Department of Health

Sustaining services, ensuring fairness

Government response to the consultation on migrant access and financial contribution to NHS provision in England

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Contents

1. Introduction

1. This is the Government's response to the 2013 public consultation on migrant access and financial contribution to the NHS. This document summarises the responses to the consultation and the Government's proposals in light of the evidence and analysis.

2. The Government has set out, in this consultation and elsewhere, its view that our health system is overly generous to those who have only a temporary relationship with the UK. It has also recognised that the NHS struggles to identify and recover the cost of care from those not entitled to free treatment.

3. The main objectives of the consultation were to examine who should be charged for care in the future, what services they should be charged for, and how to ensure the current system is better able to identify chargeable patients and recover costs. The consultation and this response deal specifically with the challenges for the NHS in England.

4. In addition to seeking respondents' views on the four overarching principles and requesting any evidence that the proposals might impact disproportionately on any protected groups, the consultation asked respondents to consider a number of issues set out under four main headings. These are summarised below.

Who should be charged?

- Whether the current qualifying residency test, for free NHS care, should be revised to reflect a permanent relationship with the UK;
- A proposal to introduce a new requirement for temporary non-EEA migrants to make an explicit contribution to the costs of their healthcare either by a levy or health insurance; and
- Whether we should continue to charge visitors and illegal migrants (including failed asylum seekers liable to removal, illegal entrants and people who have overstayed their visas) directly at the point of use for hospital treatment.

What services should we charge for?

- What services should remain free to all, and which might become chargeable in the future with the proposal that all but specified public health exemptions should be chargeable for all non-exempt individuals;
- Whether everyone should have the right to register with a GP, providing the process enables recording of chargeable status;
- If, and how, charging might be extended to NHS care provided by non-NHS providers.

Making the system work in the NHS

- How the NHS might improve how it identifies and recovers costs from those who are currently chargeable;
- How the new system might work, in particular charging for primary care services;
- Where initial registration should take place and how it should operate; and
- A proposal to establish a legal gateway, with suitable safeguards, to share information to administer the charging regime.

Recovering healthcare costs from the European Economic Area

- Proposals to reduce the UK's net payments to other EEA countries through improvements to the recording of NHS treatments provided under the European Health Insurance Cards; and
- Cease reimbursement of co-payments and funding early retirees moving to the EEA.

5. In developing the consultation document and the supporting evidence paper it became clear that there was limited information available. To support the development of the policy, and a future Impact Assessment, independent professional research was commissioned to run in parallel with the consultation. The aim of this research is to provide a more comprehensive assessment of the extent of NHS use and cost by those who are currently chargeable and those who will be in the future. A summary of the findings of both strands of the independent research are set out in Chapter 3 of this document.

2. The consultation process

6. The Government undertook an 8-week public consultation from 3 July to 28 August 2013 as part of its cross-Government work on migrant access to benefits and public services. The consultation covered England only. The consultation document was available online at https://www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs.

7. In a separate parallel consultation, to the same timescale, the Home Office has looked at three specific elements of our proposals on a UK-wide basis; redefining qualifying residency, using a health levy to ensure some migrants make a fair contribution; and extending charging beyond secondary care. The Department of Health's document necessarily contained some of the questions from the Home Office consultation and the responses to these were shared with, and considered by, the Home Office. In their response[1] the Home Office sets out proposals to introduce a mechanism to ensure non-EEA temporary migrants make a fair contribution to the costs of their healthcare commensurate with their immigration status.

8. The Department of Health, received a total of 412 responses to the consultation. A full list of organisational respondents is provided at Annex B. A breakdown of respondents by group is set out in the table below.

Number of replies	Respondent [where identified]
112	Personal (mixed including residents, expats living outside the EEA and within it, personal replies from people working in other government departments)
77	NHS (mix of sources including OVMs, Trusts; GPs; GP practice managers; CCGs; CSU; personal views from clinical and non-clinical staff)
75	Voluntary sector (of which variety of focus including women/maternity; children; refugees & asylum seekers; medical; victims of trafficking or torture; missionaries; domestic marginalised groups)
14	Education
9	Professional bodies
10	Faith
19	Commercial (including staff from commercial airlines)
11	Statutory/advisory bodies (including councils, Health and Wellbeing Boards and specific health advisory panels/ groups)
6	Legal
3	Unions
76	Anonymous
412	**Total**

9. Approximately 60 of the full emailed responses from the voluntary sector, legal organisations and unions used all, part of or a modified version of a model response drafted by the Entitlement Working Group (EWG), a coalition of organisations with expertise in migrant and refugee health.

[1] *Controlling Immigration – Regulating Migrant Access to Health Services in the UK at* https://www.gov.uk/government/consultations/migrant-access-to-health-services-in-the-uk

3. Evidence: Independent research

10. In developing the proposals for consultation, we recognised that there was a need to understand the impact and scale of the use of the NHS by visitors and temporary migrants, and corresponding costs, in more detail.

11. However, while there is a great deal of speculation about the numbers of visitors and short-term migrants using the NHS, robust data are very limited. On NHS use by visitors and migrants, it is minimal (be it in academic literature, official statistics or easily accessible data from sources such as hospital trusts) and what existed was of very poor quality. The Department undertook a limited internal review in 2012 (a summary of which was published with the consultation document) to obtain some data and information in this area. The estimates in the 2012 review were based on a small sample of overseas visitors' managers and extrapolations of passenger and Home Office data on border movements. It was presented only as an illustration of likely scope.

12. The absence of primary data in this area meant we needed to commission research to try to understand better both the impact of visitors and migrants on frontline NHS services and start to develop a more robust evidence base in terms of cost to the NHS of providing care to visitors and temporary migrants. We took a two stage approach to the research, including both qualitative and quantitative analysis which ran in parallel with the consultation. The first stage was a qualitative market research study and the second phase a quantitative analysis based on population level data to model the estimated order of magnitude of NHS costs for visitors and migrants. Both strands of work were commissioned from professional, specialist organisations through a competitive process and have been independently peer reviewed by professionals with expertise in both methodologies and analysis.

13. Together they will help the Government and the NHS understand the issues and gaps with the existing processes and support the development of proposals for the new system. They also provide answers to two of the questions we have been asked in the course of the consultation. Firstly, is there really an issue with visitors and temporary migrants accessing free NHS services? The answer is, from the qualitative research, yes. From a representative sample of services in England there is a clear message from NHS clinical and non-clinical staff that this is an area that needs addressing. The second question asked what is a reasonable estimate of the size of that use? The quantitative research provides the best estimate, based on published data, available to date.

14. Full reports and summaries of both documents are available at: www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs. The key findings of each are summarised below; with further comment provided in Chapter 5 as part of the Department's formal response.

Qualitative Assessment of Visitor and Migrant use of the NHS in England: Observations from the Front Line

15. The aim of this piece of qualitative research has been to engage with a wide range of clinicians and frontline staff in both primary and secondary care settings to help us to understand their observations of dealing with issues arising from the current charging system and their thoughts on the proposed changes. We believe the report provides a

powerful message from the frontline – that there are real issues to be addressed, centrally and at a local level.

Research methods

16. The research is qualitative in nature which means that it is based on the opinions and observations of a relatively small number of people (circa 150) but that these have been explored in considerable depth. It is not about measures of how many people thought one way or another but instead, about the range of different views and where the balance of opinion lies. The findings are indicative of the broader picture in terms of demonstrating the range and diversity of practices being adopted across the NHS, but care is needed when trying to generalise to the wider population of the NHS in England.

17. The research was made up of four main components:

- Expert briefings: to begin to develop an understanding of the issues;
- Scoping study: to gain a broader and more in-depth picture from individual Trusts selected to reflect the characteristics of all 161 Trusts in England; supplemented with views from officers on the frontline at airports
- Case studies: to build greater understanding of the impact of migrants and overseas visitors in both primary and secondary care and how practices and Trusts are coping with them
- Diary exercise: to collect data about migrants and overseas visitors in a more consistent way; a voluntary 'diary' was distributed to all Overseas Visitors Advisory Group members inviting them to keep a record of all patients brought to their attention over a two week period.

Key findings

18. One of the strongest messages is the complexity and lack of understanding of the current rules around eligibility and exemptions. This has an impact in primary care, in terms of confusion about who can or cannot register with a GP and whether or not visitors are chargeable for routine treatment, with some charging and others not. In secondary care it undermines the efficiency with which Trusts can identify patients who are chargeable. It is clear that, though staff in both settings recognise some groups are potentially chargeable for hospital care, data are not being collected in any systematic way so any evidence about the numbers presenting and the impact they are having is based on estimate and individual recall.

19. There is, however, a high degree of consensus on many of the issues both within and between Trusts and primary care practices which suggests the data are reliable. The most significant of these include that:

- EEA temporary residents and their families are often felt to be having a significant impact locally, on a range of services including maternity, because of their numbers.
- A similar picture emerged for non-EEA temporary residents and their families; in addition, there were frequent reports of family members of permanent residents coming to the UK to access treatment, sometimes on a regular basis.

- Although they may not be the largest patient group, for some Trusts taking part in the research, illegal migrants (a group which includes failed asylum seekers liable to removal, illegal entrants and people who have overstayed their visas) represent their greatest challenge both because of the amount of time it can take to establish their circumstances and, once established, because such patients often cannot or will not pay for their treatment.
- Expats present problems, partly due to the difficulty of identifying those who are visiting (as opposed to returning to reside in) the UK and partly because of the expectation on the part of many expats that they are entitled to free NHS care.
- There is recognition of people who 'fly in' with the purpose of accessing NHS services and then 'fly out' again; respondents in both primary and secondary care reported the difficulty in proving intent.

20. The pressures of treating increasing numbers of migrants and overseas visitors are widely felt in both primary and secondary care organisations involved in the research. These impacts are not only financial but also include concerns about the level of professional care staff are able to give, the knock-on effect on other patients and staff morale. While the report notes that such impacts may also be associated with treating the wider patient population, there is a call for them to be recognised and addressed.

21. In terms of the existing processes, there appears to be no consistency in how the Trusts consulted are approaching the issue of identifying and charging visitors, and the current systems used in many are not sufficiently effective and robust to identify all chargeable patients.

22. Respondents acknowledge their difficulties, even those which are most proactive, so there is clearly scope to identify substantially higher numbers of chargeable patients and to improve recovery rates.

23. Respondents in both primary and secondary care broadly supported the proposals put forward by the Department of Health in the consultation, although they raise legitimate questions and concerns about how they would work in practice.

Quantitative Assessment of Visitor and Migrant use of the NHS in England: *Exploring the Data*

24. In the absence of robust primary data in this area, this quantitative phase of research starts to estimate the potential size and extent of NHS use by visitors and temporary migrants. It does not provide 'absolute' numbers but does give us a first set of estimates, based on established data and a series of logical assumptions, of the order of magnitude of the numbers and costs. It provides a credible, independent starting point and baseline in this area.

Research methods

25. The quantitative study has looked at the cost to the NHS in England of providing services to people who are not 'ordinarily resident' (principally visitors and illegal migrants) and therefore may be chargeable. It also identified non-EEA temporary migrants, who are here subject to visa restrictions, who may be charged for services in future as set out in the consultation options.

26. The analysis provides a top-down estimate based on data from the Census 2011, the International Passenger Survey (IPS) 2012 and immigration and other statistics from the Office of National Statistics, the Department of Health and the Home Office. The costs are based on 2012-13 NHS England data; the best available in the public domain at the time of the analysis (July and August 2013).

27. The visitor numbers and population estimates have been adjusted to account for the various durations of stay in England to derive a daily equivalent population i.e. the number of people present in England on an average day. The age, gender and fertility of the visitor and migrant population have then been taken into account which impact on their average health cost per head.

28. Assumptions have been made to allow for differences in underlying health needs of the migrant population using data from the Census, and for differences in the ability to access the NHS related to length of stay.

29. The estimated costs are based on an apportionment of current (2012-13) total expenditure of NHS England, covering primary and secondary care. This expenditure includes fixed costs and other overheads.

30. The analysis considers only those groups of visitors and temporary migrants for whom charges currently, or may in future, apply. It therefore excludes asylum seekers (whose claims are still in process), and others with internationally recognised humanitarian protection status, for whom the NHS is provided free of charge for the duration of their or authorised stay.

