Charging pregnant women for NHS care and the Immigration Act 2014

This briefing outlines how charging migrants for NHS care affects pregnant women, and how the new Immigration Act risks excluding even more women from maternity care.

The Immigration Act 2014 which has just passed into law will extend NHS charging to a much wider range of migrants than are currently required to pay. It also enables charging in areas of care such as Primary Care and Accident and Emergency which are currently free to everyone.

Charging rules, in place since 2004, have resulted in women being deterred from accessing timely maternity care, and even being wrongfully denied care. The new act does nothing to prevent this. Rather, Maternity Action fears that the health of migrant women and their babies will continue to be at risk. Restrictions on access to maternity care are likely to, perversely, create a need for more medical interventions, at much greater cost to the NHS.

Charging rules from 2004 to the present

There are no charges for primary care. Current rules state that people liable to pay must be charged for secondary (hospital) care if they are not ordinarily resident in the UK or do not belong to any exempted group. ‘Ordinary residence’ means ‘living in the UK on a lawful, voluntary and properly settled basis for the time being.’ Neither the duration nor purpose of such residence needs to be specified. Exempted groups include refugees, asylum seekers awaiting a decision, refused asylum seekers supported by the Home Office, full-time students, people legally working in the UK, most nationals of the European Economic Area (EAA) states and Switzerland, and some others. Non-exempted groups include refused asylum seekers who are not supported by the Home Office, visa overstayers, and migrants in breach of their visa conditions. Such groups are known as ‘undocumented’ or ‘irregular’ migrants.

Charges apply to all secondary care except for some exempted conditions, notably infectious diseases such as TB and sexually transmitted diseases including HIV. Testing and treatment for such conditions is not chargeable. The key exemption, however, is for emergency care provided in an Accident and Emergency department.

Most relevant to maternity care is the guidance for ‘immediately necessary’ treatment. This is treatment which, like emergency care, must not be delayed or refused for any reason. Nevertheless, it remains chargeable and patients liable for charging will be billed just as for any other chargeable treatment. NHS hospital trusts are encouraged to inform the Home Office about anyone with a debt to the NHS of over £1000, and this is likely to lead to visa extensions or other immigration applications being refused.

Maternity care is the only condition for which treatment is always classed as ‘immediately necessary’. This means that from the start of antenatal care until signing off after the postnatal check, women cannot be denied treatment. However, women receiving maternity care will still be billed for the care they have received, and failure to pay may result in disclosure to the Home Office followed by the immigration sanctions outlined above.

What charging means for maternity care

Health risks

Charges at the point of care create risks that women will not present to the NHS, will present late in pregnancy, or will be denied access because of
inability to pay. This can prevent midwives from identifying and treating health conditions early in pregnancy, in turn leading to significantly worse health outcomes for vulnerable migrant women, as illustrated in the following example from a practising midwife.

A woman who had experienced problems with her first baby was found to have high blood pressure during her second pregnancy. Her doctor wanted her to be admitted to hospital but she refused this because she was fearful about being charged for her maternity care. She had been charged for the care she received when she had her first baby.

She attended appointments with a midwife during her pregnancy but continued to refuse to go to hospital despite strong recommendations from the midwife and doctor that she do so. By the end of her pregnancy she was very ill and, when she gave birth, her baby was very unwell. The woman’s kidneys failed and she was admitted to the hospital’s Intensive Care Unit. She now requires long term dialysis.

The poor health of both the woman and her baby could have been prevented had she received the care that she needed earlier in her pregnancy. (Case study provided by midwife at a London hospital)

In this case, in spite of attending her antenatal appointments, fear of further costs deterred this woman from obtaining necessary in-patient care, leaving her with long-term health problems.

The 2007 CEMACH Report Saving Mothers’ Lives found that 10% of all maternal deaths between 2003 and 2005 were in women who could not speak English. Black African women, including asylum seekers and newly arrived refugees had a mortality rate nearly six times higher than White women. Two fifths of Black African women who died had either booked late or missed more than four antenatal visits and 10% had received no antenatal care at all. This compares with 98% of women overall who reported having booked with NHS maternity services by 18 weeks of gestation.

The CEMACH report showed that recently arrived migrant women may have poor overall health, underlying and possibly unrecognised medical conditions, including congenital heart disease, HIV/AIDS or tuberculosis. Some may have been subject to female genital cutting or mutilation (FGM), or are suffering psychological or physical effects of living in and fleeing from conflict zones. Late booking prevents proper planning for labour, screening and routine scans, reversal procedures for FGM, or timely implementation of multi-disciplinary health or social interventions if they are needed.

