# DISPLACING POWER FOR DISPLACED PEOPLE: THE INACCESSIBILITY OF MATERNITY CARE FOR UNDOCUMENTED MIGRANT WOMEN IN THE UK'S HOSTILE ENVIRONMENT

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**Abstract**

As part of the UK's hostile environment, a range of restrictive social policies have been introduced for undocumented persons, including NHS charging and data-sharing practices. Current policy dictates that all those not "ordinarily resident" within the state must pay for care at an inflated rate. While these charging practices are framed as tackling the exploitation of NHS services, the binary nature of "ordinary residency" equates genuine medical tourists with undocumented migrants, despite clear divergences in nature of residency. Subsequently, undocumented mothers face extortionate charges for accessing maternity care, while also risking their irregular status being shared with the Home Office, which would lead to their deportation. Alongside these direct barriers, undocumented women also face a range of indirect consequences within the hostile environment which impact their ability to access support, such as a lack of cultural literacy and alienation in medical encounters.

Through an analysis of existing literature, this article argues that charging undocumented women for antenatal support undermines their power over their own bodies and futures. Subsequently, this conceptual essay presents three policy recommendations to address this displacement of power. Firstly, the conditions for ordinary residency should be reimaged. Secondly, unconditional firewalls between the NHS and the Home Office must be introduced. Finally, more routes to regularity must be made available within the UK. These policy changes can alleviate current issues by returning power to the individual, through the greater practical accessibility of maternity care, enhancing maternal wellbeing and outcomes in the process.

**Keywords:** Undocumented migrants; Maternity care; Healthcare charging; Hostile environment; Firewalls

## 1. Introduction

Although restricting the rights of undocumented migrants pre-dates the 2010 coalition government, Theresa May's stated intention to make their lives unbearable sparked the creation of the 'hostile environment' within the UK. In an attempt to motivate the emigration of undocumented migrants, numerous restrictive social policies were introduced, many of which remain intact today, a decade after their initial implementation. While these policies span a range of social rights and liberties, the NHS has been continuously weaponised as a site for immigration control (Fauser, De Stefano and Fattorelli, 2022). More specifically, current policies restrict access to various forms of care, including antenatal support, for undocumented migrants. Although implicitly hostile, governments have largely cited fears of NHS exploitation as justification for this restricted access to healthcare, unfairly equating undocumented migration to medical tourism, with devastating consequences[1].

This article aims understand the extent to which charging and data-sharing practices displace power from undocumented individuals by analysing existing literature. Subsequently, this paper makes a conceptual contribution to the discussion of migrant rights, particularly presenting an argument for the reimagining of current policies to acknowledge the divergent characteristics of genuine medical tourists and undocumented persons. This article also discusses further barriers restricting access to healthcare, such as language barriers and cultural inflexibility, particularly focusing on antenatal support and the impact of charging and data-sharing practices on maternal and infant outcomes (Shahvisi and Finnerty, 2019). The decision to look at

[1] Although the NHS is devolved within the UK, these hostile practices operate largely uniformly across the various nations.

undocumented migrant women is not coincidental, as these individuals face disproportionate risks in birth due to their legal precarity, with claims to accessible and affordable maternity care arising from international human rights legislation, narratives of deservingness and theories of social membership. In recognition of these claims, this article will argue for the need to redefine "ordinary residency" within the UK. For this to be effective, firewalls must be upheld between the NHS and the Home Office, and further rights to regularisation must be introduced. Firewalls refer to the separation of public bodies to protect the data of individuals accessing support. As such, a reconceptualisation of current hostile environment policies is necessary to protect the rights of vulnerable social members and return power to undocumented migrants.

## 2. Direct barriers to maternity care

Direct barriers, also referred to as practical restrictions, are those which explicitly and formally displace power from the individual, by restricting access to a service. By contrast, indirect barriers can be understood as collateral damage from these initial constraints, leading people to feel and act as though their rights are restricted, even in instances where they are legally entitled to support. Although these barriers are faced by many social groups, including documented residents and even citizens, they will be discussed with reference to the example of undocumented migrant women, to exemplify impact of such barriers on health experiences and outcomes.