31. The analysis also excludes EEA nationals who reside for more than three months as a worker or job seeker, who are eligible for free NHS services on the same basis as any other resident. EEA workers and job-seekers are free to move between EU Member States without registering at the borders, therefore it is difficult to quantify the size of this group. Neither the Census nor IPS data enable these to be estimated reliably. However this group does represent a significant and sensitive cohort, particularly in the light of issues of differentiating economically inactive residents whose qualification for free NHS treatment may be questionable. Further analysis may be necessary to support continued policy consideration in this area.

32. It is important to note that the depth and completeness of this analysis has been constrained by the time limitations as well as the limitations on the data. The Department of Health is currently considering what work is required to develop the findings of the independent research analysis further.

Key findings

33. The UK is a very globally connected country, with historical ties, economic activities and cultural attractions which bring people here from all over the world. This is borne out by the quantitative findings, which estimates each day in England, there is the equivalent of 2.5m overseas visitors and migrants (averaged across the whole year). Of these around:

- 450,000 are from EEA countries
- 1,460,000 are from non-EEA countries
- 65,000 are UK expats (residing in both EEA and non-EEA countries)

- 580,000 are 'irregulars' (including failed asylum seekers liable to removal, people who have overstayed their visas and illegal immigrants)[2].

34. The research estimates the costs per year of each of these groups at approximately:

- £260m for EEA visitors and non-permanent residents (excluding expats)
- £1,070m for non-EEA visitors and temporary migrants (excluding expats & irregulars)
- £90m for UK expats (residing in both EEA and non-EEA countries)
- £330m for irregular migrants

35. It also estimates an additional cost of at least £70m and up to a maximum of £300m may be spent on services for 'health tourism'. Health tourists are people who have travelled to England with an intention of obtaining free healthcare to which they are not entitled, either by 'flying in and flying out' or through existing registration. By their very nature they are difficult to identify and then quantify because they are likely to make efforts to conceal their true eligibility status or are not flagged up in the system.

36. The report estimates that the average annual cost per head of an overseas visitor or migrant is around £690 which compares with an average annual cost per head for the English resident population of £1,730. This difference takes into account the assumptions outlined above; that visitors and migrants tend to have a younger profile; a greater proportion of men; different propensity to access NHS services and lower perceived health needs than the English resident population. Therefore their cost of healthcare tends to be less than residents.

37. In total, the research estimates that overseas visitors and migrants (EEA and non-EEA) in England account for around 4.5% of the population that are served by the NHS and around 2% of total NHS expenditure (but 7% of the NHS resources spent on maternity services). This means the estimate of the total cost for EEA visitors and non-permanent residents and EEA based expats is around £305m; of which approximately £220m is potentially recoverable through the European Health Insurance Card (EHIC), with the remainder potentially recoverable through S1 and other arrangements. We estimate that the NHS currently only recovers around £50m, less than 20% of the total potentially recoverable.

38. For non-EEA visitors, temporary migrants and non-EEA expats the total cost (excluding irregulars) is around £1.1bn. Of this approximately 14% (around £156m) is thought to be potentially, currently chargeable because the total gross expenditure includes both the costs of non-chargeable services e.g. A&E and primary care and those individuals who are currently not chargeable due to being ordinarily resident under current rules. The NHS in fact recovered approximately £23m in 2012-2013 (15% of total potentially chargeable).

[2] The term 'irregular migrant' is used in this research, although 'illegal migrant' is a more commonly used Government term. It is important to note that there are no Government estimates on the number of illegal migrants in the UK. All published figures, including those contained in this document, are based on the research of independent academic bodies

4. Themes & issues: summary of responses

Overarching themes

39. There were three overarching themes which emerged from the consultation responses. The first was the strength of feeling from frontline staff in their responses that 'something must be done'; this was balanced by significant concerns, including an organised response, about the adverse impact of the proposals on particular groups and the implications for public health and inequalities. The third theme was the question about whether it is worth doing and the need for a cost-benefit analysis of the impact on the NHS. Each of these is discussed in a little more detail below.

1. 'Something must be done'

40. As expected NHS staff, including clinical and non-clinical, formed one of the largest groups of respondents to the consultation. The non-clinical staff, given their proximity to the issues, were almost universally supportive of the proposals and their enthusiasm for clarifying and improving the current system was notable.

41. There was a clear message that the NHS is under significant pressure to save and, given it is not resourced to treat visitors, that it should be seeking to recover costs wherever possible. However, there needed to be recognition that this is the responsibility of all, including clinicians. While the majority of respondents want to separate out clinical decision making from any conversations about money, there is a need to hold to account those making decisions to treat without charge. For temporary migrants there was also support for seeking a fair contribution towards the cost of their care until they have formed a permanent relationship with the UK.

42. With regard to how the systems and processes might be improved there was considerable support for bringing us 'into line' with other countries, particularly for visitors. This could include ensuring any charges made more fully reflect the real cost of treatment and making people either pay or provide insurance details upfront. Following on from this was almost universal agreement across all respondents that we should focus immediately on getting better at identifying use by EEA nationals and charging other Member States for those services provided by the NHS. There was also clear support in the NHS responses for a registration process that would ensure chargeable status was easily identifiable. This support extended to developing a centralised registration system with greater sharing of information between agencies.

2. The implications for public health and inequalities

43. There were also concerns expressed in the responses from organisations representing professionals in healthcare and public health as well as the voluntary sector. These reflected a principled belief that, at all cost, we should seek to avoid discouraging ill people from seeking help, potentially discriminating against vulnerable groups, including illegal migrants (including failed asylum seekers liable to removal, illegal entrants and people who have overstayed their visas), and from increasing inequalities.

44. Much of the information provided to support these views was centred on individual cases of exclusion or the impact of delayed treatment and the negative effect charging in primary care

and A&E as well as a registration process, outside the NHS, would have on further discouraging vulnerable groups from seeking timely help. There were a significant number of responses from individuals and organisations supporting illegal migrants who were making the case that illegal migrants should be eligible for free NHS care, for both health and financial reasons, as they were often unable to pay so the expense of chasing payment far outweighs any potential cost recovery. This view was diametrically opposed to the majority of NHS staff and individual respondents who believe that the NHS should not subsidise care of people here illegally.

45. There were also specific concerns raised about particular groups who might be adversely affected by the proposals. The example most frequently cited was women, in particular pregnant women, with a body of evidence on existing issues with access used to support the assertion that this would only get worse if the proposals were to be put in place. There was also widespread support for exempting all children, not just those in local authority care, from charging. Many felt the proposals would discriminate particularly against some races with the likelihood that residents from certain groups would be more open to challenge by staff on the basis of their appearance, ethnic group or name.

3. Is it worth doing?

46. The third overarching theme was around cost benefit and cost-effectiveness. Many respondents challenged the evidence behind the proposals with many respondents willing to write-off the costs of visitors and migrants as negligible compared with the NHS budget and not sufficient to justify the process of changing rules and systems. In particular those supporting illegal migrants felt that their costs were unlikely to be recovered and for humanitarian reasons should not be pursued.

47. Others were more focused on the costs of any new system exceeding potential revenue. Particular anxieties about the cost and capability of any new IT infrastructure required to support the proposals were a thread that ran through many of the responses. These were balanced by the recognition that an effective system that identified patients as eligible for free NHS care or not would help manage NHS administrative burden and improve cost recovery, particularly in busy A&E departments.

48. While the focus of responses was on the NHS in detail, there was some consideration given to the impact of the proposals on the wider economy. In particular, in relation to the levy and the degree to which it might dissuade business, workers and students from choosing to come to the UK where they would have paid taxes, both directly and indirectly, as well as encouraging growth and links across the world.

Key issues

49. In addition to the overarching themes, a number of other key issues emerged:

1. A ‘fair contribution’: levy versus insurance

50. Overall, in the Department of Health consultation, there was a small preference for the levy, though for many this was prefaced with a rejection of any additional contribution. Of the options given the levy was seen as both less discriminatory and simpler to administer for the NHS. This view was not held by many health service respondents who appeared to believe

that health insurance would be the least burdensome for the NHS, possibly reflecting the fact that insurance is widely used internationally and is well understood.

51. Within this there was generally agreement that a single system would be simpler to operate and subject to less confusion (though a small disparate group advocated a mixed levy/ insurance model with the levy covering primary care and A&E and insurance for any further secondary or community requirements). A fixed levy was seen by most as fairer in terms of reducing discrimination which might be the result of a variable levy, e.g. based on age or reflecting levels of use. Though there was support for an opt-out it was felt that it could distort the market, and also risked people making short-term financial decisions without considering the long-term implications for their health.

52. It is important to note that across all responses, views differed on whether temporary migrants from outside the EEA should make additional contribution towards the costs of their healthcare at all. For those who do not support the proposal it was felt to be discriminatory as, once here, they are part of the community and contributing as the rest of the population either through their taxes, National Insurance contributions or indirect taxes such as VAT. Also, additional contributions were seen as contradictory to the principle of 'fairness'. For others there was a clear point of principle that the NHS should be a national not an international health service, so temporary migrants should make a proper contribution.

2. Recovering costs in primary care and A&E

53. Overall this group of proposals produced some of the most in-depth responses, reflecting the strength of feeling on this issue. The range of views also recognises that these questions cover a wide variety of services and issues. Collectively the majority of responses were opposed to the proposals to extend charging into other services. Responses set out a variety of reasons, for example the potential for discrimination when people present at a GP surgery or A&E; it is possible that certain groups are more often challenged about their eligibility as a result of their appearance or dress.

54. There were also significant concerns that this would increase inequalities; with NHS England and others citing the potential to further discourage all vulnerable people (eligible or otherwise) from seeking help and risking their own health as well as that of the population at large. From a public health perspective there are many vital services which are accessed through primary care, including infectious disease clinics, screening and childhood vaccination programmes. Even if these continued to be free to all, the threat of a fee could dissuade those who are unsure of their status from seeking care. This impact could extend further e.g. antenatal care, support for victims of domestic violence or human trafficking.

55. In terms of cost benefit, many submissions set out the financial implications for the NHS of preventing people from accessing screening or preventative treatment, leading to higher secondary care costs at a later stage and questioned the cost-effectiveness of charging in primary care where the costs are very small but the number of transactions very high. There was however recognition that unregulated access to primary care does provide people, who may not be entitled to unfettered access, to full NHS care and that some sort of control was needed to manage costs. The option to charge for services beyond GP consultation was suggested as a means by which to address public health concerns but also ensure that those who should pay for routine services (e.g. diabetic clinics) do so.

56. It was widely recognised that charging in primary care and not in A&E would lead to a shift in demand to A&E which would not only be inappropriate, but also costly. Clinical concerns

extended to charging for A&E, again associated with delay in treatment whilst eligibility was established and also with the ethical considerations. This contrasted with a relatively small group of respondents who were supportive of charging in A&E and primary care, arguing it would bring us in line with other countries.

3. Registration

57. There was widespread support for the idea that everyone should retain the right to register with a GP, though this was linked to concerns about increasing the administrative burden on GP practices.

58. Most felt that any new system should stay within the NHS and many that it should be centralised. But at this point views diverged. For many, the proposed registration process, requiring formal documentation to prove status and subsequently flagging up that status throughout the system, would provide an additional barrier, discouraging vulnerable groups seeking help, including resident populations such as the homeless. This could have individual health and public health implications as discussed above in the section on cost recovery in primary care and A&E.

59. Again there were legitimate concerns expressed about needing to avoid delay in the provision of healthcare. In particular, with a central system outside the NHS, there was an apprehension that people with chaotic lives might fail to present for registration appropriately and therefore find themselves in hospital subject to an interrogation about their status when they needed care.

60. For others, the idea of a formal registration process offers an opportunity to identify those not permanently resident; ensuring if they are chargeable that this is clearly flagged whenever they access the NHS.

4. Improving cost recovery and system re-design

61. Many people responded that they did not have the experience to comment on the proposals on what the new system might look like. Of those who did respond, some had some useful ideas on how the system might be improved and these will be used in the next phase of this work. There were also substantive suggestions from the overseas visitors managers in the qualitative research.

