Department of Health

2012 Review of overseas visitors charging policy

Summary report

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2012 Review of overseas visitors charging policy

Summary document

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Comment on 2012 Review

It is important to keep in mind the limitations of the analysis presented as part of the review 2012. There is no comprehensive evidence covering this subject (be it in academic literature, official statistics or easily accessible data from sources such as Hospital Trusts). The estimates that were presented in the 2012 review were based on a small survey of overseas visitors' managers and extrapolations of travel data/border movements and are therefore considered to be subjective rather than objective and unlikely to provide us with a true national picture. In addition, estimates were derived from multiple data sources, such as Home Office, Office for Higher Education, Trust accounts, and others, which may lack accuracy, sometimes contradict each other and most of the time cannot be easily compared. Consequently the estimates in this document should be considered as no more than an illustration of likely scope.

We recognise the need for a better understanding, of the extent to which people are accessing, or attempting to access, free services fraudulently, or otherwise escaping detection because they are not identified as chargeable, or even though identified as chargeable they then fail to pay.

We have therefore commissioned an independent 'audit' to provide most recent and more comprehensive assessment of the extent of NHS use and abuse by non-residents. Specifically, the objective of the 'audit' is to provide us with an understanding on the size and nature of the problem in a systematic and robust manner. This work will take a two stage approach including both qualitative and quantitative analysis. This will run in parallel with the consultation and will report in early September 2013.

3 July 2013

Chapter 1: Introduction

1. This review was announced in March 2011 as part of the Government's response to an earlier consultation on more limited changes to current policy and regulations relating to the charging of overseas visitors in the NHS. It indicated the need for a more comprehensive and fundamental review considering the full scope of who should be charged and for what services, and how the rules are applied from identification of chargeable patients in hospitals through to charging and recovery.

2. A review of this scale has never been undertaken. Previous updates have been piecemeal and ad-hoc resulting in rules and processes that have become complex with no strategic view on their relative generosity. This has entrenched issues of variable enforcement and poor recovery of applied charges.

3. Key external drivers for the review are:
   a. Unprecedented financial demands on the NHS's budget
   b. Increased mobility of migrants and numbers of visitors to the UK

Purpose of this report

4. This is a summary report that sets out the main issues identified with current policy, and initial considerations of potential new policy options.

5. This is the conclusion of an initial phase of work that has looked in detail at problems with the current system and their underlying causes, health needs and costs of the range of visitors, and possible options both to change current eligibility rules and to apply them more effectively and efficiently.

6. Most of these options would require further development, including agreement with other Government Departments, legal advisors and key stakeholder interests prior to developing any public consultation. Moreover, a key conclusion is that to achieve any significant change will require an integrated package of changes to both entitlement rules and supporting processes.

This report therefore seeks the initial views of ministers on:

a. the broad conclusions on the current policy and its deficiencies;

b. the extent of change that they want any new policy to deliver;

c. the potential key components of such a change package that might be evaluated and developed further.

Chapter 2: Policy background

7. The 1946 NHS Act set out the duty of the Minister of Health to provide services free of charge for 'the people of England [and Wales]'. From its inception, the NHS has been funded from general taxation. Residents do not pay directly for their healthcare through any hypothecated health tax or insurance payment and there is no link between contribution and access. However, a common public perception is that entitlement to free NHS treatment is, or should be, linked to 'paying in' through the tax system.

8. Powers to charge those not 'ordinarily resident' were introduced through the NHS (Amendment) Act 1949, but were not enacted through regulations until 1982. These charges were and remain only applicable to hospital treatment.

9. The term 'overseas visitor' relates to any person who is not ordinarily resident in the UK, and therefore not automatically entitled to free NHS hospital treatment. It may include short-term tourists, longer but limited term temporary residents, those present who have no lawful immigration status, and British nationals or others with a right to permanent residence (i.e. indefinite leave to remain) in the UK but who no longer do so. Ordinary residence is not a straightforward concept and further information is provided at para.30.

10. The (Hospital) Charging Regulations also exempt a significant number of groups of overseas visitors from hospital charges. These include most students, all those working, those lawfully present for more than a year, all those taking up permanent residence (they are exempt with immediate effect), many other smaller categories and the dependants of anyone covered by an exemption. However many of these exemptions clarify rather than alter the rules, as many could anyway qualify as ordinarily resident. The Charging Regulations also exempt specific services, notably A&E (but not further emergency treatment if then admitted) and communicable diseases and sexually transmitted infections.

11. NHS hospitals have a statutory duty to identify all chargeable overseas visitors under the Charging Regulations and subsequently to make charges for and recover the cost of treatment from them. This is typically carried out by Overseas Visitor Managers (OVMs) and their teams.

