was going on, she could not understand anything at all, we couldn’t get her an interpreter and then it transpired that the partner really did want to help, and he was happy with a referral to social services and everything. And that was because I did come in on my day off, so I could see them the next day, because I felt very passionate about them”*  
(Clinic/birth centre midwife)

Translation and interpretation services are crucial to an equitable NHS, and are based on principles found within human rights law, the Health and Social Care Act and the Equalities Act 2010.<sup>76</sup> The NHS Constitution commits the NHS to “offer you easily accessible, reliable and relevant information in a form you can understand, and support to use it.”<sup>77</sup> Principles from Public Health England for migrant health are more explicit and state that “Where language is a problem in discussing health matters, offer a professional interpreter rather than using family or friends.”<sup>78</sup>

Furthermore, the use of female interpreters is essential for some women when discussing sensitive topics such as domestic violence or FGM, and to give midwives the opportunity to identify whether one of the exemption categories applies. A failure to provide interpretation services is recognized as a significant barrier to accessing good quality maternity care. However, various midwives described how budget cuts have limited their ability to provide women with an interpreter.

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<sup>76</sup> NHS England, 2018, *Guidance for commissioners: Interpreting and Translation Services in Primary Care*

<sup>77</sup> NHS for England, 2015, *The NHS Constitution* p9

<sup>78</sup> Public Health England, 2017, *Language interpretation: migrant health guide*.

Some also recognised how limited their options were to help poverty-stricken women as in the following case:

*“This one family where mum, dad, two children, and she was 36 weeks pregnant, were in one room. And it was a really difficult situation. They had all their belongings in one room, the five of them, and they were piled up everywhere and the toddler was bouncing between bunkbeds. It felt very dangerous.*

[...]

*“You feel like your hands are tied in terms of what you can offer women in that situation, they are not entitled to access. I will do a children’s social care referral, just in terms of safeguarding, and got them linked with a voluntary organisation in the borough who provides support.”*

(Community midwife)

It was not always easy for midwives to find effective ways outside their immediate professional remit to help the women in their care. One midwife contacted social services on behalf of a woman who was in unsuitable accommodation, and was advised to tell the family to “go home”. As a result, the destitute family was forced to continue to rely heavily on their church in order to survive.

In many of the accounts given to us by midwives, they had to refer to the voluntary sector to provide some sort of support for the most marginalized women. Such support was often from a local agency, and so was more available in some areas than in others. In addition, midwives recognised how stretched voluntary organisations are in trying to respond to this type of need:

*“Referring women to [local advice services], I am very aware of the strain those services are under, and how difficult it is for them to actually provide women with the advice they would like to, because they are under so much pressure. All the voluntary services are also under so much pressure, in order to be able to support migrant women, so it is very difficult.”* (Community midwife)

### *Mental health and trauma*

Midwives expressed repeated concerns about how the stress of being charged by the NHS impacted on women’s mental health and thus their maternity care.

*“Can you imagine the stress on somebody who is already in a stressful situation? And most of these women have no source of income, so to have to think about that on top of things it is just another layer of anxiety.”* (Community midwife)

One midwife described a woman who was already struggling with the asylum process in the UK, and how constant letters to recover the money had a severe traumatic impact on her health. Her baby was delivered by caesarean section, which the midwife considered was related to the trauma of both the asylum process and the charges.

*“She ended up having a C-section because she was so traumatised by everything and unfortunately the baby wasn’t growing how it should and she wasn’t eating and she was admitted for mental health problems, for banging her head against the wall. She was just completely and utterly scared and frightened by the whole process.” (Specialist midwife)*

#### *Late booking and avoiding care*

Antenatal care is conceived as a comprehensive set of services which start in early pregnancy and continue until the onset of labour. It is a process which starts early in each woman’s pregnancy beginning with a booking appointment or booking visit which is recommended to take place ideally by 10 weeks gestation.<sup>79</sup>

Given their awareness of the precarious situation of many of the chargeable women, midwives were especially concerned when women booked late or avoided care altogether. Timely booking and the need for regular care underpinned their professional ethos. In practice, however, almost all the midwives interviewed reported seeing migrant women delaying and/or avoiding their recommended maternity care.

The many examples which they gave of women avoiding or delaying antenatal care, showed that migrant women were likely to book late for a variety of reasons, not just because they were afraid of charging. Some midwives recognised that avoidance of care resulted from a wider range of vulnerabilities. One said, “It can be that scenario, where somebody actually has chosen to keep below the radar, but then potential problems arise and they present late.”

However, most considered charging or fear of being charged as a significant reason for women booking late or missing appointments, whether or not the woman should actually have been charged. The midwives saw it as part of their job to identify and understand these reasons and attempt to persuade women to attend their appointments or to find other ways of caring for them.

In the interviews midwives described women booking late because they believed they were not entitled, or because they were given misleading information about their entitlements to free NHS care. Although maternity care is classed as ‘immediately necessary’, if women believe that they are not entitled to free NHS care, they will avoid care or book late. It is the lack of entitlement to free care in itself with the concomitant requirement to pay that can be the deterrent.

*“I had a family that didn’t come until very, very late. And again it was because they are worried about being charged and they are contacted really quickly by the Overseas Visitor Office. They definitely delay, or turn up in labour. Some midwives think that it is because they don’t speak English, so they don’t understand, but they have been in the country for a long time, and they have already accessed their GP.” (Specialist midwife)*

One midwife described a woman from an EU country who was told several times that if she didn’t register with a GP here, she would not be able to get an NHS number and would be charged. This woman had only been in the country a short time, didn’t speak English and refused to register with a

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<sup>79</sup>

National Institute for Health and Care Excellence, 2012, *Antenatal care: Quality standard [QS22]*.

GP. In spite of having a very difficult pregnancy, she missed many appointments, and disappeared - the midwife believed she had returned to her home country, but had no way of knowing.

As the implementation of charging has become more widespread, some midwives reported that women are avoiding all contact with health services after hearing about charging from other people. Several midwives expressed concern about the health consequences for women and their pregnancies of avoiding care as shown in the following examples.

One midwife described a woman who was pregnant with twins but only booked at 24 weeks gestation because they *“didn’t think it was important for us to come.”* The midwife subsequently discovered that the woman and her husband were afraid of being charged for a second pregnancy, having been charged for previous maternity care. They eventually booked because of worries about how big the woman looked this time. The midwife clearly stated her concerns about only learning at the end of the second trimester that it was a pregnancy with twins. She said:

*“Luckily, the twins both had different placentas. This pregnancy could have been a twin to twin transfusion, it could have been a severe abnormality. We could have missed all of this because they were scared about coming to be booked and being charged.”* (Specialist midwife)

Another midwife said:

*“I have looked after a woman who didn’t access care until very late in her pregnancy because she was worried about charging. She had quite a lot of health problems as well. It ended up being very difficult for us to get the care plan in place before she delivered. Had she come earlier we could have got her in the right medication for her blood pressure. She had blood pressure problems etc. It just meant that everything was very last minute for her, and she was very frightened about the extra bits of care and what that would mean for her, in terms of costs. She had been avoiding health services, because of her worry about being charged. And that is the situation we don’t want for women, we always put the care first. And that is difficult when people have money in their minds first.”* (Community midwife)

Often midwives carried out significant extra work to try to ensure that the women they were looking after could receive care. This was not always successful as can be seen in from one midwife’s attempt to assist a European Union Roma woman who was charged.

The woman stopped coming to her appointments at about 34 weeks pregnant. Because the Roma population are mobile and sometimes move away without informing the hospital this midwife went to see if she was still at her home. She found her there and asked her why she had not attended her appointments and whether anything was wrong.

*“And she brought out this bill for £6000 and said, ‘Look, I’ve got this bill for £6000. How can I afford this? What am I going to do? I can’t come any more. I’m going to go back to [country].’ To be honest, at that point, I didn’t really know much about the charging rules, [country] isn’t... but I was pretty sure that we weren’t charging white people from [country], why are we charging Roma from [country]?”* (Community midwife)

The midwife was suggesting that the Trust's treatment of Roma women from that country was discriminatory, and so she promised the woman to take up the issue with the hospital and meanwhile examined her at home.

She sought out further information about the charging rules before contacting the Overseas Visitor Manager who offered to cancel the bill if the woman in question would take documentation to an office in the centre of the city. The documents requested included a tenancy agreement, and wage slips. The midwife tried to explain to Overseas Visitor Manager that this very marginalized Roma woman would not have access to any of these kind of documents. Nor would it be feasible for her at 34 weeks pregnant, without any transport, to travel to the distant office location to prove her eligibility. However the Overseas Visitor Manager was uncompromising.

*"So I had to go back and say, "These are the kind of documents you need and this is the place you have to take it. I was feeling ridiculous, really, because I was looking at someone who I knew - because I knew her - that this wouldn't be possible for her to provide. And after that, she returned to [country] at about 36 weeks. She never accessed any more care with me. She returned to [country] to have care there." (Community midwife)*

Several midwives reported cases of women who were citizens of European Union countries and normally not chargeable, who avoided antenatal care, and returned to their home countries to give birth.