### 2.1 Charging and data-sharing practices

The first and most direct barrier to maternity care for undocumented individuals is the hostile environment policies themselves, which deter individuals with unaffordable costs and threats of self-incrimination (Poduval et al., 2015; Smith and LeVoy, 2016;

Rassa et al., 2023). The *2014 Immigration Act* introduced healthcare charges for those not "ordinarily resident" within the UK, that is, not residing in the state legally, voluntarily and with the intention of remaining within the state. While primary care remains free at the point of access regardless of immigration status, all secondary care is chargeable for these individuals at a rate of 150% of the original tariff (Office for Health Improvement and Disparities, 2014). Secondary treatment typically cannot be provided until paid for by the patient, however, maternity care constitutes an exception to this rule, due to its categorisation as "immediately necessary". Maternity care cannot be denied, delayed or withheld from any individual at the point of need, though all those not ordinarily resident will be charged *after* the fact (Maternity Action, 2017; Department of Health and Social Care, 2023). NHS maternity care packages start at £7,000 and can greatly increase in price if individuals experience birthing complications, which are particularly common among undocumented women (Greenfield, 2019).

To establish an individual's charging status, care providers must question the nature and length of their residency, and request documentation. This information is then reported to the organisation's Overseas Visitors Manager, who will persistently pursue patients for payment, which some have likened to harassment (Maternity Action, 2021). Where the majority of undocumented individuals are destitute, lacking the right to work or even hold a bank account, care becomes unaffordable, leaving NHS debts unpaid (Doctors of the World, 2022). In this case, an individual's status is shared with the Home Office, leading to the detection of their undocumented status, which can be held against them in future visa applications, or lead to their imminent deportation (Department of Health and Social Care, 2023). This displaces the power of

undocumented women, as they must either choose to access antenatal care, thus risking deportation, or choose to receive no support throughout pregnancy and remain within the state, albeit without documentation. Therefore, despite being upheld in policy, the *consequences* of accessing maternity care disincentivise the use of these services, making maternity care practically inaccessible for undocumented women in the UK's hostile environment.

## 2.2 The issue of "ordinary residency"

One could question why charging for maternity care is *ever* justified. The answer is that charging does not limit the interests of all individuals, as some are exercising rights *beyond* what they are owed. For example, genuine medical tourists have the ability to receive care within their country of residence yet voluntarily (and temporarily) migrate to seek it elsewhere, as motivated by reduced costs, improved support or even luxury recovery destinations (Johnston et al., 2010; Barclay, 2022b). Aside from being similarly perceived as less entitled to social rights than citizens, genuine medical tourists and undocumented migrants are fundamentally different. Despite this, neither of these diverging populations is viewed as ordinarily resident, meaning these differences are overlooked through the binary nature of this term in social policy.

### *2.2.1 Alternative motivations behind migration*

Only 3% of undocumented migrants treated by *Doctors of the World* quoted health as one of their reasons for migrating, and only 9.5% knew of their medical condition prior to travel (Chauvin et al., 2015). Furthermore, leaving the UK is not an option for undocumented migrants, as their financial status often makes travel unaffordable, while their legal status makes their return impossible (Nellums et al., 2021).

Accordingly, the use of a tourism narrative to describe undocumented persons is misleading, whereas it is fitting for genuine medical tourists, who are motivated largely by the luxury of international treatment and hold the power to decide where and when to receive such care. Despite this divergence, both genuine medical tourists and undocumented migrants are uniformly labelled as not ordinarily resident. Crucially, UK policy is not wholly unaware of motivation when considering one's right to accessible support, as even primary care may become chargeable if an individual has travelled to the UK with the sole intention of accessing this care (Department for Health and Social Care, 2023, p.18). However, such an appeal to motivation is only cited where it *enhances* restrictions rather than alleviates them, therefore, serving the agenda of the hostile environment. This unfair homogenisation of non-citizens constitutes a direct barrier to the accessibility of maternity care for undocumented migrants.

#### *2.2.2 Alternative modes of residency*

Furthermore, the binary nature of the term "ordinary resident" equates *undocumented* residency to a *lack* of residency. Whilst this label, therefore, works appropriately for tourists, who are often described as *visiting* a state rather than residing in it, the same cannot be said for undocumented migrants (United Nations, 2010). A "visitor" intends to return home after a short period, yet the term "migrant" holds no such promise, solely indicating a change in one's country of residency (Sironi, Bauloz and Emmanuel, 2019). As Chauvin et al. (2015) report, the average length of residency among undocumented migrants seeking care for the first time within a *Doctors of the World* clinic was 6.5 years. Owen (2014) reinforces this divergence, arguing that the intentionally temporary nature of the genuine medical tourist's stay results in a drastically different experience within the state, compared to one who resides

permanently. To assume the dichotomy that either one resides in the state legally or not at all is to ignore the physical and social space populated by undocumented migrants.