Women who have had FGM are significantly more likely than those without FGM to have obstetric complications and outcomes, especially those who have had more extensive FGM. Some of these may be prevented if FGM reversal has taken place. In a study of women who had had Type 3 FGM, over 85% opted for FGM reversal after becoming pregnant. Multiparous women who had FGM reversal had significantly lower rates of caesarean section than multiparous women from the general population. Multiparous women who did not opt for reversal were significantly more likely to have a caesarean section.

Health risks relating to charges for maternity care can also affect the baby and extend beyond the postnatal period.

A woman’s baby was admitted to the special care unit after she gave birth in hospital. She was invoiced for over £3,000 in maternity costs, an amount she was wholly unable to pay. She subsequently refused to attend follow up checks with her baby because of her fear of debt collectors, and that the hospital would use the appointment as a way to deport her.

**Undermining the relationship of trust with the midwife**

The principle of woman-centred care, has underpinned maternity care in the UK for over 20 years, emphasising choices in antenatal and postnatal care, and continuity of care. The philosophy behind midwifery-led continuity models is normality, continuity of care and being cared for by a known, trusted midwife during labour.” NICE guidance on caring for women with complex social factors emphasises the importance of developing trust with vulnerable women, and gives examples of specialist maternity services and strategies to enable this.

Such strategies consistently emphasise facilitating early booking, continuity of midwifery care throughout pregnancy, birth and postnatally, inter-professional and inter-agency collaboration, and provision of language and translation services, including extra time at antenatal appointments. Midwives working with vulnerable women report the need to build a trusting relationship if women are to feel secure enough to disclose personal details such
as experiences of trauma or abuse, which might be important to their maternity care.

It is impossible to build this kind of relationship if women avoid seeking maternity care because they are afraid of being charged, resulting in the midwifery role becoming one of crisis management rather than planned care.

**Cost savings to the NHS**

Undetected or untreated health conditions in pregnancy can lead to complex interventions at a later date if not identified during antenatal care. Such interventions, as well as the persistence of health problems because of late intervention can lead to significant costs for the NHS. For example, identifying and treating a urinary tract infection during standard antenatal care can prevent a woman developing pyelonephritis (infection of the kidneys), which can result in premature birth. Such a minor intervention could avoid over £50,000 in costs associated with treating a very premature baby.

Similarly, routine antenatal HIV testing, recommended to prevent mother to child HIV transmission, is likely to save the lifetime cost of HIV treatment for an infected child, estimated at around £300,000. It is estimated that 2% of children born to all HIV positive women between 2005 and 2011 became infected with HIV. This rate fell to less than 1% among women with diagnosed HIV infection. HIV prevalence in black African communities in England is approximately forty times greater than among the white population but nearly half black Africans with HIV are diagnosed late. In a study of people living with HIV in London, over half the black African women surveyed had insecure residency status in the UK. Routine antenatal testing is an especially effective way of preventing HIV transmission to a child among this group.

**Aggravating barriers to accessing maternity care**

Administrative difficulties, lack of knowledge about entitlements and being refused treatment are the most common obstacles currently faced by vulnerable pregnant women seeking to access NHS services. In addition, current rules for maternity care charging are complex and confusing and are poorly understood by migrant women and NHS staff, leading to the rules often being inappropriately implemented by hospital trusts. Research commissioned by the Department of Health suggests that as many as 30% of the people assessed by trusts were incorrectly classified, resulting in charges being imposed on people actually entitled to free care. The Immigration Act does nothing to clarify entitlements, and, under its provisions, even more women are likely to be deterred from seeking antenatal care by fears of immigration penalties if they incur a debt. Barriers to early booking are thus likely to remain and even to be increased.

A woman had become pregnant by a British man whom she met in her country of origin. She came to the UK on a six-month visitor’s visa. She developed complications with her pregnancy. Her baby had not moved for several weeks and no heartbeat had been detected. Clinicians at a hospital she visited told her that this meant that it was likely her baby had died, and that she would have to be induced, but the treatment would cost approximately £2,500. She refused treatment because she wanted to travel back to her own country in order to apply for a two-year spouse visa to live with her husband in Britain. A lawyer acting for her directed her to an international relief charity which ran a clinic staffed by volunteer clinicians but did not know the outcome of her case.

