# **Charging for NHS Maternity Care Report**

# **Situation**

Following the findings from a report based on Romanian Women’s Experiences of Accessing Maternity Care in Leeds, it became evident that some women’s access to maternity care in the UK was impacted by fears or the reality of NHS charges if they did not have EU Settlement Status. There is thus a need to dismantle the NHS charging process to equip maternity staff to discuss guidance and best support women who are liable to be charged for their care.

This report examines how and when women are charged for NHS maternity care and what measures can be taken to encourage women to continue engaging with services using a ‘situation, background, assessment, recommendations’ (SBAR) format.

# **Background**

The NHS Migrant and Visitor Cost Recovery Programme (‘the NHS Charging Programme’) was established in 2004 to charge those who are not ‘ordinarily resident in the UK’ (*see Appendix A*) for their NHS Care in England to limit their access to healthcare and prevent ‘health tourism’ (Maternity Action, 2021). It is widely documented that the NHS Charging Programme forms part of the ‘hostile environment’- a set of policies aimed at making life unbearable for undocumented migrants living in the UK (The Joint Council for the Welfare of Immigrants, 2020). Since the Charging Programme was extended to include some of the most vulnerable people living in the UK, there has been a national call for NHS charging policies to be abolished by Parliament, to protect people at increased risk of the poorest health outcomes in the UK from associated harm. Despite this, the NHS Charging Programme remains active, affecting population health and standing in stark opposition to the NHS Core Values within the Constitution (Department of Health and Social Care, 2023b).

# **Assessment**

A literature search was performed to explore how women and midwives are affected by the NHS Charging Programme. Guidance on charging regulations was studied to provide an overview of who is exempt from NHS charging and proof needed to prevent women from being charged incorrectly. The charging process remains convoluted and is often misunderstood by healthcare professionals and overseas visitor managers themselves (Feldman et al, 2019), so this report acts as a learning tool to disseminate to staff at Leeds Teaching Hospitals NHS Trust.

*Who are the women who are charged for their maternity care? (See Appendix B)*

It is some of the most vulnerable people living in the UK who are charged for their NHS care, including those on short term visas of less than six months, such as fiancée visas or some student visas; destitute asylum seekers whose claims have been refused (and not in receipt of government support); and other ‘undocumented migrants’, such as women who left an abusive relationship and were dependent on their partner for their immigration status (Maternity Action, 2021). These are the women who live at the margins of society, without the ability to work or claim benefits, let alone pay charges of thousands of pounds for maternity care. For example, the Maternity Action Care Access Advice Service (MCAAS) delivers specialised legal advice about NHS charges for maternity care and provides data about the demographics of the service users. In 2021, minority ethnic women made up 85% of women using the MCAAS. Of the 220 women that the MCAAS supported in 2021, 10% reported at least one form of gender-based violence, 85% had annual incomes below £10,000 and 40% of the women were single parents (Maternity Action, 2021). These cohorts of women are already disproportionately affected by the worst perinatal health outcomes in the UK (Knight et al, 2022) and there is evidence that the NHS Charging Programme contributes to these by exacerbating poverty, destitution and stress. Further contributing to poor mental health is the fact that women who have a miscarriage, stillbirth or termination of pregnancy are still charged for their NHS maternity care (DHSC, 2023a).

There is also evidence that NHS charging and data sharing are impacting on other patients from migrant or ethnic minority backgrounds. This is due to the complexity of the charging and exemption regulations, poor provision and/or lack of information for healthcare professionals on charging guidance (Nellums, 2021). This leads to inconsistent and inaccurate charges for some. Women who are entitled to free NHS maternity care therefore experience discrimination, inequitable care and barriers to accessing urgent care due to erroneous charges ([Bragg et al, 2019](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7895812/#bib10)).

*Undocumented migrants and the Immigration Health Surcharge*

The Immigration Health Surcharge provides those who come to live, study and work in the UK on a temporary basis (more than 6 months) with comprehensive access to NHS services (except assisted conception services) (DHSC, 2023a). This is regardless of the amount of care needed during a person’s time in the UK and including treatment for pre-existing conditions. Overseas visitors who are subject to immigration control and intending to stay in the UK for more than 6 months will usually need to pay the IHS as part of their visa application process.