One midwife told of a refused asylum seeker with HIV who declined to continue antenatal care after she was sent a large bill. She was considering delivering the baby at home without professional help.

Although HIV treatment is exempt from charging, maternity care is not. This means that although maternity can create complications and, without proper treatment, a woman may risk transmitting HIV to her baby during labour or afterwards, maternity care for a woman with HIV is not automatically exempt. Further, women who have HIV are placed onto highest payment pathways because of the extra care they require. This means HIV-positive women will be charged a higher price for their maternity care by virtue of their HIV diagnosis, even though 'HIV treatment' itself is exempt.

The woman's experience of charging made her reluctant to engage with health services in general and negatively affected her mental health in relation to her pregnancy and the future for her child. Her midwife said:

*"It's horrific, she doesn't trust anyone anymore, she doesn't trust to talk to anyone. She's very negative regarding her pregnancy. She felt that the midwife in the booking was quite judgemental. Unfortunately it's left a feeling that people along the way are quite judgemental in considering why she's not married. She's African, and obviously she was going to deny herself any care during pregnancy because she was frightened of what she would have to pay." (Specialist midwife)*

In this case the midwife managed to access some additional funding in order to continue the woman's antenatal care at home.



One community midwife described a case of a woman with a serious medical condition who had missed a number of important appointments and tests because she had been charged but was unable to pay. The midwife had to chase her up and then had to stress the importance of the appointments and why she needed them.

These kinds of responses all took considerable time, effort and commitment on the part of midwives. Although in some cases they were able to reinstate care or persuade a woman to continue to attend her antenatal appointments, fear of the charges itself, late booking and missed appointments, all made it much more difficult for the midwives to develop or maintain a trusting relationship with the women involved. It also means increasingly stressful and overstretched workloads for midwives having to find women who have been deterred from attending appointments.

### ***Establishing trust with women***

All the midwives interviewed stressed the importance of establishing trusting relationships with women under their care, especially if the women had social vulnerabilities.

*“You don’t have as long to develop that relationship, unfortunately. If you are only starting to develop that at around 28, 30 weeks, you haven’t had the build-up in the pregnancy in order to do all the work around birth planning, and develop the trust and help women access other services that might be useful for them. It’s not what we want.”* (Community midwife)

Another midwife commented:

*“They think you are going behind their back. It might make families think that we don’t see them as a pregnant woman, that we see them as a person who shouldn’t be here. That kind of thing definitely affects your care.”* (Community midwife)

The erosion of trust caused by charging undermined the quality of the care midwives could give as women were less likely to disclose sensitive issues and information to them because of fears of repercussions. This made it harder for midwives to gain information from women which might actually qualify them for exemptions from charging such as domestic violence or mental health issues.

*“Like domestic violence and previous trauma, anything like that they will be more anxious to say anything as if it would cost them more money. And if you, as it were, told on them and called the Home Office, called the overseas, they will be less likely to trust you and tell you other stuff.”* (Community midwife)

In one case a midwife told of how a woman with severe-post traumatic stress refused to attend for talking therapy after referral by the midwife.

*“When you’re trying to engage vulnerable women, it can be difficult anyway. But when the additional challenge is coming from the hospital where you work or the trust itself, that feels*

*like it just adds a barrier to their care. It makes it more complicated and makes it more risky.” (Community midwife)*

A few midwives among those interviewed, however, believed that it was possible to form a trusting relationship despite the charges and the link between the hospital and the Home Office. One specialist midwife said that once women have met her, and a relationship has been established, they are more likely to continuously attend care. Another specialist felt that building a trusting relationship helped overcome the client’s perception of her as a “police woman.” However, these were rare views and most midwives interviewed felt that charging and the risk of being reported to the Home Office undermined their ability to build trust between women and their midwives.

Whether or not midwives succeeded in building a trusting relationship with women, it is clear from their accounts that extra effort, time and energy had to be put into keeping women engaged with maternity services. Midwives tried to maintain contact by means of phone calls and home visits. One midwife said she had *“to keep ringing her and beg her to come in.”* (Community midwife)

*And it does take up a lot of their time as well, as midwives we do tell them to keep coming. That is all we can do to tell them to ‘keep coming, keep coming’ because we don’t want them to not have that care. Unfortunately we never get to see the outcome of that. Whether they got charged or not, that is not something that we are aware of, as midwives, we don’t always know if they got charged or not.”* (Community midwife)

### ***How cost considerations influence women’s decisions about their maternity care***

One midwife commented that some women want to select discrete items of care in order to reduce the costs and did not understand the clinical judgements involved in the care plan. This actually made it more difficult for them to offer good care.

*“I’ve seen that, knowing the cost of each thing, the majority of the clients that we see don’t necessarily have a medical background so it’s hard for them to choose which things are most important for them. We’ve got a care plan for our clients and each part of it is evidence based. There’s a reason for each appointment and each test. But if clients are thinking, that one is really expensive, say maybe a blood test is more expensive than another appointment, then they’ll miss it. And that’s quite frustrating because you can’t make good clinical decisions with only half the information.”* (Community midwife)

NICE guidance states that each antenatal appointment has a specific purpose, related to the progression of the pregnancy.<sup>80</sup> As stated in the introduction, missing out on routine antenatal care is a risk for maternal death, as successive Inquiries into maternal deaths have shown women who died consistently received less than recommended levels of antenatal care.<sup>81</sup> As well as the health

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<sup>80</sup> NICE (2019). Antenatal care for uncomplicated pregnancies (CG62) Information for the Public.

<sup>81</sup> Lewis G, ed. ‘Saving Mothers’ Lives: Reviewing maternal deaths to make motherhood safer—2003–2005’. The Seventh Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. CEMACH, 2007; Cantwell R, et.al. ‘Saving

risks involved in this strategy, it is unlikely to make much difference to the costs women faced as fees are charged as packages rather than as itemized bills where each procedure is charged separately.<sup>82</sup>

## ***Conclusion***

This section has described midwives' approaches to addressing the vulnerabilities faced by some of the migrant women in their care. It also shows the extra efforts which midwives make to ensure women do receive the care they need. Most of the midwives interviewed felt that the implementation of charging had made their job more difficult, particularly in terms of building a trusting relationship with women. The next section explores in more detail how midwives perceived the professional and ethical implications of charging for maternity care and the strategies they used to overcome its effects.

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Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom.' BJOG, 118 (supplement), 2011. pp.1-203; Knight M, et.al. 'Saving Lives, Improving Mothers' Care: Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13.' MBRRACE-UK Confidential Enquiry into Maternal Death 2015. December 2015.

<sup>82</sup> Feldman, R. 2018, *op.cit.*

## 4. Issues charging raises in midwives' role and professional practice

The previous section has shown how midwives felt that charging made their work more difficult. Mostly this was a result of how charging affected women in their care who were in very vulnerable situations already. This section explores how charging also creates conflicts in professional practice among midwives looking after women who are charged. Such conflicts arise from contradictions between midwifery professional standards and the requirements of the charging regulations. Midwifery standards are set out in the Nursing and Midwifery (NMC) Code, but also derive from developments in midwifery during the twentieth century and beyond which have changed the scope and style of midwifery education and have expanded the role of midwives trained in the UK.

The new charging rules have also created new administrative requirements for charging to which clinicians, including midwives, have to adhere. How charging is implemented varies between trusts and may involve clinicians in different ways. Whatever the particular arrangements in any trust, how charging is implemented can give rise to professional conflicts between clinical and administrative staff in relation to clinicians' concerns about patient care.

### ***Professional standards and midwives' responsibility to address inequalities***

The current NMC Code requires all nurses and midwives not only to "respect and uphold people's human rights"<sup>83</sup> but, more specifically, to "act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care."<sup>84</sup> This can include identifying the need for additional support when needed.<sup>85</sup>

At the time of writing, the NMC is in the process of reviewing standards of proficiency for midwives which more explicitly address expectations of midwives' responsibilities towards women and babies in their care. Some of these have specifically social reference points. For example, the draft proficiencies refer to midwives' role in "enabling and advocating for the human rights ... of women, partners and families, and their responsibility in "understanding and mitigating health and social inequalities".<sup>86</sup>

More than the existing Code, the draft proficiencies also require midwives to "work with other professionals, agencies, and communities to share understanding of the needs of women, newborn infants, partners and families when considering factors that promote and protect health and well-being, including transport, housing, welfare, access to food, and services for very young children and families".<sup>87</sup>

Other proposed standards focus on the kinds of relationships which midwives are expected to make with the women in their care, such as to "develop, enable, manage and maintain trusting, respectful,

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<sup>83</sup> Nursing and Midwifery Council, 2015 Para. 1.5

<sup>84</sup> *Ibid.* Para 3.4

<sup>85</sup> *Ibid.* Para 13.2

<sup>86</sup> Nursing and Midwifery Council, *op.cit.* 2019 p5

<sup>87</sup> *Ibid.* Para 2.9

kind, and compassionate person-centred relationships with women, their partners and families.”<sup>88</sup> Particular attention is given to “The midwife’s ability to provide and promote continuity of care and carer.”<sup>89</sup>

The provisions in the current midwifery standards, and even more, those in the revised draft standards reflect a more holistic approach to midwifery care and show an understanding of the inter-relation between the clinical and non-clinical aspects of midwives’ roles. Combining these aspects is particularly important for midwives who look after poor and marginalised migrant women. However, the charging regulations and guidance reflect very different concerns from maternity care policies and the Nursing and Midwifery Codes. In line with their obligations to mitigate health inequalities and to advocate for the vulnerable, the midwives interviewed demonstrated considerable understanding of vulnerable migrant women’s personal and social situations.