Leading on from this, the idea of being *deserving* of rights is present in many state policies pertaining to the accessibility of public services. This is effectively an appeal to a *proxy* for social connection and benefaction; only those who have contributed to the state should reap its rewards. This argument against accessible healthcare for all individuals is somewhat justifiable, with states struggling to mediate access to public resources, thereby drawing on the characteristics of active social membership as the qualifying criteria. However, theories of social membership indicate that one who has resided within a state, whether legally or not, becomes a valid member over time, as a result of the relationships they form with that territory and culture (Carens, 2013). In other words, permanent undocumented residency constitutes a *moral* claim to rights within that state, much like a birthright citizen's *foreseeable* connection with a state generates a claim to regularity (Owen, 2014). Building on this, Waldron (1992) argues that the state's right to deport an individual fades over time, because of their growing social membership and cumulative contributions. Subsequently, the undocumented migrant, with a moral case for additional rights, a background of social contribution and an intention of permanent residency, has a much stronger claim to accessible maternity care than genuine medical tourists, yet these two groups are homogenised in current policies.

## 3. Indirect barriers to maternity care

The previously stated direct barriers create and maintain further restrictions to the accessibility of care, indirectly displacing the power of displaced persons. At the individual level, for example, prospective patients may be unaware of their rights due to their ongoing social isolation (Pangas et al., 2019; Kvamme and Voldner, 2022) or may be deterred due to fears of detection (British Medical Association, 2021). At the institutional level, healthcare workers may be ignorant towards diverse health needs (Britz and McKee, 2015; Scammell and Grumman, 2019) or may incorrectly implement charging policies (Jones, Finnerty and Richardson, 2019; Papageorgiou et al., 2020) Finally, at the level of policy, the maintenance of the hostile environment motivates racial discrimination within medical encounters (McHale and Speakman, 2020), while insufficient resources within hospitals mean many are restricted by language barriers (Nellums et al., 2018). Whilst these barriers can be said to face all residents within the state, they are exacerbated in the case of those without legal documentation, by virtue of their precarious legal and social status (Crenshaw, 1989; Centre for Reproductive Rights, 2020). Such intersectionality means undocumented women are also far less responsive to support where it is available, as other responsibilities take priority, such as sourcing food or accommodation (Downe et al., 2009; Niner et al., 2014). For these individuals, power over one's own body is often the main source of autonomy available, as their undocumented status limits most other freedoms. However, as this article demonstrates, NHS charging and data-sharing practices displace this power, leaving these individuals without agency, in the name of protecting state sovereignty.

To look at one of these barriers in more detail, pregnancy and birth are biologically universal, yet the experiences of this reproductive journey are diverse and heavily influenced by culture. As such, individuals from different backgrounds may be divided

over elements of a woman's reproductive journey, including birthing positions (Benza and Liamputtong, 2014), caesarean sections (Higginbottom et al., 2013), pain management (Pangas et al., 2019), and diet throughout pregnancy (Essén et al., 2000). Subsequently, the undocumented migrant's construction of what is 'right' or 'healthy' in pregnancy may significantly conflict with the constructs of wellbeing within the UK. This difference in cultural perceptions can create tension between midwives and patients, transforming a mother's birthing experience into one of alienation, uncertainty, and a perceived lack of bodily integrity, again exemplifying the displacement of power that arises as a result of charging policies. Here, critics may argue that Westernised care for undocumented women is still better than no care. However, as recognised by Balaam et al. (2013), individual support is no longer sufficient for an empowering and safe birth; labour must also be culturally sensitive to optimise physical and mental maternal outcomes. Evidently, even where undocumented individuals make the difficult decision to seek support and thus risk detection and deportation, they may still be powerless in their encounters with healthcare providers, as a result of the hostility generated and maintained in the current political environment.

## 4. Effects of barriers on undocumented migrant women

Although there is limited literature pertaining to the UK's undocumented population, generalisations can be made from existing research to better understand the impact of direct and indirect barriers on maternal and infant outcomes. The importance of antenatal care for the wellbeing of both mother and child is well documented, with Almeida et al. (2016) reporting that roughly 20% of maternal deaths in European states are the result of scarce or delayed antenatal care. Despite this, De Jong et al.'s (2017)

meta-analysis finds that 63% of studies report the infrequent, late or non-existent use of antenatal care by undocumented women, leading to a higher risk of maternal mortality. Migrant women also have significantly higher rates of perinatal infection (Almeida et al., 2016), anaemia (De Jong et al., 2017), gestational diabetes (Pedersen et al., 2016), hypertension and pre-eclampsia (Urquia et al., 2014, 2015). The negative consequences of charging policies also extend to the unborn child, as the children of undocumented migrants are disproportionately impacted by low birth weight, premature delivery, and mortality (De Jong et al., 2017).