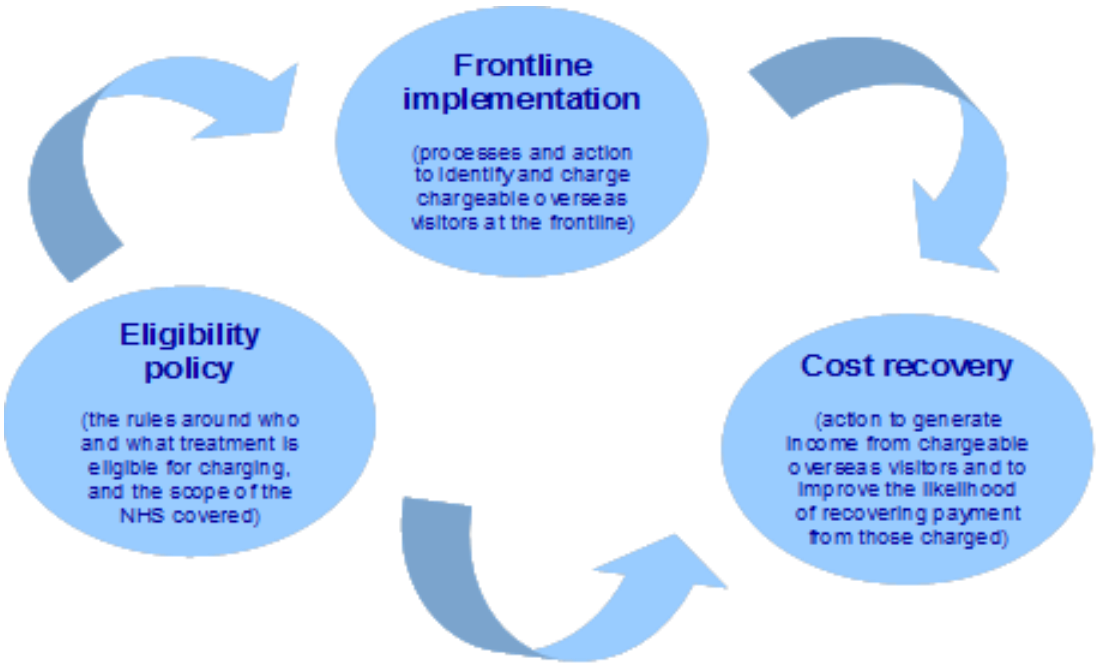
12. In October 2011, new Immigration Rules provide for a person with an outstanding debt of more than £1,000 for NHS treatment to be denied new or extended entry to the UK.

13. Overlaying the overseas visitor charging system are the EU Social Security Regulations, where the NHS provides healthcare to any 'insured' person visiting from the EEA (and registered EEA pensioners now residing here), but the UK is entitled to reimbursement by the patient's home Member State. In addition, EEA nationals and their non-EEA family members have a right to reside in the UK under the European Free Movement Directive, meaning that they can immediately receive free NHS treatment.

Chapter 3: Analysis of the charging policy and system

Overview

14. The 'system' that delivers the policy of charging non-residents for healthcare services provided by the NHS comprises three elements – the rules, the frontline process of identifying and charging and the subsequent recovery of those charges. The eligibility rules cover the scope of services as well as who and what treatment may be chargeable. The three elements are highly interdependent.



15. Although they are interdependent it is necessary to consider each separately to understand the main problems and weaknesses of the current system. 'Eligibility' can be further split into the scope of chargeable NHS services and who is chargeable within that scope.

16. Our research and evaluation of the current system has been informed by engagement with frontline NHS staff, interest groups and policy experts. We have also substantiated our understanding of both current performance and the potential for change through analysis of:

    a. Trust accounts relating to invoices raised and debts written off

b. Responses from 23 Trusts on a range of specific issues

c. Migration and border movement and health economics data to quantify potential health needs and costs for key migrant groups

17. Some significant quantitative conclusions have been drawn from this analysis. However, findings are often caveated by limited availability of data and poor accuracy of local data. Financial estimates in particular should be considered only as indicative of scale. Any future policy development will need to consider the need for new data collections or other means to generate a more reliable database.

Eligibility rules – NHS scope

18. The current power in primary legislation to charge those not ordinarily resident has never been enacted for any setting other than NHS hospitals. This disparity of the scope of charging results in a number of significant issues.

19. Areas excluded from charging include

a. primary care (GP services, prescriptions, dental and optical)

b. community based services outside of hospitals

c. most NHS continuing care packages

d. NHS commissioned services provided by non-NHS bodies/providers

e. Treatment in Accident & Emergency units

f. Treatment for infectious diseases

Primary care

20. There is no legislation or extant guidance relating to the provision of primary care to visitors so all overseas visitors have a right to free primary care. GPs have a broad discretion to register any person regardless of residential status, and can only refuse a registration on reasonable, non-discriminatory grounds. Where a GP practice refuses to register a person under the current rules, that person can request the PCT to assign them to a provider of primary medical services. The PCT must comply. A person who is present in the country for more than three months will typically be given a permanent registration.

21. However, there is extensive anecdotal evidence of widely differing approaches between GP practices, and confusion among both GPs and PCTs. There is evidence of a prevailing incorrect belief that a person must be ordinarily resident in the UK in order to qualify for free primary medical services. Some practices have deregistered or failed to register people they believe to be ‘ineligible’ in some way due to their immigration status. This has resulted in legal challenges from those denied access.