62. There was almost universal support for focusing on recovering monies from EEA visitors immediately rather than trying to develop any new systems. But along with this there was recognition that there needs to be a culture change within the NHS, with greater responsibility across all staff groups for the opportunity costs of failing to charge those who are not eligible for free care. It was not that respondents were advocating for medical staff to be managing the conversations about eligibility or money but that they have responsibility towards taxpayers to ensure NHS funds are spent appropriately.

63. There was some support for making better use of data systems (e.g. Home Office) from NHS staff but a comprehensive anxiety about the legal aspects of this from the voluntary sector and professional organisations. This concern extended to the proposal for an information gateway and questions about whether such a system could be established without contravening data protection and patient confidentiality principles.

64. In the case of professional bodies, concerns centred as expected, around patient confidentiality, a breakdown of trust and putting migrants and their dependents off engaging with the NHS; all of which we recognise as legitimate concerns. Those working on identifying and charging patients in the NHS were almost universally in favour of establishing a legal gateway for information sharing, with appropriate safeguards. Some of the practical suggestions about how this might be done practically will also be explored in the implementation work.

The Government and Department of Health would like to thank all respondents to the consultation for their very helpful comments and insights.

5. Department of Health reply

Introduction

65. The combination of the responses to the consultation and the results of the independent research make it clear that there are very real issues at the frontline in managing NHS services for visitors and temporary migrants in England. The current system is neither fair nor effective, so doing nothing is not an option.

66. However, because there is limited alternative provision of comprehensive healthcare services in the UK, while they are in England, the NHS has a responsibility to provide healthcare to anybody who needs it; just not at the expense of the British taxpayer. At its heart the NHS has a social contract between taxpayers and the resident population; with taxpayers paying for a comprehensive health service that is free at the point of delivery to all those who live here on a lawful and settled basis. In principle, others should pay for most, if not all, services they receive. We want to ensure everyone makes a fair contribution to the NHS.

67. Applying a new system will be hugely challenging and will require us to moderate and refine our proposals over the coming months. In particular, we recognise the need to balance the Secretary of State for Health's responsibilities with regard to NHS finances and recovering costs with the duty to reduce health inequalities. Consequently, in developing this response and the next steps we have taken into account, as far as possible, the concerns raised around public health, issues with discrimination against certain groups and the need to reduce inequalities. We will be seeking to work with individuals and organisations that represent vulnerable groups as we develop the programme.

68. Ultimately we have a responsibility to ensure the NHS is sustainable. We cannot afford to provide free healthcare to the world. We need to ensure we get better at identifying those who are chargeable and recovering the costs which are due; in part through improved systems and also through the immigration health surcharge[3]. This section sets out the Government's response to the issues raised by the consultation and the research and how we will take this forward in partnership with the NHS.

The Independent Research

69. The degree of speculation about the numbers of visitors and migrants using the NHS and the financial impact of this usage made it necessary to establish a robust baseline estimate. The commission of both qualitative and quantitative research gives us independent, extensive and robust evidence on which to base our policy developments. This extensive peer-reviewed research gives us the most solid evidence base ever compiled on this issue.

70. The qualitative research reinforces our belief that the complexity of the current rules undermines the ability of staff to identify chargeable patients. This leads to much confusion and inconsistency in practice; every Trust that took part approaches identification and charging differently, and in primary care there was variation in application of the rules both in

[3] In the consultation questions were asked about a health 'levy' so in the sections that reflect back respondents' views we still use this terminology. However, this is now called the 'immigration health surcharge' so in this section and 'Implementation and next steps' which address future action it is referred to as such.

terms of who should be allowed to register and whether or not they could charge visitors for non-emergency treatment.

71. Most of the challenges reported by staff appear to reflect the fact that there is no 'fool-proof' means of identifying chargeable patients. Often patients are simply not being asked the appropriate questions at any point during their admission or care either because staff are reluctant to ask for fear of discriminating against certain groups or because they feel it is not part of their role. There are additional issues associated with charging and recovering costs with patients refusing to pay or claiming that they unable to do so. Collectively, these challenges are reported to have an impact on clinical and non-clinical staff morale, causing frustration and anxiety.

72. The figures in the quantitative research are based on robust data from reliable sources, combined with some logical, plausible assumptions which are informed by academic research. They therefore provide us for the first time with an objective and independent estimate of the order of magnitude of the potential income to be recovered for the NHS, although it is important that this set of estimates in considered with the necessary caveats and qualifications that have been provided. The key data is set out in the table at Annex C.

73. In summary it is clear from the two studies that:

- There are significant numbers of visitors and temporary migrants who access necessary NHS services and should pay for some NHS services under current rules (either directly or through their EEA government).
- Age, gender, health need, access and other factors mean that per capita migrant health usage and costs are typically lower per individual than for the core English resident population. Nevertheless the total cost of this healthcare provision is considerable. The estimated gross cost for visitors and non-EEA temporary migrants under current rules is around £1.4bn. Further costs in excess of £300m are incurred in providing necessary treatment to illegal migrants (including failed asylum seekers liable to removal, illegal entrants and people who have overstayed their visas).
- Of this cost, around £950m relates to those non-EEA temporary migrants who it is intended will in future pay an immigration health surcharge that will contribute to this cost.
- These baseline costs are based on routine use of the NHS according to arising needs. This is consistent with the behaviour of the overwhelming majority of temporary migrants and visitors.
- However a small minority actively make excessive and expensive use during their limited stay (it is this smaller category that we have defined as 'health tourists'). Health tourists are people who have travelled to England with an intention of obtaining free healthcare to which they are not entitled. It is this category of direct and deliberate abuse that is, by its nature, hardest to quantify. However, their use of NHS services is estimated to add at least a further £70m and up to a maximum of £300m to the baseline costs of the NHS. This health tourism broadly falls into two types:

    i. Individuals whose need is typically for high-cost urgent or emergency hospital treatment, sometimes sought immediately on arrival, usually but not always as a one off. It may include maternity care. The research estimates that this type of health tourism could be costing the NHS between £20m and £100m per year.

ii. Frequent visitors (who may have family or friends who are residents in England) whose need is for more routine, typically lower-cost healthcare and, for example, take advantage of NHS services by registering with a GP and obtaining treatment including prescriptions and some elective (non-emergency) hospital referrals. This type of health tourism could be costing the NHS between £50m and £200m per year.

74. We estimate there is a potentially chargeable amount of around £388m per year. In addition, introducing a new health surcharge will generate an estimated £200m per year. This suggests over £500m could be raised from overseas visitors' and temporary migrants' use of the NHS each year. As part of the programme on the next steps, discussed in the section on *Implementation and next steps*, we will be working with the NHS to determine the detail of how this will be achieved. The breakdown of the £388m is discussed in more detail below.

75. Under current rules not all NHS services are chargeable. This means that the approximately £388m of additional potentially chargeable costs is for 'normal' use of the NHS. This does not include the additional 'abnormal' costs of health tourism or the costs of illegal migrants who may have no means to pay for chargeable care. However, the NHS currently only recovers around £73m.

76. A number of factors contribute to this low level of recovery and need to be considered in any estimate of how much more could be recovered for different groups.

77. The NHS, like all other public healthcare providers, has a legal, ethical and moral duty to provide emergency healthcare to anybody, even if costs are not recoverable. Much of the real costs of this safety net are currently hidden as Trusts are not charging and accounting for it as they should. This necessary provision, and other practical difficulties of recovery, means that full recovery is difficult in many cases.

78. The NHS only recovers about £23m of the estimated £156m chargeable cost of routine NHS secondary care use by non-EEA visitors, temporary migrants, UK expats and others who currently should be charged. This is largely attributable to the inconsistent, ineffective and poorly incentivised identification and charging of these patients that the qualitative report has evidenced. Some emergency treatment costs will be unrecoverable but there is potentially up to £133m per year of additional charges that could be recovered from this group or in some non-urgent cases their treatment avoided.

79. At least 60% of the estimated £330m per year costs of illegal migrants (including failed asylum seekers liable to removal, illegal entrants and people who have overstayed their visas) should be charged under current rules. However it is unlikely that many will have the resources to pay. The qualitative report suggests that few are actually being identified and charged. More robust identification and charging may recover a proportion but recorded debts will increase.

80. While the extent to which deliberate health tourism is occurring remains speculative, the qualitative research confirms that it is an issue for the NHS. Some of this will be acute emergency cases, including maternity, where full post-treatment cost recovery will be difficult, but more widely enforced controls could reduce this traffic. Inappropriate treatment through primary care and elective referrals should be controllable to a large degree through more effective frontline processes to charge for, or deter, much of this.

81. The research that we commissioned draws a clear distinction between 'health tourism' as qualified and quantified here, and 'medical tourism' that is the subject of some other research and academic studies[4].

82. Medical tourism relates to the incidence of a small but increasing number of healthcare consumers travelling to another country to obtain high quality treatment for which they are willing and able to pay a premium price. Many NHS hospitals offer this as a separate 'non-NHS' service, but the surpluses it generates are reinvested into NHS facilities and capacity. Health tourism by contrast is where visitors seek to obtain NHS treatment and avoid paying the appropriate charges for it, thus costing the NHS. Some commentators have wrongly conflated and reported the impact on the NHS of health tourists and medical tourists. Our proposals for change need to tackle health tourism while not compromising, and where appropriate supporting, medical tourism.

83. Calculated healthcare costs do not include the significant costs of EEA nationals who are residing as workers or active job seekers, for whom EU law requires we provide healthcare on the same basis as for any other resident. At the same time, however, the qualitative study raises issues of differentiating these categories from other residents who are economically inactive and who we may be able to charge.

84. For EEA nationals, where we are not responsible for their healthcare costs, we are typically reimbursed by their home country; this includes visitors, students and resident state pensioners. We are currently recovering around £50m of the total cost of £305m, a shortfall of £255m per year. Much of this is due to poor identification and recording of individuals when they obtain treatment, as the qualitative study corroborates. However, a proportion will not be recoverable for reasons including individuals not eligible for state-funded healthcare in their home country, or qualifying for another exemption under our own legislation.

85. Currently only secondary care provided in NHS Trusts and Foundation Trusts is chargeable. The recent consultation proposed extending charging to some or all of those services for which we do not currently charge, such as community services. However the potentially significant additional income would be heavily reliant on more effective frontline systems and administration to identify, make and recover those charges.

86. The EU Commission study[5] published on 14 October 2013 provides new information on the numbers and costs of EEA migrants, some of which our own research has as yet not been able to quantify. The headline estimated migrant numbers and associated healthcare cost in the Commission's report cannot be compared to the independent research calculation. They appear to include many long-term residents and apply treatment costs that are significantly higher than actual NHS costs. The evidence and conclusions in this report require specific consideration and we will undertake our own further analysis.

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[4] Section 8.3, page 63; *Quantitative Assessment of Visitor and Migrant Use of the NHS in England: Exploring the Data (Main Report)* www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs

[5] *A fact finding analysis on the impact on the Member States' social security systems of the entitlements of non-active intra-EU migrants to special non-contributory cash benefits and healthcare granted on the basis of residence*; DG Employment, Social Affairs and Inclusion via DG Justice Framework Contract ; 14 October 2013 http://ec.europa.eu/commission_2010-2014/andor/headlines/news/2013/10/20131014_en.htm

Who should pay for their NHS treatment?

Visitors

87. Visitors (those here on a short-term basis for less than 6 months) to the UK will continue to be expected to pay for their treatment whilst in the UK. We believe this payment should be required for their treatment, at an agreed tariff, and should represent the full cost of treatment. We expect that treatment provided to visitors would be that which is required to meet unanticipated needs and that visitors should be expected to have adequate travel insurance to cover any necessary or unexpected health needs whilst in the country.

88. The NHS has an obligation to be more rigorous about charging visitors either directly, through their personal travel insurance or, for EEA visitors, through the European Health Insurance Card (EHIC) scheme, although action is clearly needed to apply these rules more effectively. This combined with more vigorous pursuit of bills will encourage visitors not to take the risk of trying to avoid detection.