In addition to compromised physical outcomes, the inaccessibility of maternity care can lead to the significant deterioration of mental health in undocumented women. As a stand-alone factor, undocumented status is heavily associated with an increased risk of postpartum depression, post-traumatic stress disorder and even suicide (Almeida et al., 2016). Exacerbating this initial predisposition is the general lack of screening for mental health issues among migrant women, as reported by Latif (2014). These statistics indicate not only a severe health discrepancy between populations but, more importantly, that those with a higher risk of complications within pregnancy are the least likely to want or have the power to access antenatal care. While it is unclear whether these instances are the result of causation or mere correlation, it is evident that undocumented migrant women require far more support than is currently available to them, in order to have their human right to a safe birth upheld.

One may question why these barriers are so effective in preventing access to maternity support when such care is pertinent to individual and infant wellbeing. However, migrant women view the consequences for one's health as the lesser of two

evils, where the other option is detection and potential deportation (Smith and LeVoy, 2016). This indicates the powerlessness facing those in this complex and impossible position; undocumented women would rather jeopardise the health of themselves and their families than sacrifice their residency within the UK. If undocumented migrants were categorised as "ordinarily resident", these women could access support without fear of detection and deportation, thus improving maternal and infant outcomes among this population. It is, therefore, clear that the state's policies must be reviewed, to return individual power to our most vulnerable, yet equally deserving, social members.

## 5. Policy proposal

This article presents three policy recommendations to address the displacement of power that has occurred as a result of charging and data-sharing practices within the NHS. These recommendations have the potential to greatly enhance maternal outcomes, by returning power to undocumented migrant women throughout pregnancy and birth, while simultaneously benefiting the NHS and wider population.

### 5.1 Redefining key terms

As this analysis has emphasised, the condition of 'ordinary residency' unfairly homogenises diverse social kinds into one category, to the detriment of many, particularly undocumented migrants. To address this, all those who describe the UK as their primary place of residence, or, more colloquially, their 'home', should be categorised as 'ordinarily resident'. This will extend the provision of accessible healthcare to those who live within the state permanently, regardless of documentation, thereby removing the direct barriers that displace power from these individuals. Those without documentation will, however, be required to prove that they

have resided within the state for more than a pre-determined threshold, for example, three months, to qualify for healthcare without being charged. Ascertaining permanent residency is potentially difficult for undocumented individuals who are unlikely to have any formal evidence, such as payslips, tenancy agreements or bank statements (Ellermann, 2020). In light of this, individuals would be asked to prove their permanent residency via less formal routes, for example, providing references from existing residents vouching for their residency and intention to remain. This may appear *overly* inclusive, however, the chances of genuine medical tourists qualifying for affordable healthcare are slim due to their 'permanently-temporary' status; to be a medical tourist is to *visit* a state, rather than reside in it (Rajkumar et al., 2012). Even if an individual *does* attempt to exploit the system by residing within the state beyond the minimum threshold, they will likely have contributed during this period, for example, by supporting the local economy or immersing themselves in the community (Waldron, 1992; Carens, 2013). Finally, it is worth noting that rates of genuine medical tourism are very low within the UK, with only two of the 15 midwives surveyed by Maternity Action (2019) reporting encounters with genuine medical tourists, and both indicating that these mothers had come to the UK with the full intention of paying. This suggests that such fears of over-inclusivity are misplaced and are not effective in undermining the proposed reimagining of ordinary residency.

### 5.2 Introducing firewalls

As this paper has stressed, *having* rights to healthcare does not always mean that one can *exercise* these rights, exemplifying the displacement of power within the hostile environment. Subsequently, the introduction of firewalls is a necessary part of the protection of migrant rights, as it alleviates fears of self-incrimination. Firewalls should

be in place for all individuals whose information will be shared with the Home Office, *except genuine medical tourists*. Unlike undocumented migrants, this data-sharing is unproblematic, as the genuine medical tourist's stay within the state is both finite and legal, and would not lead to deportation. Additionally, these firewalls should be in place *indefinitely*, rather than being dependent on the political views of the government of the day. Individuals should feel secure knowing that their data can never be used against them in a future visa application or to terminate their undocumented residency. Critics may argue that constructing firewalls is unsafe for the public, however, this critique perpetuates the narrative of undocumented migrants as a threat to this state which, as this article has shown, they are not. By contrast, the introduction of firewalls can not only benefit the individuals who are currently deterred from seeking antenatal support due to fears of detection, but also improve the public perception of the NHS by re-establishing the doctor-patient relationship many view as fundamental to healthcare (Papageorgiou et al., 2020).

