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The Attitudes of Midwives Towards NHS Fee-Charging and Data-Sharing Policies for Migrant Mothers in the UK: A Q-Methodology Study

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ABSTRACT

As part of the UK's "hostile environment", individuals who are not "ordinarily resident" within the state are subject to fee-charging and data-sharing practices when accessing maternity care. This Q-methodological study aimed to capture and analyze attitudes towards these practices, by asking 21 midwives to rank a range of statements by level of agreement. A factor analysis of these rankings identified four distinct attitudes towards fee-charging within maternity care, with some supporting these policies as a means of protecting the institution, while others rejected them as discriminatory or difficult to implement. Consequently, this paper presents recommendations to improve efficiency and alleviate conflict around the implementation of these practices within maternity care..

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Introduction

The UK's "hostile environment" was proposed by Theresa May, the then-Home Secretary, in 2012, in an attempt to stifle the steady growth of net migration by making undocumented residency unbearable within the state (Goodfellow, 2019). Over a decade after its initial implementation, the "hostile environment" remains intact, with strict social policies still alienating and limiting this population. One of the main sites of such social restriction is the National Health Service (NHS). Despite the organization's constitution outlining that access to care should be based on "clinical need, not an individual's ability to pay," *The National Health Service (Charges to Overseas Visitors) Regulations* (2015) introduced fee-charging for all those not "ordinarily resident" within the UK (Department of Health and Social Care, 2021, p. 2). To be ordinarily resident, one must reside within the UK voluntarily, legally and with the intention of remaining for a prolonged period, thus excluding undocumented migrants (Home Office, 2017). Those found not to be ordinarily resident are billed for all secondary care at an enhanced rate, before said care can be accessed or provided (Powell, 2020). This has transformed NHS support into an inaccessible service for many undocumented residents, who are often unable to afford the costs of treatment.

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Although maternity care is categorized as secondary, rather than primary care, it is also one of the few forms of treatment termed "immediately necessary." This clause means that while care remains billable, individuals will not be required to pay for their treatment before it is provided, but rather, are invoiced after the fact. This means that no one can be denied access to this support due to their financial capability. However, if unable to pay for care after receiving it, the mother's migrant status will be shared directly with the Home Office, thus alerting immigration officers to her undocumented residency within the state. This forces many migrant mothers into a "rights trap"; they must either incriminate themselves to receive the safe maternity care they are owed under international legislation or go through pregnancy without sufficient support (Barclay, 2023b).

The current fee-charging and data-sharing policies are not straightforward, leading to inconsistencies and errors in their implementation. Evidence suggests that NHS Trusts do not apply charging exemptions uniformly, with one's billable status largely depending on the Trust they attend and even the carer who treats them (Feldman, 2021). Furthermore, current guidance dictates that each Trust's Overseas Visitors Manager (OVM) is responsible for establishing exemptions and chasing billable persons for payment. However, OVMs make judgements on fee-charging status based on the residency information collected in appointments, making midwives and other healthcare providers effectively responsible for the identification of chargeable (or exempt) persons (Feldman, 2021). This responsibility creates numerous ethical dilemmas for midwives, as the implementation of these practices can be seen to contradict their duty to prioritize the patient, treat all individuals equally and uphold confidentiality, as outlined in the Nursing and Midwifery Council's (2015) *Code of Practice*. Despite these dilemmas, healthcare providers are not able to "opt out" of these practices, as those who choose not to enforce maternity care costs are seen as committing a fraudulent act, which could result in civil or criminal sanctions (Department of Health and Social Care, 2018). Accordingly, current policies create conflicts for healthcare providers, as they must decide whether to violate their professional obligations or disobey national policies, both of which could have negative consequences for the career security of the individual (Feldman et al., 2019; Reynolds & Mitchell, 2019; Yuval-Davis et al., 2018).

More specifically, this issue of dual loyalty creates significant challenges to the individual's professional and moral obligations to others (Furman et al., 2007). For example, the act of sharing a patient's data with the Home Office is seen to not only violate the right to privacy, as outlined in the UK's *Data Protection Act (*2018), but also destroy "the values of trust, empathy, and rapport [which are] essential elements to the doctor–patient relationship" (Papageorgiou et al., 2020, p. 7). Such practices also set a dangerous precedent for clinical interactions more broadly, compromising expectations of privacy not just for migrant mothers, but also for the wider public (Robinson et al., 2018). Scholars argue that confidentiality is even more essential in the case of pregnancy and birth, due to the importance of antenatal support and the often-heightened vulnerability of individuals who seek such support (Jones et al., 2021; Smith & Levoy, 2016). Despite this, maternity care has often been utilized as a means through which to uphold border controls, particularly within the "hostile environment" (Lonergan, 2024).

Similarly, where residency status can be difficult to establish, healthcare providers may find themselves relying on stereotypes of what they believe an undocumented

migrant typically looks or sounds like. For example, there are reports of individuals being billed for treatment simply because they had foreign accents or non-English surnames, despite being British citizens or otherwise exempt from NHS costs (Bulman, 2017; Papageorgiou et al., 2020; Sheppard, 2017). This concern has been explicitly highlighted by midwives, who report that the compulsory questioning of one's background and residency status equates to prejudicial treatment and discriminatory practice (Feldman et al., 2019). These healthcare providers also report fears that their patients perceive them as racist or xenophobic because of the policies they are forced to implement (Ruiz-Casares et al., 2013; Verma et al., 2020). This indicates how charging policies may re-introduce prejudice into the NHS, thereby impacting both citizens and non-citizens alike, while also violating the General Medical Council's (2013) commitment to the provision of equal treatment to all persons.

In addition to the racial discrimination that seemingly arises from these practices, the categorization of antenatal support as "immediately necessary," rather than primary care, exacerbates gender inequality (Julien, 2015). The human right to safe motherhood constitutes a necessary step toward female empowerment and liberation, as specifically recognized within the United Nations' (2015) *Sustainable Development Goals*. Fee-charging practices within maternity care are targeted exclusively toward mothers, with these individuals holding complete responsibility for the cost of treatment (Feldman, 2021). Even where individuals are married or present to healthcare services as a couple, the bill will still be logged exclusively against the mother's name, and she alone will be subject to data-sharing practices, if it goes unpaid. To place the financial onus of pregnancy solely on women is to push migrant mothers into further destitution, making them even more vulnerable to exploitation by partners or others on whom they may rely financially (Feldman, 2018). It could also be argued that the unique categorization of maternity care as "immediately necessary" is inherently contradictory. To present this form of care as essential, while also implementing strict practices which deter the use of this care, indicates that antenatal support is not truly accessible to all. This categorization, therefore, may be an attempt to restrict the reproductive freedoms of certain populations, thus presenting an attack on female autonomy (Julien, 2015). With 99.7% of UK midwives identifying as female, this increase in gender inequality and discrimination has a much greater impact on this group of healthcare providers, highlighting the importance of examining the attitudes of these individuals toward fee-charging policies (Nursing and Midwifery Council, 2019).