## ***Midwives’ professional responsibilities in practice***

### *The booking appointment, immigration status and chargeability*

Midwives’ professional relationship with women begins with what is known as the booking appointment or booking visit,<sup>90</sup> however this is often the point at which the first professional conflicts arise as a result of the charging regulations. The booking appointment enables midwives to communicate information about good self-care, preparation for childbirth and parenting, as well as to explain the risks and benefits of procedures such as scans, screening and blood tests occurring throughout pregnancy. This discussion has become situated within a philosophy and ethos of personalised care and informed decision making by the pregnant woman herself.

The evidence associating poor pregnancy outcomes with late booking or too few appointments, has also given rise to studies investigating barriers to antenatal care for marginalised women including minority ethnic and migrant women. As we have seen, for midwives who are charged with ensuring effective antenatal care, much rests on seeing women early, maintaining contact and developing trust. However, they may have little control over barriers to access for marginalised migrant women so how they deal with such women’s entry into antenatal care at the booking appointment is of special importance.<sup>91,92</sup>

The booking appointment represents a major moment in the shaping of such care. Indeed the NICE Clinical Guideline on routine antenatal care states that “The booking appointment needs to be earlier in pregnancy (ideally by 10 weeks) than may have traditionally occurred and, because of the large volume of information needs in early pregnancy, two appointments may be required.”<sup>93</sup>

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<sup>88</sup> *Ibid.* Para 1.9

<sup>89</sup> *Ibid.* p16

<sup>90</sup> National Institute for Health and Care Excellence, 2008, *Antenatal care for uncomplicated pregnancies* Clinical guideline 62.

<sup>91</sup> Hollowell, J. et al. 2012, *Increasing the early initiation of antenatal care by Black and Minority Ethnic women in the United Kingdom: a systematic review and mixed methods synthesis of women’s views and the literature on intervention effectiveness: Final Report.* Oxford, National Perinatal Epidemiology Unit.

<sup>92</sup> Downe, S. et al. 2009, “‘Weighing up and balancing out’: a metasynthesis of barriers to antenatal care for marginalised women in high-income countries” *BJOG* 116:518–529.

<sup>93</sup> National Collaborating Centre for Women’s and Children’s Health, 2008, *Antenatal care routine care for the healthy pregnant woman: Clinical Guideline.* London, RCOG p78

Although not necessarily the first contact with a health professional in pregnancy - the women is likely to have seen a GP first - the booking appointment is the gateway which significantly determines the shape and direction of care in the coming months.

On the face of it, the booking appointment has nothing to do with identifying migrant women who may be chargeable for their maternity care. However, midwives must complete a *booking form* on which various details about the woman are recorded. Although there is a standardized NHS England booking form available, many trusts have their own booking forms. Maternity Action sent Freedom of Information requests to all NHS Trusts in England to find out what information was sought on booking forms for maternity care. All the booking forms received in response included questions on at least one of the following: a woman's place of birth and/or nationality, immigration status and length of time in the UK.<sup>94</sup> The answers to these questions are relevant in developing personalised care plans. However, once on the system this information can be used to identify a woman's chargeability and can have serious consequences for her.

Midwives could not be sure that such information would not be used to determine chargeability. The answers to questions such as 'Have you lived in the UK for the last six months?', "Country of Birth", "Place of Birth", "Visa Status" could then 'flag' the woman's file to be reviewed by the Overseas Manager Department who would determine whether they are chargeable, and contact them.

*"I'll say, 'how long have you been in the country?'. And I'll ask 'Were you born in this country?' which is a question that I have to ask in our booking form. Then if they say no, I have to put into it "When did you enter this country?" and whatever information they tell me, I believe that. If they say 'I have only been here...' I'll say 'OK. What I will need to do is pass the information on to the overseas office because they need to be aware of people who have been in the country for less than six months'" (Clinic/birth centre midwife)*

In some cases they tried to circumvent procedures individually in order to avoid information reaching the Overseas Visitor Department. For example one midwife said that if she learns that someone she is caring for is undocumented, and therefore chargeable, she will purposely not contact the Overseas Manager in order to prevent the family from being charged.

*"If I find out about somebody who is an overstayer but it's still on the system that they are not chargeable I won't tell anybody about it – I don't think it is our place really. We find it to be an impossible ethical dilemma to put midwives in this position, of not only feeling like a police officer, but reprimanding them if they don't do so." (Specialist midwife)*

Midwives could often see clearly that the information they were collecting could have problematic outcomes. One said:

*"I don't like asking women about their visa status full stop. I don't mind if it's for their needs, so I can direct them to the right support. It's on our booking pro forma. "Visa status", it says, and I don't always ask it. I'll ask them what support they need, because I'll direct them to what they need for support, but it just feels so intrusive to ask somebody that." (Community midwife)*

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Maternity Action, 2019, Freedom of Information responses (unpublished)

Several midwives described innovative and creative solutions to enable women to receive some care but avoid incurring charges.

However, midwives reported that they faced pressure from their management if they refused to provide the required information. *“It’s pushed on us, as midwives, by the management team.”* For some midwives management pressure was couched in terms of the need for financial savings by the trust even though the midwives knew the women in question would be unable to pay.

Sanctions for failing to provide information are not clear but NHS professionals may be at risk of misconduct charges if they are suspected of this. The Guidance on Implementing the Overseas Visitor Charging Regulations suggest that *“When there is a suspicion that....an NHS employee is attempting by fraud and deception to facilitate a chargeable patient receiving free care without identification or correct charge (or has already done so), this should be reported to the relevant body’s Local Counter Fraud Specialist.”*<sup>95</sup>. This clause clearly creates a conflict of obligations on staff to decide where their duties lie, especially when, as midwives, they are aware that women who are charged may avoid further care.

One midwife said that she would record a woman’s migration status, not to share with anyone else, but just so that she would know if the woman was likely to be charged. This was so that this could be understood as a factor if the woman stopped attending for care. However, she felt it was inappropriate for her as a midwife to bring up charging in a consultation before a woman chose to share it. This reticence is understandable as women are often very ashamed about the fact they are being charged and cannot pay and can be afraid of what their midwife might think of them.<sup>96</sup>

#### *Data sharing and confidentiality*

Midwives acknowledged that information such as length of time in the country or immigration status could be important in making clinical decisions, identifying particular risk factors or signposting to support. Most of the conflict raised by data sharing arises around the booking appointment, although information picked up later can also be affected. The fact that data collected as part of clinical appointments is shared with administrative staff and, potentially, the Home Office in this way has two adverse effects.

Firstly it affects pregnant women by introducing suspicion at exactly the moment that they are entering antenatal care, implicitly warning them to be careful about what they say, just when midwives are trying to get them to speak openly. Downe et al. explored the barriers not just to initial access to antenatal care for marginalised women, but also barriers to continuing care. They argued that, for such women, continuing to attend appointments depends on a strategy of *“weighing up and balancing out”* the perceived gains and losses of continuation. This balance depends both on personal issues and resources specific to the women concerned and on their perceptions of the service and service providers. For women who fear authority, a fear of how authorities might treat them was a deterrent to further engagement with maternity services.<sup>97</sup> This can be particularly true when women are afraid of being reported to immigration authorities.

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<sup>95</sup> Department of Health and Social Care, 2019, *op.cit.* p99

<sup>96</sup> Feldman, R. 2018, *op.cit.*

<sup>97</sup> Downe, S. et al. 2009, *op.cit.*

Secondly, it also affects midwives, who know that their information and history taking from the woman is not simply benign. The use of information acquired during the booking appointment for charging purposes contradicts many principles in the Nursing and Midwifery Council Code, especially those which require nurses and midwives to “prioritise people”. Under this heading they are required to “recognise when people are anxious or in distress and respond compassionately and politely”<sup>98</sup> and “share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality.”<sup>99</sup> The sharing of patient information obtained during the booking appointment may also be in breach of the Caldicott Principles designed “to ensure that information that can identify a patient is protected and only used when it is appropriate to do so.”<sup>100</sup>

Several midwives mentioned how the charging regulations have changed the scope of their role and affected their practice beyond the loss of the trusting relationship they need to build with the women they care for. A specialist midwife for migrant women, who had worked with migrant women for over 10 years, expressed great frustration to find that her job was ‘becoming about charging’, rather than having the time and capacity to develop a care plan which addressed other pressing needs migrant women have during pregnancy. Another stated:

*“As a midwife, it’s an awful, awful feeling. We are told we have to call the overseas office if we have anybody – and you feel like you are working for the Home Office!”* (Community midwife)

One specialist midwife compared the letter containing the warning that the Home Office would be informed of the debt, and the potential immigration implications, to blackmail. Another community midwife pointed out that the very act of sharing the information with the Home Office erodes the trust between a midwife and the woman under her care in general.