### 5.3 Creating routes to regularisation

Finally, this article recommends the creation of more accessible routes to regularisation for undocumented migrants in the UK. Routes to regularisation are the paths via which individuals can become documented members of society, thus transforming their residency into a legal and regular one (Finch, 2013). Currently, there are very few routes available to undocumented individuals, all of which are convoluted and costly, sometimes requiring up to 20 years of undocumented residency within the state before individuals may apply for regular status (RegulaRise, 2023). As this article has argued, undocumented individuals are deserving and valued social members, whose contributions are currently overshadowed by their arbitrary categorisation as

not ordinarily resident (Carens, 2013). To provide a right to become a documented member of society is to recognise the existence and contribution of undocumented individuals (Crépeau, 2013). This additional recommendation may not seem necessary, as the proposed extension of the conditions for ordinary residency will allow undocumented persons to receive NHS care without facing extortionate fees. However, creating further routes to regularisation recognises the contributions of these social members and allows them to move out of legally precarious positions, resulting in the considerable enhancement of their overall livelihood and wellbeing.

### 5.4 Benefits

The recommendations have the potential to greatly enhance the maternal outcomes and broader wellbeing of undocumented residents within the UK (Shahvisi and Finnerty, 2019). However, they also have the ability to benefit those beyond this population, specifically streamlining care provisions and improving the cost-efficiency of NHS processes, among other advantages. Multiple studies have indicated that those unable to access maternity care experienced worse maternal outcomes and were subsequently hospitalised for longer than average after pregnancy, as a result of issues that could have been avoided if identified early on (De Jong et al., 2017; WHO, 2018; Jones, Finnerty and Richardson, 2019). In addition to the negative effects for the individual, this is a highly inefficient cycle, as the emergency treatment subsequently required costs more than the care they would have initially accessed (Kennedy et al., 2015; Jiménez-Rubio and Castelló, 2020). Furthermore, in many cases, it is more economical to absorb an individual's debt than attempt to retrieve it. As Cutler (2018) reports, the NHS often spends more on attempting to track down chargeable patients than they would gain from cost-recovery. Although a more

detailed cost-benefit analysis would be required ahead of implementation, existing literature indicates that the reconceptualisation would improve the cost-efficiency of the NHS (Rodriguez et al., 2020). Here, one may query the need for greater resources and administrative staff to implement these changes. However, it is again evident that existing policies exacerbate workload and complicate NHS processes; the removal of these convoluted and controversial policies would streamline NHS practice, thus benefiting both healthcare providers and the wider institution (Barclay, 2022a). Finally, allowing undocumented individuals to become legal residents within the state, under the previous recommendation of more routes to regularisation, would create a new subset of residents who could contribute physically and financially to the NHS and broader economy (Greenway, 2007; Ommerborn et al., 2022).

## 6. Conclusion

To be denied access to affordable healthcare, whether directly or indirectly, is to be denied a right to autonomy, a right to free choice and the ability to hold power over one's body. This article has presented a conceptual critique of existing policies within the UK. Through an analysis of existing literature, the impact of NHS charging and data-sharing practices on the accessibility of care for undocumented migrants has been explored, particularly utilising the example of pregnant undocumented women to exemplify the direct and indirect barriers to antenatal support. Specifically, this article has shown that current conditions for accessible healthcare in the UK are overly exclusive, ignoring the deservingness of undocumented individuals, on the grounds of their permanent residency, social contributions and, most importantly, their basic human rights. In light of this, three policy recommendations have been made to return power to the individual. These recommendations include a reimagining of what

constitutes ordinary residence, the introduction of unconditional and indefinite firewalls, and the creation of more accessible routes to regularisation.

Many undocumented migrants have already been dealt a poor hand in the birthright lottery, hence their initial migration (Shachar, 2009). To further burden these vulnerable individuals by denying them access to a right which affects their most fundamental wellbeing is indefensible. Despite the animosity of its hostile environment agenda, the UK should re-imagine current policies to protect the accessibility of maternity care for undocumented migrants living within the state's territory, to the benefit of both the individual and the collective.

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**Biography:** Ella is a second-year PhD student and Associate Lecturer at the University of the West of England. Her doctoral research aims to capture the experiences of pregnancy and birth for undocumented migrant women in the UK's hostile environment, through ethnographic methods. This conceptual paper was originally written as a dissertation for Ella's Masters in *Migration and Mobility Studies*, although it has been greatly revised and reshaped since then. It was this paper that kickstarted her career in academia and passion for the topic of migrant reproductive rights. Ella welcomes any contact about her article, research interests or potential collaborations.