It is also evident that the responsibility to identify chargeable and exempt individuals has practical implications for midwives. Deciphering an individual's legal or immigration status is a convoluted and laborious task, as this status is often fluid and changes over time, including throughout one's pregnancy (Feldman, 2021). Such fluidity is further problematized amid confusion amongst healthcare providers regarding the asylum process, exemptions and even the word "migrant" (Papageorgiou et al., 2020). A recent study highlighted that 20% of healthcare providers were unable to correctly match the terms "refused asylum seeker" and "undocumented migrant" to their relevant definitions, and 50% were unable to distinguish between "refugee" and "asylum seeker" (Jones et al., 2021). Although understanding this terminology may seem fastidious, being able to differentiate between an asylum seeker and a refused asylum seeker

could be the difference between an individual accessing maternity care or not. There is similar confusion surrounding what care is chargeable, with large proportions of healthcare workers incorrectly asserting that all care is billable for nonexempt groups or that maternity care is universally exempt from charging practices (Ipsos MORI, 2017; Jones et al., 2021). This lack of knowledge directly impacts the accessibility of antenatal support for vulnerable migrant women, with organizations reporting numerous instances of individuals being deterred from accessing maternity care, after being wrongly charged (Pellegrino et al., 2021). This incorrect and inconsistent knowledge concerning such hostile practices highlights a serious issue in the implementation of fee-charging policies, alongside the impact that healthcare providers' attitudes and beliefs have on the accessibility of support.

These conflicts in duty and practical difficulties arising from charging policies have, subsequently, transformed the attitudes of healthcare providers into key health determinants for many migrant women. Their opinions toward and knowledge of these policies, or migrant status more generally, may dictate the accessibility of maternity care for vulnerable mothers. Despite this increasing influence of healthcare providers' attitudes on the experiences and outcomes of migrant women, there is very little research into this topic. Furthermore, literature concerning the attitudes of maternity care providers toward the unique restrictions surrounding antenatal support within the UK is sparse, with only one paper explicitly addressing the concerns of these individuals within the "hostile environment" (Feldman et al., 2019). As such, this article makes an original contribution to the academic sphere by examining the attitudes of midwives toward NHS fee-charging and data-sharing practices within the UK through a Q-methodology study.

With this in mind, the following study aims to answer two research questions:

1. What are the attitudes of midwives toward the charging and data-sharing practices that are currently in place for certain migrant groups accessing NHS maternity care?
2. Is there a uniform voice among midwives toward these practices?

Methodology

Q-methodology was developed by William Stephenson (1935) as a scientific framework that overcomes the elusiveness of subjectivity by objectively analyzing the attitudes of individuals, which Stephenson believed to provide invaluable insight into many socially contested issues (Coogan & Herrington, 2011; Simons, 2013). Q-methodological research aims to describe a population of viewpoints, rather than a population of people. This means the results cannot be generalized to the entire social group; the findings represent a selection of possible attitudes, rather than a comprehensive account of all positions within this group (Ellingsen et al., 2010). The value of this method arises from its "qualiquantilogical" approach, combining quantitative factor analyses with a qualitative interpretation of data, to better understand emergent attitudes (Cordingley et al., 1997; Watts, 2015). This combination of approaches makes the empirical and systematic analysis of subjectivity, a concept often viewed as abstract and immeasurable, possible. This has led many scholars to view this method as particularly valuable and well-suited not just to social research, but to feminist social research, more specifically

(Brown, 2006; Davis & Michelle, 2011; Ramlo & Newman, 2011; Saheed & Becker, 2016). By virtue of this focus on subjective experience and recognition of diversity, Q-methodology has been used by multiple feminist researchers to examine female perspectives on a range of typically gender-specific issues (Breinlinger & Kelly, 1994; Kitzinger, 1987; Kitzinger & Rogers, 1985; Senn, 1993; Snelling, 1999). As Julien (2015) acknowledges, research concerning the accessibility of maternity care cannot be satisfactorily elaborated without said research adopting a feminist perspective. Consequently, the use of this method to analyze the attitudes of midwives toward fee-charging policies within the provision of maternity care is appropriate, innovative and effective.

Phase 1: Creating the Q-Set

This study began by sampling the concourse, that is, the sphere of statements, ideas and concepts from which people formulate their views on a given topic (Simons, 2013; Stainton Rogers, 1995). This study's sample of the concourse included journal publications, organizational guidance, social media posts and newspaper articles, as sourced through phrase searches, such as "NHS charging policies" and "attitudes of healthcare providers." This stage of data collection continued until a saturation point was reached and no new opinions or ideas were found. The final concourse consisted of roughly 70 statements, which were then further refined to create a representative sample to be sorted by participants (Q-set). To achieve this, a structured approach was taken, which involved identifying key themes within the sample, coding each statement and recognizing subsequent patterns. From this, five primary themes or "sites of impact" were established, each of which is affected by the presence of restrictive policies: migrants, citizens, the NHS, midwives, and the economy. The final Q-set contained 40 statements, with each theme being represented by eight statements (Table 1). This structured approach to refining the concourse sample ensured that the Q-set remained unbiased yet comprehensive (Ellingsen et al., 2010; Saheed & Becker, 2016).

Phase 2: Conducting the Q-Sort

A pilot study was completed by two student midwives, who provided feedback on both the content of the Q-set and the accessibility of the online activity. Following this, participants (P-set) were recruited purposively via midwifery community pages, with a poster containing information about the study being shared across several relevant social media groups. Eligible individuals who showed interest were then emailed a link to the online activity and encouraged to complete the study in their own time. The study was carried out via *QMethod Software*, an online software specifically designed to collect and analyze Q-methodology data (qmethodsoftware.com). The decision to utilize virtual methods of data collection was primarily motivated by the availability and accessibility of the sample, as participants lived throughout the UK and were often working on tight time schedules. This virtual approach also enhanced the reliability of the findings, by reducing instances of human error in the collection and analysis of data (Lutfallah & Buchanan, 2019).

Table 1. The finalized Q-set, alongside each factor's ranking of these statements, as presented in the factor arrays.