Some midwives described how the duty imposed by the charging regulations conflicted with their duty of care as a midwife.

*“I am not here to enforce immigration rules, I am not here to enforce people’s entitlement, I have a duty of care as a midwife and I need to fulfil that duty of care. Part of my duty of care as a midwife is to gain the trust of people who are giving me medical history, who are entrusting me to guide them through the booking process which is the first step they are taking in pregnancy care. I need them to trust me and to trust the service.”* (Clinic/birth centre midwife)

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<sup>98</sup> Nursing and Midwifery Council, 2015 Para. 2.6

<sup>99</sup> *Ibid.* Para. 5.4

<sup>100</sup> NHS, 2013, *What are the Caldicott Principles?* Department of Health Information Governance Toolkit. <https://www.igt.hscic.gov.uk/Caldicott2Principles.aspx>



### Concerns about discrimination

As we have seen, some midwives felt that questions about a woman's background were fundamentally discriminatory.<sup>101</sup> The midwife who gave the example of a Roma woman who was billed and subsequently stopped attending appointments said:

*"To be honest, at that point, I didn't really know much about the charging rules. I was pretty sure that we weren't charging white Europeans, so why are we charging Roma Europeans?"*  
(Community midwife)

Another said:

*" [The questions] are uncomfortable for everyone. They are uncomfortable for us as midwives, uncomfortable for people who have been born and brought up here who feel grief when being asked those questions. 'Why do I have to prove who I am?' There are people who are here under difficult circumstances who then feel like they have to explain really convoluted reasons that we don't need to know. And then there are people like me who are born and brought up in this country whose parents come from a migrant background who then, again, feel like 'Are you asking me this question because of my name, or because of the colour of my skin?'"* (Clinic/birth centre midwife)

Despite efforts to identify and attempt to address the structural barriers to accessing healthcare that are faced by women as a result of their immigration or socio-economic status, many still face discriminatory practices within the health system, whether directly or indirectly. This was recognised by many of the midwives we spoke to:

*"The inequality in the system is more to do with people being told what they are entitled to, people being given tools to question clinical decisions that are made on their behalf, women having access to the information of what they can ask for and what they can't ask for. That is the inequality that is there. I work in London, in a very diverse area, but where I personally live is not as diverse and I see my neighbours, the women on the school run, getting much better care because of who they are."* (Clinic/birth centre midwife)

Some midwives reported what they saw as discriminatory practices from both the Overseas Managers Team, as well as from other health professionals and colleagues. They also felt that some colleagues were less aware of the political context surrounding the charging regulations, and were therefore less likely to question the impact they had on women in need of care. One community midwife commented that, where her colleagues felt a woman might be chargeable, they might notify the Overseas Managers automatically, in accordance with their trust's procedure. However, this might occur without any consideration as to how it would impact on the women's access to care.

Four of the midwives interviewed felt that both their fellow midwives and Overseas Managers were racially profiling those attending appointments in order to identify chargeability. For example, some expressed concerns that Overseas Managers failed to identify white British women as chargeable, even when they clearly were not ordinarily resident, as defined by the regulations. They reported caring for such women who live abroad, but who were asked no further questions than their place of

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<sup>101</sup> See p21 above

birth, whereas minority ethnic women are asked further questions regarding their eligibility, despite being born in the UK.

*“The checking system is flawed as far as I am concerned, because it is there to pick up what is labelled as illegal immigrants, or immigrants, as opposed to people who may well be playing the system, who have not lived in this country in the past six or seven years and have come back to have a baby and will literally be leaving 10 days after the baby is born.” (Clinic/birth centre midwife)*

### **Informing women about charging**

Neither midwives nor other clinicians are legally responsible for informing patients about charging. Nevertheless, it sometimes fell to midwives to inform women that they would be charged for their maternity care. NICE guidance gives midwives a generic responsibility for providing information about their care that women “can understand and that is relevant to (their) circumstances... Your care, and the information you are given about it, should take account of any religious, ethnic or cultural needs you may have.”<sup>102</sup> However, this guidance was written without reference to the circumstances of charging though it is arguable that information about charging is relevant to women’s circumstances.

Since 2017, new regulations mean that people must now be informed of charges before they receive care, even if, like maternity care, it is ‘immediately necessary’ and cannot be deferred. This study took place too early to show whether, under the new rules, midwives become any less involved in the charging process. Here, we describe how midwives were affected by different approaches to informing women that they would be charged.

In some cases women were informed routinely by administrative staff as part of their initial contact with maternity services. In others, women were informed later in the course of their care. The latter approach was taken for two different reasons.

In some trusts the rationale was to give chargeable women time to engage with maternity services before the potential deterrent effect of such a notification. For example, in one trust women were informed generally about charges and eligibilities at their booking appointment but they did not receive notification of their personal chargeability until after their twenty week scan. This reasoning raises questions about informed choice and the implications should women choose to terminate the pregnancy at such a late stage in order to avoid more charges.

At other trusts, later notification appeared to be simply the result of the procedures for identifying chargeability on the part of Overseas Visitor Managers.

Some midwives with concerns about the women in their care simply tried to avoid engaging with the charging regime altogether. Most of the midwives interviewed felt that charging was not something that should be part of their role. This led to some choosing not to bring up charging whatsoever:

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<sup>102</sup> NICE (2019). Antenatal care for uncomplicated pregnancies (CG62) Information for the Public.

*“Charging is not discussed until something is found out. That is when they [patient] will say “we didn’t come because we can’t afford to pay.” (Specialist midwife)*

On the other hand, other midwives felt that they ought to raise and discuss the implications of charging with women as soon as possible, so that the women know they can discuss it further with their midwife if they receive a bill. In one midwife’s opinion, the failure to discuss it with patients prior to their being billed, leads to them panicking and stopping attending care rather than coming to the midwife to open a dialogue with the Overseas Visitor Department and have the midwife advocate to put a payment plan in place, whilst ensuring they still attended care.

*“What I do, is that in that very first booking appointment, I explain to women how it works: ‘This is what we do in [this hospital]. They will have a look to see if you’ve been in the country for less than 12 months. If you have, they will have documentation. All you have to do is this – this and this. If you are struggling with it, just come here and I will help you.’ A lot of my asylum seekers and refugee families have support workers who are extremely good at helping them.” (Specialist midwife)*

In some cases women spoke too little English to understand the letter which they received informing them that they would be charged. Some midwives reported that it was common for women to attend maternity appointments asking for help in understanding a letter informing of them that they would be charged and it became part of their role to explain it.

*“They often bring me the letter, a lot of the women can’t read the letter. Because they can’t read English, and I’ve had a couple of ladies bring me the letter, ‘What’s this?’” (Specialist midwife)*

Therefore, when women have a problem understanding charging procedures, they turn to their midwife for help as a trusted individual, meaning the midwife then becomes the messenger of the charges. It is clear that it is difficult to make a clear cut distinction between midwives and Overseas Visitor Managers’ roles in informing women about charging.

While most midwives referred to women receiving some sort of a letter advising them that they would be charged, a few mentioned Overseas Visitor Managers approaching women in person. While some described this happening early on or sensitively, two midwives said that they had observed Overseas Visitor Managers visiting women’s bedsides and discussing the issue while they were in an open postnatal ward.

*“The overseas officer approached [the woman] who was one or two days postnatal. I don’t know what triggered it but she was in an open ward with her baby and she was approached and asked pretty difficult questions. All of these things are very dependent on how people bring them across as well. They were basically saying to her “You will be charged because of X, Y and Z.” It felt, as a midwife, very against what we are there for and what we are supposed to do.” (Clinic/birth centre midwife)*

Another midwife said:

*“The father was very scared, very frightened, and for me the difficulty was that after they were out of the room, having had the baby they would have to go to a postnatal area, which is a shared facility, and those conversations with the overseas managers are conducted at*

*the bedside. For me, that sticks in my mind that there must be more effort to promote dignity and respect for these families who are being asked very personal questions.” (Clinic/birth centre midwife)*

Despite this type of bad practice, some of the midwives interviewed were able to build constructive relationships with the Overseas Visitor Managers at their trusts.

### **Midwives’ relationships with Overseas Visitor Managers**

It was difficult, though not impossible, for midwives to challenge aspects of charging policy collectively. The study only encountered one report of this. A midwife in one trust said that there had been a suggestion that midwives should take responsibility for informing the overseas team if they saw that patients were chargeable. However, she said that:

*“As a group of midwives, the decision was that we didn’t want to do that and that we wouldn’t agree to do that, even if that was the trust policy.” (Community midwife)*

However, she was also aware that they could not control the Overseas Visitor Department’s access to information collected in the process of delivering maternity care.

