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Why it is unethical to charge migrant women for pregnancy care in the NHS

Abstract

Pregnancy care is chargeable for migrants who do not have indefinite leave to remain in the United Kingdom. Women who are not "ordinarily resident," including prospective asylum applicants, some refused asylum-seekers, unidentified victims of trafficking, and undocumented people are required to pay substantial charges in order to access antenatal, intra-partum, and postnatal services as well as abortion care within the NHS. In this paper we consider the ethical issues generated by the exclusion of pregnancy care from the raft of services which are free to all. We argue that charging for pregnancy care amounts to sex-discrimination, since without pregnancy care, sex may pose a barrier to good health. We also argue that charging for pregnancy care violates bodily autonomy, entrenches the sex-asymmetry of sexual responsibility, centres the male body, and produces health risks for women and neonates. We explore some of the ideological motivations for making maternity care chargeable, and suggest that its exclusion responds to rising xenophobia. We recommend that pregnancy care always be free regardless of citizenship or residence status, and briefly explore how these arguments bear on the broader moral case against chargeable healthcare for migrants.

Keywords Migrants; NHS; gender; women; pregnancy.

Word count 8817

BACKGROUND

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The National Health Service (NHS) in the UK was founded seventy years ago on the principle that all medical care would be free at the point of delivery for anyone in need. In recent decades, fears about "health tourism" have heightened amid rising xenophobia [1,2], and the UK government has accordingly sought to limit free health services to those who are "ordinarily resident," requiring that non-qualifying migrants are charged for their care. Two major changes have been implemented within the last few years. The first set of changes were introduced as a result of the 2014 Immigration Act, which restricted free NHS care to those who have resided in the UK for the last five years. Those who do not meet the residence requirement, but hold a visa, must pay the "Immigration Health Surcharge" of £400 per person per year, after which they may access NHS services without further charge. All other "visitors" are required to pay for each individual healthcare treatment. Nationals of the European Economic Area (EEA) pay the face-value cost of care,[i] non-EEA nationals are required to pay 150% of that sum. The second change, an amendment to these charging regulations, came into effect in 2017, requiring that chargeable patients provide payment upfront, i.e. *before* they receive treatment [4]. This change was designed to optimise cost recovery. NHS providers are now legally obliged to establish a patient's residence status and accordingly recover the cost of any agreed treatment prior to its provision [5].[ii] These duties are generally carried out by dedicated "overseas visitor managers" as part of an administrative and finance team.

Caveats apply to both of these changes, and these will be relevant to our arguments. First, charges for treatments are only demanded upfront if the treatment is "non-urgent"; the assumption being that in the case of non-urgent treatment, patients could return to their home country and access medical treatments there. "Immediately necessary" or "urgent" care is provided as needed regardless of status, and if the patient is found to be chargeable, fees are recovered afterwards,

[i] Holders of a valid European Health Insurance Card can access some additional services without charge [3].

[ii] It is important to note that although charging "visitors" for care is obligatory, the reality in practice is confused and the practical protocol yet to be standardised. It is common for patients to be given inadequate or incorrect information, and for some chargeable patients to be given care for free, while some non-chargeable patients are refused care or asked to pay [6].

or while they await treatment. Unpaid invoices are referred to debt collection agencies. If a non-EEA national holds a debt of £500 or more two months after treatment, their data must be forwarded to the Home Office, who are entitled to make use of that information in refusing that person's future applications to enter or remain within the UK [5].[iii]

The second caveat is that some NHS services are free to *everyone*, regardless of residence status. These are: primary care; medical treatment *in situ* within an accident and emergency department; services for particular communicable diseases (e.g. HIV, TB, and sexually-transmitted infections); family planning (excluding abortion care); treating the mental and physical effects of violence; and palliative care [7]. These services are free to all, presumably because it is deemed to be infeasible and/or inhumane to ask a person to return to their home country in order to be treated, and/or because the ailment poses a risk to others if left untreated. Primary care is necessary in order for a person to ascertain whether their condition requires further medical attention, which could determine whether or not they travel home. Access to emergency care recognises that in the case of an emergency a person must be treated without delay. Treating communicable diseases contains the risk of spread to the local population, which could lead to further costs.