Non-EEA temporary migrants

89. Non-EEA temporary migrants, including workers, students and family members, currently, in the majority of cases, have free access to the NHS. The Government believes that those subject to immigration control should have access to public services in a manner commensurate with their immigration status; the current law does not achieve this for healthcare. The intention is therefore to align the rules regulating migrant access to the NHS with wider government policy on migrant access to benefits and social housing. To do this, the Home Office introduced an Immigration Bill on 9 October 2013 to amend the current rules so that:

    - Permanent residence will be set as the new qualifying criteria for free NHS care for non-EEA migrants subject to immigration control.
    - Temporary, non-EEA migrants will be required to pay an immigration health surcharge as part of any visa application, subject to limited exemptions.

90. We believe the immigration health surcharge is the best way to ensure non-EEA migrants make a fair contribution to the costs of their healthcare. Responses to our consultation support our view, that pooling the risks across the groups is the best way to keep the costs lower for everyone, ensuring those with disabilities or long-term conditions are not discriminated against either in terms of cover or affordability. It also meets the duty to ensure that those who live here legally, even on a temporary basis, have access to a comprehensive healthcare system as payment of this surcharge will allow access to NHS services in much the same way as a British citizen or permanent resident (possibly subject to paying for certain treatments). The surcharge will also avoid a burden on the NHS in terms of staff time, training and infrastructure.

91. We believe an insurance model would have struggled to cover similar levels of care. In addition, it would be impractical to enforce health insurance as a solution for those who come here for more than a visit - this is discussed in more detail in the Impact Assessment supporting the Home Office consultation response at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/251972/Health_impact_assessment.pdf.

92. The exact amount of the immigration health surcharge will be set by the Home Secretary through secondary legislation, but is expected to be set at around £150 per year for students and £200 per year for other non-EEA temporary migrants. By keeping the immigration health surcharge at a competitive level, it also enables the Government to recognise the contribution that non-EEA temporary migrants make to the wider economy and keep the UK competitive. The lower relative cost also recognises that temporary migrants tend to be younger than the resident population and evidence suggests their use of health services is lower. This is supported by the independent quantitative research that estimates full average costs for the temporary migrant groups in question at £690 per head.

93. As noted above, visitors and illegal migrants, who will continue to be liable for full treatment charges when accessing the NHS (subject to existing exceptions), will not have the option of paying a surcharge. The surcharge is not a license for 'health tourists' to come to the UK to obtain high-cost healthcare for existing needs. They must fulfil stringent conditions to obtain the necessary visa for their residency, and will typically be fitter and healthier. We also do not accept the contention that requiring a migrant to pay an upfront surcharge, particularly a relatively small amount, will incentivise them to seek treatment because they have 'paid for it'.

94. Non-EEA temporary migrants currently benefit from full access to free NHS care so this is a new burden for them. It would be inappropriate to limit the benefits to the wider economy by denying those with any pre-existing health conditions from coming to the UK, where their condition does not compromise their ability to undertake a skilled job or study. The pooled risk of a standard charge balances the few with higher health costs with the many with lower or minimal health costs. We will however continue to monitor for any significant adverse consequences of the surcharge approach.

95. In our consultation we raised the option of excluding some expensive treatments from the otherwise free access to the NHS provided to temporary migrants after they had paid the levy. The Immigration Bill allows for such exclusions to be specified. On consideration, we believe that exclusions would be contrary to the principles of the surcharge and that all treatment should remain freely available on the basis of clinical need. We will not therefore apply any such exclusions when the surcharge is introduced and would only consider this in the future in the event of any exceptional and compelling specific justification.

96. Some temporary migrants will come from non-EEA countries with which the UK has a reciprocal healthcare agreement. These agreements are typically provided for the benefit of short-term visitors who are able to obtain treatment for unexpected illnesses or accidents. They do not provide for comprehensive healthcare needs for an extended period as would be required by somebody who has moved their residence. We therefore anticipate that persons from these countries seeking visas allowing long term stay would still be liable for the surcharge. However, the specific conditions of each such agreement vary and some may offer more extensive or extended cover. We will therefore undertake a full review to confirm whether they may trigger an exemption from the surcharge, and where appropriate discuss and agree any conclusions with representatives of their governments.

97. Vulnerable groups such as asylum seekers, refugees, humanitarian protection cases and victims of human trafficking will also continue to have free access to the NHS in line with our international commitments, and will not be subject to the surcharge. Certain vulnerable groups, including children in local authority care, will not be required to pay a surcharge, and will continue to have free access to the NHS.

Expatriates

98. Currently many, but not all, expatriates are chargeable for healthcare when returning to the UK to visit and they are immediately exempt if they resume permanent residence. The consultation responses acknowledged that current rules are poorly understood and difficult to enforce. Responses broadly supported the idea that those with a previous long-term relationship with the country should be able to continue to access free NHS care when they are here. However others argue that full exemption (that could have significant potential cost implications) should be limited to those who have left the UK more recently or who have previously worked for the majority of their life here.

99. The Government supports the principle of those who have previously made a fair contribution continuing to be entitled to free NHS treatment and this should be consistent with the principles of ex-pat eligibility for UK pensions and other state benefits. We will therefore undertake further analysis and financial appraisal before confirming the details of any proposed new eligibility rules. We anticipate that these would come into force later in 2014 at the same time as other changes are made to introduce the new migrant health surcharge.

Illegal migrants

100. Illegal migrants (including failed asylum seekers liable to removal, illegal entrants and those who have overstayed their visas) pose a particular challenge. They may be integrated into society and the economy to varying degrees, and though they are not here lawfully they need to have access to the NHS to cover their healthcare needs. However, as a matter of principle the Government believes that this group should not be afforded the benefits of free access to the NHS but should continue to be charged, with more rigorous enforcement of cost recovery for any necessary treatment that they are given. We also propose later in this response to extend charges for those who are chargeable to a wider range of NHS treatment.

Other exempt groups

101. Understandably, an open consultation offered an opportunity for groups to make the case for new exemptions. These were many and varied and set out in more detail in Annex A, Q14. We are already committed to retain the exemptions for those present on humanitarian grounds, international obligations and treaties.

102. The most strongly supported requests included:

Pregnant women

This is a complex and sensitive area where the risks to the health of both the mother and baby if refused or deterred by the need to pay are significant. A small number of countries already exempt this group. However, our independent research confirms that deliberate maternity health tourism through the short-term visit entry is a problem, and this could only increase, potentially significantly, if services were provided free of charge. We therefore shall not be introducing any new exemptions from charging for maternity services.

Other vulnerable groups

These include victims of domestic and other violence as well as victims of human trafficking (of whom only those who have been given formal recognition as a victim, or suspected victim, are currently exempt). We are persuaded by the moral and humanitarian case, but there are practical difficulties in how NHS staff can determine objectively who this exemption might apply to. We will therefore give further thought to this area, seeking the views of relevant agencies and advisors as appropriate.

We do not intend to establish an exemption for children as we believe this poses a significant risk of abuse by visitors seeking treatment for children with existing serious illness, and may act as a draw to illegal migrant families. Vulnerable children, such as victims of trafficking, those seeking asylum, and migrant children in local authority care currently receive free healthcare and will continue to do so. We will listen to arguments about how best to cover other vulnerable children who might otherwise be denied treatment.

EEA nationals

103. We have clear obligations under EU law to the nationals of other EEA Member States. However there is evidence from the qualitative strand of the independent research of difficulties in applying the rules to this group of visitors and migrants.

104. Most visitors from the EEA should be covered under the EHIC scheme and in lesser numbers by S1 forms for state pensioners and S2 forms for planned treatment. However, many are currently not being identified, nor are the costs of their care being recovered from their home countries. Improving frontline systems to identify this group is one of our priorities in the short term. We need to improve the system so that we are better at identifying those EEA nationals who are not ordinarily resident in the UK and who do not have other rights of equal access to our healthcare system (such as workers and their family members). We will also continue to examine access to the NHS by economically inactive EEA migrants, and will explore any possible solutions that are within the parameters of EU law.

What services should we charge for?

105. The proposals to extend the requirement to recover costs for services outside NHS hospitals formed a key component of the consultation. The research gives us a reasonable estimate of the significant amount of provision which is not chargeable and it was important to consider whether charges should be extended to any other or all settings, services and treatments (with the exception of those deemed integral to protecting the public's health). There was support, particularly amongst NHS staff (and supported by the research) for limiting people's rights to access care, of any kind, in any setting, for free when they are not eligible, but this was not the majority view.

Primary care

106. We will be retaining free access to GP consultations in recognition of the critical importance of unrestricted access to early prompt diagnosis and intervention in the health interests of both public and patient health, as well as the likely cost benefits of treating the patient early to avoid emergency treatment at a later stage. We also believe that the administrative cost may outweigh the recoverable charges for frequently used but relatively

inexpensive services, but we will examine this in detail in the implementation impact assessment.

107. Our decision is reinforced by the responses to the consultation, in which all major NHS stakeholders and professionals from health and public health expressed concern that deterring people from accessing care through GPs would have a significant and negative impact on individual and public health and costs to the service of delayed treatment. In particular they provided evidence regarding the needs of children, pregnant women and women more generally, as groups who would be disproportionately affected by the proposals. There were also very real concerns about the impact on vulnerable resident populations (e.g. the homeless, travellers) who could also struggle to provide evidence of eligibility for free care and might therefore be assumed to be chargeable or who may fail to seek necessary primary care.

108. However, the GP consultation process is also the gateway to subsequent treatment that is chargeable for those who are not exempted. Currently there is little if any exchange of information between GPs and subsequent treatment providers regarding a patient's potential chargeability. Other proposals in the consultation seek to develop and implement a new registration and chargeability administration linked to their NHS Number and patient record.

109. We will therefore retain free access to GP consultations but expect GP practices to participate actively in the administration of this new system. The qualitative research, our engagement programme and a recent survey of GPs indicate that they are generally supportive of a clearer and fairer system. We will be working with GP practices to design a system that is not unduly burdensome for them.

110. Primary care includes a broader range of treatment services, mainly but not solely triggered by GP consultation. These include community based services, dental and optical services. The weight of the argument for charging in these is much stronger, e.g. for drug prescribing where there is evidence of otherwise chargeable non-residents accessing NHS prescriptions at the subsidised fixed tariff or even free if, for example, they are exempt on the basis of age.

111. We will therefore work with the NHS to determine how best to introduce and recover costs from chargeable patients in other primary care services. This will require effective registration and proper patient tracking and will pose a number of challenges (legal, operational and financial) in the detail of how this will be taken forward. This further work will be done in partnership with the NHS, other providers and professionals, in particular to safeguard public health, but in the clear expectation of extending charging to all NHS services.

Accident and emergency

112. Responses on charging in A&E were more equivocal, with less stress on the effects on public health or long-term management of health. We recognise however that there are similar challenges. There were concerns about the practicalities of charging in such a high-pressure environment and the potential delays to necessary treatment as eligibility was established, as well as the risk of limiting access or inappropriately charging vulnerable permanent residents including the homeless and travellers. These were countered by many international examples of high-quality care being provided where charging of non-residents or indeed all patients is expected and a matter of routine.

113. We believe there is a good case for visitors to pay. In parallel we recognise that A&E services are currently under considerable strain, receiving more than one million visits per year. It will be crucial that any new systems for the identification of chargeable patients and recovering their healthcare costs in such a high-pressure environment be designed in such a way as to minimise the impact on patients, staff and services. However, charging visitors might reduce the number of unnecessary A&E attendances. We therefore intend to charge for A&E care when we are confident that the new systems will work efficiently and effectively, without compromising rapid access to emergency care.

Other healthcare providers

114. This question has caused some confusion that requires clarification. In this context we are not referring to different services but to different non-NHS organisations providing the same services to patients on behalf of the NHS. Currently if a chargeable patient was to receive rehabilitation following a stroke in an NHS hospital, the Trust has a statutory obligation to recover those costs. If the same patient was discharged to a community rehabilitation facility they would not be liable for charges as those services are not chargeable. We need to address this anomaly in the current regulations to make charging possible in these other settings, subject to avoiding excessive bureaucracy.

Improving cost recovery: recouping costs from the EEA

115. There was a widespread view expressed by the majority of respondents that there is much to be done with regard to improving the current system for charging visitors in secondary care. This focused particularly on improving cost recovery from other EEA Member States through the EHIC scheme, and other arrangements including the S1 form, which provides healthcare cover for EEA state pensioners.