Q-Set		Factors			
		A	B	C	D
S1	Maternity care is a basic human right and should be available to all, without exception	+6	+2	+5	−1[b]
S2	Immigrants don't receive the support they need as a result of immigration restrictions within the NHS	**+1**	**+1**	**+1**	**−1**
S3	Charging immigrants for maternity care alienates the many immigrants who work for the NHS	+2	−1	+1	0
S4	Although they will be charged after the fact, immigrants cannot be denied maternity care and, therefore, current policies are not unethical	−1	+2	0	−3
S5	Restricting access to NHS maternity care for immigrants negatively affects public health	+1	0	+6	+4
S6	Treating migrant mothers makes my work more interesting	**+1**	**0**	**+3**	**+1**
S7	Restricting access to NHS maternity care for immigrants reintroduces racial divisions within the institution	+4	+3	0	−1
S8	I have received sufficient training concerning who should be charged for NHS maternity care	−1	+4	−3[b]	0
S9	I have a duty to provide maternity care to vulnerable people, even where those people may not be legally entitled to care	**+5**	**+2**	**+5**	**+4**
S10	Charging immigrants for maternity care is beneficial as it circulates money back into the NHS	−2	+3	−1	0
S11	Providing maternity care to immigrants is unfair to citizens	−5	−1	−1	−3
S12	The focus of my job has changed significantly since the introduction of NHS charging and data-sharing practices for migrant mothers	−2	−5	−1	+2[b]
S13	Differential treatment on the grounds of immigration status does not constitute discrimination	−5	+1	−5	−2
S14	Immigrant patients are difficult to treat as they do not follow the routine and processes of the NHS	−1	−4	−2	+1
S15	NHS migrant charging policies force me to violate my professional duties to uphold confidentiality and treat all patients equally	+2	−6[b]	+2	+1
S16	NHS charging policies do not disproportionately impact certain minority groups, if implemented correctly	−2	+6	0	+2
S17	We have no moral obligation to provide free maternity care to immigrants	−6	−3	−3	−2
S18	Enforcing immigration restrictions should not be part of my job	+4	−2[b]	+2	+2
S19	Denying NHS maternity care to immigrants is not unethical, as they can access this care in their native country	−4	0	−4	−3
S20	I struggle to communicate with migrant mothers, making it harder to provide high quality care to them	0	−3	+2	−5
S21	Access to maternity care should not be a political issue	+2	+5	+3	+5
S22	Immigrants do not pay taxes, therefore, should not be entitled to free maternity care	−3	−1	−4	+6[b]
S23	Discrimination of any form has no place within the NHS	+5	+5	+4	+1[b]
S24	My workload is unaffected by NHS charging and data-sharing practices	**0**	**0**	**+1**	**0**
S25	I feel the need to rely on racial stereotypes to establish who may be charged for NHS care	−1	−2	−6[b]	−1
S26	Charging migrant women for accessing maternity care violates their right to bodily autonomy	+3	−5[b]	0	+1
S27	Establishing the charging status of patients limits the amount of time available to provide care to immigrants and citizens alike	+1	+1	−2	+3
S28	Immigrants are integral to the NHS and, therefore, should be able to access it	**+2**	**+2**	**+3**	**0**
S29	Providing maternity care to immigrants indirectly compromises the care provided to citizens	−4	−1	0	+2

(*Continued*)

Table 1. Continued.

Q-Set		Factors			
		A	B	C	D
S30	I am not confident in my knowledge of charging policies and regulations	0	−2	+4	+3
S31	The introduction and implementation of charging policies have made me think about quitting my job	0	−2	−3	−5
S32	Establishing the charging status of migrant mothers puts additional, unnecessary pressure on care providers	+1	+1	+1	+5[b]
S33	Sharing data concerning a patient's immigration status is not a violation of confidentiality, as if they are here illegally, they should be reported	−3	0	0	−6
S34	The exclusion of certain communities from NHS care enhances segregation within the general population	+3	+3	+2	−2[b]
S35	Establishing the charging status of patients is not cost-efficient	0	−3	+1	−4
S36	Migrant mothers place a financial strain on the NHS	−3	0	−1	−1
S37	I am more inclined to question a patient's immigration status if they are not white	0	−4	−5	+3
S38	It is unethical to use the NHS as a site to exert immigration controls	+3[b]	−1	−1	−2
S39	Charging for NHS maternity care prevents the migrants from exploiting our health service	−2	+4[b]	−2	−4
S40	Public trust in the NHS has improved as a result of the introduction of healthcare restrictions for immigrants	−1	+1	−2	0

The rankings of consensus statements are indicated in bold and distinguishing statements are presented as S[b] (significant at $p < .01$).

Before completing their Q-sorts, participants were presented with the study's information sheet and privacy notice, explaining what the goals of the study were, why they had been asked to partake and how their data would be used. After reading through these documents, participants were then asked to consent to take part in the study. Only after this consent was given could participants progress to the first stage of the activity, which asked individuals to provide some demographic information, although all questions were optional. Following a short video tutorial (QMethod Software, 2021), participants read through the Q-set and sorted the statements into categories of "agree," "disagree" and "neutral," in response to the prompt "To what extent do you agree or disagree with this statement?." Participants were then asked to place each statement on a fixed quasi-normal distribution grid according to their level of agreement (+6) or disagreement (−6) (Figure 1). Once all the statements were placed on the grid and the participant was happy with their final ranking, they submitted their Q-sort, after which they were asked three optional questions:

1. If any, which statement(s) stood out to you, and why?
2. Do you believe migrant mothers receive enough support from the NHS?
3. How, if at all, has the introduction and use of charging and data-sharing policies within NHS maternity care changed your attitudes toward migrants?

These responses were used to add explanation and depth to the emergent factors, as well as aid the interpretation of the attitude clusters. Before closing the activity, individuals were thanked for their participation and reminded of the researcher's contact details, in case they wanted to withdraw from the study at a later point.

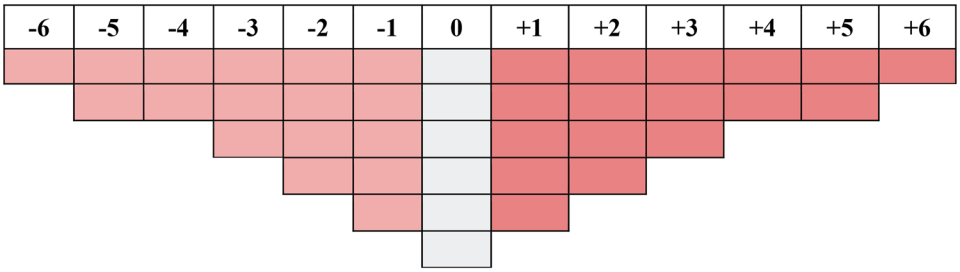

Figure 1. The fixed distribution grid onto which participants place their Q-set items, to create their finalized Q-sort.