The potential to travel "home" for treatment appears to be critical to the division between free care and chargeable care. Indeed, doctors are encouraged to "stabilise and discharge" patients wherever possible, i.e. provide the minimum level of treatment that is required to discharge safely, on the assumption that the patient will seek further care elsewhere. If a medical condition is life-threatening, it needn't be treated immediately unless it is "immediately life-threatening"; likewise, preventing damage to the patient is not required unless "serious damage" is likely [5]. "Immediately" and "serious" are never rigorously defined. Further, this distinction relies on a false dichotomy between those who have access to free non-urgent healthcare in the UK and those who can return to their countries of

[iii] In Wales, this can data can only be shared with the patient's signed consent and this information does not include the patient's home address.

origin for non-urgent care. It wilfully neglects the needs of the more than half a million undocumented migrants who spend many years in the UK without access to free healthcare, yet who cannot (easily) return to their countries of origin for treatment, and are often destitute and therefore unable to pay for care [8]. It also ignores the fact that many people in the UK do not have any reasonable recourse to treatment in their home country, due to the inability to return safely, the inability to pay, or the lack of adequate services there.

Changes to the provision of care for migrants has been met with condemnation by many medical professionals, whose concerns are multifarious: that those in need will be deterred from seeking medical care; that clinicians are already over-stretched; that establishing a patient's status is not straightforward; that the bureaucratic costs will outweigh the savings; that the changes are ideologically-motivated; that racial profiling will be encouraged; and that the Home Office will misuse data [9–12].

These progressively more restrictive changes have been introduced under the guise of economic frugality, in response to the widespread myth that the NHS loses significant sums through health tourism, i.e. people visiting the UK with the intention of making use of a free medical service. Of course, resources *are* scarce in any publicly-funded health service, but distributive justice can be realised in more ethically defensible ways, by e.g. shifting the ratio of money spent on upstream versus downstream interventions. In any case, the claim that the health service is threatened by health tourism is not borne out by the data: health tourism amounts to at most 0.3% of the total NHS budget [13], while the bureaucratic cost of implementing these restrictions is almost certainly higher than that sum [14]. Consider that in 2016, under the previous charging regime, £50,000 was recovered from chargeable patients at a hospital in Hampshire [15], but financing the overseas visitor management team cost almost five times as much, at £231,000 [16]. It seems implausible that the new upfront charging regime could lead to the five-fold increase in recovery that would render the system cost-effective.

The anticipated financial benefit of the new charging regulations is based on a paucity of evidence and does not take into consideration the secondary financial effects of deterring people from seeking health-care until they develop complications. Indeed, investigative journalists have found that important details have been omitted from the government's calculations, notably, the additional pressure placed on accident and emergency services (which remain free for all) by those attempting to avoid charging, or those whose conditions have become critical in their attempt to avoid the cost of treatment [17]. The government itself grants that its "Cost Recovery Impact Assessment" is based on data which is "incomplete or inconsistent," making "broad assumptions" [18], and has admitted that it has not attempted to gather data regarding the number of people who are chargeable, which is presumably essential to generating a realistic estimate [17]. Whatever the real figures are, it is significant that the government has introduced a system which impacts the health of many without having any reliable sense of its cost-effectiveness. This seems to suggest that other, non-economic, considerations are at work, a point we return to in section 3. Regardless of any of these factors, one may ask whether it is morally consistent to charge *anyone* for their care, health tourist or otherwise, when the NHS relies so heavily on health workers from abroad whose training was subsidised by the taxpayers of other nations [19].

In this article, we are concerned with the exclusion of pregnancy care from the raft of free healthcare services available to all. By "pregnancy care" we mean all care that relates to the period before, during, or immediately after a pregnancy, whether it be to facilitate a pregnancy or to terminate one. Pregnancy care is chargeable for migrants who do not have indefinite leave to remain in the United Kingdom. Various groups of women, including visitors to the UK, prospective asylum applicants, some refused asylum-seekers, [iv] unidentified victims of trafficking, and undocumented women are required to pay substantial charges in order to access antenatal, intra-partum, and postnatal services as well as abortion care within the NHS.[v] We argue that charging for pregnancy care violates the Equality Act 2010

[iv] Not that in Scotland and Northern Ireland, refused asylum seekers are not chargeable.

[v] Given that (a) there were around 618,000 undocumented people in the UK in 2007 [7], a figure which covers just one of the categories listed above, and which is likely to have since risen, and

in relation to the protected characteristic sex, since without free pregnancy care, sex may pose a sex-differential barrier to good health. We also argue that charging for pregnancy care violates bodily autonomy, entrenches the sex-asymmetry of sexual responsibility, centres the male body, endangers the health of women and neonates, and leads to a range of inconsistencies. We explore some of the ideological and biopolitical motivations for making maternity care chargeable, and suggest that its exclusion responds to rising xenophobia. We recommend that pregnancy care always be free regardless of citizenship or residence status, and briefly explore how these arguments bear on the broader moral case against chargeable healthcare for migrants.