*“We don’t have any active part in it. But at the same time, we do collect details and we can’t stop it being followed up by the overseas team that does the charging.”*

This very pertinent observation meant that although midwives might try to avoid cooperating with the Overseas Visitor Departments, they could not altogether avoid dealing with them. They dealt with Overseas Visitor Departments in different ways. Some were anxious to establish a good relationship with them in order to be able to advocate for women while others regarded the work of Overseas Visitor Departments as completely separate from their concerns.

One midwife worked together with the Overseas Visitor Officer to find a viable solution for a woman who was deterred from attending care as a result of the charges:

*“This lady was refusing care because she was frightened of being charged. She had already got a bill, and she decided that she didn’t want to have any care. She had complex issues anyhow, medical issues. And it was really important that she have care. This impacted mainly on her mental health. She was extremely, extremely stressed about everything that was going on. ... So, the overseas officer and myself have done a lot of work into looking at how we can, or how they can put together a repayment package for the charges that is manageable. So then the hospital trust can say ‘This lady is on a repayment plan so it shouldn’t have any impact on her [immigration] claim’ which I think is the best of the bad situation. We can’t avoid the charges unfortunately.” (Specialist midwife)*

Two midwives stated that they felt the Overseas Visitor Departments at their trusts were understanding and interested in finding an achievable solution for women. One said:

*“I’ve got quite an understanding with our overseas team, so we always talk about setting up a payment plan because they know a lot of the ladies around here really can’t afford that*

*money. They are easy to talk to and will discuss all the options with the women.” (Specialist midwife)*

Some trusts had dedicated staff who act as a liaison between the Overseas Visitor Department and as advocates for women receiving maternity care, either as part of the Overseas Visitor teams or as interpreters. Midwives at these trusts felt that such roles were useful for sensitively broaching the topic with chargeable women and encouraging them to continue to attend for care. However, it is not clear how much such staff feel able to act as advocates for the women, especially if they form part of the Overseas Visitors team.

One specialist midwife thought that some Overseas Visitor staff were themselves worried about the impacts of charging on those women most in need of support. She described an Overseas Officer who was concerned that many of the women with whom she was dealing had fled abusive relationships which were the basis of their visas.

*“They are women who have come over here in all good faith, and then fled an abusive relationship, so obviously the Overseas Office is having a look at it. I know that she wants to take it to a higher level when she has meetings with NHS people and things. I have quite a few ladies who have been in that situation.” (Specialist midwife)*

## **Conclusion**

This section shows how the measures to identify chargeable women are now inextricably woven into the practice of maternity care. Midwives’ recording of information which is important to promote good maternity care also threatens women with large bills which they will not be able to pay, and with being reported to the Home Office. This inherent contradiction is problematic for midwives in terms of their professional duties and ethics.

Whether or not they want to, midwives find themselves involved in the charging process. Both the practice of good record keeping in health care, and midwives’ need to enquire and know about a woman’s personal and social situation mean that information collected for the purpose of providing good care can easily be used for the purpose of charging. Midwives are uncomfortable about this, because even if they would like to have nothing to do with the charging process, their professional responsibility forces them to.

At the same time they are also conflicted about the clash between their professional responsibility to address health inequalities, and the way in which the charging regulations contribute to inequalities in access to care, as well as to the anxieties their patients experience. Moreover, whatever their attitude to the charging regulations, some midwives experienced them as discriminatory and unfairly weighted against non-British migrants, with expatriate British citizens able to avoid being billed. There is now a clear conflict of interest between administrative staff tasked with implementing charging, and clinicians with very different objectives. There is no simple way out of this dilemma without either an end to charging or an acceptance that the NHS now operates a dual system likely to increase health inequalities.

## 5. Midwives' knowledge of and attitude towards the challenges posed by charging

How midwives felt about charging was influenced both by their prior attitudes and by their perceptions of how charging affected their professional practice. In this section we explore midwives' views on the charging regulations, the extent of their knowledge and training on NHS charging and how both their expertise and seniority enabled them to better fulfil their role as advocates for the women in their care.

It is likely that that because the midwives in this study all had some background looking after migrant women, their attitudes were shaped by this in a way not possible for other midwives without such experience. So while their views may not be representative of all in their profession, they can enhance our understanding of the impact of charging on professional practice in midwifery.

### ***Midwives' views on the charging regulations***

Most of the midwives interviewed felt strongly that charging for NHS maternity care had a very adverse impact both on their practice and on women's health.

*"I'm not a politician, but women need pregnancy care. We know that their health needs are greater in pregnancy. And the majority of these women have underlying issues anyway, both physical and psychological, so charging them is not... they need... they don't come for care when we charge them, because they can't afford to come, so it's just ignoring women's health needs really." (Community midwife)*

*"I think it's introduced a huge bureaucratic burden. I think it's introduced lots of queries about who is and who isn't chargeable. I think it has increased barriers between midwives and women. I think it creates a pretty problematic public health issue, particularly in terms of women avoiding access to routine antenatal care and screening etc. It's fairly disastrous, to be honest." (Specialist midwife)*

One midwife felt that there was a danger that 'legitimately' charging some people could have a negative effect on others who are very vulnerable. She said:

*"In some respects there has to be a point at which people are charged for NHS care, but unfortunately the very nature of doing that targets the people who are most vulnerable and need healthcare more than anyone else. By trying to catch those who are genuinely abusing the NHS, we're targeting those who genuinely do need NHS care. We know, historically, a lot of these women have poor health, poor mental health, the worry for me is the impact on the children as well." (Specialist midwife)*

On the whole, the midwives interviewed felt that 'health tourism' as a justification for charging had been overstated by the media and the government and that in fact such instances were rare and did not justify charging vulnerable women. Two midwives described caring for women who had come to the country purely for the purposes of receiving maternity care, but stated that these women were well aware of the charges involved and were able to pay immediately.

Only one midwife felt that there weren't any particular issues around charging but unlike most of the others interviewed, she had only twice come across charging as part of her practice.

*"I think what we're doing here is generally fair. We see a lot of women who are from outside the UK who are here for different reasons, from lots of different places. And very rarely have to get involved in any kind of money issues, but it doesn't seem unfair to me. We only try and charge people in extreme circumstances."* (Community midwife)

In general the midwives interviewed indicated that the burdensome impact of the charges on vulnerable women they cared for, as well as on their own professional practice, outweighed any justification made for them.

### ***Knowledge and training about NHS charging for 'Overseas Visitors'***

Many midwives felt very conflicted about acquiring knowledge about the charging regulations as though they felt that training might in some way implicate them in colluding with the charging regime. At the same time, however, some midwives recognised the importance of understanding charging regulations. They needed such knowledge in order to be able to support and advocate on behalf of women who were charged. The following comment shows how conflicted a midwife could feel as a result of women being charged.

*"I feel like it's a real ethical dilemma because I don't want to be ignorant about charging if women need the support and help, but I don't want to know about charging, I just want to give care to women. I feel like they deserve that primary care. It's not that I don't want to know, because I do want to know if it helps the women, but I don't want to ever have to discuss costs with them."* (Community midwife)

In practice, the interviews revealed that there was an almost total absence of training on the charging regulations and guidance and their implications for midwives' work. Although midwives are trained to achieve safe and personalised pregnancies and delivery, they have no comparable knowledge of or training in the charging regulations and guidance. Specialist midwives for migrant women were the best informed while community and clinic-based midwives had the least awareness of charging rules.

Midwives also had variable levels of knowledge about appropriate local services which might be able to help women in their care who were charged in order to signpost them effectively. Such knowledge needed to be spread among all midwives, even in areas where specialist midwives were in post to ensure that women could receive appropriate care.

Some specialist midwives described cases in which their own knowledge was instrumental in encouraging women to take action in relation to their immigration status. For example, one

recognised that a woman had been trafficked and was therefore entitled to enter mechanisms that would exempt her from the charges for her care, even contacting the Home Office on her behalf.

Another specialist midwife explained the need to ensure that midwives have enough knowledge to guarantee women an appropriate level of care:

*“I am currently on a seconded role where I am writing clinical pathways for vulnerable pregnant women, and one of those groups are asylum seekers and refugees. And that’s because there isn’t only me looking after those women, they could be scattered throughout the GP surgeries across the city. And we were concerned that those women weren’t getting equitable care. So I am writing clinical pathways to make sure that when community midwives who maybe don’t deal with asylum seeking or refugee women are able to ask the right questions, provide the right support and show that they have got understanding of the complexity of women who come through these routes.”* (Specialist midwife)

Most of the midwives had not received any training on the charging regulations themselves, and felt that their professional training and previous experience had not prepared them to deal with such matters although there is some cursory e-learning material about charging available on the DHSC website.<sup>103</sup>

One midwife said:

*“We don’t get training here for things like that. No, nobody has a clue. Nobody has any idea, people just ring me and expect me to know, and I found out for myself. So it’s been personal training.”* (Specialist midwife)

Another midwife described how they were simply expected to refer the Overseas Visitor Manager any ‘flash on the system’ they encountered. This meant that if the computer record indicated any question about a woman’s eligibility for free care, they were supposed to inform the Overseas Visitor Department. She said that they had:

*“Very little training. We had a talk with the man from the overseas office and basically all we have been told to do is that ‘if we feel the alert, flash it out’. If they have no NHS number, that is all we have to do, and that is as far as we as health care professionals go. If we see a flash on their system, we call the overseas manager because that is what we are told to do. And that is where it finishes for us.”* (Community midwife)

Clearly such ‘training’ does not give a broader overview of the consequences of NHS debts, nor does it provide the midwives with details of the charging Guidance which would enable them to advocate for those who are being charged. In research done by Medact, 67% of NHS trusts that responded to FOI requests did not provide any specific training for staff on the charging regulations.<sup>104</sup> In this study some specialist midwives described cases in which their own knowledge of the regulations was instrumental in encouraging women to take action to challenge charges that they were held to have incurred.