Phase 3: Factor Analysis and Interpretation

The participants' Q-sorts were then factor analyzed via *QMethod Software*, which involved the creation of an intercorrelated matrix of all participant responses, alongside the use of Principal Component Analysis and varimax orthogonal rotation. This led to the emergence of four distinct factors, each with an eigenvalue of >1.00 and at least two significantly loaded participants, collectively accounting for 75% of the variance. Each participant was then associated with one of the identified factors, based on their individual Q-sort. Those who loaded significantly onto the same factor are seen to share the same set of beliefs concerning fee-charging and data-sharing practices. All statements were statistically significant at p = <.05 and statements that were significant at p = <.01 are marked with an asterisk. This factor analysis also produced exemplar factor arrays (composite Q-sort), which illustrated each factor or cluster's shared attitudes toward charging and data-sharing practices (Table 1).

The final step in this study was to understand the defining features of each factor. To do this, the statements placed at the extremes of the Q-set grid were analyzed first (−6, −5, +5, +6). Following this, statements with significant placements, that is, those placed higher or lower than within any other factor, were discussed and examined (Gallagher & Porock, 2010). The factor analysis of each participant's Q-sort also identified various areas of agreement across the emerging clusters, known as consensus statements. These statements are understood as those which did not significantly differ between any pair of factors. By contrast, distinguishing statements (S^b) are those ranked uniquely by an individual factor, with a significance value of $p < .01$. These areas of agreement and disagreement between factors were also used to aid factor interpretation. Finally, the free-text responses of participants who loaded significantly onto each factor were considered, with the quotes from these responses adding depth to the narratives. Viewing factor arrays in conjunction with the individual post-Q-sort responses led to the construction of a holistic, meaningful narrative for each factor (Haua et al., 2022). The factors were also labeled, to improve understanding of the defining features of each cluster.

Ethical Considerations

This research was conducted as part of a taught post-graduate program. Following standard university procedures, this student project was evaluated to be low risk by

approved academic supervisors. Approval was granted under the overarching ethics umbrella of the Faculty of Environment and Technology's Faculty Research Ethics Committee (Approval reference: UWE.CATE.6632). Participants were provided with full information about the study and how their data would be used following its completion, before consenting to take part. Individuals were also reminded that they may withdraw at any point while completing the online study, or up to a week after submitting their response. All initial questions concerning participant characteristics were optional, allowing individuals to only share the data they felt comfortable having published. Data was also fully anonymized, with the automatic participant codes created by *QMethod Software* being used to identify the individuals throughout the project. The study taking place online created an additional layer of anonymity, which not only allowed participants to be certain that their privacy would remain intact, but also to feel more comfortable expressing their genuine opinions, unaffected by social desirability bias (Davis & Michelle, 2011).

Results

Twenty-one participants took part in this Q-methodology study. All participants identified as female (except one who left this question blank) and over half defined themselves as mothers. Participants also represented a wide variety of ages, spanning over 40 years, though the 18–25 category was the most popular within this sample (38%). Such diversity was also present in the length of time spent working within the NHS, ranging from less than a year to over 10 years, though 3–5 years was the most common response (38%). By comparison, there was little racial diversity within the final P-set, with the majority of respondents describing themselves as White British ($n = 18$). Details of the participants' demographics can be found in Table 2.

Factor A: Dismayed Policy Skeptics

Eleven participants significantly loaded onto Factor A, titled the *Dismayed Policy Skeptics*, accounting for 53.1% of the study variance. The *Dismayed Policy Skeptics* strongly agreed with the claim that maternity care constitutes a basic human right (S1 + 6; S17 − 6) and that the inaccessibility of such care violates bodily autonomy (S26* +3). With reference to the UK's "hostile environment," proponents of this factor asserted that current fee-charging and data-sharing practices rendered antenatal support inaccessible for migrant women (S4 − 1; S16* −2; S19 − 4). This was explicitly addressed by Participant VZEY, who stated "*It is discriminatory and dangerous to deny care or threaten to charge.*" Accordingly, the *Dismayed Policy Skeptics* asserted that differential treatment on the grounds of residency does constitute discrimination and that such discrimination has no place within the NHS (S13 − 5; S23 + 5; S33* −3). Similarly, the *Dismayed Policy Skeptics* agreed with the claim that it is unethical to use the NHS as a site for immigration controls, which distinguished this factor from the other three (S38[b]* +3). They also asserted that antenatal support should not be a topic of political debate, as it is a basic human right (S21 + 2). More specifically, proponents of this factor claimed that fee-charging exacerbates racial tensions within the NHS, both in

Table 2. Breakdown of the characteristics within the P-set, as organized by the factor onto which participants significant load.

Participant	Age	Gender	Ethnicity	Job title	Length of time working for the NHS	Would you describe yourself as a mother?
				Factor A		
6M1P	18–25	Female	White British	Band 5 rotational midwife	Less than 1 year	No
C7UQ	18–25	Female	White British	Midwife	1–2 years	No
KZBE	18–25	Female	White	Midwife	3–5 years	No
RUXL	18–25		White British	Student Midwife	1–2 years	No
UJBQ	26–31	Female	White British	Midwife	1–2 years	No
5E05	26–31	Female	White British	Midwife	1–2 years	No
QPJF	26–31	Female	White British	PhD researcher (in midwifery)	3–5 years	No
V6ZX	40–49	Female	White British	Midwife	10+ years	Yes
VZEY	40–49	female	White British	Band 6 midwife	10+ years	Yes
0UOM	50–59	Female	White other	Midwifery lecturer. Midwife up to one month ago.	6–9 years	Yes
PXHC	60+	Female	White British	Independent Midwife	6–9 years	Yes
				Factor B		
KXKY	18–25	Female	White British	Midwife	3–5 years	No
YY8Y	18–25	Female	White British	Midwife	3–5 years	No
				Factor C		
3SI7	18–25	Female	White European	Final Year Student Midwife	3–5 years	No
DF53	18–25	Female	White British	Midwife	3–5 years	No
X2FA	32–39	Female	Black British	Midwife	3–5 years	Yes
69G1	32–39	Female	White British	Midwife	10+ years	Yes
6JFU	50–59	Female	White British	Research Midwife	10+ years	Yes
7Y63	50–59	Female	White British	Midwife	10+ years	Yes
				Factor D		
6QQF	32–39	Female	Black African	Midwife	1–2 years	Yes
LHC0	40–49	Female	White British	Midwife	3–5 years	Yes

terms of the patient population and the workforce itself, despite these policies only explicitly targeting undocumented residents (S3 + 2; S7 + 4; S34 + 3). Additionally, Participants 0U0M and 5E0S both mentioned "*institutional racism*" in connection with charging policies, and Participant RUXL confessed, "*We are clearly not doing well enough at being an anti-racist service.*"