This article is structured as follows. In section 1, we outline the current situation for non-visa holding migrants who are pregnant. We critique the government's equality analysis in relation to the charging regulations, explore the effects of charging on pregnant women, and show that charging for pregnancy care is a violation of the 2010 Equality Act. In section 2, we give additional arguments for pregnancy care being free for all women, focussing specifically on sex-asymmetry, bodily autonomy, and health risks. Section 3 explores the ideological reasons for charging for pregnancy care, and challenges the broader logic of charging migrants for healthcare. Section 4 concludes.

1. PREGNANCY CARE FOR MIGRANTS

The guidelines around eligibility to free healthcare during pregnancy are complicated, and most non-citizens need guidance in unpicking them and establishing their eligibility [6]. In brief, a woman[vi] who is not ordinarily resident may see her general practitioner or be seen in the event of an emergency without charge, but is required to pay for care before, during, and after birth, for any additional non-urgent specialist care that may be needed, or for a termination.

(b) that women of reproductive age constitute around a quarter of asylum-applications in the UK [19], a lower bound on the estimate of the number of affected women is around 154,000.

[vi] While we use "woman" in the interest of conciseness, and in line with the literatures we draw on, we recognise that "woman" is a gender term, corresponding to a social category, and that trans-men and non-binary people may also become pregnant.

As it stands, the cost of pre-natal, intra-partum, and post-natal care in the UK for those from within the EEA is £4706.71, and £6993.63 for those from outside the EEA. Terminations cost £910.70 and £1353.19, respectively [4]. Consider that undocumented people, whose care is chargeable, are unable to work legally in the UK, and are therefore obliged to depend on others, or are confined to low-paid jobs in unregulated sectors, often working for less than the legal minimum wage. Even if such a person was earning the minimum wage, the cost of pregnancy care would still amount to more than half a year's pay. It is important to emphasise that the cost of receiving treatment is only one aspect of the barrier to healthcare, the other major barrier is the threat of Home Office involvement if a debt is incurred which cannot be repaid sufficiently quickly.

It seems reasonable to assume that as charging regulations for migrants using the NHS has become more stringent, the potential for discrimination and unfairness towards service-users has increased, both because the changes are themselves problematic, and because their implementation produces opportunities for failure. Yet one of the "overarching principles" of the Cost Recovery Programme was "not [to] increase inequalities – the Secretary of State has a duty to have due regard to the need to reduce inequalities relating to the health service. In developing these proposals we shall ensure the needs and interests of vulnerable or disadvantaged patients are protected" [20].

In 2015, the government, via its "Visitor and Migrant NHS Cost Recovery Programme" within the Department of Health, carried out an analysis [21] of the effect of charges to overseas visitors in relation to the "protected characteristics" identified by the Equality Act 2010 [22]. The protected characteristics recognised within the Act are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. All public sector institutions (within which: healthcare services) have a duty to protect people from unequal treatment as a result of their membership within social groups defined by protected characteristics.

In this case, we are interested in two protected characteristics in particular: sex, and pregnancy and maternity. Remarkably, the government's analysis does not find that the charging regulations will have *any* serious impact on equality, or result in any discrimination towards groups described by protected characteristics. It even suggests that the regulations may have a positive effect by promoting "good relations between groups" [21]. Specifically, in its section on sex, the report notes that men and women are entitled to the same free NHS care, and that the only differences relate to free care relating to female genital mutilation (FGM), "which by definition can only apply to women or girls," and care relating to sexual and domestic violence, which primarily affects women and girls. Interestingly, it does not mention pregnancy, which is presumably just as limited to women and girls as FGM is. Its section on analysing equality in relation to pregnancy and maternity is baffling in that it makes no reference to sex or gender, and instead merely reiterates the commitment to charging for these services, conceding that since pregnancy involves "significant risks to both mother and baby," charges may be recovered afterwards, rather than upfront.

Why FGM and domestic violence are considered to be legitimate grounds for providing free healthcare, while pregnancy is not, is not spelled out. FGM and domestic violence may be described as forms of torture, but so too can being unable to end an unwanted pregnancy. Indeed, the 2013 report of the United Nations' Special Rapporteur on Torture described violations of reproductive rights as forms of torture, including: "denial of legally available health services such as abortion and post-abortion care" as well as "violations of medical secrecy and confidentiality in health-care settings" [23]. Depending on one's interpretation, the UK government may be guilty of both with respect to migrant women.