22. In addition, many patients, and indeed some GPs and hospital staff, wrongly believe that registration with a GP or holding an NHS number gives entitlement to free hospital treatment whereas they are in fact irrelevant.

23. Any overseas visitor who is accepted onto a GP's list is entitled to receive NHS prescriptions and is subject to the same rules as any other patient, i.e. they pay the NHS prescription charge per item unless they hold a valid exemption under the prescription charging rules. This means for instance that all overseas visitors aged over 60 are entitled to a free NHS prescription. Visitors are less likely to be able to access free prescriptions through other exemptions linked to the benefits system, but they would be able to apply to the NHS Low Income Scheme.

24. Residence status is also irrelevant for optical or dental services. Short-term residents, visitors and irregular migrants are entitled to pay NHS charges or qualify for an exemption for dental treatment and gain a free sight test or optical voucher on the same eligibility criteria as permanent UK residents. However, unlike GP services, there is no evidence of significant confusion or other issues relating to overseas visitors' access to these areas.

Other NHS providers and non-NHS providers

25. Regulations only allow charging of overseas visitors where an NHS hospital (or its staff) provides the services. Therefore they do not permit charging for services provided by:
    a. NHS providers that are not a 'hospital', e.g. care homes providing NHS continuing care;
    b. Other providers that are not NHS bodies but are providing NHS funded and commissioned services, including social enterprises, independent sector treatment centres (ISTCs) and other independent providers;
    c. Local Authorities, which may begin to provide or commission secondary care in the provision of public health services as a result of the Health and Social Care Act (2012).
26. Therefore, under the current scope of the charging rules, the same treatment could be chargeable or not dependant on what body provides it. It also means that continuing healthcare treatment referred from hospitals following chargeable major acute treatment may have to be provided for free. As an example, Community Health Services once provided by PCTs are chargeable if they transferred to hospitals, but not where transferred to the third sector.

Exempt hospital services

27. Treatment for listed communicable diseases and all sexually transmitted infections are free so as not to compromise infection control and public health. Family planning services are free (but not abortion, IVF, or obstetric services including childbirth). Mental Health treatment for those detained compulsorily is also exempted. This review has not called these exemptions into question.

28. Treatment in hospital accident & emergency departments is also free, although any subsequent treatment as a result of admission as an in-patient

from A&E or as an outpatient is chargeable. There is some evidence of higher, and sometimes inappropriate use of A&E by short term visitors and others who may experience barriers to registering with a GP, or be unaware of the role of primary care.

29. Overall, these exclusions mean that settings and services that account for about 40% of total NHS treatment costs are not covered by overseas visitor charging.

Eligibility rules – ordinary residence and exemption categories

30. At present, ordinary residence (OR) determines someone's automatic entitlement to free hospital treatment. OR is not defined in legislation but is based on case law and means, broadly, living in the UK on a lawful and properly settled basis for the time being, whether of short or long duration. Nationality, citizenship, and the past or present payment of taxes or National Insurance contributions have no bearing on ordinary residence. The vagueness of the definition means that OR is difficult to interpret and apply on an individual case basis.

31. Yet despite this difficulty it can be very easy to pass an OR test so that those lawfully present in the UK for only a short period of time, or those without an actual right to reside here, may qualify and then be inalienably entitled to free NHS hospital treatment as well as entitlement to a UK-funded EHIC and to group 1 entitlement to a donated organ. The following are illustrative examples of people who would pass an OR test and be legitimately entitled to free NHS hospital treatment under the current rules:

    - A non-EEA woman coming to the UK on a marriage visa to marry a UK resident is 6 months pregnant when she arrives and will need maternity treatment and to deliver before the wedding. She is OR on arrival.
    - A non-EEA man visiting family in England on a visitor's visa has a stroke and accesses health treatment, for which he is charged. He applies to UKBA for leave to remain so that his family can care for him. From the point of making the application he could pass an OR test, making further treatment free.
    - A non-EEA woman with multiple health needs exercises rights under the European Free Movement Directive to move in with her EEA passport-holding daughter who lives and works in the UK. On arrival the mother would pass an OR test and be entitled to free hospital treatment.

32. There are no official statistics of the number of ordinary residents in England so an estimate has been derived from 2010 migration statistics. We estimate that, on average, there are about 1.4 million ordinary residents in England who have been here for less than five years and do not have a right of permanent residence (i.e. indefinite leave to remain).

33. The main categories of ordinary residents with less than 5 years of residence are students, workers and various categories of dependant family members.

About half would have arrived in the last year, reflecting regular turnover, and around one third are from EEA countries.

34. Most of the above groups are not only covered by ordinary residence, but also explicitly by an exemption from charging contained in the Charging Regulations. This overlap between OR and specific exemption categories in secondary legislation reduces the need for hospitals to consider OR specifically in many cases. However, it leads to an unwieldy and confusing system for the NHS and the public. It also makes any standalone proposal to tighten up the exemptions effectively redundant.