116. Whilst the UK is likely to continue to pay out more than it receives under these agreements for demographic reasons - because many more of our citizens visit other EEA countries and many more UK state pensioners reside in other EEA countries than happens in reverse – we agree that there is more we can do to reduce our net payments. We have already started a programme of work to undertake this and will be continuing with this over the next year.

117. More effective cost recovery would require EHIC and S1 details to be more systematically recorded by the NHS, including in general practice where S1s are presented, to facilitate claims against other EEA states. As a result, we need to make sure that any new system of registration (see Phase one of implementation section) identifies EEA citizens and effectively captures all the necessary EHIC and S1 information. This will be an integral part of improved frontline processes that also manages direct visitor charging.

118. Few respondents had views about changing current arrangements on payments which the UK is not legally obliged to make under EU law, including issuing residual S1 forms to early retirees who move to another EEA country, and the practice of refunding EHIC co-payments made when receiving healthcare in another EEA country. As these payments exceed our obligations under the EU agreement, and most other states do not make them, we intend to investigate ending them as soon as is practicable; probably from April 2014.

Implementation and next steps

119. The case for change is compelling, both in terms of the financial benefits, and to respond to the stakeholder views that the system needs to be simplified.

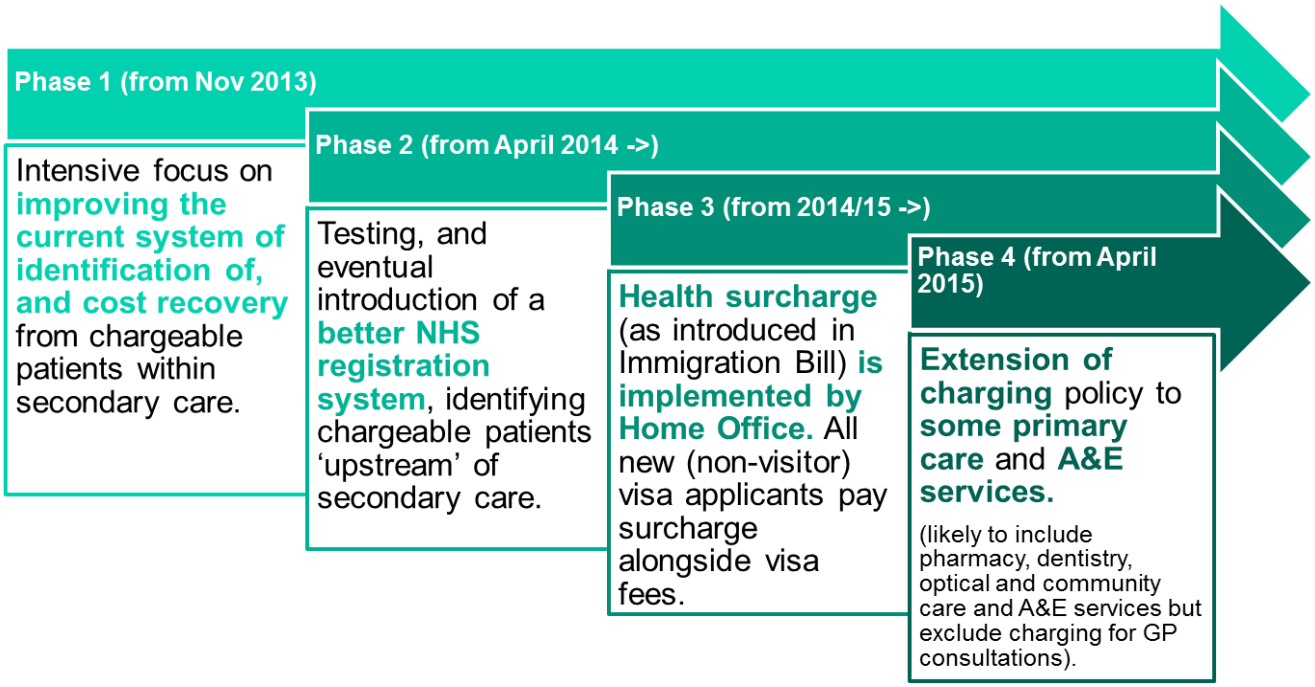
120. However, the concerns of stakeholders about how change is implemented are significant, and to ensure that we are designing practical, operational and proportionate solutions, we will work in partnership with the NHS and other stakeholders to take this forward. This will include an assessment of costs for implementation and net recoverable amounts.

121. We have appointed an independent NHS Advisor, Sir Keith Pearson, to lead implementation. He has established a senior NHS Reference Group to support design and delivery. We have also appointed a Cost Recovery Director who will lead a Cost Recovery Unit supporting implementation with NHS organisations.

122. We have included a commitment in the Mandate with NHS England to work together and with providers to identify cost-effective ways of maximising the recovery of costs incurred through the treatment of chargeable patients.

123. The high-level direction of travel for implementation is set out below. More information will be available in January and a detailed, co-produced and costed implementation plan will be published in March 2014; this will include any revised guidance to the system.

124. We will take forward implementation in **four phases**:



1) Improving the current system within the current rules;
2) Better early identification of chargeable patients;
3) Introduction of the immigration health surcharge[6]; and
4) Extending charging beyond the current rules.

[6] Implementation details, including timescales to be determined by the Home Office

Phase One: Improving the current system within the current rules

125. The consultation reinforced our view that there is a great deal of confusion and inconsistency across the system in terms of who to recover costs from and how this should be done. This is borne out by the results of the qualitative research where GPs and others spoke of their frustration with the ineffective systems that exist currently. This inconsistency extends to the actual amounts that individual hospitals are charging overseas visitors for the services they receive.

126. We will raise awareness amongst the public, visitors and migrants, and amongst NHS staff of the current rules, why they are important and why everyone has a role to play in supporting them to work. We will draw from existing good practice to develop and publish new guidance to clarify, simplify and explain the system and the rules for the NHS in early 2014. In some parts of the identification and charging pathway, incentives do not currently align, and so as part of this guidance, we will revise financial and behavioural incentives to support delivery.

127. The newly appointed Cost Recovery Director will establish a Cost Recovery Unit from the beginning of 2014 to take forward implementation.

Phase two: Better early identification of chargeable patients

128. The current system of identification and charging is concentrated in secondary care, with variable success. Identifying chargeable patients at first contact with the NHS will significantly improve cost recovery. The majority of first contacts take place in primary care, so we will be working with GPs and other primary care organisations to design and test a better system of identification of chargeable patients.

129. We face a particular challenge in demonstrating eligibility for free NHS care in that we have a residency-based system of eligibility for our healthcare system, but no ready means by which to officially prove our residency status. This was identified by a significant number of respondents, some of whom advocated the re-introduction of an ‘NHS card’. The Government does not believe an NHS card is the right way to do this, not least because of the impact it might have on the resident population. However, establishing a more rigorous registration system which identifies people’s eligibility and enables them to be tracked through the system would provide an effective means to readily confirm individual rights to free care.

130. Developing a better registration process will manage free access to the NHS through better use of information and identification of individual status throughout the NHS. There was no firm consensus on whether this should be done through individual GP practices or through a more centralised system. There are advantages to both, but in either case we will ensure that GPs do not have to be directly involved in the process of identification and establishing eligibility. We will explore and test options with stakeholders including costing proposals in time and money, and set out further plans in our full implementation plan in March 2014.

131. The improved registration process will target new registrations and it will build on current registration systems. Design and testing will take place in 2014/15 and details will be set out in the guidance we will be publishing for the NHS in March 2014. In the future, the intention is that this will link with the issuing of an NHS number, and be integrated into NHS IT systems. We will have to take a staged approach to this, initially utilising existing systems

but later developing a more integrated process. We will consider the feasibility of looking at existing registrations once we have implemented an effective system for new registrations.

132. A key part of this phase of the work will be to look at the different options to inform the final decision process; ensuring the new system is proportionate and the benefits outweigh the costs. Additionally, we will continue to take account of the impact of the policy on inequalities and protected groups, drawing on the Equality Analysis published with this document.

Phase three: Implementing the health surcharge

133. The immigration health surcharge will be implemented via Home Office legislation. The expectation is that the surcharge will be paid to the Home Office at the same time as a visa application fee. We will work with the Home Office and with the NHS to ensure that temporary migrants are aware of the surcharge, how it applies to which patients, and how this integrates with the other changes to the identification and charging system that we are implementing.

Phase four: Extending charging beyond the current rules

134. As outlined in the sections above, charging for NHS care currently only takes place in secondary care, and this consultation response sets new policy to extend services which will be chargeable in the future.

135. We will work with the NHS to test and roll out cost-effective and practical charging for services in other settings, including primary care in 2015/16, and then A&E in the future. This will be particularly conscious of minimising any negative impacts on patients, staff and services. The GP consultation will remain free.

Information sharing

136. The identification and subsequent charging of non-resident patients necessarily requires the checking and storage of personal data. This may involve information sharing across Government departments (e.g. Home Office, Department for Work and Pensions, HM Revenue & Customs) and/or appointed agencies.

137. Any systems of procedures will be developed to ensure that data sharing will be done lawfully and in compliance with the Data Protection Act. As part of the development of the new system we will consider whether it is appropriate or necessary to formalise arrangements through specific legal gateways. Such gateways could also impose appropriate limits on use of data, including recognition of the need to protect medically sensitive information. When setting out specific details of the new system we will state clearly what specific information sharing will be required to support it.

6. Next steps

138. The following table outlines how we are proposing to tackle the major issues, what we intend to deliver and by when this will occur. The list is not intended to be exhaustive but to set out the expected policy and delivery developments.

Issue	**Deliverable**	**By when?**
Involvement of NHS leadership to ensure new and/or improved policy solutions fit-for-purpose within the Service	NHS independent advisor appointed NHS reference group (including senior experts from within/outside NHS) established	September 2013 September 2013
Requirement to ensure that any new policy meets the public sector equality duty	Equality analysis of programme	November 2013
New / improved cost recovery procedures required	Cost recovery director appointed and Cost Recovery Unit established	November 2013
Policy requires translation into workable solutions for introduction into the Service (Stage 1)	Direction of travel and options for the engagement programme	January 2014
Further appraisal of case for extending exemptions to expatriates and potential new groups	Detailed analysis and development of new exemptions	January 2014
Review current reciprocal agreements against new residency criteria for those paying the migrant health surcharge	Confirmed extent of all reciprocal agreements	January 2014
Further analysis of economically inactive EEA migrant use of the NHS	Additional quantitative analysis, external legal advice and policy options	January 2014
Current rules complex and inconsistent	Publication of revised guidance to the NHS	March 2014

Policy requires translation into workable solutions for introduction into the Service (Stage 2)	Full implementation plan coproduced with the NHS	March 2014
Better NHS registration systems	Build on current systems and pilot new system Rollout new integrated IT system	2014/15 2015/16
Extending charging	Test and rollout extended charging	2015/16

Further Response

139. This initial response to our consultation signals further work to develop and evaluate new NHS processes to administer visitor and migrant charging; a key part of which will be a cost-benefit analysis. As noted above a detailed, co-produced and costed implementation plan will be published in March 2014. This will also include a full Impact Assessment for any confirmed proposals and be accompanied by any revised guidance to the system.

140. Further actions will also be set out, prior to final decisions, on expatriates and some of the charging rules themselves. More details of these will also be provided in March 2014 when we set out further progress, decisions and plans.

Annex A: What we heard - responses to consultation questions

In order to provide further background, the responses to each of the consultation questions are addressed in turn below.

Overarching principles

1. Are there any other principles you think we should take into consideration?

Responses to this question were broadly split between those believing passionately that the NHS should be open and free to all, and those who believe, equally passionately, that it should not. Instead of commenting on the proposals set out in the consultation document, a great many respondents commented on real or perceived unfairness or public health dilemmas that do not arise specifically from those proposals. Many individual responses were focused on ensuring their own and their family's free access to the NHS.

Some respondents, including British Medical Association, Trades Union Congress and the Royal College of Midwives (RCM), agreed with the principles, proposed no additional ones, but argued that the proposals did not comply with the principles.