According to Feldman et al (2019), 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. A woman may have entered on a short-term visitor visa to join a partner, but may have not been able to obtain longer leave, so overstays her visa. Similarly, some may have entered the UK on student or work visas. In some cases, undocumented migrants may have entered the UK without valid documents.

It is not uncommon for people to overstay their visas at present, as the fees for renewing residence permits have raised to extortionate levels, far beyond the rate of inflation (Glover and Barlow, 2014). For example, residence permit renewal can be more than £1000 and the Immigration Health Surcharge can be the same price; these fees are per individual, so adult or child (Feldman et al, 2019). It is therefore unaffordable for some people to remain in the UK legally, forcing them into destitution and a life of precarity.

*How women are charged*

Since 2017 NHS hospital trusts are required to ask patients for advance payment for an estimated charge for treatment, unless care is ‘urgent’ or ‘immediately necessary’ (Nellums et al, 2018). All maternity care is deemed ‘immediately necessary’ and must not be refused or delayed if a woman is unable to pay in advance (Maternity Action, 2021).

If the woman is chargeable for her maternity care, the Government’s guidance states that she should not be asked to pay any money towards her care until after the baby is born (Maternity Action, 2021). Before delivery, the NHS provider hospital will issue the woman with an invoice outlining how much the charges are likely to be, but no advance payment should be expected due to maternity care being classed as ‘urgent.’ The woman will then receive a final invoice informing her of the total charges after the baby is born. If the woman is unable to pay the charges in one instalment, she should be given the opportunity to speak to the local ‘Overseas Visitor Team’ at the hospital to arrange a repayment plan. Research has highlighted however, that there are significant inconsistencies in how chargeable patients are identified, notified, or charged across NHS Trusts and a lack of transparency about charging policies (Feldman, 2017). There have been numerous cases where women have been charged incorrectly, causing unnecessary stress (Feldman et al, 2019). Furthermore, women may not be notified about any maternity charges until years after delivery (Maternity Action, 2021).

The charges will depend on the care that has been accessed by mother and baby in community and hospital settings. Most chargeable patients are charged 150% of the standard tariff applied to normal commissioning. Maternity care is divided into antenatal care, birth and postnatal care; approximate charges for this standard package start from £7,000 for an uncomplicated pregnancy and birth. It is noteworthy that even if a woman has a miscarriage, stillbirth or termination of pregnancy, she will still be charged for her maternity care; a fact that has been widely discussed and contested within the media (Oppenheim, 2019) but with no Parliamentary amendments to such charging occurring.

*NHS reporting to the Home Office*

National Legislation on NHS charging states that the NHS is required to tell the Home Office about unpaid charges of over £500 which have been outstanding for more than two months (Department of Health and Social Care, 2023a). The NHS cannot inform the Home Office if the woman has an agreed repayment plan. Outstanding debt can therefore affect an immigration claim; a salient measure which exacerbates stress and destitution for certain women and their families already living in poverty (Jones et al, 2022). A key report on NHS Charges (Department of Health and Social Care, 2023a) highlights that the Home Office are not compelled to refuse an immigration application based on outstanding debt if there are compassionate circumstances or human rights considerations which would make a refusal disproportionate. There are no set criteria on what constitutes ‘compassionate circumstances’ however. Seemingly each application is therefore judged individually by the Home Office, without any standardised guidelines, which one could argue puts the current system under questionable equitability.

*Writing-off debt*

The Department of Health and Social Care (DHSC, 2023a) guidance confers the only discretion available to Trusts, which is to write off debt where the individual is destitute: *“Where it is clear that a person is destitute or genuinely without access to any funds, a relevant body can conclude that it is not cost-effective to pursue payment and write it off in their accounts. This is not a waiver nor extinction of the debt and the written off debt remains on the relevant body’s records and can be recovered”*. Proof of the woman’s destitution or risk of destitution must be submitted to the Overseas Visitor Team for considerations to be made (see Appendix C).

Writing off a debt does not eliminate the debt or prevent the Home Office being notified of that debt. The debt no longer appears on the Trust’s accounts and is generally no longer pursued by the Trust finance staff or debt collectors. The debt still remains however, and the NHS Trust can seek to recover the debt in the future, but Maternity Action (2021) claim that this does not appear to be standard practice amongst NHS Trusts.