35. The full Charging Regulations are lengthy, exempting seven services and thirty three categories of person. The exemptions include most students, all workers (irrespective of the extent of such work) and former residents who have emigrated to work up to five years previously. There are many miscellaneous categories, plus the family dependents of exempt persons cannot be charged. Anybody arriving to take up permanent residence is immediately exempt regardless of any connections to the UK or if they have existing high cost health needs. A full list of exemptions is at Annex A.

36. The entitlement of EEA nationals is determined by EU Social Security Regulations. In principle the UK recovers the cost of treating these short-term visitors from the EEA member state – however this is dependent on Trusts identifying such patients at the frontline, the patient presenting a valid European Health Insurance Card (EHIC), and Trusts reporting details via a web portal. This also is problematic and a separate programme of work is underway to maximise recovery of this income.

37. EEA citizens and their non-EEA family members have a right of residence here under the European Free Movement Directive, but for those who are economically inactive, this is dependent on them being self-sufficient and having Comprehensive Sickness Insurance (CSI) to avoid a burden on the host State. A valid EHIC from another Member State is acceptable as CSI. However, the UK's provision for entitlement to healthcare appears incompatible with these requirements – such a person would pass an OR test and be entitled to use the NHS for free if they possessed CSI, meaning the CSI requirement is largely ignored and the burden falls on the UK. The UK is vulnerable to EEA nationals and their non-EEA family members moving here to seek extensive free healthcare when they ought to be funding it themselves through CSI, or by their Member State through EHIC.

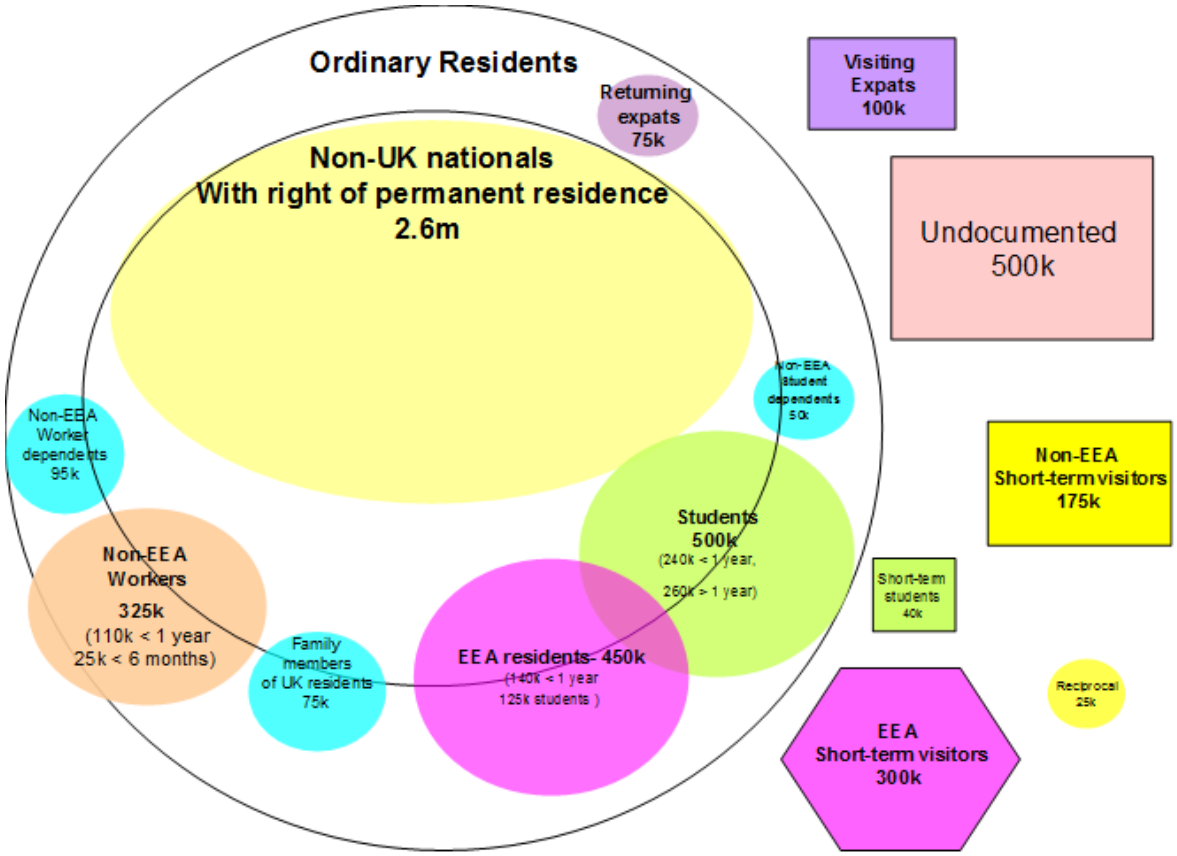
38. Reciprocal healthcare agreements are also in place with 28 other countries whereby nationals of each country receive largely free healthcare when visiting. They include Australia, New Zealand and Caribbean countries (but not other ex or current Commonwealth countries) plus a cohort of ex-Soviet and other eastern European countries resulting from ad-hoc but longstanding individual treaties. These reciprocal agreements in effect extend free healthcare to UK citizens who travel to those countries (even though they may separately have their own travel/Health insurance) at a cost of providing free treatment to visitors from those countries.