All proponents of this factor recognized their professional and moral duty to provide antenatal support to all mothers (S9 + 5; S15 + 2), "*regardless of immigration status*" (PXHC). Participant RUXL reasserted this obligation, writing that "*whilst [migrants] are with us, they deserve the best care we have to offer.*" Accordingly, the *Dismayed Policy Skeptics* asserted that charging and data-sharing practices should not be part of their job (S18 + 4), as they are "*completely unethical*" (QPJF) and they "*[Go] against everything [we] stand for as a midwife*" (UJBQ). This sentiment was further expressed by Participant VZEY, who wrote "*I feel so strongly that I am not a customs officer, this is not my job at all.*" Despite this distaste for fee-charging within maternity care, proponents of this factor neither strongly agreed nor disagreed with statements suggesting that their job role had changed significantly since the introduction of these practices (S12* −2; S24 0; S32 + 1). Similarly, the *Dismayed Policy Skeptics* did not hold

strong opinions concerning their knowledge of fee-charging practices (S30 0) or the training they had received in relation to these processes (S8 – 1). However, some participants expressed stronger opinions in their free-text responses, with Participant 6M1P stating, "*I have only recently qualified, and I have not been educated about these policies*," and Participant 5E0S explaining, "*I was not aware that [charging practices] were going on*."

Furthermore, proponents of this factor neither agreed nor disagreed with claims that the workload or responsibilities of midwives are impacted by migrant mothers' use of NHS services (S6 + 1; S14 – 1; S20 0). As explained by Participant 0UOM, she "*refuse[s] to be complicit in any kind of gatekeeping*," thus "*[Doesn't] bother asking at all about citizen status*." This conscious reluctance to view migrants as any less deserving of care than citizens was also reflected in the shared belief that the provision of care to migrants is not unfair or detrimental to citizens (S11 – 5; S29* –4) and that migrants do not undermine the economic stability of the NHS (S10 – 2; S22 – 3; S36 – 3). However, proponents of this factor were indifferent toward statements concerning the cost-efficiency of charging and data-sharing practices (S35 0). Finally, although the *Dismayed Policy Skeptics* neither agreed nor disagreed that they had considered quitting their jobs in light of these "hostile environment" policies, all other factors strongly disagreed with this statement, suggesting these individuals were more impacted by charging policies than proponents of the other three attitude clusters (S31 0).

Factor B: Medical Tourism Critics

Two participants significantly loaded onto the second factor, titled the *Medical Tourism Critics*, explaining 8.62% of the study variance. Proponents of this factor shared the previous factor's belief that maternity care is a basic human right (S1* +2) and that there is a moral obligation to provide support to vulnerable migrant women (S9 + 2; S17 – 3), with Participant YY8Y claiming it is "*worrying to think anyone disagrees with this*." The *Medical Tourism Critics* also asserted that maternity care costs enhanced inequality and segregation within the institution (S7 + 3; S34 + 3), although they did not report an increased likelihood of discrimination on an individual level (S25 – 2; S37 – 4). Similarly, they tentatively disagreed with claims that providing care to migrants is unfair to citizens (S11 – 1; S22 – 1; S29 – 1), instead recognizing the essential contribution of migrants to the NHS workforce (S28 + 2). The *Medical Tourism Critics* also shared Factor A's belief that discrimination has no place in the NHS (S23 + 5), strongly asserting that the accessibility of maternity care should not be a political issue (S21 + 5).

One of the defining attitudes held by the *Medical Tourism Critics* was that fee-charging and data-sharing practices are not unfair for migrant mothers, if implemented correctly (S4* +2; S16* +6). They also neutrally ranked the claim that differential treatment on the grounds of migrant status does not constitute discrimination (S13 + 1). This sentiment was emphasized by Participant KXKY, who wrote "*I believe that when [migrants] do access care appropriately, they are given adequate support.*" Crucially, these individuals asserted that the implementation of NHS costs does prevent migrants from exploiting the NHS (S39^{b*} +4), while simultaneously circulating money back into the institution (S10* +3; S35 – 3). This belief that NHS charges protect the

institution from exploitation distinguishes this factor from the other three emergent clusters. As Participant YY8Y stated, "*I am glad there are charges to ensure the NHS is supported.*" The defining element of this group was captured in the free text response of Participant KXKY, who wrote "*I know of many women who come over to England… to claim free maternity care and then as soon as they can after the baby is born, they go back to their homeland, which I think is an exploitation of our NHS.*" As this latter response indicates, proponents of this factor interpreted the term "migrant" to mean "medical tourist," that is, one who is traveling to the UK with the sole intention of accessing maternity care, despite such care being available within their home state. This is further evidenced in their distinguishing belief that charging migrants for maternity care does not violate their bodily autonomy (S26^{b*} −5). Similarly, although it was ranked neutrally, when compared to the factor arrays of the other three attitude clusters, the *Medical Tourism Critics* were more likely to agree with claims that individuals cannot be denied access to care, as they have recourse to such support in their native states (S19 0).

In keeping with this, the *Medical Tourism Critics* asserted that, while there is a duty to support vulnerable migrant women, current "hostile environment" practices do not force them to violate their professional duties (S15^{b*} −6; S18^{b*} −2). These latter rankings distinguish this factor from the other three factors in this study, as they all somewhat agreed that such practices undermine their ability to uphold confidentiality and equality of treatment in clinical encounters. Although they tentatively reported that fee-charging practices do limit the time available for care provision in appointments (S27 + 1) and may place extra pressure on NHS staff (S32 + 1), they did not feel as though their jobs have changed significantly since the introduction of these policies (S12* −5; S31 − 2). Additionally, proponents of this factor were the only ones to report feeling confident in their knowledge and application of charging policies (S8* +4; S30* −2). They also did not find migrant mothers any more difficult to treat than citizens (S14 − 4), though the *Medical Tourism Critics* did not suggest that these individuals made their work any more interesting (S6 0).

