Maternal charging in the NHS widens health inequalities

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Worst outcomes for the poorest mothers

In 2019, the NHS Long Term Plan set an ambition of halving stillbirth, neonatal and maternal mortality rates by 2025 from 2010 levels [1]. For neonatal mortality (deaths in first 28 days of life), this represents a reduction to 1.5 deaths per 1000 live births [2]. This commitment was timely, as England's neonatal mortality rates were stagnating following a long period of decline, and the country was lagging behind other European countries [2]. Neonatal deaths represented 42% of all child deaths in England in 2019/20 and were concentrated amongst the poorest in society [3]. In 2019/20, a third (31.7%) of neonatal deaths were to mothers in the most deprived quintile of the population; only 8.8% were to mothers in the least deprived quintile [4].

Meeting the Government's commitment to halving neonatal mortality will be impossible without also narrowing disparities between more and less advantaged families. Crucial to redressing this balance is ensuring equity of access to maternal care.

Barrier to accessing care

However, since 2017 maternity care has not been a universal provision to all women living in England [5]. Those that are not 'ordinarily resident' in the UK (including undocumented migrants, refused asylum seekers, visa overstayers), with some exemptions, are invoiced for maternity care at 150% cost of the NHS tariff. Should a debt greater than £500 remain unpaid for two months or more, the responsible NHS trust must share this information with the Home Office [6]. Migrant women fearing potential immigration enforcement are delaying their access to antenatal care [7-9]. In the year 2020, the charity Maternity Action were able to report on personal information from 136 service users seeking advice on NHS charging; 85% were from Black, Asian and Minority Ethnic background and 78% had annual incomes of less than £10,000. One in three were single mothers [10]. The recovery of debt in destitute women is unlikely, and clinical commissioning groups cover 75% of the NHS cost [11]. The human costs of problems in pregnancy due to delayed maternity care can be life-threatening; three maternal deaths were recorded by MBRRACE-UK in 2019 where NHS charging was implicated in delayed access to care [12]. The Academy of Medical Royal Colleges have called for an immediate suspension of the charging regulations and separation of the roles of the healthcare sector and migration authorities [13].

Mitigating the harm from local to national action

A stakeholder summary of an unpublished Government Internal Policy Assessment has no analysis of NHS data on charging and health impacts [14], likely because there are no routine data collection of the impact of charging on maternal and neonatal outcomes. Since April 2021, the National Child Mortality Database has been providing routine data collection through child death overview panels to try and plug this gap. However, deaths are the 'tip of the iceberg' and urgent data is needed on maternal and neonatal morbidity resulting from delayed access to maternity care. Child Death Overview Panels across England have been encouraged to use their statutory role to scrutinise the adherence of their local trusts' implementation of national charging guidance. Maternity Action, along with the Royal College of Midwives, have produced guidance on 'Improving access to maternity care for women affected by charging', which local trusts can adopt as a means of damage limitation.[15]

Nonetheless, there is far more to be done. National guidance states '*If at any point a maternity patient ceases to attend planned appointments, safeguarding procedures should apply, with immediate action taken to locate and speak to the individual to discuss any concerns they may have and their options for provision of care.*' [5] However, finance departments may not routinely share information with frontline maternity staff to inform them that women have been invoiced for care. This must be rectified. Charging policy should include robust processes from the overseas visitors team and maternity services to (1) ensure that no women are denied care due to a lack of ability to pay, (2) identify women who meet exclusion criteria prior to issuing notifications of charge, (3) use discretion to write off charges for destitute women, (4) offer affordable repayment plans based on individual circumstances, (5) encourage continuity of healthcare with provision of high quality interpreter services and translated information, alongside signposting to relevant support services. Commissioners and providers within local maternity systems should identify maternity charging as a risk within the system and audit compliance of finance departments with national guidance. Furthermore, they could audit the policy impact locally on health outcomes for mothers and neonates. Ultimately, however, the costs of implementing these processes coupled with poor maternal and neonatal outcomes is likely to outweigh any monies raised by the charging regime. Revoking this discriminatory legislation offers the only clear way to safeguard the health of all migrant women and babies.

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NP had the original idea for the article. All authors contributed to the literature search and writing of the article. NP is the guarantor. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted.

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Competing Interests

All authors report no competing interests.

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