**Contradictions between NHS charging and maternity care policy**

Maternity care policies for some time have been increasingly concerned to address health inequalities and have set out mechanisms to ensure that the same standards of care should apply to socially disadvantaged or excluded women. For example, NICE guidelines relating to women with ‘complex social factors’ stress that such women have “may have additional needs” and set out “what healthcare professionals as individuals, and antenatal services as a whole, can do to address these needs and improve pregnancy outcomes in this group of women….As a minimum, all migrant women should be able to fully access the standard antenatal care package as outlined in the NICE Clinical Guideline 62 Antenatal care (2008). This means that for women with complex social factors, special measures needed to be put in place additional to the standards for routine care. This is to enable such women to access the same level of care as other women, and move towards achieving improved pregnancy outcomes.

Strategies to accomplish this have consistently emphasised identifying and reaching disadvantaged women early in pregnancy in order to facilitate early booking, continuity of midwifery care throughout pregnancy, birth and post-natally, inter-professional and inter-agency collaboration, and provision of language and translation services, including extra time at antenatal appointments.
Such policies are inevitably undermined when midwives and other healthcare professionals are actively prevented from treating the most vulnerable women. Although the ‘immediately necessary’ stipulation for all maternity care is supposed to ensure access, in practice, both women and healthcare staff are confused about eligibility, and women are still required to pay on completion of their care. As a result, this specification for maternity care has little value.

**Challenging the rationale for charging for maternity care**

**Maternity ‘health tourism’**

The government’s consultation exercise on charging for NHS care was particularly concerned with ‘abuse’ of the NHS by ‘health tourists’ and made specific mention of ‘maternity health tourism’ as a special category. For this reason, it refused to exempt maternity from charging despite strong support for this in the consultation, and even though it acknowledged that ‘a small number of countries’ exempt pregnant women from health charging.

However the evidence it cites for ‘health tourism’ is slim and the authors of its own research for its 2013 consultation themselves acknowledge that it is “based on judgments and little direct data.”

In the light of this, Maternity Action compared the UK’s present charging arrangements with those of other European countries, many of which make specific exemptions for maternity care, even though many categories of migrants are required to pay for health care generally. Most exemptions also cover emergency care or treatment and vaccinations for children.

In France, Belgium, Spain and Italy, the Netherlands and Portugal free care is not available to undocumented migrants, or only available under specified conditions. But in all cases these conditions include the provision of free maternity care. For example, in Spain, which recently restricted access to free healthcare for migrants without a residence permit, maternity and child care remain available free of charge. In 2008 the Swedish government passed a law excluding undocumented migrants from accessing the national health system. However, five years later, it restored access to emergency care, including maternity care and other sexual and reproductive health care to all undocumented migrants.

It is therefore improbable that, in the context of widespread exemptions for maternity care in these and other countries, that the UK is at significant risk of ‘maternity health tourism’.

**User fees**

The policy of charging migrants for health care has been driven by media and politically motivated hostility to foreigners using the health service, in spite of a lack of evidence for any significant health tourism. But the effect of charging is to introduce further ‘user fees’ into the British health care system where, already, charges for prescriptions and dental care deter people from collecting prescriptions or seeing a dentist who could help prevent further dental problems.

Ironically, the government supports international aid programmes designed to abolish existing user fees. Such support is often directed at maternal and child health services in order to reduce infant mortality in poor countries. The Department for International Development (DFID) has enabled the delivery of a range of interventions in Liberia including family planning, maternity and child health services, reducing perinatal mortality from 41 to 26 per 1,000 births in the five years since this programme began. A DFID report stated that “financial cost represents a significant barrier, and often the most important barrier, preventing the poor from accessing essential health services.” It is hard to reconcile this understanding with health care charges within the UK itself, which disproportionately target the most disadvantaged and vulnerable groups.

**Conclusions**

The proposals on health in the new act do nothing to allay fears of continuing risks to both individual and public health due to charging for maternity care. Charging for primary care and accident and emergency is particularly dangerous, as a majority of women access maternity care via a GP and such a policy would create further barriers to health care for vulnerable migrant women.

Maternity Action therefore calls for all pregnant women living in the UK to have access to free NHS care, including maternity care, primary care and accident and emergency services.

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1 Immigration Act, 2014, Part 3 Chapter 2, Sections 38 and 39
2 N. Kelley and J. Stevenson, 2006, *First Do No Harm: denying healthcare to people whose asylum claims have failed*, London: Refugee Council
10 J. Sandall et al., 2013, ‘Midwife-led continuity models versus other models of care for childbearing women.’ *Cochrane Database of Systematic Reviews* 2013, Issue 8.