Given that migrant women are often destitute and unable to work, they are more likely to turn to transactional sex in exchange for money or accommodation on their way to the UK or within the UK [24,25]. Pregnancy can therefore become an occupational risk. Migrant women also experience high rates of non-volitional sex, which often goes unreported [26,27]. (It pays to note that rates of pregnancy occurring after rape are estimated at 5% in women of child-bearing age [28].) While

treatment for medical conditions that occur as a direct result of sexual or domestic violence are not chargeable, eligibility requires disclosure. The UN Special Rapporteur on Violence against Women (VAW) has criticised the UK's inadequate response to violence experienced by asylum seekers and migrant domestic workers [29].

In short, the government has not adequately considered the way in which charging for pregnancy care violates the public sector commitment to equality. In the next section, we offer several arguments for the inclusion of pregnancy care within those NHS services that are free to all.

2. WHY PREGNANCY CARE SHOULD BE FREE

In the following subsections we present a series of arguments against the exclusion of pregnancy care from the set of NHS services that are free to all.

2.1 Sex-asymmetries of risk and burden

Pregnancy is (generally) the result of consensual or coerced sexual intercourse between a man and a woman, either with the intention of becoming pregnant, as a consequence of omitting to use contraception, or of that contraception failing. Despite two parties being causally involved in the production of a pregnancy, there is a tendency across cultures to hold women responsible for pregnancies because of the logistical fact of their occurrence within female bodies. This tendency is evident in many ways. Consider that: all but one form of contraception involves intervention with a woman's body, rather than a man's; women are generally held responsible for ensuring that contraception is used; in many countries women must pay for contraception, which means there is also a financial asymmetry [30,31]. A similar asymmetry applies in the case of termination of pregnancy, where despite the pregnancy being the result of two people's actions, the woman is liable to be left with the physical, emotional, and financial consequences [32].

Since contraception is free to all within the NHS, one might argue that there is no reason for unwanted pregnancies to occur within the UK, and therefore no reason to provide the care needed as a result of unwanted pregnancy in migrants. Yet: (a) not everyone is empowered to insist on contraception use even if it is available [33,34]; (b) undocumented people are known to minimise interactions with healthcare providers to avoid indirect interactions with the Home Office, and may therefore struggle to access affordable contraception [35]; (c) contraception often fails; (d) not all sexual intercourse is consensual.

Point (b) is particularly important. Practically speaking, in order to access contraception, a woman must see her GP or attend a sexual health and contraception clinic. In the UK, everyone is entitled to register with a GP, but research conducted by Doctors of the World shows that one in five requests for registration are wrongly refused due to lack of understanding about entitlements by staff [36]. Subsequently, in the cohort under study, the average length of time spent in the UK before accessing primary health care was 5.9 years. In addition, a survey carried out by one of the authors shows that considerable confusion exists amongst sexual health and contraception staff regarding eligibility to free healthcare [Redacted].

The claim that one ought to rely on contraception is strongly sexed, because when contraception is not used or does not work, women necessarily bear the consequences, while men usually have some choice over how much and what kind of responsibility is taken. Pregnancy is by its nature a sexed experience; only those with a womb may become pregnant. But regardless of their chargeable status, women are made pregnant by other people (who may or may not be chargeable themselves), yet they are made to pay for the consequences of that pregnancy, since either abortion care or pregnancy care will be necessary. Given the inevitability of health-care needs in pregnant women, the steep cost of that care for migrants, and the fact that pregnancy is necessarily caused by the actions of two people, it seems unreasonable that many migrant women and girls live under the threat of a bill of several thousand pounds should they become pregnant, while the person who

impregnated them bears no equivalent consequence for his actions.[vii] This turns sexuality, which is an important part of most adult lives, into an incredibly high-risk behaviour for one sex only. Migrant women may well practice abstinence as a way of avoiding such an expensive consequence (though not all will have this option); men need have no such cost or worry. While it is true that sex always comes with risks, those risks need not be financial in nature, and it is not obvious that any person's sex life should be connected to health costs in this way.

Further, excluding pregnancy care from the services that are free for all entrenches the idea of the male body as the normal human body. Ignoring the risk of pregnancy—and the subsequent need for pregnancy or abortion care—when deciding which services are essential to an average person requires one to have conceived of an "average person" as male, and *ipso facto*, someone for whom the risks of sex are limited to sexually-transmitted infections, whose treatment is free for all. This is in keeping with the broader ways in which the male body is centred and universalised, and even statistically-normal female bodily experiences (such as menstruation and pregnancy) are treated as aberrant and negative [37,38].