With regard to the specific principles set out in the document, many respondents covered various aspects of the public health and immediately necessary care principles "*genuine emergency situations"* with a number of references to the special case of vaccinations requiring 'herd-immunity'. There were also a wide range of views on ways in which people 'contribute' – income tax, VAT, employment by a UK company based abroad, unpaid care-giving, work for various overseas NGOs/aid agencies for little or no pay.

Everyone who commented substantively agreed with the concept of 'fairness'; but there was little agreement as to how to define fairness, with many describing their own situation as 'unfair' compared to others using the NHS for free. [A few respondents equated 'inequality' with 'unfairness']. Additionally, for those who commented in detail, the commitment to a system which does not increase inequalities produced a fairly universal response, that these proposals are likely to increase, rather than reduce inequalities as the duty on public bodies requires.

There were a significant number of other general principles proposed including through the Entitlement Working Group model answer. Other responses articulated quite an extreme range of views rather than principles:

> "*Not to provide free services to those people that abuse the system, i.e., drug users, alcoholics, obese people, etc., that despite being treated time and time again by the NHS, have made no significant life style changes thereby costing the system more money. Be more like the French …*"
>
> *"...creating some mechanism for genuine worldwide coverage… to reimburse services received anywhere in the world at the lower of actual cost or some notional NHS average …It bears noting that those most likely to take advantage of worldwide coverage would be those living in developing countries with much cheaper pricing and without adequate public systems; they are also the people most likely to fly back to the UK and be treated at higher cost…*"

A number of respondents supported a need to encourage early presentation as well as expressing anxiety about the 'damage' charging might do to the doctor patient relationship.

Many suggested a principle around "*ethical obligations on doctors*".

There were a significant number of proposals for principles around the paramount importance of the welfare of children. This was extended by a number to women and in particular pregnant women and often linked to requests to add adherence to the UN High Commissioner for Refugees (UNHCR).

Of those who were broadly supportive of the proposals, there were a number of responses which suggested placing responsibility and accountability for decisions to treat free of charge on the heads (and budgets) of those making the decisions, such as

> "*GPs/CCGs should be made financially responsible for referring patients that are not entitled to Hospital treatment e.g. referrals without information about temporary registration… Tertiary providers should be given the opportunity to charge secondary hospitals …"* and, notably *"airlines etc. to be made financially responsible for any pregnant women they bring to this country who should not be travelling"*

One or two respondents called for clear, non-conflicting and mandatory guidance, a unified approach across the whole system and greater transparency of data:

> "*Generic approach by all Trusts… with proper training…by a central body. …centralizing the debt collection … would highlight the real problems as well as identifying those patients who hospital surf!*"

Though there were as many supporters of the principle that NHS staff should not be put in the position where there is an expectation they will exercise immigration controls.

2. Do you have any evidence of how our proposals may impact disproportionately on any of the protected characteristic groups[7]?

Though there were many well-argued responses to this question the majority of respondents did not provide any evidence, other than those who cited examples and data from their own clinics and projects, largely concerning groups who will remain exempt from charging under the government proposals. There were, however, many assertions in the majority of the substantive responses based on the respondent's individual or organisational priorities.

Some appeared to demonstrate a lack of understanding of the proposals, e.g. there was a common misconception that they will apply to asylum seekers (which they will not). Others expressed very strong views against the concept that any groups are protected, while others wanted to add vulnerable, but indigenous population groups, such as travellers and the homeless to the list of protected groups.

Groups who were felt by a majority of respondents to be impacted disproportionately included vulnerable women and children, either because they are less likely to have made National Insurance (NI) contributions for the qualifying period, or because, in some communities, or with abusive partners, they might not be in charge of their own documentation. There was particular concern expressed around maternity, where there is evidence of the poor outcomes experienced in disadvantaged communities. A large majority of respondents identified the potential for greater discrimination on grounds of race in the identification of chargeable patients and that disabled people will suffer disproportionately as a consequence of having pre-existing

[7] As defined in the Equality Act 2010: age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity

conditions. A number of suggestions were made that those with communication difficulties; either language, illiteracy or mental health-related, may suffer disproportionately.

Many respondents identified, quite rightly, that in order to develop a set of proposals there would need to be a full equalities impact assessment, and many will wish to comment on that. Finally, a small number of respondents make suggestions for practical ways of alleviating the discriminatory effects they perceive.

From the weight of views expressed, it is clear any future proposals will need to take particular care to explain a number of points including the rights of asylum seekers, and how they will be affected.

There were a number of suggestions on how to alleviate disproportionate effects. For example University College London Hospital provides such suggestions in relation to homeless or illegal migrants:

> "*perhaps compulsory NHS cards could be introduced…*"
>
> "*there could be a central homeless register held on SCR for example … This would involve an integrated multi- agency approach.*"

Who should be charged?

3. Do you have any views on how to improve the ordinary residence qualification?

Many respondents provided general views on a charging regime rather than views on how to improve the ordinary residence qualification (OR). Overall the responses suggest there is a need for clarification of OR and how it sits within the overall charging regime.

Of those who did specifically consider ordinary residence, there were two main groups. One group, a slight majority, supported the current definition remaining. They felt it is well understood as it stands, although these tended to be people who may not have to apply it in practice. However, many of those seemed under the impression that there is currently no link to immigration or residency status in the current application of the OR test, when in fact these already form part of the current decision making process. In this group there was also a view that permanent residence was too high a bar and that temporary residents should continue to qualify.

Some of this group thought that the justification for charging temporary migrants for NHS care, that they do not fully contribute to the economy, was not met by basing OR primarily around permanent residence,

> "*possession of ILR [Indefinite Leave to Remain] status seems an inadequate definition of such a contribution*".

The RCM suggested that if the relevant principle is making a fair contribution, there needs to be evidence of whether or not this is presently the case for ordinary residents, and how this would be affected by any proposed changes to the charging regime.

In the second group there was support for OR to be redefined, including for ILR to be a starting point. One respondent, although in favour of narrowing the definition, suggested that the scope of changing OR should be much wider than simply health, covering housing, education to name a few. Others called for clarity and distinction within the OR test, with one respondent saying

> "*Ordinary Residence is too ambiguous and open to interpretation. There needs to be clear advice on what qualifies someone as a current settled resident*".

There was little by way of tangible suggestions for achieving clarity, some suggesting evidence of proper settled residence in the UK, eg council tax bill; others holding a British passport or directly linked to payment of NI contributions and taxes, or a combination of nationality or citizenship and payment of taxes and NI. One respondent said there should be

> *"a qualifying period of at least 6 months for EEA nationals"*

The implication was generally that, whatever the definition, it should be communicated better to the NHS to introduce consistency and ease for those making the decision. ID cards in one form or another were mentioned as mechanism to prove OR status.

4. Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK?

The majority of respondents disagreed with this proposal, arguing that many migrants without indefinite leave to remain (ILR) were already contributing through taxes and national insurance and should be entitled to free NHS.

Those respondents who were opposed to the proposal provide several common reasons why, relating in the main to their organisational or personal interests. One of the main reasons related to the position of migrant workers, whom many identified as already "paying their way" and contributing through their taxes and national insurance contributions. There were also widely held concerns about the time it can take to get ILR. Although most immigration routes leading to settlement should render migrants eligible for permanent residence after five years, additional requirements mean that in practice many migrants take much longer to acquire permanent residence. There could potentially be migrants who have lived in the UK for many years and made a significant contribution to society, without having qualified for NHS access.

There were a number of groups which respondents deemed to be particularly vulnerable with regard to this proposal, in particular women living with HIV or those who are victims of domestic abuse and trafficking, all of whom may be dependent on others (possibly the perpetrator of the violence) for their immigration status. More generally, spouses, coming here to settle would be required to pay for healthcare, which does not appear consistent with the proposal that free access is linked to permanent residency.

Other groups whom respondents identified for specific exemption from the permanent residence requirement included failed asylum seekers and those who have been granted temporary or discretionary leave to remain (either as Zambrano Carers on Article 8 grounds or temporary leave to remain outside immigration rules). Their argument was largely that these individuals would neither be able to secure permanent residence, nor have the means to pay for their healthcare.

Quite a number of responses were in favour of the proposal, as one said:

> *"the NHS serves the 59 million people of the UK from cradle to grave, it is not resourced or funded to do this for the element of the world's population that can afford to fly to the UK and avoid paying for healthcare in their own country."*

Of these, some described the current rules as very ambiguous, and felt that the various residency tests of different government departments caused confusion for staff and patients (e.g. being able to meet a residency test and be able to claim 'benefits', which leads to the patient believing that they are OR under NHS rules). They suggested that there needs to be consistency across the system. There were suggestions that it could be changed to "Lawful Permanent Residence", with varying ranges of qualifying periods.

5. Do you agree with the principle of exempting those with a long-term relationship with the UK (evidenced by National Insurance contributions)? How long should this have been for? Are there any relevant circumstances under which this simple rule will lead to the unfair exclusion of any groups?

On the whole the vast majority of respondents who answered this question were in favour of this proposal, though some respondents appeared to have conflated past payments of NI contributions by expats visiting the UK with those temporary migrants currently paying NI or UK tax. At least 75% of respondents agreed with the proposal, including a small proportion supporting it because they are opposed to all charging for healthcare.

However, the majority were in favour as they thought it right that those who had previously paid NI and taxes in the UK should continue to enjoy free NHS treatment on visits to the UK after they have moved overseas. There were a range of views on the length of contribution ranging from 1 day to 30 years, with some suggesting a sliding scale of the number of years of NI payment equaling the number of years (after leaving the UK) of entitlement. The majority suggested 5-10 years.

Some pointed out the administrative difficulties that might arise in using this as a criterion for exemption.

> *"We have no legal gateway to obtain this information, so would need a limited access to the DWP data"*

Less than 25% of respondents were against the proposal. Of those, some felt that an artificial link between NI payment and NHS entitlement should not be made as it would confuse the basis on which the NHS is founded and could begin to redefine it as contributions based health system. One respondent said

> *"It would appear inconsistent with the thrust of the consultation proposals to place the qualification threshold on the concept of permanent residency for the majority, and an exemption for UK nationals who live abroad".*

A few respondents felt that the NHS should only be free to those who were currently resident, and not those who have chosen to live overseas.

Other responses rejected the proposal on the basis that some groups would be excluded from the exemption because they have not paid NI contributions, despite making contributions to the UK in other ways. These potentially excluded groups included people with disabilities, carers and women (and children) who may not have worked enough to have paid the necessary NI contributions but contributed through other means such as caring for family members. Young adults were specifically highlighted as potentially excluded by this proposal if they have studied, worked or volunteered abroad in the short term but fully intend to return to their homes in the UK. People granted discretionary leave to remain on asylum or humanitarian grounds will not have been able to work before the decision was granted, so less likely to have the necessary NI payments if they move overseas.

6. Do you support the principle that all temporary non-EEA migrants, and any dependants who accompany them, should make a direct contribution to the costs of their healthcare?

Respondents to this question in the Department of Health consultation were split approximately 50:50, though many used it as an opportunity to reiterate responses to other questions on payment mechanisms and exclusions.

Those who opposed this principle did so for a variety of reasons (many well-rehearsed elsewhere). These included the fact that visa fees are already substantial and a health payment could further deter people from coming to the UK. There were suggestions that some of the existing visa charges should be diverted to cover health costs. The case was also made that temporary migrants already contribute through the tax system.

The key reasons for opposition to the proposals in terms of health impact included the potential public health risk; introduction of charges might reduce access to healthcare (even when payment exemptions exist, e.g. for TB, HIV etc.) with implications for individual health and potentially the wider population. There were associated concerns related to the risk of displacing demand from appropriate primary care to expensive, and delayed, emergency care. The same respondents suggest that checking entitlement for a new group of NHS users would increase the administrative burden on the NHS and add to any implementation costs. Amongst this group of respondents there was also support for the exemption from charging of whole groups of the population e.g. children and pregnant women.

Of the other half of the responses, most were in agreement with the principle of an additional contribution by temporary non-EEA migrants. The support was either on the grounds that British citizens are not provided with 'free' healthcare when visiting other countries or that a permanent relationship should be required to gain the benefits of any society.