39. Compared to the total number without permanent leave to remain and who have been here for less than five years, most of whom are exempted, the number of genuine chargeable visitors are a small group. Many such visitors stay for a period of less than a week, but a few may stay for six months or more. On average, at any moment in time, we estimate that there are about 200,000[1] such short-term non-EEA visitors in the country.

40. Figure 1 summarises our best estimates for the categories and numbers of short-term visitors compared to ordinary residents present in England at any moment in time, and shows whether they are charged for their healthcare (or in the case of EEA, costs are recoverable from their government).

[1] This estimate is derived from the International Passenger Survey data – checked July 2013

Figure 1: Estimate of numbers of non-UK ordinary residents and overseas visitors present in England at any moment in time (2010)



Large circles

- outer circle contains all "visitors" who are ordinarily resident in England;
- middle circle indicates anyone who has been in England for more than a year
- inner, highlighted, circle represents all non-UK nationals with a right of permanent residence (mostly more than five years of residence)

Small circles – groups who are currently non-chargeable (either exemption or because of reciprocal agreement)

Hexagon – currently non-chargeable, but costs reimbursable from other EEA Member State (via EHIC)

Note: *Estimates needed to be derived from multiple data sources and we expect them to have at least +/-25% uncertainty.*

Key groups

41. Evaluation of the Charging Rules has identified specific challenges relating to some high profile groups who are currently chargeable.

Expatriates

42. Expatriates (British nationals no longer resident in the UK) are not automatically entitled to free NHS treatment as they are not 'ordinarily resident' here. At any moment in time, on average, there are estimated to be about 100,000 ex-pats visiting England of whom 15,000 are older than 65.

43. Many argue that they all should be exempt due to their past payment of taxes, indeed some may still be paying some UK tax. Ex pats are exempt immediately if genuinely returning to resume permanent residence (estimated to be about 75,000 ex-pats each year).

44. Effective screening and subsequent application of the charging rules for ex-pats is extremely challenging for hospital staff, in terms both of validating entitlement and of confronting the patient. Ex pats who have managed to stay registered with a GP (contrary to the Contract Regulations), may also access prescription drugs during short-term visits. In addition, as the UK already statutorily pays for the healthcare of its state pensioners residing in another EEA country (the EEA medical costs scheme), this means we effectively pay twice for the healthcare of this group if they access free treatment while visiting.

Undocumented migrants

45. A significant number of undocumented (illegal) migrants are present in the country. These include many failed asylum seekers and some human trafficking victims, other vulnerable groups, visa over-stayers and illegal workers (economic migrants). Those here unlawfully cannot be ordinarily resident so in the absence of any specific exemption they are required to pay for their NHS treatment.. A small number of other documented failed asylum seekers and human trafficking victims are exempted under the Charging Regulations see Annex A.

46. It is obviously difficult to estimate numbers of undocumented migrants but various analyses suggest around 500,000. This makes them the largest of the categories of chargeable 'visitors' and overall they account for more than half of those who are currently chargeable.

47. The overall health needs of this group are higher than for short-term visitors as they are here indefinitely. Some members of this group, e.g. failed asylum seekers and trafficked victims are likely to be vulnerable with living and welfare conditions typically associated with greater individual health needs. Others, such as illegal workers, may be healthier than the average UK resident and will therefore have little healthcare needs.

48. While here, undocumented migrants have no alternative to the NHS to meet their immediate health needs. While some are registered with GPs, others find registration difficult or do not approach a practice for fear of disclosure. Failure to identify and treat promptly risks delayed emergency hospital admission as well as public health risks. In the main, this group are unable to pay charges levied for urgent treatment and figure significantly in debts to Trusts.

49. The government needs to be mindful of international treaty commitments to which it is a signatory. The 1966 UN International Covenant on Economic and Social and Cultural Rights provides for 'the right of everyone to the highest attainable standards of physical and mental health', and 'the creation of conditions which would assure to all medical services and medical attention in the event of sickness'. The 2008 World Health Assembly organised by the WHO endorsed an international commitment to 'migrant sensitive health policies and equitable access to services'. A fundamental review of charging policy needs to have considered these and other relevant international and EU law commitments to health provision.

50. However, policy on this group's access and charging is also framed by their unlawful immigration status with a wider government, public and popular media view of the need to discourage their continued presence and for them not to benefit from 'welfare' provision.

'Health Tourists'

51. Health tourism is difficult to define, with any definition predicated on the actual rules of entitlement at the time but often distorted by personal perceptions of who should be entitled to free care. The common view is that any unpaid debts for chargeable NHS treatment constitute 'health tourism', although this excludes those who have evaded identification and charging in the first place. By definition, this latter activity is impossible to quantify.