In short, charging for pregnancy care unfairly affects women's sexual lives, and reinforces the idea that they alone must bear the consequences of sex.

2.2 Bodily autonomy

It is critical to a person's bodily autonomy that they are able to determine the uses of their body. This contention is central to arguments in favour of women's access to contraception and abortion, since an unwanted pregnancy may be seen as an unwanted use of a person's body, regardless of one's views about the moral status of the foetus [39].

[vii] While one might argue that UK law requires fathers to pay child maintenance in most circumstances, undocumented women are very unlikely to avail themselves of this right given their own legal status.

Migrant women are placed in a situation akin to that of women in the more than two dozen countries in which abortion is still illegal without exception [40]. While they face a *de facto*, rather than a *de jure*, barrier, this distinction is likely to be of little relevance when financial resources are scant. Even setting aside the cost of an abortion for a migrant woman, the aforementioned (real or presumed) risk of disclosure of one's details to the Home Office is likely to act as a strong deterrent, as it does for healthcare more generally [35].

It is also puzzling that both termination and continuation of pregnancy are chargeable. This traps pregnant women into a situation in which a significant charge will be incurred regardless of the choice that is made. This seems to demonstrate that the regulations are not attempting to incentivise a particular behaviour (i.e. not becoming pregnant while in the UK), but rather to create a situation in which all instances of conception end in payment. Whether or not it is directly intentional, the result is a hostile, punitive environment for the sexuality of migrant women. Further, it is significant that abortion, like maternity care, is a chargeable treatment, while contraception is not. This seems to commit to a particular view of abortion which is not shared by those who believe that abortion is a legitimate form of birth control.

Even if a woman does not have a legal right to live in the UK, to penalise her by creating additional barriers to the realisation of her right to bodily autonomy is an incongruous, disproportionate, and problematic form of retribution, which may have lasting effects in the form of unwanted children being born, or children being born into dire financial situations. Further, abortion is still highly-stigmatised, and any additional barriers may lead women to refrain from ending an unwanted pregnancy.

2.3 Health concerns

Given the steep cost of pregnancy care, there is the chance that a migrant who becomes pregnant may feel cornered into "free-birthing": undergoing pregnancy and childbirth without the advice, care, or presence of trained medical

professionals [41]. While the term is usually used to describe women who have access to medical care but spurn it (generally in search of a less medicalised experience), it may also be applied to those whose pregnancies are driven underground in an attempt to avoid incurring a hefty medical bill. In those cases, the person may place herself and her future child at medical risk, yet at the same time a decisionally-capable pregnant person is permitted to refuse care, so medical professionals cannot force a pregnant woman to engage with treatment [42].[viii]

It is well documented that migrant mothers have avoidable increased maternal morbidity and mortality compared to their UK-born counterparts, especially those who have recently arrived and those seeking asylum. A confidential enquiry into maternal and child health estimated maternal mortality in this group to be six times higher than for UK-born mothers [45]. This trend has also been noted elsewhere in Europe: pregnant migrant women experience worse pregnancy outcomes than their peers, with a 45% higher risk of low birth weight, 24% increased risk of pre-term delivery, and 50% increased risk of perinatal mortality [46]. A 2015 report by the Doctors of the World clinic in London showed that fear of charging is a significant deterrent to migrant women with insecure immigration status accessing antenatal care, which puts women and neonates at risk of pregnancy-related complications [47]. This also increases the transmission-risk of communicable diseases that are preventable with timely antenatal care. For example, avoidance of vertical transmission of HIV requires very careful management of pregnancy and labour [48].

Considering that those who do not qualify for free NHS care may fail to seek treatment for other health issues, or may decline referrals from primary care due to the cost of outpatient care, there is a risk that pregnancy will exacerbate existing health issues, or that the pregnancy will itself threaten the wellbeing of the patient if she is subsequently in a state of poor health. Concerns about eligibility, cost, and

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[viii] There are two additional limiting factors to consider here. First, under the Children Act, a pregnant woman may be referred to social services if an unborn child is considered to be at risk of "significant harm" due to birth choices, or non-compliance with medical treatment [43]. Second, the Nursing and Midwifery Order 2001 makes it unlawful for anyone other than a registered midwife or medical practitioner to attend a woman in childbirth [44].