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<sup>103</sup> NHS Health Education England, 2019, *Overseas Visitors Cost Recovery programme*. E-Learning for Healthcare. <https://www.e-lfh.org.uk/programmes/overseas-visitors-cost-recovery/>

<sup>104</sup> Medact, 2019, *Patients Not Passports: Challenging healthcare charging in the NHS*. Medact, London p25.



Only one midwife interviewed (a specialist for refugee and asylum-seeking women) mentioned any exemptions to charging, despite many others describing cases to which it seemed likely they would apply. Knowledge of the exemptions is key for midwives to be able to identify women who fall into one of the categories in order to advocate on their behalf.

Most of those who had some knowledge about the charging rules had researched entitlements in their own time in order to support and advocate on behalf of women in their care who were being charged. Even midwives who specialised in refugee, asylum-seeking and migrant women had generally not received any training on the regulations and their implications. Due to resource pressures on trusts and time pressures on midwives, it is likely to be difficult for them to attend further training on how best to advocate for women facing charges: a survey in 2018 of Heads of Midwifery (HOMs) by the RCM found 31% of HOMs have had to reduce training in the last twelve months and 7% of HOMs said no CPD is provided during working hours.<sup>105</sup>

### ***Seniority and expertise***

The midwives' narratives suggested that specialist and senior midwives were best able to influence the approach of the Overseas Visitor Departments, and also to be more proactive in challenging what they considered were mistakes by the departments.

For example, one trust with a specialist midwife for asylum seekers has a reciprocal arrangement with the Overseas Visitor Department. This midwife helps in the team's induction programme for new staff and they refer all refugees back to her. If she feels that a woman is an asylum seeker waiting for her Application Registration Card she contacts the Overseas Visitor Department and asks them to put any charging on hold.

*"We have an arrangement here in our Trust whereby, if I review the documents which I have done routinely because that has been agreed many years ago, then they would cancel the bill there and then. So any potential bill gets cancelled, any misunderstanding gets cancelled there and then..."*

*"I've had the scenario where somebody has been charged and it is quite obvious when I look at her notes that they have been issued with a bill and it has been inappropriate, for whatever reason. I've phoned the overseas team saying that it needs to be cancelled. And they have cancelled it straight away. On one occasion, where I was extremely assertive because I was quite annoyed about it, the woman did come back to the ante-natal clinic and the matter was closed. Because she was also homeless and there were other things going on, and she didn't need this." (Specialist midwife)*

As this example shows, midwives can overtly challenge the Overseas Visitor Departments if they believe a woman has been inappropriately charged. It may even be an advantage if they have already established a good relationship with the Overseas Visitor Department. Such a relationship, however, also depends on co-operative attitudes on the part of the Overseas Visitor Department.

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<sup>105</sup> RCM (2019). *RCM Pay Review Body Evidence January 2019*.

Actual charging practices depend on both the attitudes and approaches of particular Overseas Visitor Departments and the authority of individual midwives. Overseas Visitor Department attitudes undoubtedly affect how successfully midwives are able to advocate for women in their care, but equally midwives' own knowledge and seniority plays a significant part in effective advocacy. In hospitals without any specialist staff, it is likely to be harder for less well-informed midwives to advocate on behalf of women in their care who have been charged.

The study found one case where there was a serious difference in attitude between a senior midwife and the Overseas Visitor Manager in her trust. In her view:

*“He is very aggressive. He is very negative. He has said that most women will get pregnant in order to get free care. That’s his exact words. It’s not easy.”* (Specialist midwife)

Moreover, the complexity of the charging Guidance means that mistakes can be made in identifying both individual eligibility as well as exempted conditions. One specialist midwife was concerned that Overseas Visitor Departments did not always apply the charging regulations appropriately.

*“I think they find the rules quite difficult, particularly around the exemptions. Because some of that is really difficult to define. I mean, if somebody’s been raped and they’re pregnant, which of their services should be exempt? Maternity care? Mental health services? It’s actually not easy to define. So I think they find it really difficult to implement as well. The regulations are not clear, and they’re not simple.”* (Specialist midwife)

## **Conclusion**

This section outlined how the majority of the midwives we spoke to felt that charging impacted negatively on both their practice and women’s health, and that the charging regulations disproportionately affected those women most in need of support. It also showed how midwives had been provided very little by their trusts to prepare them for the impact charging for maternity care has on their work. Senior and specialist midwives are able to exercise some influence on Overseas Visitor departments, so that vulnerable and non-chargeable women can be better identified and, where applicable, be offered advocacy for repayments.

## 6. Conclusions

There is already evidence that the introduction of NHS charging has created significant barriers to health care and has had adverse health impacts on patients.<sup>106,107,108,109</sup> This study is the first to investigate whether and how NHS charging affects the work of health care professionals. We have explored this in the context of the experience of midwives delivering maternity care to women who have been charged for it.

It might be thought that charging for maternity care would have less impact than for other conditions because it is the only care that, while not exempt from charges, is unequivocally deemed 'immediately necessary' in the charging Regulations. This means that "no one must ever be denied, or have delayed, maternity services due to charging issues".<sup>110</sup> However, as this and other studies have shown, women are still often deterred from attending some or all of their maternity care due to the fear of being charged. This study shows that in spite of the 'immediately necessary' concession charging has a pronounced effect on midwives' ability to look after women who are charged and on how they feel about their professional role.

Throughout this study we have seen that for midwives looking after women who have been charged, there are three main consequences:

- Midwives face conflicts in their professional practice as a result of charging
- They also experience an increased workload as a result of women's responses to charging
- They find themselves having to deal with ethical dilemmas about how far they need to engage with the charging regime

### *Conflicts in professional practice*

Charging imposes problems of both principle and practice on midwives. Increasingly midwifery standards have emphasised a holistic approach to midwifery care taking account of the clinical and non-clinical aspects of the needs of women whom they are looking after. This makes it incumbent on midwives to try to tackle the social and emotional as well as physical health needs of the women they care for.

In practice this means (and is required by the NMC Code and Midwifery Standards)<sup>111,112</sup> midwives advocating for vulnerable women, challenging discrimination, and understanding and seeking to

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<sup>106</sup> Feldman, R. 2017, *op.cit.*

<sup>107</sup> Feldman, R. 2018, *op.cit.*

<sup>108</sup> C. Shortall et al. 2015, *op.cit.*

<sup>109</sup> Nellums, L et al., 2018,

<sup>110</sup> Department of Health and Social Care, 2019, *op.cit.* p67

<sup>111</sup> Nursing and Midwifery Council, 2015, *op.cit.*

<sup>112</sup> Royal College of Midwives, 2016, *The RCM standards for midwifery services in the UK.*

mitigate health inequalities. Yet the impact of NHS charging is to exacerbate inequalities in access by deterring women from attending care. They also suffer increased mental distress at the prospect of incurring a debt to the hospital and of probably being reported to the Home Office.

Midwives do continue to advocate for women they are working with, both with Overseas Visitor Managers, and by referring them to other agencies or by other means. However, they are simply not in a position to alleviate the central problem that chargeable women face - that they face large bills that they are unable to pay, and may, in consequence, have immigration applications refused.

Midwives therefore find themselves working in a dual health care service, in which it is harder for 'excluded' women, often already carrying significant social and emotional as well as health problems, to access care as freely as the majority who do not have to pay. Some midwives also feel that this system is not only intrinsically discriminatory against the most vulnerable but also discriminates in the process of selecting who is chargeable in a process of racial profiling.

The contradiction between midwives' holistic and anti-discriminatory duty of care and the constraints that charging imposes when they exercise this duty is a theme that has run throughout this study. Many of the midwives interviewed described how working in a charging environment makes them feel conflicted and disturbed. This is not about working with women who pay for privileged private care because they can afford it, but about being forced to participate in a system where charges stigmatise and punish women for, in some way, being 'other'.

The NHS' own principles state that "Access to NHS services is based on clinical need, not an individual's ability to pay." (NHS Constitution). Although this is now qualified to cover exclusions "in limited circumstances, sanctioned by parliament,"<sup>113</sup> the overall ethos of the NHS, and the midwifery standards into which midwives have been inducted, are wholly at odds with the practical consequences of such exclusions.

