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Maternity charges in NHS widen health inequalities

This discriminatory legislation should be revoked

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In 2019, the NHS long term plan set an ambition of halving stillbirths and neonatal and maternal mortality from 2010 levels by 2025.[1] For neonatal mortality (deaths in the 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 figures were stagnating after 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 among the poorest in society.[3] In 2019-20, a third (31.7%) of neonatal deaths were in babies born to mothers in the most deprived fifth of the population; only 8.8% were to mothers in the least deprived fifth.[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.

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 and people who have been refused asylum or overstayed visas), with some exemptions, are invoiced for maternity care at 150% of the cost to the NHS. Should a debt greater than £500 (€590; $620) remain unpaid for two months or more, the responsible NHS trust must share this information with the Home Office.[6] These charges are a barrier to safe maternity care.

Migrant women are delaying seeking antenatal care because they fear potential immigration enforcement.[7-9] In 2020, the charity Maternity Action was able to report personal information from 136 service users seeking advice on NHS charging; 85% were from ethnic minority backgrounds and 78% had annual incomes of less than £10 000. A third were single mothers (unpublished data). The recovery of debt from women with little or no income is unlikely, and clinical commissioning groups cover 75% of unpaid NHS costs.[10] Problems in pregnancy related to delayed maternity care can be life threatening: in 2019, MBRRACE-UK reported three maternal deaths in which NHS charging was implicated in delayed access to care.[11] The Academy of Medical Royal Colleges has called for an immediate suspension of charging regulations and separation of the roles of the healthcare sector and migration authorities.[12]

Harm reduction

A summary of an unpublished government internal policy assessment of the overseas charging regulations sent to stakeholders contains no analysis of NHS data on charging and health, probably because no data are routinely collected on the effects of charging on maternal and neonatal outcomes. Since April 2021 the National Child Mortality Database has been collecting routine data through child death overview panels to try to plug this gap. However, deaths are the tip of the iceberg, and data are urgently 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 local trusts' adherence to national charging guidance. Maternity Action and the Royal College of Midwives have produced guidance on improving access to maternity care for women affected by charging, which local trusts can implement in their efforts to reduce harm.[13]

But far more should 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 inform maternity staff that women have been invoiced for care. This must be rectified. Charging policy should include robust processes within overseas visitors teams and maternity services to ensure that nobody is denied care because they are unable to pay; identify those who are exempt from charges before issuing notifications of charges; use discretion to write off charges for those experiencing destitution; offer affordable repayment plans based on individual circumstances; and encourage continuity of healthcare, including provision of 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 and audit finance departments' compliance with national guidance. They could also audit the policy's effect 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 money raised by charging. Revoking this discriminatory legislation is the only clear way to safeguard the health of all migrant women and their babies.

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