Home Office surveillance are not the only barriers to care for migrants, who may also contend with cultural and linguistic barriers, poverty, and stigma [49].

Under the current system, migrant women expecting a complicated pregnancy are arguably better off refraining from seeking medical advice until an obvious emergency situation is reached, since care in accident and emergency departments is free. Such a decision may appear to be entirely rational for a migrant woman with limited funds, but may well put her life in danger, since there is a fine and unpredictable line between waiting for a medical emergency to develop, and not having left enough time for it to be safely resolved.

A recent report conducted by Maternity Action described pregnant women's responses to charging as "uniformly one of enormous stress", leading in many cases to anxiety and depression, and contributing to levels of postnatal depression that are already elevated amongst migrant women [25]. Anxiety and stress are known to contribute to pre-term birth and low-birth weight [50,51], sometimes causing health issues which persist throughout childhood and adulthood. These effects are particularly significant as they are likely to be exacerbated by the negative effect on birth outcomes as a result of racism, which many migrant women also experience [52,53].

Charging women for abortions, and linking their abortions to the Home Office, may lead migrant women to seek precisely the kind of "backstreet" abortion that the Abortion Act 1967 sought to prevent. Globally, around 10% of maternal deaths each year are the result of an unsafe abortion [54]. Failing to include abortion care within the health services that are free to all may lead to a rise in unsafe abortions amongst some of the UK's most vulnerable women.

2.4 Complexities

Even if one grants that only those who are ordinarily resident should be afforded pregnancy care, troubling inconsistencies arise. What if the father of the child is a UK citizen, or is legally settled in the UK? In that case, the child automatically

becomes a UK citizen [55], even if the parents' relationship (if any) is not recognised in law. That citizenship presumably applies from the moment of the child's birth. The care which is provided to the mother before, during, and after delivery is intended to safeguard her own health *and* the health of the neonate. Yet in this case the neonate is automatically entitled to free NHS healthcare by virtue of their citizenship. How much of the pregnancy care should therefore be provided for free, by virtue of the fact that it is directed towards the safe gestation and care of a UK citizen? Obviously the two sets of care cannot easily be disentangled, yet it does not seem acceptable for a non-citizen to be charged for a health condition caused by one citizen and leading to the production of another citizen.

This leads to another discrepancy. If an infant's mother is ordinarily resident in the UK, that infant will be gestated and born through a process that is free; if an infant's father is ordinarily resident in the UK, the same process is chargeable. Given the points made in the previous subsection, let us assume that there are additional risks to the health of a child who is born to a mother who is subject to a chargeable process. This seems to present a sex-asymmetry in citizenship rights: the child of a citizen who is a woman is favoured above the child of a citizen who is a man. So even if one believes that it is morally acceptable to favour citizens over non-citizens, there is a sex-inequality that seems insoluble.

More generally, it must be recognised that pregnancy care differs from other kinds of healthcare in a morally significant way, because it necessarily involves another life. Again, the services that are currently free for all cater to the needs of singular, atomistic patients: men, not women. Under ordinary circumstances, women do not need to interact with healthcare services as a matter of course. Yet (in the UK, at least) even well women undergoing uncomplicated pregnancies expect to have regular pregnancy care. That care is directed at the *pregnancy*, not the woman *per se*. It may be argued that pregnancy care is therefore primarily care of a foetus, including the environment necessary to its wellbeing. Indeed, in some jurisdictions, women are treated as foetal carriers whose full autonomy is temporarily suspended [56]. While that view may be unpalatable, if the women intends to carry the pregnancy to term, she clearly has some moral duties towards the foetus [57], and

her ability to discharge those duties is critically dependent on her social and economic situation. In this case, a migrant women's obligations to her foetus are impaired by the new charging regime. While one might argue that the multifarious costs associated with pregnancy affect many women in their ability to meet their obligations, migrant women are being specifically targeted as liable for additional costs, and those costs are related directly to medical care, rather than the more indirect social determinants of health and wellbeing. Further, data-sharing with the Home Office presents another barrier. In adjudicating the moral implications of the charging regulations, one must therefore ask not only whether the government's duties towards pregnant women are being upheld, but also what its independent duties are towards neonates, and how honouring these duties might necessarily confer certain health entitlements upon the mother. One must also ask whether medical professionals and pregnant women are able to discharge *their* duties [57], and whether the costs recovered can be claimed to offset the resultant moral distress.