52. It is more helpful to understand the different circumstances under which income due to the NHS from chargeable visitors is not realised:

    a. Visitors who conceal a prior intention to access NHS services that they are not entitled to access for free, with the intention of avoiding detection or, if charged, payment. Visitors from countries where healthcare is not free, available or of good quality may be incentivised to travel to the UK with the intention of accessing healthcare. Anecdotal evidence from Trusts points to a strong inflow of women from Nigeria to receive maternity services and some tentative evidence from our survey supports this. Visiting ex pats seeking NHS treatment may also fall within this definition.

    b. Visitors who, when receiving unexpected treatment, seek to evade identification or payment. If we have laws that require visitors to pay for their treatment they should have sufficient funds or insurance to cover needs that arise. Many are not doing so, and may therefore be breaking the conditions of their visa.

    c. Those who are residing here unlawfully and who receive emergency treatment but have no resources to pay for this.

53. Others that may be perceived as health tourists are only taking advantage of current (lawful) exemption categories under the Charging Regulations to access extensive and/or expensive treatment for pre-existing needs. For example, the exemption for students entitles them to free treatment, including pre-planned treatment such as IVF. However, in general most exempt visitors appear to use the NHS no more, and usually less, than the resident population.

Frontline implementation of the charging rules

54. The Charging Regulations place a legal obligation on NHS Trusts to identify patients who are not ordinarily resident, charge those liable to pay, and recover those charges. However, based on responses to our survey of NHS Trusts, we estimate that Trusts identify, on average, only between 30% and 45% of all chargeable overseas visitors.

55. The most significant reason for this low level of identification is fundamentally misaligned incentives. There is no incentive for NHS Trusts to identify overseas visitors because failure to do so has no impact on their income. This is because they still receive payment from NHS commissioners who do not know the patient was not entitled to free treatment. By requiring Trusts to identify chargeable overseas visitors we are in effect expecting them to turn down this guaranteed funding source, incur administration costs in establishing a system for identifying and charging overseas visitors, and rely on full recovery from the patient to cover their costs. As much of this will never be recovered, Trusts are effectively penalised for implementing the charging regime.

56. The screening process required by DH guidance has significant weaknesses:

    I. OVM resource is limited and thinly spread across 24/7 patient access and often several sites. Even using reception and other hospital staff to assist with initial screening it is impossible to cover all admissions.

    II. All patients should be screened on arrival to ensure none are missed and to avoid discrimination. In practice, selective and potentially discriminatory practices (such as relying on nurses' tip-offs) are employed that are ineffective and potentially unlawful. Our survey suggests less than half of all patients are screened in accordance with DH guidance.

    III. First stage screening questions, over where the patient has resided for the last year, relies on honesty and this can easily be evaded.

    IV. Engaging acutely ill patients is inherently difficult.

    V. The regulations are extensive and complex and require staff with specialist knowledge to apply them.

    VI. Many exemptions do not harmonise with easily demonstrable evidence, or require follow up checks.

    VII. GPs have no duty or incentive to flag potentially chargeable patients when making referrals (to be followed up by a specific hospital check) and there is no effective process for them to do so, which increases the likelihood of overseas visitors being missed by Trusts.

    VIII. Clinical staff have little interest in supporting OVMs in this process and may individually be resistant to the whole principles and process.

57. In some instances a charged patient's exempt status is not ascertained until some time after invoicing them, at which point the Trust has missed its chance to obtain commissioner payment.

58. Although where possible Trusts should seek payment in advance of chargeable treatment, they have a further legal duty not to delay or deny treatment that is immediately necessary or urgent (that could otherwise create an immediate or future risk to life). Such emergency

treatment is usually expensive, and therefore more difficult to recover. The misaligned incentives may result in hospitals inappropriately limiting or even refusing this treatment with major ethical, humanitarian and legal consequences.

Cost recovery

59. Based on Trusts' accounts and our survey of Trusts, we estimate that Trusts currently invoice between £35m and £55m to chargeable overseas visitors.

60. From the survey, we estimate that Trusts only manage to recover about 40% of all invoiced charges (£15m - £25m). Where Trusts receive no payment they must cover the costs of providing the treatment from their own reserves.

61. A number of factors make it difficult for Trusts to recover costs from patients. In particular:

    I. The duty to provide all immediately necessary or urgent treatment in advance of payment and regardless of the patient's ability or willingness to pay leads to inevitable unrecovered costs. The likelihood of recovery diminishes rapidly after discharge, particularly where patients leave the country or give incomplete or false contact details.

    II. A large share of costs is borne by a small number of individuals with high bills. This makes it more likely that these individuals may simply not be able to pay (notably some undocumented migrants).

    III. Trusts do not have expertise in chasing debts. Many at some point use specialist debt recovery companies but even these have very limited success and Trusts lost up to half of any such recovered income in fees.

    IV. The overall process of invoicing, and follow up recovery (including individual case handling) is time consuming and expensive. Trusts rarely recover these additional incurred costs.