Factor C: NHS Value Preservers

Six participants significantly loaded onto this factor, labeled the *NHS Value Preservers*, accounting for 6.57% of the study variance. Proponents of this factor were primarily concerned with the values of the organization alongside the integrity and efficacy of its processes. Much like the previous factors, these individuals strongly agreed that maternity care is a basic human right and that there is an obligation to provide such care to vulnerable individuals (S1 + 5; S9 + 5; S17 − 3; S19 − 4). This is supported by the free text responses of those loading onto this factor, with Participant 6JFU stating "*We should just be able to treat them, whether or not they are entitled to care*," echoing the values outlined in the NHS constitution (NHS England, 2023). The *NHS Value Preservers* did not differentiate between migrant and non-migrant patients, with Participant 3SI7 explaining that the support she provides to migrants is the "*same care [she] would provide to any British national*" (S11 − 1). In keeping with this latter sentiment, proponents of this factor asserted that the accessibility of maternity care should not be a political or

economic issue (S21 + 3; S22 – 4) and that upholding border controls should not be the responsibility of midwives, as they contradict their professional and moral duties (S2 + 1; S15 + 2; S18 + 2). This conflict between the integrity of the institution and the state's political agenda was emphasized in the free-text responses, with Participant 6JFU writing, "*It is not the job of NHS employees to ascertain the immigration status of individuals.*" Furthermore, proponents of this factor believed that discrimination had no place in the NHS (S23 + 4) and that differential treatment based on migrant status constituted discrimination, subsequently alienating this population (S13 – 5; S34 + 2). Their disapproval of current policies, therefore, appears to arise from the fact that such policies undermine the values of equality and patient-centered care that underpin the NHS.

The *NHS Value Preservers* were also unphased by statements alluding to migrants placing a financial strain on the institution (S36 – 1; S39 – 2). Instead, they suggested that it is the fee-charging policies which create an economic issue for the NHS, rather than those being billed (S10 – 1; S35 + 1). Fears of the deteriorating efficacy and integrity of the institution were also evident in their strong agreement with the claim that policies are undermining public health (S5* +6). Additionally, proponents of this factor felt that the implementation of charging and data-sharing practices led to the deterioration of trust and confidentiality in the institution, impacting both migrants and citizens alike (S40 – 2). In keeping with these concerns for the workings of the institution, the *NHS Value Preservers* recognized that migrants make up a significant portion of the UK's healthcare providers and that upholding such hostile policies within the NHS greatly alienates these workers (S3 + 1; S28 + 3). In addition to the recognized value of migrants as NHS staff, these individuals also acknowledged the value of migrants as patients, suggesting that migrant mothers make their work more interesting (S6 + 3). Although identifying some issues with communication in appointments (S20 + 2), the *NHS Value Preservers* did not report issues in supporting migrant mothers, nor did they feel strongly toward claims that their jobs had changed significantly since the introduction of charging policies (S12* –1; S14 – 2; S24 + 1; S31 – 3).

Finally, these individuals did not report receiving sufficient training concerning fee-charging and data-sharing policies and did not feel confident implementing these practices in their clinical work (S8^{b*} –3; S30 + 4; S32 + 1). As expressed by Participant 3S17, "*When you're on the 'shopfloor' providing care, you know very little about the… government restraints… because you treat all individuals as equals.*" Despite this lack of confidence in their knowledge, these individuals strongly rejected the claim that they may need to rely on stereotypes to enact these policies (S25^{b*} –6; S37 – 5). These attitudes toward training and knowledge concerning fee-charging and data-sharing practices, as illuminated via this factor's ranking of relevant statements, distinguished the *NHS Value Preservers* from the other factors.

Factor D: Citizen Partisans

Two participants significantly loaded onto the final factor, termed the *Citizen Partisans*, explaining 6.01% of the study variance. Much like the previous factors, the *Citizen Partisans* recognized a professional and moral duty to provide maternity care to vulnerable persons (S9 + 4; S17 – 2), asserting that the accessibility of this support should

not be a political concern (S21 + 5). However, in contrast with these beliefs, proponents of this factor somewhat disagreed with the statement that maternity care should be freely and equally available to all, particularly endorsing the claim that migrants are less entitled to support as they are not taxpayers (S1[b*] −1; S22[b*] +6). The ranking of these two statements distinguished this factor from the other emergent attitude clusters. The *Citizen Partisans* were also the only participants to agree that providing care to migrants may indirectly undermine the care provided to citizens, however, they disagreed with the claim that that allowing migrant mothers to access maternity support was unfair to others (S11 − 3; S29 + 2). Similarly, they did not view the current fee-charging practices as effective in preventing individuals from exploiting the NHS (S39 − 4).

Furthermore, the *Citizen Partisans* did not support the fee-charging and data-sharing practices currently facing migrant mothers, as they found them to be unethical (S4 − 3; S19 − 3), significantly violating confidentiality (S33* −6) and somewhat undermining bodily autonomy (S26 + 1). Furthermore, although they suggested that fee-charging policies may be cost-efficient when implemented correctly (S16 + 2; S35 − 4), they were indifferent toward claims concerning a financial strain resulting from migrants' use of the NHS (S10 0; S36 − 1). In addition to concerns for the efficiency of such processes, the *Citizen Partisans* asserted that maternity care costs undermine the integrity of the institution (S13 − 2; S38 − 2). For example, proponents of this factor strongly agreed with the claim that restricting access to maternity care for migrant women negatively impacts public health (S5 + 4). Despite this, the *Citizen Partisans* were neutral toward the claim that discrimination has no place within the NHS and did not believe such practices introduced segregation into the institution, constituting distinguishing rankings for this factor (S23[b*] +1; S34[b*] −2). Although indifferent toward these claims of differential or prejudicial treatment, proponents of this factor still found issue with current policies, with participant 6QQF writing that the introduction of such practices led her to feel "*more empathetic towards immigrants.*"

Finally, although the *Citizen Partisans* had not considered quitting as a result of charging practices (S31 − 5), they strongly believed that the implementation of such policies had placed unnecessary pressure on midwives, a ranking that distinguished these participants from other factors (S12[b*] +2; S32[b*] +5). More specifically, these participants tentatively agreed that implementing these policies extended beyond their professional remit and prevented them from meeting their obligations as healthcare providers (S15 + 1; S18 + 2). Furthermore, although they were neutral toward the claim concerning the level of training in relation to current policies, the *Citizen Partisans* agreed that they lacked confidence in their knowledge of charging policies (S8 0; S30 + 3). This was emphasized by Participant LCH0, who claimed "*I have not had appropriate training to recognize immigrant mothers or what to do if they are required to pay for treatment.*" Although they did not report any issues communicating with migrant mothers (S20 − 5), they did somewhat agree that these patients may be harder to treat (S14* −1). To bring this back to the experiences of citizens, these proponents recognized that their lack of knowledge concerning charging policies motivated them to rely on racial stereotypes to identify chargeable persons (S37* +3) and limited the time available for care provision in appointments (S27 + 3), impacting both migrants and citizens.