"Every person should make a contribution to the cost of healthcare" RC O&G

However many of respondents, who broadly supported the proposals, suggested any changes should take into account a number of things, including:

- how to ensure the revenues collected would be transferred back, in a transparent process, to the NHS,
- what services would remain exempt from charging or covered by the levy (with professional bodies opposed to charges in primary care), and
- ensuring that there was sufficient evidence that the financial benefits would justify the additional administrative burden on the NHS.

"NHS figures suggest the amount lost providing care for foreign nationals in 2012/13 was £12 million, just 0.01% of the total £108.9 billion NHS budget for the same period"

There was, however, a widely held view, both from those supporting the proposals and those who disagreed, that the Department should 'sort out' the reciprocal health agreement with the EEA and a belief that improving processes will raise further funds for the NHS, ensuring all those who should contribute are doing so.

7. Which would make the most effective means of ensuring temporary migrants make a financial contribution to the health service?

a. A health levy paid as part of the entry clearance process
b. Health insurance (for NHS treatment)
c. Other – do you have any other proposals on how the costs of their healthcare could be covered?

There was no clear consensus on this question. A small majority of respondents were in favour of having health insurance, the next largest group suggested other means (discussed below), although within this group many also suggested that it should be down to the individual to decide whether to pay for private insurance, or choose the levy. A slightly smaller number opted outright for the levy, though those who favoured no charging at all felt the levy was the best option.

A number of responses from all three groups stated that there is a lack of evidence to support the proposals and identified the potential impact on numbers of students and workers coming to

the UK. Across the board there was considerable support for focusing on recouping costs from other EEA nations for the treatment of their citizens as the best place to start.

In terms of each of the mechanisms there were a number of advantages and disadvantages identified for each. These are briefly summarised below.

Health insurance was the most favoured option by a small margin, with most respondents of the view that it would reduce the burden on the NHS. It was recognised that insurance would generate higher administrative costs across the whole health economy relative to a levy but many responses concluded that the risk and most of the administrative burden would be carried by the insurer. This was not supported by the commercial responses which identified requirements for investment in national processes and infrastructure, including the setting of a minimum level of cover and probably a recognised supplier list to prevent fraud. There was also support for health insurance as an internationally well-recognised and understood process. Concerns about insurance focused on the impact on inequalities with the likely exclusion of people requiring cover but who have long-term conditions, require maternity cover or are disabled, who would be faced with prohibitively high premiums.

Those who supported the option of a levy largely did so because it was seen as a 'fairer', simpler, having less impact on specific groups and enabling greater recognition of existing migrant contributions. In addition it would offer the opportunity to make entitlements to care explicit to all migrants, potentially reducing the tendency of some migrant groups to defer treatment for fear of incurring charges [e.g. the RCM]. Such clarity could only be optimally achieved if the levy provided access to the NHS on the same terms as ordinary residents – i.e. no services would be excluded, as suggested in the consultation. In comparison to insurance the levy is thought to be more cost-effective with lower administrative costs for the system (which acts in effect as a socialised insurance scheme).

There were questions about how people might recoup the costs of their levy should they leave the UK before the period of their visa expired. A few respondents were worried that a health levy would have the opposite effect than intended; ie that should the levy fee be too small, overseas visitors may elect to come to the UK for healthcare, knowing that any treatment would outweigh the costs of the levy. There were tentative suggestions that certain medical exemptions maybe needed i.e. for cancer care.

Many respondents suggested alternative mechanisms for payment; though most of these were hybrids of the insurance and levy. The RCM suggested that groups could be charged differentially based on the duration of their visas or the duration of their right to remain for those who do not require visas. Charges could fall for longer stays to reflect the increased likelihood of contributing to the economy. The only other specific means to cover costs was a minority view that temporary migrants should pay directly for treatment as and when it is needed ('pay as you go').

A significant minority of respondents were against any form of contribution, arguing that it would be unfair to ask temporary migrants who work and pay tax/NI to contribute twice.

8. If we were to establish a health levy at what level should this be set?

a. £200 per year

b. £500 per year
c. Other amount (please specify)?

The responses did not give a clear indication of the level at which the levy should be set (the range of suggestions were between £zero and £10,000), nor was there a clear split between the two opposing views.

A significant number of responses from migrant support groups and others said that, while they did not believe a health levy should be introduced, if it was, it should be no higher than £200. Anything higher would represent a steep increase in the costs for migrants applying to enter the UK and deter workers and students from choosing the UK. It might also put the cost of applying for visas beyond the means of some families, especially if several family members are applying to travel together.

A small number of respondents raised an issue around migrants coming to the UK for less than one year, specifically under the 'domestic worker in a private household' visa route. Their concern centres on the fact that these workers often face exploitative working conditions, warranting special consideration. The suggestion is that they should either be exempted from NHS charges, or there should be a six month levy.

The commercial and health sector respondents in the main supported a closer link between the actual costs of healthcare for individuals and either a higher or more representative levy. These responses were concerned that there is a risk that if the migrant health levy is set below a level that reflects the expected healthcare cost there will be a financial disincentive to both individuals and companies to pay for health insurance when they can choose, instead, to pay the migrant health levy on access to all NHS care. Others advocating a higher charge proposed that an administration cost should be incorporated within the levy, or that access covered by the levy should be restricted to cover GP and emergency care, but other services should be covered by health insurance.

9. Should a migrant health levy be set at a fixed level for all temporary migrants? Or vary according to the age of the individual migrant?
a. Fixed
b. varied?

The majority of respondents supported the idea of a fixed levy. Many thought that a varied levy could lead to discrimination and also be too bureaucratic to administer.

A number of respondents felt they had to answer the question but were concerned that the phrasing of the question suggested tacit approval of the levy concept which they did not support.

Support for the fixed levy came largely from lobby groups but also professional organisations such as the BMA. The primary reason was that one charge for all groups would avoid discrimination against different groups such as older people or other characteristics such as age or gender, in particular the need to access maternity services. A fixed levy would also keep it simple and decrease bureaucracy and administrative burden.

Reasons given by those who support a varied levy included the fact that costs of healthcare are not evenly spread across the age groups, the young and the old in particular are heavy users of services as well as women of childbearing age. There was also some support for varying the levy according to the health status of the individual (in the same way as health insurance). Some respondents thought the levy should vary according to the income status of the country of residence to reduce the burden on low income countries.

10. Should some or all categories of temporary migrant (Visa Tiers) be granted the flexibility to opt out of paying the migrant levy, for example where they hold medical insurance for privately provided healthcare?

Of those who answered this question a small majority would prefer that there was no flexibility to opt out of paying the migrant levy.

The majority of those that were against the idea of an opt-out in favour of private health insurance had concerns that insurance may not cover all services and potentially discriminate against groups such as people with disabilities or pre-existing health conditions. This would potentially mean the NHS having to provide cover for the complex or potentially expensive care such as maternity or long-term condition management with very little possibility of recovering any charges. Concerns were also expressed about how people might opt out in the short term to save money up-front or allow their policy to lapse, but then find that they could not fund their own care if they developed a serious condition. There was also recognition that running two systems in parallel might also place an additional administrative burden on the NHS and its staff.

For those who supported the opt-out, the advantage expressed was that those already with private health insurance would not be obliged to pay twice for a levy. There was also a view that it could be a means of reducing pressures on the NHS. For those supporting the opt-out there was recognition that the implications of their choice must be made explicit to migrants.

11. Should temporary migrants already in the UK be required to pay any health levy as part of any application to extend their leave?

The respondents to this question were split fairly evenly on this question, and as with other questions the majority of those in favour were either responding on behalf of their NHS organisation or on a personal basis.

Those responses which suggested that it would be unreasonable to pay the levy on applying to extend leave to remain did so largely on the basis that these migrants will have been living in the UK for a considerable period, during which time they have contributed to the NHS through taxation, NI and VAT. In addition, the act of applying for extension of leave clearly indicates that the migrant does not consider their stay ‘temporary’ and should, at this point access healthcare as a UK resident. It was also felt that it would be ‘unfair’ to implement any levy which would affect migrants who arrived in the UK under different entry rules, mid-way through their journey to permanent residence.

There was one suggestion that the requirement might potentially breach international humanitarian legislation. For example where an applicant or sponsor for a family visa were unable to pay the levy, refusal to renew on the basis of lack of available funds would be a disproportionate interference in the family.

Of those that support the proposal, a number said that it would bring “parity with incoming visa nationals” and that if there was to be a levy it should apply across the board. Some Overseas Visitor Managers expressed the view that those with outstanding NHS debt should settle their debt before being allowed to extend their leave [as is in fact the current position if details of the patient have been supplied to the Home Office].

A few respondents suggested that there should be scope for discretion when determining if a person should have to pay a levy when their leave to remain is extended. Centrepoint made a specific case for young people come to the UK with their families on temporary visas and then subsequently become homeless due to family breakdown. They believe young people in this position should be exempted from any levy when their status is up for renewal.

12. Do you agree that non-EEA visitors should continue to be liable for the full costs of their NHS healthcare? How should these costs be calculated?

About half of respondents agreed with the proposal that non-EEA visitors should continue to be liable for the full cost of healthcare received (outside of emergency treatment and primary care), either through reimbursement using health insurance policies or cash payment in full.

They overwhelmingly advised that payments were taken where possible before treatment was given, thereby reducing the need to chase payment and reducing administration requirements. Some offered other solutions to improve the efficiency of the collection of the money. These included basing an upfront fee on an 'anticipated care package' with reconciliation at the end of treatment and offering cost estimates before care is given so the individual can make an informed choice as to whether they still want treatment.

In terms of how the costs should be calculated, there was no clear majority. Some supported using the NHS tariff, others full cost recovery (often suggesting whichever is higher); others suggested creating a national overseas tariff which could take into account the costs provided in the UK private sector or international charges; yet others felt the tariff should reflect the level of care provided e.g. more in a specialist hospital. Some wanted an upfront administrative charge as part of the tariff. There was support for incentivising organisations to chase payments to enable reinvestment in local services. There was a belief that centralising the collection of fees would reduce the time Trusts were diverting resources.

Of those who disagreed or were less sure that we should continue to charge non-EEA visitors as we have done to date, a number of reasons were given (many of which are similar to those reasons given in answers to Question 6) namely that:

- More evidence is needed
- Chasing further payments will increase burden on clinical staff and it may be difficult to distinguish those who should be charged. It may also not be cost effective - payment should only be sought when the costs recouped outweigh the cost of obtaining the payment
- Increasing clarity regarding the rules may lead to greater use of services by visitors
- Many visitors may be deterred from accessing care (to which they are entitled) for communicable diseases, etc. due to mistrust or confusion, this may lead to increases in prevalence of some diseases, increasing public health risk.
- It may lead to those who have contributed through NI being charged for services, to which they are entitled, if they can't prove entitlement.

13. Do you agree we should continue to charge illegal migrants who present for treatment in the same way as we charge non-EEA visitors?

Responses to this question were particularly polarised and broadly fell into three clusters. There were some who wanted clarification of the term 'illegal' into two groups, those who entered and are staying illegally and failed asylum seekers who are awaiting deportation or decisions on their status. Others spoke about the wider system and the need to align any decisions with those being made for other services, e.g. social care.

The largest group of respondents (approximately 50%) agreed in principle that illegal migrants should be treated as non-EEA visitors and charged for the care they receive. Some suggested that this should be considered on a case by case basis with potential for exceptions on humanitarian grounds. Many recognised the impracticalities of doing so in many cases, either because the individual has no funds to pay, has given false information to avoid being tracked

and deported, or because pursuing payments takes substantial NHS resource, which is not always available or cost effective.

Approximately one third of respondents felt that illegal immigrants should not be charged at all; instead they should be given free access to all NHS services, irrespective of status. The reasons given included it being contrary to the founding principle of the NHS, its moral and legal obligations to the most vulnerable. There were concerns about the public health implications of dissuading people from seeking care appropriately and the impact requiring proof of entitlement might have on resident homeless and other vulnerable groups. Also practical issues about those who are in the process of trying to regularise their status and the fact they cannot work to earn the money to pay for their care.

The third group suggested that illegal migrants should only be entitled to emergency care, and therefore given no option to receive or pay for on-going NHS care. The reasons given were that it was not for the British population to subsidise the care of people here illegally and also that offering NHS care to illegal migrants (even subject to payment) risked attracting more people to come here illegally, increasing the burden on the NHS.