While a person born in a particular jurisdiction does not necessarily become a citizen, clearly the state has responsibilities, some of which will fall to the health service. If the woman died in childbirth, or opted to (or was forced to) relinquish care of the child, the child would likely end up in the care of the state. As it is, the likelihood of the child acquiring citizenship is not insignificant, in which case the state may later be seen to have impeded the antenatal and neonatal care of some citizens. Whatever the child's future citizenship, limiting or restricting a woman's access to pregnancy care means limiting or restricting the first, highly formative healthcare that is offered to a person. The effect of restrictions may manifest as a longer-term health deficit in the eventual child, which seems an unacceptable outcome even if one believes that the mother has made poor decisions. This may be seen as a punitive measure which is inflicted intergenerationally, a move which seems unjustifiable given that the neonate did not choose to be born, or to be born under those conditions.

Other concerns arise in relation to abortion. The 1967 Abortion Act suggests that doctors approve an abortion where the pregnancy would likely cause injury to a

woman's mental health or the mental health of an existing child [58]. In practice, financial constraints are often cited as posing a sufficient risk in this regard. For chargeable pregnant women, the financial impact of childbirth is amplified, and is much greater than the cost of abortion. This may lead to the discomfiting scenario in which sympathetic doctors legitimately sign off the abortions of chargeable women not because either party believes that abortion is preferable to childbirth *per se*, but because it is a fifth of the price. This seems antithetical to the purpose of abortion, which is to optimise a woman's reproductive autonomy.

As noted in section 1, free NHS care is available to those who have undergone female genital mutilation. While it is undoubtedly important to provide for the specialist needs of such women, particularly during pregnancy, failing to provide free pregnancy care for migrants who have *not* undergone genital alterations might be seen to impose a penalty on migrants from FGM-prevalent communities who are in the process of abandoning the practice. This is a particularly important consideration given the broader discourse within which asylum-seekers' claims must be made legitimate according to "victim identities" espoused in relation to Western values [59,60].

Returning to the idea that chargeable treatments are generally those for which the patient is able to return to their country of origin for treatment, consider that pregnant women are discouraged from travelling during pregnancy. What if a woman discovers she is pregnant at a late stage, or if labour commences prematurely, and she is no longer able to travel home for treatment? Ought that to invalidate the presumption that the woman could travel home for treatment, and render care free? Or, conversely, what if a woman becomes pregnant while in her country of origin, or a country she is passing through, and then finds herself subject to chargeable pregnancy care in the UK? Is the jurisdiction in which the woman becomes pregnant, and her situation at that time, relevant?

3. THE ROLE OF IDEOLOGY IN CHARGEABLE CARE

Why is pregnancy care excluded from the set of NHS services that are free to all? The government has never given an explicit reason for its exclusion, but may argue (erroneously) that pregnancy is a planned or plannable life event, the onset of which leaves women sufficient time to return to their countries of origin for treatment, or that maternity health tourism is a significant economic burden. Certainly the latter is widely asserted in the tabloid press [61]. There have been no independent reports assessing the prevalence or cost of this phenomenon, and again, the sums recouped from charging are likely to be significantly overshadowed by the cost of antenatal, intra-partum, and postnatal morbidity and mortality, as well as neonatal complications as a result of barriers to accessing care.

Economic justifications tend to be a red herring in the debate about chargeable NHS care. There is a much more determinative ideological context, at whose root is the perception that the UK is, or soon will be, over-run with "foreigners," a misapprehension that is regularly endorsed by the tabloid press [62]. A key component of this myth is the idea that women come to the UK to give birth, even though *jus soli* birth-right citizenship has not been available in the UK since 1983. These days, citizenship is conferred if at least one parent is "ordinarily resident." Even so, amid rising xenophobia across Europe [63], the idea of the state providing free care to a migrant as she produces yet another "outsider" requiring yet more healthcare is an unwise move for a government prioritising electoral success.

Further, while citizenship, or entitlement to free healthcare, is not automatic, it can be obtained by applying for asylum, so that a currently chargeable woman may later obtain free care for herself and her child(ren). As such, there is presumably a desire to strongly discourage the "wrong" women from procreating, by imposing a biopolitical barrier in the form of a financial deterrent. This is fed by another myth: that migrant women have higher birth-rates than UK-born women, which has recently been shown to be false, drawing on data from across Europe [63]. Even so, like other European countries, the UK is undergoing a demographic crisis: future economic prosperity is threatened by falling birth-rates and the demands of an ageing population, and net immigration would likely bolster the economy [64]. Yet again, economic factors pale beside nationalist considerations.