Debts must be cancelled completely if the charges are found not to have been applicable in the first place; if a woman has been incorrectly charged, the Trust should withdraw the invoice. The effect is that the woman has never received an invoice. (Maternity Action, 2021).

*Health Policy Framework*

The charging policies must be viewed through the lens of the current wider health policy frameworks to fully comprehend the dichotomy between what maternity services are striving to achieve and how the NHS Charging Programme acts as an overwhelming barrier to safe, equitable care. The NHS is an organisation intended to improve health and wellbeing, guided by seven core principles (The NHS Constitution for England, 2015). However, Somerville et al (2009) argues that the Immigration System however, has been purposefully moulded as part of a system intended to create a hostile environment with a ‘deterrent effect’. Since the NHS Charging Programme was introduced, the two systems have become intertwined and health inequalities have intensified.

At the forefront of UK maternity care lies the national maternity safety ambition which has set a target of halving the rate of stillbirths, neonatal deaths and maternal deaths by 2030 (DHSC, 2017). It is widely acknowledged that tackling health inequalities through addressing the wider determinants of health is paramount to achieving this ambition; a standard which is further reiterated in recent policies such as Saving Babies Lives Version 3 (NHS England, 2023), the NHS Long Term Plan (NHS England, 2019) and the CORE20PLUS5 (NHS England, 2022) agenda. Migrant and asylum seeking women have long been recognised as having ‘complex social factors’ and thus a more targeted midwifery approach to improve their access and engagement with maternity care (NICE, 2010). This is because of the stark data from reports such as MBRRACE (Knight et al, 2022) which highlight that Black and Asian women are more likely to die during or after childbirth than their White counterparts and their babies are up to twice as likely to be stillborn or die neonatally (Draper et al, 2020). There is now increasing data on the direct link between NHS charging and maternal health inequalities. For example, Public Health England (2020) has identified NHS charging for maternity care as one of the key issues that intensifies poorer health outcomes for women and babies from Black, Asian and mixed ethnicity communities. The 2019 confidential enquiry into maternal mortality reported that 3 of the 209 women who died between 2015 and 2017 were affected by charging for NHS maternity care and ‘may have been reluctant to access care because of concerns over the costs of care and the impact of their immigration status’ (Knight et al, 2019).

On the one hand there is a recognition that women who are classed as ‘vulnerable’ require timely, individualised, sensitive maternity care, but on the other hand, the NHS Charging Programme deters these very women from attending for care for fear of being charged and being reported to the Home Office. This erodes women’s trust to the NHS and discourages them from accessing NHS services; the exact opposite to the core values embedded within the NHS and maternity services.

*NHS Midwives’ opinions*

A report by Maternity Action (Feldman et al, 2019) about midwives experiences of NHS charging further reiterates the dilemma that midwives face when caring for women who are chargeable for their maternity care. The role of the midwife is to be ‘with woman’ and act as an advocate for women to ensure safe, equitable care is provided. The report highlights that there is lack of knowledge about NHS charging policies and regulations amongst midwives, with them having little or no training on this subject (Feldman et al, 2019). This can lead to inconsistent advice and information being shared with women and midwives not being able to advocate for women who are charged for care; thus, undermining their ability to provide individualised, ‘woman-centred care.’ Midwives within the report also found themselves involved in the charging process regardless of whether they wanted to be. Midwives felt particularly uncomfortable that the details from their record keeping, such as women’s personal and social situations that were collected for the purpose of providing good care, were also used for the purpose of charging.

A key recommendation from the Maternity Action (Feldman et al, 2019) report was that midwives should access training on the NHS Charging Programme in order to assess women’s eligibility for free NHS maternity care; advocate for them if they are unable to pay the charges by signposting to relevant services; and increase confidence to liaise directly with local overseas visitor teams if they believe a woman has been incorrectly charged.