62. Although some Trusts mitigate these problems by stringently limiting treatment to that which cannot wait until the patient can go home (notably West Middlesex Hospital through its 'Stabilise and Discharge' system), this has increased risks around legal duties to provide care. Clinicians are also reluctant to support it so few Trusts have applied it to any comparable extent.

63. Patient debt from unpaid charges affects Trusts' bottom lines and attracts scrutiny. Trusts are being forced to write off significant debts – £14m in 2010/11. The visible outstanding and written-off debt is problematic from a reported performance management perspective, particularly for Foundation Trusts. The written-off debt is only part of the lost income - our estimates above suggest that in 2010/11 between £20m and £30m were charged to overseas visitors, but not recovered in-year.

Costs of the overseas visitor charging system

64. We estimate that the total cost of employing OVMs in the NHS may be up to £17m and that the value of staff time lost in screening patients may be more than £1m. This reflects the current less than universal commitment to providing necessary resource to fulfil statutory

duties in respect of charging in hospitals only.

65. Further, non-quantified costs of the overseas charging system include translation costs, costs of using debt recovery agencies, record keeping by non-OVM staff etc. It is not clear whether the OV charging system is generating a net benefit to the NHS or whether the costs of operating it outweigh the income generated.

Costs of providing NHS services to non-permanent residents and visitors

Caveat [July 2013]

When we reviewed this section as part of developing the consultation documents paragraphs 65-70 were identified as being particularly speculative. As set out at the start of this document these estimates were based on a small survey of overseas visitors' managers and extrapolations of travel data/border movements and are therefore considered to be subjective rather than objective and unlike to provide us with a true national picture. In addition, estimates were derived from multiple data sources, such as Home Office, Office for Higher Education, Trust accounts, and others, which may lack accuracy, sometimes contradict each other and most of the time cannot be easily compared. Consequently the estimates in this document should be considered as an illustration of likely scope rather than a precise estimate.

The independent 'audit' is aiming to provide a more robust estimate of the costs of the use of the NHS by visitors and temporary migrants (the EEA and non-EEA) in secondary care and other services (including GP practices). It will also look to estimate costs for illegal migrants, but if this is possible the estimates will remain.

66. Using data drawn from the Trusts survey, migration/border movements and health economics data, we have estimated the cost of NHS services provided to both currently exempt and currently chargeable visitors. All of the figures in this section should be treated with caution and are presented as the upper bounds of the likely costs.

67. The value of secondary care treatment that is chargeable under current rules is estimated to be between £80m and £170m (mid-point £125m). The same treatment provided to other visitors and non-permanent ordinary residents who are currently exempt from charges is estimated to be up to £600m.

68. Other treatment and services which are not currently covered by the charging rules are estimated at a further cost of up to £640m. Within this total GP services, prescriptions and community based services each account for up to £170m. A&E accounts for more than £40m and contractual treatment by independent providers at least £50m (and likely to continue to rise). Over 85% of these costs relate to people currently not chargeable.

69. Total treatment costs for short-term overseas visitors, undocumented migrants and non-permanent residents who are ordinarily resident in England are thus estimated to be up to £1.4bn. The average costs of treatment per person are below those for the average permanent resident. It should also be recognised that some of these groups are contributing to the costs of funding the NHS through their active participation in the UK economy.

70. Around one third of visitors and temporary residents are EEA nationals whose entitlements are determined by EEA Regulations. There is therefore little scope to influence the healthcare costs of these groups (although income recovery can be improved via reporting EHIC data – see para 35).

71. At any point in time, undocumented migrants account for more than 60% of the currently chargeable population. Based on this, their total costs of treatment are estimated at up to £140m. However, they are likely to have different patterns of accessing the NHS than other groups so this is an initial estimate only.

72. The geographical spread of chargeable visitors is not distributed equally. In our survey, just 10% of all Trusts account for about 50% of all current income. All of these are in London where there is a much greater concentration of both short-term visitors and temporary residents.

73. Similarly, chargeable treatments are strongly concentrated in certain clinical specialties – broadly in the same way as treatments for permanent residents, with the notable exception of a large share of overseas visitor costs being generated in Obstetrics/Maternity. Detailed evidence from one Trust shows that a small number of highly expensive cases generate most costs. The potential to raise income from overseas visitor charging will be strongly influenced by this concentration of treatment costs in a small number of Trusts and patients.

International comparisons

74. We conducted a comparison of other countries' healthcare systems and their approaches to charging overseas visitors for treatment, to find out if there were any lessons, and to establish the relative generosity of the provision of free treatment to overseas visitors exempt from charge in the NHS, compared with that provided free by other countries to visiting UK residents.

75. Most healthcare systems that were reviewed are insurance based whereby the individual, or in some cases their employer, makes direct contributions for future potential healthcare needs. In such cases, temporary residents will be able to buy into the state system, but short-term visitors (other than intra-EEA) would be required to pay. In a few countries, additional payments or co-payments are required for some services for both qualifying residents and visitors. These can include for primary care consultations, drugs and specified treatments.