Consensus Statements

Despite the emergence of four distinct factors indicating diversity in midwives' attitudes toward fee-charging and data-sharing practices, there were several areas of consensus across these diverging positions. Firstly, all participants agreed that midwives have a duty to provide maternity care to vulnerable mothers, even where those individuals may not be freely entitled to such support (S9, +2 to +5). Migrant mothers were also viewed by all participants as somewhat integral to the NHS, which they believed gave these individuals more of a claim to access the services this organization offers (S28, 0 to +3). There was also a shared, albeit tentative, agreement that migrant mothers make the work of midwives more interesting (S6, 0 to +3). The participants of this study uniformly neutrally ranked the claim that migrant mothers do not receive the support they require as a result of fee-charging policies (S2, −1 to +1). Similarly, participants did not hold any strong attitudes toward the idea that such practices have affected their workload, with all factors ranking this relatively neutrally (S24, 0 to +1). These areas of consensus indicate a shared feeling of duty toward migrant mothers and other vulnerable patients. However, they also suggest that the practicalities of implementing these policies may not be as pronounced as previous studies suggest.

Discussion

This study was designed to explore midwives' attitudes toward fee-charging and data-sharing practices within maternity care. The use of Q-methodology illuminates key areas of agreement and disagreement, which may not have been identified via more traditional research methods. Primarily, this study identified two viewpoints toward fee-charging and data-sharing practices; those supporting such practices (Factor B) and those who reject them (Factors A, C, D). However, as illustrated by the interpretation of these factors, these attitudes are far more nuanced than this dichotomy may suggest. One crucial area of disagreement concerns where the problems with current policies lie; some participants challenged the values inherent in the formulation of these policies, while others critiqued their practical implementation. This highlights that the problem with current regulations may not be in its introduction of charges within maternity care, but rather in more practical elements of this policy, such as who may be charged and how this status is established. Despite existing evidence calling for the removal of fees within maternity care, this sentiment was not found uniformly throughout this dataset (Pellegrino et al., 2021; Royal College of Midwives, 2024). This lack of consensus in attitudes toward the overarching existence of fee-charging and data-sharing practices shapes this article's recommendations, motivating a call for the reimagining of current policies, rather than their complete removal.

As this study reports, participants who challenged the fundamental values of fee-charging and data-sharing policies often cited concerns around discrimination. Although conflicted over how and where it manifested, all participants agreed that current fee-charging policies motivated the unfair treatment of certain social groups both within and beyond the healthcare service. These findings align with existing literature that examines the discriminatory nature of data-sharing, particularly the unfair use of migrant status as grounds for the disclosure of personal information

(Hiam et al., 2018; Medact, 2020). When questioned about the impact of these practices on the perceived experiences of others, multiple participants mentioned racial disparities in maternal outcomes, while others reflected on institutional racism within the NHS. This indicates the midwives' understanding of contemporary research around this topic and awareness of broader healthcare inequalities within the UK (Birthrights, 2022; Knight et al., 2022; Women and Equalities Committee, 2023). Furthermore, the midwives' association between fee-charging practices and racial health inequalities highlights the far-reaching impact of these policies. The midwives' attitudes in this study suggest that fee-charging policies undermine the accessibility and quality of care for all minority women, not just those with an insecure migrant status, echoing the conclusions of existing literature (Birthrights, 2022; Pellegrino et al., 2021). These policies are seen by many of this study's participants to encapsulate and uphold the antagonism toward migrants within the UK's "hostile environment," thus being inherently flawed.

Additionally, this study brings to light various issues with the implementation of fee-charging and data-sharing policies. Proponents were divided over their knowledge of charging processes, with some feeling well-versed on this topic while others were unaware that such practices existed, mirroring the inconsistencies flagged in previous studies (British Medical Association, 2019; Ipsos MORI, 2017; Nellums et al., 2018; Scott et al., 2019). This was primarily illustrated via the different interpretations of the word "migrant" throughout this study. For example, in the context of this study, proponents of Factor B took the word "migrant" to refer to genuine medical tourists, while other participants did not make such an association. This misappropriation of undocumented migrants as medical tourists could indicate that current policies must redefine "ordinarily resident" to only encompass those who traveled to the UK with the sole intention of utilizing the state's healthcare service (Barclay, 2023a). This would allow charging practices to protect the NHS from "genuine" exploitation, while still allowing for the provision of maternity care to vulnerable women. However, this conclusion could not be clearly drawn from this dataset, instead constituting an area that requires further research.

Despite numerous reports recognizing the existence of a knowledge deficit among healthcare providers, there is very little speculation around why this deficit exists. This study addresses this gap in the literature, as the findings indicate two explanations for this difference. Firstly, a lack of understanding around the details of fee-charging practices may be the result of varying levels of practical and educational training. For example, this study found that the individuals who had received sufficient training in relation to charging processes were more likely to feel confident in their knowledge of these policies. This indicates a strong correlation between the availability and/or accessibility of training and the practical implementation of fee-charging policies. However, the participant responses, particularly from student midwives, indicate that relevant training is not always offered as part of the traditional route into the sector. This reflected healthcare providers' attitudes as captured in previous studies, which report a lack of training among these individuals, with some clinicians suggesting they only heard about such policies via discussions in the media (Ipsos MORI, 2017; Jones et al., 2021; Papageorgiou et al., 2020). Furthermore, where such policies have been described as a "huge bureaucratic

burden" within the literature, a sentiment shared by some participants, it is evident that rigorous training is required to make sense of such policies and streamline their implementation in practice (British Medical Association, 2019; Feldman et al., 2019, p. 34). Though deciphering migrant and legal status remains a complex task, understanding the grounds for exemption, or at least who to signpost such concerns to within individual Trusts, is a crucial step to ensuring that fee-charging policies do not exacerbate the workload of midwives and that exemptions are identified correctly.