*The Effects of NHS Charging:*

*Deterring women from accessing care*

It is well recognised that maternity care should never by withheld due to inability to pay, but this does not mitigate against women not accessing maternity care for fear of being charged and suffering the repercussions that follow. There is a growing body of evidence to suggest that NHS charging is a contributing factor to women booking after the recommended 10 weeks gestation (Jones et al, 2022). The justification for encouraging women to book before 10 weeks is to ensure that the ‘three Ps’ that underpin public health- health promotion, prevention of ill health and health protection- are addressed in early pregnancy to improve outcomes in pregnancy and beyond (Griffiths et al, 2005).

Research from the Doctors of the World London clinic (Jones et al, 2022) in 2016 found that 2 out of 3 pregnant women had not accessed antenatal care by 10 weeks and 1 in 3 women had been deterred due to charging regulations. When analysing by region of origin, women from Sub Saharan Africa presented to book the latest, with only 38% attending before 16 weeks gestation (Jones et al, 2022). This mirrors the data from a local audit carried out in Leeds Teaching Hospitals NHS Trust in 2021-2022 where 48.1% of Black African women booked after 10 weeks. These women were from lower socio-economic backgrounds, living in index of multiple deprivation (IMD) decile 1 areas of Leeds- the top 10% of deprived neighbourhoods in England. A deep dive into these women’s immigration status and personal reasons for not booking before the recommended 10 weeks would be useful in determining if NHS charges played any role in affecting access to care.

Significantly, from the Doctors of the World 2016 data, the majority of women who accessed maternity care late had insecure immigration status, including asylum seekers, undocumented migrants and refused asylum seekers (Jones et al, 2022). This research is further supported by a paper by the Equality and Human Rights Commission (2018) which found that the charging policy has made healthcare ‘unaffordable’ for refused asylum seekers. The fear of charging acts as a deterrent to accessing maternity care, which consequently increases the risk of poor outcomes for the women who are already disproportionately affected by some of the worst perinatal outcomes in the UK (Knight et al, 2022).

*Mental Health Problems*

The link between women who are charged for their NHS maternity care and poor mental health has been widely discussed in literature (Feldman, 2018). Data from the Doctors of the World report (Jones et al, 2022) showed that despite women feeling supported by family or friends, mental health issues occurred in over a third of the women they were caring for, coinciding with the fact that over a third of the women were charged for their maternity care. The majority of the women who are charged for their NHS maternity care are the women who are most likely to face destitution, homelessness, deportation and additional health problems (Maternity Action, 2021). Such women are also more likely to suffer mental health disorders than the rest of the population. This may be attributed to the traumatic experiences from conflict or crisis situations before their arrival in the UK, or experiences of torture or sexual exploitation (Collins et al, 2010). The risk for developing perinatal mental health problems can be further exacerbated by the financial burden of charging, low-socio economic status, unemployment, language barriers and lack of understanding about how the NHS works (Feldman et al, 2019). The impact that stress and anxiety can have in pregnancy- such as low birth weight and pre-term birth (Maternity Action, 2021)- is well acknowledged by healthcare professionals, but as highlighted above, certain midwives find themselves stuck in the dilemma between wanting to provide holistic care and simultaneously being associated with the NHS Charging Programme.

*Domestic Violence*

Collins et al (2010) has found that NHS charging can increase women’s vulnerability to domestic violence. This becomes pertinent when a woman’s immigration status is dependent on a partner (for example, spouse visa) who may be abusive; if the woman leaves the relationship, she will also lose her entitlement to free NHS care (Maternity Action, 2021). This leaves the woman in a position of not being eligible for mainstream benefits, not being able to obtain a full UK Driving Licence or rent from private landlords, which can lead to destitution if she ends the relationship. Charging women in this situation increases their debts and leaves women with very few options to bring in an income, consequently forcing them into precarious situations of exploitation and risk (Maternity Action, 2021).