76. In most countries the onus is on all patients – whether resident or visiting – to prove that they are entitled to access state healthcare. This typically means demonstrating adequate insurance to cover the cost of treatment, even if the insurance is provided by the State and funded through taxation. In the majority of countries, a medical card provides this proof. Some health systems are fully integrated with social security information systems enabling automatic, efficient and reliable verification of entitlements.

77. Because the NHS contains no link between someone's direct contribution to the healthcare system and their entitlement to access services, provision to overseas visitors exempt from charges, appears generous by default when compared with that afforded to UK residents visiting countries with contribution or insurance-based healthcare systems.

Chapter 4: Overall conclusions of analysis

78. Bearing in mind the degree of uncertainty around the analysis presented in this report the conclusions of the analysis are:

- **The NHS appears to be recovering gross income of £15 - £25m for treatment provided to chargeable visitors and non-residents.**
- **This represents less than 20% of estimated chargeable costs.**
- **This low recovery is accounted for by only 30% - 45% of chargeable income being identified, and 60% of the charges levied not being recovered.**
- **Administering the current system (in NHS hospitals) may be costing over £15m, suggesting that the overseas visitor charging system may at best be generating a small net gain and possibly none at all.**

79. The process of screening all patients at the point of admission to determine their eligibility status has significant inherent weaknesses. It requires staff with specialist knowledge covering multi-site 24/7 access and the identification processes themselves are burdensome and unreliable. Basic screening questions can easily be evaded by the patient.

80. A significant proportion of the income is recovered from a small number of Trusts. While in part this reflects the skewed geographical spread of migrants and visitors (in particular London and some other major conurbations), it also suggests variable application of the charging regime between Trusts.

81. The most significant weakness is the fundamental financial disincentive to identify and charge visitors. By doing so Trusts forego a guaranteed full commissioner payment for the treatment provided, and replace it with a direct patient payment liability that they can never fully recover. The system actively penalises those Trusts that fulfil their duties, with no consequences for those that do so half-heartedly or not at all.

82. Separate obligations to provide expensive urgent treatment in advance of payment to those who are unlikely to have the means to pay, or pay in full, as well as difficulties in tracking patients after they leave the hospital, mean debt recovery rates will inevitably be low even where local practices are efficient.

83. The amount of income recovered within the current eligibility rules and frontline screening and recovery process is also compromised by the fact that both the largest and third largest chargeable groups of patients are ex pats and undocumented migrants. Ex pats are particularly difficult to screen and identify, and many undocumented migrants have least resources to pay charges incurred.

84. Where Trusts do not correctly identify and apply charges they receive funding from the finite funds of commissioners. Where they do identify and charge patients but they do not pay, the costs are funded from the Trust's general reserves or efficiency gains. Both create an opportunity cost and the foregoing of care for patients who are entitled to free treatment. Some such treatment stems from the NHS's humanitarian obligations, but it is individual Trusts that are bearing the brunt – there is no separate funding available.

85. Improved practices could increase both identification and recovery from the current very low levels, but the circumstances of the main chargeable groups and inherent process weaknesses limit the potential improvement. Based on our estimates, if all chargeable overseas visitors were identified, we would expect chargeable income to increase by £45m - £115m. However, given the low recovery rate, it is unlikely that this would generate more than £20m - £50m of recovered income. Even this would be dependent on removing the financial disincentives.

86. By contrast, the numbers of visitors and temporary residents who are not chargeable under the current rules is high. More significant revenue could be realised by charging some or all of those currently exempt.
87. The estimated secondary care costs (those for which powers to charge already exist) of currently non-chargeable groups is up to £600m, although one third of this relates to EEA nationals. Of the remainder, non-EEA students, workers and various categories of dependants of exempted persons comprise the largest groups. However, workers may be recognised as already contributing to NHS and other public service costs.

88. Moreover, because of the overlap of many exemptions with ordinary residence, just removing some specific exemptions that are the most commonly used would have negligible effect without replacing OR with a more definitive and less generous core residency basis for NHS entitlement.

89. Extending charging to other categories of visitor and/or NHS services carries similar risks to identification or recovery although the characteristics of some may make them slightly less problematic. However, Trusts will still only identify and recover a proportion of the potential extra income.

90. The power to charge those not ordinarily resident has only been enacted for secondary care in NHS hospitals (and not other new providers). No charges can be made for services including primary medical services, community care (given outside of hospital or provided by non-hospital staff) or prescriptions. Together these exempted services comprise around 40% of NHS treatment expenditure. Their estimated cost for all temporary residents and short-term visitors is up to a further £550m. Practical operational issues and related administrative costs may limit the scope to extend charges to some of these.

91. We estimate the total healthcare costs of non-permanent residents and visitors to be up to £1.4bn**,** of which some £360m we estimate of this could relate to EEA nationals.

92. Although there may be good policy reasons, and potentially significant income opportunities in extending the scope of charging, the NHS is not currently set up structurally, operationally or culturally to identifying a small subset of patients and charging them for their NHS treatment. Only a fundamentally different system and supporting processes would enable significant new revenue to be realised.