### *Heavier workloads for midwives*

Not only does the charging environment make midwives feel conflicted in their professional duties, it also has the effect of increasing their workload. The study has shown that the midwives interviewed were very aware of the very difficult living situations of women who were charged, and were concerned to do everything they could to help them through their pregnancy and birth as effectively as possible. This could often involve a great deal of additional work. Midwives described having to chase women who missed appointments. In some cases this meant having to find out where they were and visiting them in their homes rather than in a clinic. It meant spending time persuading them to accept the care, negotiating with Overseas Visitor Managers to check or challenge a woman's chargeable status, studying the charging regulations and guidance in their own time. Even when women were attending appointments, it could also take longer to establish trust.

Midwifery services are already stretched, and it has been suggested that midwives are leaving the profession because of the excessive workload they face.<sup>114</sup> None of the midwives interviewed in this study suggested that they were contemplating this, but they frequently commented on the extra

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<sup>113</sup> NHS for England, 2015, *op.cit.*

<sup>114</sup> Leversidge, A. 2016, "Excessive workload causing midwives to leave the profession", *Midwives*, 19:4 19

work they had carried out to ensure that women affected by charging continued to access maternity care. Indeed their responses testified to their commitment and responsibility to all the women in their care.

All the midwives interviewed for this study had considerable experience of working with migrant women, and a strong commitment to ensure that they received all the maternity care necessary for them even if it meant working beyond their hours. There is a risk that midwives with less knowledge and experience would not recognise the additional needs faced by migrant women who are charged for their maternity care. Consequently, in some cases, the deterrent effect of charging could result in more adverse pregnancy outcomes for such women.

### *Ethical and professional dilemmas*

Above all, this study has shown that the penetration of the Home Office into health care has created ethical dilemmas for midwives in carrying out their normal professional duties. This was clearly shown in Section 4 in the discussion of how the booking appointment and history taking, important and routine aspects of maternity care, acquire new meaning when the information gathered can be used as a basis for charging women who are poverty-stricken and vulnerable. The established practice of midwifery involving understanding women's circumstances could result in women becoming fearful and suspicious of their midwife.

Some midwives felt that charging made their role ambiguous and forced them into acting as Home Office enforcers rather than health professionals. For some, asking questions about a woman's background felt discriminatory, but failure to provide requested information to Overseas Visitor Managers could put midwives at risk of sanctions. While traditionally midwives' duties have always lain with their responsibility to the women in their care, overseen by senior midwives, now they face a possibly conflicting duty to the Overseas Visitor Manager and the charging regime.

Many midwives said that their initial response was to distance themselves from having any involvement with charging. However, they realised that this is not possible if they are to carry out their advocacy duties. It became clear to a number of midwives that even though they wanted no role in the charging procedures, they needed to inform themselves about the charging rules in order to be able to help women in their care in various ways.

Many of the midwives interviewed in this study knew about local services which were available to migrant women who were charged, but even these did not address all the needs which the midwife might identify. While it is clearly essential to know what services are available to help a woman who may be destitute or has experienced domestic violence, it is also important to know her eligibility for particular services and this requires an understanding of her immigration situation. For example, undocumented homeless women are excluded from virtually all state housing support. Without knowing a woman's immigration status, a midwife would have difficulty making an appropriate and speedy referral.

### *A way forward*

This is an early study in how a particular group of health professionals cope with their roles in a divided NHS, a division for which few have had training, and which conflicts with the declared principles of the NHS. Yet many health professionals are already alarmed at the implications of charging rules for their practice as NHS clinicians.

The experience of midwives is central to these concerns. Women are not required to pay in advance for maternity care, yet are nevertheless deterred and, at the very least, deeply anxious about how they will repay their bills, and the consequences of not being able to do so. This situation has created conflicts, contradictions and dilemmas for midwives in their duty of care to pregnant women and women giving birth. It is likely to create similar or worse dilemmas for other health professionals whose patients are required pay in advance.

The midwives interviewed gave a great deal of thought and effort to mitigating the impact of charging on the women in their care, but overwhelmingly they conveyed the view that charging limits their capacity to carry out their professional obligations.

This study shows that the division of the NHS into free treatment for the eligible and punitive charges for the 'ineligible' not only has a detrimental effect on how patients engage with it, but also changes health professionals' relationships with their patients. This is particularly damaging in the case of maternity care, despite its 'immediately necessary' status, as creating a relationship of trust is absolutely central to midwives' roles.

It is for these reasons that in our recommendations in the next section we advocate an immediate cessation of charging for maternity care. Recognising that this is unlikely to happen in the immediate future we have made some recommendations which, in our view, if implemented, meanwhile mitigate some of the damaging effects of charging. These recommendations draw on those made in Maternity Action's earlier study of the impact of charging on pregnant women and new mothers, *What Price Safe Motherhood: Charging for NHS Maternity Care in England and its Impact on Migrant Women*.<sup>115</sup>

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<sup>115</sup> R. Feldman, 2018, *op.cit.*

## 7. Recommendations

### *Preamble*

This report has concluded that there is an irreconcilable conflict between midwives' duty of care as set out in professional midwifery standards and in relation to NHS principles and values, and measures required by trusts to identify chargeable women. In our view this conflict can only be resolved by ending charging for NHS maternity care. This is therefore our first recommendation. Other recommendations should be read as interim measures pending the full suspension of charging which may help to mitigate the negative effects of charging on both midwives and the women they look after.

#### 1. **Immediately suspend charging**

The government should immediately suspend charging for NHS maternity care given the deterrent effect on women's access to maternity care

#### 2. **Amend immigration rules to stop debts affecting future immigration applications**

The government should amend the immigration rules to stop debt from maternity care affecting future immigration applications as fear of being reported to the Home Office affects women's engagement with maternity services.

#### 3. **Improve data collection on charging practices and maternal outcomes**

Both the Department of Health and Social Care and NHS Trusts should regularly audit files relating to the treatment of women who are charged for their maternity care. This is to ensure that the practices of finance staff are in accordance with Trust policy and reflect the Trusts' obligation to reduce health inequalities. NHS Trusts should also regularly audit clinic attendance and pregnancy outcomes of all migrant women, noting whether or not they were charged. The MMBRACE-UK Confidential Enquiries into Maternal Death should include information on the immigration status of the women who died and whether or not they were charged for their maternity care.

#### 4. **Ensure Trusts take all measures possible to safeguard maternal and newborn health in administering cost recovery**

NHS Improvement's overseas cost improvement programme, which seeks to improve Trusts' overseas visitor identification and debt collection, must ensure Trusts take all measures possible to safeguard maternal and newborn health in administering Cost Recovery, and must commit to sharing and endorsing good practice where found.<sup>116</sup> It should work with those in third sector, midwives, and patient/women's groups to develop its best practice and case studies. It should monitor the health impact of its activities with Trusts in keeping with its other remit as the lead organisation for improving maternity and neonatal safety within the Maternity Transformation Programme.<sup>117</sup>

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<sup>116</sup> See <https://improvement.nhs.uk/resources/overseas-visitor-cost-improvement-programme/>

<sup>117</sup> See <https://improvement.nhs.uk/improvement-hub/maternity-and-neonatal/>

**5. Develop policy and practice guidelines on charging procedures to mitigate damage done to women**

All hospital trusts should develop policy and practice guidelines on charging procedures in order to mitigate damage done to women by charging for maternity care. They 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 care they need. The implementation and impact of such policies should be monitored and regularly evaluated. 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.

**6. Ensure all communications and actions treat women respectfully**

All trusts should ensure that all communications and actions relating to charging treat women respectfully and show an understanding of the particular inequalities and challenges they face. The central concern should be to not deter women from seeking maternity care, and to enable them to retain trust in their midwives and other clinicians.

**7. Do not assess chargeability by way of information collected as part of routine clinical care**

Finance staff should not assess migration status and chargeability by way of any information about women collected by midwives or maternity support workers as part of routine clinical care. The only exception to this is in the assessment of the application of Regulation 9(f) which applies to women who are survivors of violence or abuse. Before the Overseas Visitors Team issues an invoice for any maternity care, specific reference must be made to midwives' records regarding violence or abuse which a woman may have experienced, and her eligibility for an exemption under Regulation 9(f) should be assessed in every case. No other clinical information should be accessed. Medical records, both electronic and hard copy, must be laid out in such a way that OVM need only access this relevant information. Midwives are trained to identify cases of FGM, domestic violence and sexual violence and they have expertise in supporting vulnerable women and building high levels of trust and confidence. No further approaches are then necessary by OVMs in any circumstances to prevent re-traumatisation.

**8. Do not share any clinical information with the Home Office**

Finance staff must not share any clinical information or anything related to clinical information with the Home Office. It is important that midwives can build a relationship of trust with the woman.<sup>118</sup>

**9. Notify women in good time, with an opportunity for face-to-face discussion**

Trusts should notify women that they are chargeable in a timely fashion, with an opportunity for a face-to-face discussion about charging with the Overseas Visitor Manager and signposting to independent advice and support. Early notification will enable women to make informed choices

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<sup>118</sup> Department of Health and Social Care, 2019, *op.cit.*



about further action which they consider appropriate. A face-to-face meeting enables issues to be clarified.