# **Recommendations**

* **Considering the inequity in outcomes and access to maternity care experienced by vulnerable, migrant women who are charged for their maternity care, abolishing the NHS Charging Programme could improve health equity for some of our most vulnerable women accessing maternity care at Leeds Teaching Hospitals NHS Trust.**
* Provide training for all midwives-especially the Specialist ‘Haamla’ team working directly with vulnerable women at risk of being charged, such as asylum seekers and undocumented migrants- on the NHS Charging Programme, including charging criteria, eligibility, exemptions and how to advocate for a woman who may have been incorrectly charged. Having a link person in the Overseas Visitor Team would be beneficial for midwives to liaise with about certain women at risk of being charged.
* Further local audit to examine the link between women who are charged (correctly/ incorrectly) for their NHS care and:
* book >10 weeks gestation
* experience poor pregnancy outcomes
* experience mental health problems (e.g., antenatal/postnatal depression)
* their personal experiences of the impact of the charges (through qualitative data)
* their personal experiences of how and when they were notified of the charges and whether this information was understood and anticipated (through qualitative data)

This evidence could then be presented the Overseas Visitor Office at LTHT to explore options for re-assessing how, when and under what circumstances women in Leeds are charged for their maternity care and the impact this has on their pregnancy outcomes.

* Liaise with the Overseas Visitor Team at LTHT to explore how and when they charge women for their NHS maternity care; eligibility for charging; exemptions for charging and how midwives can support women to submit evidence of certain exemptions (e.g., FGM, torture, domestic violence, destitution) and the process for repayment/ writing off debt/ challenging decisions to charge
* Revisit the Trust policy and practice guidelines on NHS Charging to ensure that information is concise; easily accessible for all staff within the CSU and has the health needs of migrant women and babies as the central focus of the document, as per the NICE Guidance on ‘Caring for Women with Complex Social Factors’ (NICE, 2010)
* Ensure all communications and actions treat women respectfully by offering cultural competency and anti-racism training to all staff within the CSU to highlight the inequalities that women from vulnerable groups can face when accessing maternity care and how the NHS charging programme can act as a barrier at times.
* Explore the possibility of linking with third sector/ community groups working with women who are recent migrants to encourage early booking and help to develop trust and confidence in maternity services. For example, linking with the befrienders at the Maternity Stream of the City of Sanctuary to support them to share information about:
* Preconception care (vitamins, cervical screening, vaccinations, accessing the Blossom Clinic for non-pregnant survivors of FGM)
* The role of a midwife and how maternity care is structured in the UK
* How and when to book with a midwife (giving them a direct link to Haamla if they meet criteria, to ensure continuity and build trust from the outset)
* NHS charges and where to signpost women to if more advice/support is needed (Maternity Action Care Access Advice Service)
* Their rights within maternity services (the right to interpretation services, the right to choice) to encourage self-efficacy
* Other local services such as free antenatal/ wellbeing/ ESOL classes to enhance social mobility.

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# **APPENDIX A- Who is EXEMPT from NHS Maternity Charges? (DHSC, 2023a)**

The NHS applies a test to determine whether women are ‘ordinarily resident’ in the UK and therefore entitled to free maternity care:

|  |  |
| --- | --- |
| **EXEMPTION** | WHAT DOES THIS MEAN? |
| **Lawfully resident in the UK****AND…** | * British citizens
* Individuals with a Right of Abode
* Irish Citizens
* EEA nationals who have Settled Status or Pre-Settled Status
* Non EU nationals who have Indefinite Leave to Remain in the UK
* Non EU nationals who have settled status or pre-settled status
 |
| **Living in the UK Voluntarily****AND…** | If you have chosen to live in the UK for the time being you will be ‘voluntarily’ in the UK.  The government guidance states: ‘*it will be rare for a person not to be in the UK voluntarily’.* |
| **Properly settled in the UK for the \*\*‘time being’ (evidence required as detailed below table)****AND…** | * You can be in the UK for one reason (for example your or your partner’s employment or course of study) or for several reasons.
* How long you have lived in the UK at the time you start receiving your NHS care is relevant, but there is no minimum period. You can, depending on your circumstances, be living for ‘settled purposes’ from the date you arrive in the UK.
* You need to intend to remain settled in the UK for the time being, but you do not have to intend to live here permanently or indefinitely
 |
| **If EEA national, Settled Status or Pre-Settled Status** | Applied through the EU Settlement Programme. If the woman is in the process of applying for Settlement Status, NHS charges are paused.  |
| **Granted Leave to Enter or Remain in the UK if Immigration Health Surcharge has been paid as part of an application to enter or remain in the UK** | Overseas visitors who are subject to immigration control and intending to stay in the UK for more than 6 months will usually need to pay the IHS as part of their visa application process. This is also the case for overseas visitors applying from within the UK to extend their stay, even if they are extending it by less than 6 months. |
| **Some ‘Vulnerable’ groups-** 1. **ASYLUM SEEKERS**
 | * ASYLUM SEEKERS: anyone who has made a formal application to the Home Office (for themselves and any dependants) to be granted asylum, temporary protection or humanitarian protection, the outcome of which has not yet been determined.
* Asylum seekers who have had their application rejected as a ‘fresh claim’ and have been granted appeal rights, will be exempt from charges
* they are supported by the Home Office under section 4 of the Immigration and Asylum Act 1999, because while making reasonable efforts to leave the UK, there are genuine recognised barriers to doing so
* failed asylum seekers who have dependants under 18, may remain supported under section 95 of the Immigration and Asylum Act 1999. Any failed asylum seeker or asylum seeker with an inadmissible claim receiving support from the HO in this way (eg, pregnant women **after 34 weeks gestation** are entitled to HO section 95 support if destitute)
* they are supported by a local authority under Part 1 (care and support) of the Care Act 2014 through the provision of accommodation. Eligible failed asylum seekers receive this support because they require care and attention (usually because of a disability) and are in an analogous situation to those receiving section 4(2) support under the Immigration and Asylum Act
* they are undergoing an existing course of treatment, which started before their application was refused. This course of treatment continues to be free of charge until it is complete, or the person leaves the country. This is also the case for anyone who ceases to be supported by the HO or a local authority as described above
 |
| **Vulnerable Group:****2. Refugees and their dependents** | * Includes: anyone who has been granted asylum, temporary protection or humanitarian protection under the immigration rules and anyone who has leave to enter or remain in the UK as their dependant. Charges incurred prior to a person being recognised as a refugee must be refunded or, if not yet paid, cancelled if they can demonstrate that they were in the UK for the purpose of making an application for asylum or protection under the immigration rules at the time of being provided the services
 |
| **Vulnerable Group:****3. Victims and suspected victims of modern slavery and family members** | * Includes: anyone who has been identified by the Single Competent Authority (SCA) through the National Referral Mechanism (NRM), as being either a suspected victim or confirmed victim of human trafficking, slavery, servitude or forced or compulsory labour. The exemption also covers their spouse or civil partner and any children under 18 (provided they are lawfully present in the UK), regardless of whether they have resided with the victim of modern slavery during the entire period of their stay.
* If the SCA determines that they are not a victim of modern slavery, the patient (and dependants) becomes chargeable from that point onwards, other than for courses of treatment already under way, which remain free of charge until complete, or the person leaves the country
 |
| **Vulnerable Group:****4. Children who are looked after by the local authority** | * This includes children who are voluntarily accommodated by a local authority, as well as those accommodated by virtue of a (court) care order, children who are unaccompanied or abandoned by a parent or guardian in the UK and children for whom there is no one with parental responsibility.
 |
| **Vulnerable Group:****5. Prisoners and detainees** | * Their exemption from charge applies for services needed during their detention and to an existing course of treatment that was started during their detention and continues after their release, until complete.
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| **Vulnerable Group:****6. Residents of Ukraine** | * Entitled to: all relevant services received on or after 24 February 2022, except assisted conception services.
 |
| **Vulnerable Group:****7. Treatment for victims of torture** | * Entitled to: services required to treat a condition directly attributable to torture, free of charge, provided that the overseas visitor has not travelled to the UK for the specific purpose of seeking that treatment.
 |
| **Vulnerable Group:****8. Survivors of Female Genital Mutilation (FGM)** | * Entitled to: services provided to a girl, woman or transgender man for the treatment of any condition, including a chronic condition or a mental health condition, that is caused by FGM, free of charge. This includes any maternity services (antenatal, perinatal and postpartum treatment) the need for which is caused by the mutilation. The exemption applies wherever and whenever the FGM was performed, provided that the overseas visitor has not travelled to the UK for the specific purpose of seeking that treatment.
 |
| **Vulnerable Group:****9. Treatment for victims of domestic abuse** | * Entitled to: any services – including mental health services - provided for the treatment of a condition that is directly attributable to domestic abuse are free to overseas visitors, provided that the overseas visitor has not travelled to the UK for the specific purpose of seeking that treatment.
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| **Vulnerable Group:****10. Treatment for victims of sexual violence** | * Entitled to: services provided for the treatment of a condition directly attributable to sexual violence, free of charge, provided that the overseas visitor has not travelled to the UK for the specific purpose of seeking that treatment. Treatment will include mental health services and maternity services needed because of sexual violence.
 |
| **Some specified personnel, including members of the UK armed forces and their**  | * Employee of the Crown, the UK government or NATO are exempt from charge for relevant NHS services
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\*\*The evidence that is relevant to prove you are ‘*properly settled in the UK for the time being’* will depend on your circumstances but could include evidence of:

* Your Passport OR
* If you are an EEA national, your Share Code, Settled Status or Pre-Settled Status OR
* If you are an EEA national and do not yet have Settled or Pre-Settled Status, you will need to provide your Certificate of Application to confirm that you have an outstanding application
* How long you have been resident in the UK – this could include your ticket to come to the UK, bank statements, utility bills.
* your accommodation – such as a tenancy agreement, mortgage statement, utility bills, council tax bills
* your and/or your partner’s employment – such as pay slips or an employment
* your or your partner’s enrolment on a course of study.
* a UK bank account
* a UK mobile phone contract
* registration with a GP
* your children attending school in the UK
* family members living in the UK
* connections with the UK, including previous visits – particularly if relevant to your decision to move to the UK.

# **APPENDIX B- Who is charged for NHS Maternity Care? (DHSC, 2023a)**

* Those who are not ‘ordinarily resident’ in the UK, or on the ‘exempt’ list (classed as an ‘oversea visitor’)
* Women who sadly have a miscarriage/ stillbirth/ termination of pregnancy have the right to care but will be charged if they are not ‘ordinarily resident’ or exempt from paying.
* Anyone who has had their asylum, temporary or humanitarian protection application and ALL appeals rejected becomes a failed asylum seeker. Failed asylum seekers and their dependants are charged for relevant services.
* If women are on dependant visas (eg. Spouse Visa) and leave their partner, they may be charged even though they are not able to claim mainstream benefits.
* Undocumented migrants- those who have overstayed work/ visitor/ student visas or entered the UK without any documents and have not claimed asylum.

# **APPENDIX C- Writing off charges due to Destitution (DHSC, 2023a)**

In some cases, the patient may be able to demonstrate that they are either destitute or likely to be destitute imminently.

The definition of Destitution according to Section 95(3) of the Immigration and Asylum Act 1999:

* a person does not have or is unable to secure adequate accommodation
* a person does have adequate accommodation but are unable to meet their essential living needs (which includes that of their dependants)

Imminent destitution refers to circumstances in which a person currently has adequate accommodation and can meet their other essential living needs, but there is at least one of the following pieces of evidence that:

* they will be destitute within approximately the next 3 months
* their living conditions, while not amounting to destitution, are not sustainable
* repayments would leave the applicant with insufficient funds to pay for accommodation and essential living needs

# **APPENDIX D- NHS Services which are always free (Maternity Action, 2019)**

The following services and treatments are exempt from charges, and are *free* for everyone that needs them, regardless of nationality, immigration or residence status:

* **Accident and emergency** (A&E) services up until the point that you are admitted as an inpatient (A&E services provided at an outpatient appointment are chargeable).
* **Family planning services** (not including pregnancy termination)
* Diagnosis and treatment of **certain contagious diseases** e.g. TB or HIV
* Diagnosis and treatment of **sexually transmitted infections**
* Treatment of ***any physical or mental condition* caused by torture, female genital mutilation (FGM), domestic violence or sexual violence** (as long as you did not travel to the UK for the purpose of seeking that treatment). If you have come to the UK to escape torture that does *not*mean you travelled to the UK for the purpose of seeking treatment
* Anyone in England, regardless of nationality or immigration status is entitled to **register with a GP** as an NHS patient and to receive NHS services provided by the GP free of charge. This applies even if you are chargeable for hospital treatment. GPs also have a duty to provide free of charge treatment which they consider to be immediately necessary or an emergency, regardless of whether you are registered with that practice.

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