It is surely all of these populist concerns, stemming from widespread xenophobia, that have driven the government's determination to charge for pregnancy care despite its patent violation of the 2010 Equality Act, and the enormous burden it places on migrant women. In acceding to these concerns, the government reinforces them; charging migrant women for their pregnancy care entrenches the idea that their intentions are dishonest and that free care would pose a threat to the nation, economic or otherwise. Even if the government did not "intend" to cause harm to migrant women and neonates, there was undoubtedly an intention to avoid the backlash if they *had* included pregnancy care as a non-chargeable NHS service. It is testament to the current political climate how easily the reader will imagine the headlines in that counterfactual world.

Regardless of the strength of the justification for charging for care, clearly the empathy that is extended to pregnant migrant women has been suspended or limited. This seems concerning, because even setting aside sexist discourses which insist upon "women and children first," it *is* inarguable that pregnant women and their neonates have specialist needs vis-a-vis their health and wellbeing, migrants particularly so. The charging guidelines place women, who are invariably the sole or primary carers for their infants, in a more financially precarious situation at a time when they have new care-giving responsibilities which necessarily require additional resources. This demonstrates a more general disregard or denigration of care and motherhood, and the conditions that are required to reproduce healthy people. Perhaps most importantly, this suspension or withdrawal of empathy for an obviously indigent group may be taken as a litmus test for the dwindling empathy towards migrants as a whole, and sets the tone for the current "hostile environment" [65] by pushing the Overton window of compassion towards migrants downward. For this reason, particular moral attention should be paid to this particular feature of the new charging regime.

In this paper we have focussed on the moral implications of charging for pregnancy care. What of the broader question of whether or not other NHS services should be chargeable? There is much to be said about the ethics of charging for healthcare

more generally, namely, it is morally inconsistent given the service's reliance on migrants, it violates the principles of the NHS, it is very likely not cost-effective, and it poses risks to public health as a whole [19,66,67]. Moreover, charging on the basis of citizenship or residence does not fit with our moral intuitions, since not all citizens contribute to the healthcare budget, while many non-citizens do. We therefore do not intend for our arguments to imply that if pregnancy care were to be made free, there would be no problem with the current charging guidelines. When we argue that pregnancy care should be removed from the set of chargeable services, we do so on the understanding that other arguments can and will be made as to why charging for any essential health service is not ethically justifiable.

Pregnant migrant women are vulnerable by virtue of their need for medical advice and intervention, but so are *all* people in need of medical care. People do not choose to require healthcare, it is not a luxury or amusement, and that fact is not changed by citizenship or residence status. Moreover, the NHS is already a "lean" system in that it does not offer free services that are non-essential for health and wellbeing, and offers good value for money compared with other health systems globally, meeting the same quality of service despite spending a smaller fraction of its GDP [68] [69]. It offers only what is needed, and ought to be able to do so to *all* those in need. If the government considers the NHS unable to meet this demand, it might reflect on the limiting effect of its own austerity measures. As a proportion of national spending, NHS funding has been cut over the last decade [70], as have other forms of welfare, leading to additional pressure on the health service [71]. It might also consider the two to three billion pounds spent each year on employing agency staff at higher rates of pay to address serious staffing issues [72,73], and focus on reforms which incentivise healthcare training and improve recruitment and retention of staff. Charging migrants may seem like a shrewd political decision against the backdrop of rising xenophobic populism, but it makes little sense from an economic perspective, and is ethically indefensible.

4. CONCLUSION

We believe that there is no moral justification for excluding migrants from accessing free NHS healthcare of any kind, especially within a healthcare service that has always been critically dependent on migrant workers [19]. Yet it is particularly morally troubling to leave pregnant women and neonates without free medical care. Charging for pregnancy care places unfair risks and burdens on women, undermines a woman's right to bodily autonomy, and endangers the health of women and neonates. Further, under the current system, charging is never a lone threat. Given the current guidelines around reporting debt to the Home Office, making a service chargeable means risking the surveillance of the patient, and jeopardising their future in the UK. Migrant pregnant women face multiple burdens, some of which could be relieved if pregnancy care was free and confidential for all women.

More broadly, we recommend that all medical care be insulated from ideological influences, and that the NHS answer only to the function of providing healthcare to all those within its jurisdiction, as dictated by their need, and independent of their citizenship or residence status. After all, that would be a return to its original pledge in 1948, that it: "meet the needs of everyone […] be free at the point of delivery […] be based on clinical need, not ability to pay" [74].

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