**10. Set up transparent criteria for establishing inability to pay**

Trusts should set up transparent criteria for establishing inability to pay. These can be based on existing assessments of low income or destitution. Use of recognised eligibility criteria for low income or destitution would make charging decisions comparable and transparent, recognising certain groups' inability to pay charges.

**11. Provide an invoice that clearly states which payment level they have been charged for**

Women should be given an invoice that clearly states which maternity pathway payment level they have been charged for (standard, intermediate or intensive), for each stage of maternity care they have received (antenatal, intrapartum and postnatal). They should be shown the calculation of these payments by 150% to give the final amount owed.

**12. Invest in more community midwifery services that conduct outreach with recent migrants and women with little or no English**

Trusts should invest in more community midwifery services that conduct outreach with 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. Interpreting services should be provided routinely if a woman is unable to communicate satisfactorily with midwives or other clinicians. It is inappropriate to use family members as interpreters, particularly children. Wherever possible, interpretation by a female interpreter should be offered, particularly in cases where there is a context of FGM, sexual or domestic violence. NHS Trusts must commit to translation and interpretation services for all Cost Recovery information conveyed to women.

**13. Be mindful of the obligations contained within the NMC and GMC codes of practice**

Trusts and Overseas Visitor Teams should be mindful of the obligations contained within NMC and GMC codes of practice, such as the duty to act as an advocate for the vulnerable, and should not require midwives to act in ways which will bring them in to conflict with their professional ethics.

**14. Be mindful of the ways in which charging for NHS maternity care undermines efforts to optimise care for disadvantaged migrant women**

Midwives and others should be mindful of the ways in which charging for NHS maternity care undermines efforts to optimise care for disadvantaged migrant women. Specialist midwives should receive training about charging for NHS maternity care which enables them to support access to maternity care by vulnerable migrant women and identify cases where one of the exemptions applies, but this does not mean that they are responsible for implementing the charging regulations.

## 8. 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 or under Article 15c European Qualification Directive. 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 exempt from NHS charges for 'overseas visitors'.

### *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 is where a woman books for 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.

### *Complex social factors*

The National Institute for Clinical Excellence (NICE) has used the terminology of 'pregnant women with complex social factors' to refer to women whose social situation might impact adversely on the outcomes of pregnancy for them and their baby. They thus distinguished social problems or disadvantage from additional health problems which could complicate a pregnancy.

### *Community midwives*

Community midwives work in the community and are based, for example, in GP surgeries and health centres. They also visit women at home, usually for up to 10 days after they have given birth. They often work as 'caseload' midwives to improve continuity of care. Community midwives also provide postnatal care for women who have been looked after during labour by hospital midwives.

### *Continuity of Carer*

Continuity of carer in midwifery is a model of care "in which women receive seamless care from a primary known midwife"<sup>119</sup> who will be her main carer throughout her pregnancy, labour and after the birth. This enables women and midwives to establish a relationship with each other in the course of maternity care.

### *Destitute*

The Immigration and Asylum Act 1999 deems an asylum seeker to be destitute if they or their dependant(s) do not have adequate accommodation or any means of obtaining it (whether or not their other essential living needs are met); or they have adequate accommodation or the means of obtaining it, but cannot meet their other essential living needs now or within the next 14 days.

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<sup>119</sup> Royal College of Midwives, 2018, Position Statement Midwifery Continuity of Carer (MCOC)  
<https://www.rcm.org.uk/promoting/professional-practice/continuity-of-carer/>

### *Dispersal*

Under the Immigration and Asylum Act 1999 and the Nationality and Asylum Act 2002, asylum seekers or refused asylum seekers requiring support and accommodation may be accommodated anywhere in the UK. The process of providing accommodation for asylum seekers outside of London and the South East of England is known as dispersal.

### *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. Women who have had female genital mutilation are exempted from costs for treatment for a physical or mental condition caused by it. It is not clear from the DHSC guidance how this should apply in antenatal care.

### *High-risk pregnancy*

A high-risk pregnancy is one in which physical or social or psychological factors place the woman, her developing foetus, or both at higher-than-normal risk for complications during and after the pregnancy and birth.

### *Hospital or clinic midwives*

Hospital midwives are based in a hospital obstetric, or consultant unit, a birth centre or midwife led unit, and they staff the antenatal clinic, labour ward, and postnatal wards.

### *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)*

The Immigration Health Surcharge (IHS) came into effect on 6 April 2015. The charge is paid as part of immigration applications by non-EEA nationals who apply for a visa to enter or remain in the UK for more than six months. Once the charge has been paid and the visa or application has been granted, individuals are entitled to free NHS treatment on the same basis as permanent residents, for the duration of their visa. Visitors and those with less than six months are not required to pay the health surcharge and are chargeable for any NHS care they receive.

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). Where the Immigration Health Surcharge has been paid, individuals are still required to pay for prescription charges, dental treatment and eye tests.

### *No Recourse to Public Funds (NRPF)*

The Home Office can grant Limited Leave to Remain in the UK with a 'no recourse to public funds' condition. The effect of the NRPF condition is that the individual will be unable to claim most welfare

benefits. This can include people on spouse visas, student visas, or with limited leave granted under family or private life rules.

### *Nursing and Midwifery Council (NMC)*

The professional regulator of nurses and midwives in the UK, and nursing associates in England, the NMC sets the education standards professionals must achieve to practise in the United Kingdom. Only those who have met their requirements may practice as a nurse or midwife, and once registered, nurses, midwives and nursing associates must uphold the standards and behaviours set out in the NMC Code. Where concerns are raised that a professional does not fulfil the standards in the code, the NMC will investigate and take professional disciplinary proceedings where appropriate.

### *Ordinary residence*

The residence test used by the UK to determine entitlement to free NHS healthcare is known as 'ordinary residence'.

The criteria for 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. Most non-EEA nationals cannot pass the ordinary residence test unless they also have Indefinite Leave to Remain. British Citizens, EEA nationals and those with Indefinite Leave to Remain who live overseas will not be considered ordinarily resident on their return to the UK unless they intend to 'resume properly settled residence'.

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.

### *Overseas visitors*

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

### *Overseas Visitors Managers*

Overseas Visitor Departments now exist in most hospitals. A designated Overseas Visitor Manager (OVM) is responsible for the department who oversee the implementation of the Charging Regulations. OVMs are responsible for identifying patients who are chargeable and those who are exempt from charging based on Department of Health and Social Care Guidance on implementing the overseas visitor hospital charging regulations. They may also have responsibility for delivering regular training and briefs on overseas visitors charging regulations and raising awareness with key staff in the front line.

### *Refugees*

A person is a refugee when their claim for asylum has been accepted by the UK government. If the government agrees that an individual who has applied for asylum meets the definition as set out in the Refugee Convention, that person will be 'recognised' as a refugee and issued with refugee status documentation in the form of a Biometric Residence Permit valid for five years. At the end of the five years, an application can be made for Indefinite Leave to Remain as a Refugee. People with refugee status are entitled to use the NHS free of charge and have access to the same benefits as UK citizens.

### *Refused Asylum Seekers*

Refused asylum seekers, also often referred to as ‘failed’ asylum seekers or ‘appeal rights exhausted’ (ARE), are those who have exhausted their appeal rights in the asylum process. Many refused asylum seekers fear that they will be in danger if they return to their country of origin. 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 accommodation and subsistence support known as Section 4 support. Pregnant women can usually only obtain Section 4 support after 34 weeks gestation.

In England refused asylum seekers are chargeable for all NHS secondary care including maternity care. A pregnant woman who receives support from the government under section 95 or section 4, will be exempt from charges for her maternity care. Pregnant women who are appeal rights exhausted can apply for section 4 once they reach 34 weeks gestation. The woman will be invoiced by the NHS Trust for any care received whilst she is appeal rights exhausted and not supported under section 95/section 4.

### *Royal College of Midwives (RCM)*

The Royal College of Midwives is the professional organisation and trade union dedicated to serving midwives and midwifery teams. It aims to: promote midwifery, quality maternity services and professional standards; support its members, both individually and collectively; and influence policy on behalf of members and the women and families they care for.

### *Specialist midwives*

In the context of this report specialist midwives have specialist knowledge and experience of looking after migrant women especially asylum seeking women, or other marginalised women such as those who are homeless or drug users.

### *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 and people who have entered without required documentation. Undocumented migrants do not have permission to work or claim benefits in the UK. They are chargeable for most NHS hospital care unless they fall within one of the exempt categories.

The Home Office may curtail a residence or work permit where an individual is in breach of their visa conditions. People in this situation are likely to be prohibited from working, or from receiving benefits.

### *Woman-centred care*

Woman-centred care is a widely accepted concept in midwifery which prioritizes the woman’s individual unique needs, as defined by the woman herself and strongly emphasises the woman-midwife relationship during the childbearing period enabling the midwife to help women make decisions based on their clinical need, values and preferences, on the research evidence and on the context of care.