On the other hand, this knowledge deficit may represent a conscious decision on the part of midwives. As suggested in previous articles, many healthcare providers choose not to acquire knowledge concerning fee-charging policies, even where it is accessible, for fear this presents them as supporting the restrictive practices (Feldman et al., 2019). Various participants in this study discussed the alternative approaches they adopt within their own practice to avoid the implementation of charging policies, including not asking individuals about their residency status or recording the length of residency incorrectly. Such evasive practices have also been documented within the literature, as healthcare providers reported turning a blind eye to an individual's billable status (Straßmayr et al., 2012), prescribing medicine in their own name to avoid detection (Drewniak et al., 2017) or adopting a "Don't ask, don't tell" policy (Furman et al., 2007). This decision not to implement charging practices in the provision of care explains why some participants felt unaffected by charging policies, despite strongly rejecting them. Although OVMs are in place at each Trust to carry out these practices, previous discussions in this article have outlined that the responsibility to identify chargeable persons effectively falls on healthcare providers. Midwives have become acutely aware of this, as illustrated by this study's findings, hence the increased feeling of duty to uphold these hostile practices. This shift in responsibility places a moral burden on midwives, which can leave them feeling emotionally drained, as well as pressured to adhere to state guidance over the institution's values, motivating the conscious decision of some participants to remain oblivious toward these practices.

Finally, this study indicates that the problematic implementation of charging policies is exacerbated by the complex needs of migrant women during pregnancy and birth. Recent reviews of UK maternity care have emphasized the importance of a personalized care plan for all birthing individuals (Ockenden, 2022; Women and Equalities Committee, 2023). This personalized approach is even more crucial for migrant mothers, as they are more likely to suffer from complications during birth, struggle with communication and have a complex medical history (de Jong et al., 2017; Doctors of the World, 2017; Higginbottom et al., 2019; World Health Organization, 2018). However, where midwives are also tasked with explaining charging policies and identifying exemptions within appointments, very little time is left to cultivate this personalized plan or build a trusting relationship with the mother. Furthermore, evidence suggests that when healthcare providers have limited time or increased administrative burden in appointments, their medical decisions are more likely to be influenced by racial stereotypes, which leads to poorer outcomes for minority patients (Burgess et al., 2010; Drewniak et al., 2016, 2017; Stepanikova, 2012). In a healthcare system that is already underfunded, understaffed and overworked, the obligation to uphold fee-charging practices in clinical

encounters may increase the reliance on racial stereotypes in the treatment of migrant women (Social Market Foundation, 2022). In this context, the narrative of migrant mothers as a "strain" on the NHS is heightened, particularly as those in favor of charging policies, including participants of this study, often call on values of cost-efficiency and deservedness to justify their stance. Not only does this highlight the discriminatory impact of charging policies, but it also suggests that the quality of care available to migrant mothers may be worse as a direct result of these practices, a sentiment echoed by some of this study's participants.

In light of these findings, this artcle recognizes the need for various shifts within the current landscape surrounding fee-charging and data-sharing policies. Firstly, greater emphasis should be placed on educating individuals about these policies within the initial midwifery curriculum, as well as throughout practice. Healthcare providers should understand the grounds for exemption and be equipped to signpost chargeable persons to appropriate external support where required, including legal representatives. Additionally, greater efforts should be made to separate the role of identifying billable persons from providing clinical care. These changes will ensure that the implementation of charging policies does not exacerbate the workload of midwives, while also removing the potential for ethical conflicts between professional obligations and personal morals, thus improving the experiences of healthcare providers. Furthermore, improvements are required within the healthcare service's infrastructure to better serve the needs of migrant patients. The introduction of longer appointments for migrant mothers, alongside improved accessibility of high-quality interpretation services, will not only improve the experiences of care for migrant women, but also remove the risk of reliance on biases and stereotypes among healthcare providers. In lieu of eradicating charging policies, as previous publications have suggested, the attitudes of the midwives captured within this study indicate that a re-imagining of these practices is required to overcome the current barriers they create, not just for migrant mothers, but also for healthcare providers and the wider institution.

Limitations

One of the primary limitations of this study is the extent to which the Q-set represents the concourse. Due to time and resource constraints, the concourse was sampled through a range of formal and informal literary sources; however, there was no input from human participants in this phase. This could lead one to argue that the Q-set is not representative of the entire discourse regarding charging and data-sharing and its implications for maternity care provision. Great care was taken to ensure the representation of all issues identified in the public sphere and the statements were piloted with student midwives before sharing with participants. However, it is recognized that future research would benefit from greater engagement with stakeholders throughout this sampling process.

Furthermore, the sample size for this study may undermine the reliability of the findings. As a rule, a study's P-set must always be smaller than its Q-set, as each statement presents a different attitude, therefore, having more participants than attitudes would be illogical. In addition to this, having fewer statements than participants makes both the activity and the analysis more manageable, allowing for the formation of significant attitude clusters. Despite this, the recommended sample size for Q-methodology

studies often sits between 40 and 60 participants (Watts & Stenner, 2012). Although the 21 participant opinions captured via this study present a valuable insight into the attitudes of midwives toward charging and data-sharing practices, the study does not necessarily represent the genuine diversity of views among this population.

Finally, the participants do not entirely reflect the diversity of the midwife population. While the lack of gender diversity is somewhat unproblematic, as most midwives identify as female, the lack of racial diversity within the P-set should be noted, as 90% of this study's respondents described themselves as "White" ($n = 19$). Just under a quarter (20.5%) of NHS workers are from Black and minority ethnic backgrounds, meaning this study does not represent all elements of the diversity among midwives (NHS England, 2019). As such, future research would benefit from the use of stratified sampling, to ensure better representation of all ethnic groups within the research.

Conclusion

This study aimed to understand and explore midwives' attitudes toward NHS maternity care costs and data-sharing practices and establish whether a uniform voice exists among this population. This research is founded on the argument that the attitudes of healthcare providers constitute a key health determinant that is often overlooked, yet could explain maternal health disparities, as well as provide an insight into the practicalities of healthcare charging. Through a Q-methodology study, this research established the existence of multiple, distinct attitudes among the participants, indicating that there is no one, uniform voice which can be said to represent all midwives. Although areas of consensus were identified across all four emergent factors, clear points of disagreement arose both in the experiences of implementing charging policies and the attitudes toward them. Crucially, there was no consensus around the policies themselves, as proponents of Factor B felt "glad" that charges were in place to better protect the organization, while proponents of Factors A, C and D felt largely frustrated or alienated by these practices. Despite previous literature calling for the removal of costs within maternity care, the varied responses within this study suggest that the issue, in the eyes of midwives, lies with the implementation of these policies, rather than exclusively in the principles they aim to uphold.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

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Data Availability Statement

The author confirms that the data supporting the findings of this study are available within the article and its supplementary materials.

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