Some suggestions were made about how the costs might be recouped including charging the individual's country of origin, recouping the funds from the international aid budget and improving the current recovery system with national support and local financial incentives.

14. Do you agree with the proposed changes to individual exemptions? Are any further specific exemptions required?

Several responses did not engage with the specific question and there was some criticism that these two questions were asked together as some thought they were incompatible. Again, much opposition was based on the fact that a large group of respondents feel all should have free care, so exemptions are not necessary. Others thought there should be no exemptions at all, that every visitor should pay and that exemptions lead to a confusing system.

While most voluntary sector responses welcomed the consultation's continued exemptions, where they were specific to their interests, most of the other responses did not answer the first part of the question. In the main, respondents went straight to the second part, listing their own particular interest groups, in some cases even if they are already covered by existing exemptions. It was not possible therefore to assess any degree of agreement to the proposed list of exemptions or not.

Some of the most significant categories identified by respondents for exemption are set out below (children and maternity care most often cited):

- Children under 18
- Maternity care
- Women who have experienced domestic and/or sexual violence
- Those who have been and continue to contribute UK NI
- Long-term family visitors
- Those granted humanitarian protection or discretionary leave (the latter including those granted it outside the immigration rules as part of the case resolution exercise)
- Those with limited leave to remain as a result of successful applications under the Immigration Rules (Appendix FM)
- Ex-armed forces with more than 5 years' service
- Spouses of UK citizens/spousal visa holders
- Those working overseas for not for profit organisations and humanitarian aid organisations (with a UK-based agency)

- Anyone in need/vulnerable including rough sleepers (who may struggle to provide proof of entitlement), failed asylum seekers (FAS) with reporting restrictions and all destitute FAS
- Exemptions for infectious diseases such as STIs should be extended to include the overall health needs of migrants with mental health problems including developmental disorders and intellectual disabilities
- Those with long-term conditions such as diabetes.

What services should we charge for?

15. Do you agree with the continued right of any person to register for GP services, as long as their registration records their chargeable status?

Overall the majority of respondents to this question felt that the right to register with a GP should continue. Of these, a number agreed that chargeable status should be recorded at registration. Other suggestions were also made as to conditions individuals should meet before registration; e.g., a number felt that all residents should be able to register but not short-term visitors, so proof of residence or even a minimum period of residence should be required. Others argued that everyone should be able to register but for a limited period of time or as a temporary patient, potentially with a temporary NHS number.

> *"Visitors should only be registered as temporary patients and they should not be able to obtain an NHS number"*

Others felt strongly that the GP registration process should not include any questions about eligibility or chargeability. They were particularly concerned with the principle of NHS services being accessible to all those in need, and felt that this proposal could violate people's human rights or would create a two-tier system with reduced access to GPs for people without the ability to pay. Questions about eligibility or immigration status at registration would deter people from going to the GP at all; particularly vulnerable groups of illegal migrants but also residents and or British citizens, and that not seeking services could damage both individuals' health and potentially public health. There were also concerns about deterring people seeking (cheaper) preventative treatment and being redirected to A&E and other secondary services, costing the NHS more in the long term. It was also suggested that people residing in the UK should be actively encouraged to register for GP services.

> *"It is our experience that for many migrants in an irregular situation it is fear of disclosing their lack of immigration status which is the main barrier to accessing healthcare"*

> *"This is a risk for groups such as the elderly, homeless population and those without permanent or fixed addresses including some parts of the Gypsy and Traveller population…we will undoubtedly deter people with uncertain status from registering with GPs and seeking medical advice, creating a barrier to detecting disease"*

Some suggested that GP practices simply did not have the capacity, staff or skills to determine whether individuals were chargeable or not, particularly as individuals' eligibility for free treatment can change.

The respondents who answered 'no' mainly felt that people who were not entitled to receive NHS services without paying should also not be entitled to register with a GP. They argued that GPs should see those patients privately or that they should be seen on a temporary basis and not registered as this implied permanence to their access. Respondents working in the NHS noted that it is confusing for staff and patients to have a different system in primary and secondary care and that, in the current system, being able to register with a GP and/or gain an

NHS number implied to patients that they had free access to healthcare in general, rather than specifically to primary care.

> *"It is imperative that their registration reflects their chargeable status; this would ensure that patients are easily identified as chargeable and, perhaps more importantly, the individual is made aware from the first point of entry to the NHS that there will be charges."*

16. Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs?

Responses to this question appear to agree with the principle of charging temporary migrants for healthcare in all settings, albeit by a very small majority. However, it is worth noting that it is somewhat inconsistent with the response to Question 25 which asks specifically about charging in primary care and to which there was a clear majority opposed to the proposal.

There were a variety of opinions as to why respondents agreed with this proposal including, concern that the NHS is reaching a financial crisis, therefore should not continue to provide free healthcare to those who are not taxpayers of the country. It is also argued that British citizens when abroad have to pay for their own healthcare, so it is not unreasonable for migrants to the UK to do the same. Amongst those who agreed with charging across all services, views varied about the specifics of charging in the different settings; some respondents argued that both emergency and primary care should remain free at the point of access. Others suggested overall that they agreed with the principles and wanted to see those who pay National Insurance be recognised.

A number of respondents who answered 'Yes' to this question did so as they saw GP registration as the gateway to NHS care and consequently it was for the GP surgery to check an individual's eligibility to free NHS care and to inform the hospital when the patient is referred.

Although there are fewer people who said 'No' they did not agree with the principle that chargeable temporary migrants should pay for healthcare, the rationalisation provided was much more varied. The main reason cited was belief that there is not sufficient evidence to support it and concern that the cost of administration and the bureaucracy surrounding it would not be offset by the money saved.

There are also concerns that charging could deter those who have to pay to seek medical advice early, and that this could have cost implications to the NHS later as they could end up presenting at A&E in an emergency condition and end up requiring an inpatient stay. This would end up costing the NHS far more than a single visit to a GP and perhaps a prescription.

Some respondents have concerns that a policy of charging would lead to serious health inequalities and are apprehensive a policy of charging for healthcare to only a selected group of people may lead to discrimination against particular races and/or marginalise certain groups such as the homeless, refugees and those from travelling communities.

17. Do you have any comments or ideas on whether, and if so how, the principle of fair contribution can best be extended to the provision of prescribing, ophthalmic or dental services to visitors and other migrants?

Responses to this question were overall reasonably evenly split with a small majority agreeing on the principle that there should be some kind of payment to access these services.

Those that stated they are against charging in this area appear to have a general policy against charging at all; believing that the NHS should meet the needs of all regardless of immigration status and costs should be covered by general taxation. A further small percentage of people

who have stated that they would be against charges in this area have said that this is because the additional administrative burden in charging for these services would not be cost effective. Others have commented that as 'co-payments already exist in these areas it would be unnecessary and unfair to introduce additional charges for migrants'. A few respondents answered that they would be against charging for prescriptions but whilst in principle they are against charging for dental and ophthalmic treatment, they understood it is a much more difficult case to make.

The principle of fair contribution was unsurprisingly not talked about by many respondents. In the main, responders who answered this question either felt that fair contribution should be based on residency status or income.

The small majority that agreed on some form of charging for these services were hugely split between the principles of insurance, direct payment, a health levy and the idea of a migrant card or a temporary NHS number.

18. Should non-EEA visitors and other chargeable migrants be charged for access to emergency treatment in A&E or emergency GP settings?

The majority of those who responded to this question were against charging for emergency treatment, with an approximate 60:40 split.

Those who supported the proposal were clear that this should only be after treatment had been received, ensuring that the ability to pay did not have implications for whether treatment was given and was not delayed. Some also suggested that charges should be made only where the individual had the ability to pay, or had travel/health insurance that would cover this. A number noted that if the levy were introduced, this would already cover emergency care.

> *Yes but they should never be denied treatment based on ability to pay. Payment should be sought after treatment and effectively followed up for people who claim they cannot afford to pay.*

Of those who were supportive of charging for A&E and GP emergency care, many argued strongly that this was fair because UK residents are likely to be charged for these services when using them abroad e.g. in the US. Others mentioned fairness to the UK taxpayer.

Of those who responded 'no', the majority felt very strongly and gave ethical and humanitarian reasons and stated concerns about deterring vulnerable groups from accessing care. This included national organisations such as Public Health England, the BMA and other key stakeholders. The issues raised by these respondents fell into two broad categories; implications for the NHS, and concerns about the impact on patients, particularly vulnerable groups. In terms of the NHS, a number of respondents noted that the administrative burden of charging in these settings could be significant, with concerns in particular about the implications of this for the complex environment of A&E. It was felt that it could have adverse implications for patient flows and increase waiting times.

> *"*[Charging would] *impede the flow of patients in the emergency setting and cause further delays in a system that is already under considerable strain"*

Many respondents noted that defining an emergency must remain a clinical decision rather than one for administrators or receptionists. If charges were to be made, in the case of real emergencies, as identified by clinicians, the ability to pay should be investigated after treatment. A number of respondents raised concerns about charging in these settings affecting the flow of patients and the need to ensure it did not redirect demand to avoid charges.

"If A&E remains free and GP services become chargeable, this is almost certainly likely to have a direct impact on A&E services. They would run the risk of being used as a free GP walk in centre"

Many responses felt that the proposal is unethical and risks violating human rights, by delaying treatment, or because it would deter people from accessing healthcare.

"Any delays caused by ambiguities about eligibility could have disastrous consequences."

In addition, respondents raised the potential public health implications of the proposal. As well as posing a risk to individuals' health, it was felt that in cases of infectious disease, this could be damaging to public health. Some respondents argued that health professionals would not accept these risks.

"This would be ethically unacceptable to health professionals"

Others noted that charging might have implications for preventative care if individuals sought treatment later than they might otherwise, costing the NHS more overall. These issues were raised in particular in relation to vulnerable groups such as illegal migrants. A number of respondents proposed a compromise to mitigate this risk.

"I feel to be fair the first initial consultation should be exempt so the patient will be aware how serious the problem is but all the investigations and procedures should be charged."

19. What systems and processes would be needed to enable charging in A&E without adversely impacting on patient flow and staff?

Reponses to this question were reasonably evenly split. A proportion of respondents were very clear that care given in A&E should be free to all and that there should be no further consideration to charging at the point of access, nor for a specific health levy. Furthermore there were very real concerns that patients could inadvertently suffer should there be a delay in an individual presenting to A&E and treatment commencing. Others stated, as with other questions, that the extra bureaucracy and administrative burden would not be cost effective for any form of charging for healthcare.

A significant proportion (of those who were not against charging for healthcare overall) commented that charging in A&E, particularly given the current challenges of managing demand, would be unworkable and will have adverse effects.

"'*would have a negative impact on the 4 hour wait target if conversations and decisions had to [be] made regarding charging. If there is time to discuss then it is probably not an emergency*.'

To varying degrees, others gave potential examples of how it might work, such as running an advertising campaign, ensuring reception staff to check eligibility rather than placing the burden on clinical staff. One response suggested a realignment of current administrative staff in hospitals to check eligibility and others that, if a patient presented in A&E who needed to be there that they should not be charged, however if they had attended inappropriately they should be 'sent on their way'.

Respondents who favoured charging were also generally supportive of the use of health insurance. Other suggestions included ID presentation at discharge, a card stating that the bearer is entitled to NHS care, a pre-registration centre, getting one treatment in an emergency department free but then having to sign up for insurance with an on-site agent, UK identity cards, a healthcare card for all, and a tariff. The suggestion which was picked up most often was the idea of placing a credit card machine in A&E, bringing the UK in line with other European countries.

There was no agreement on whether patients should have to pay when they present at A&E or once they had been seen, with a fairly even split between responses. What was largely agreed upon by those who were in favour of charging for emergency services was that the NHS and DH should consider how costs are recouped in other countries and in particular in the United States.

20. Do you agree we should extend charges to include care outside hospitals and hospital care provided by non-NHS providers?

Respondents were divided on this question. The minority of respondents who responded 'yes' stated that this was because community services are currently stretched and with more care taking place in the community this is likely to become an increasing issue. However, others pointed out that if care is being provided by non-NHS providers they should have their own procedures for charging.

The vast majority of comments were not supportive of charging for care provided by non-NHS providers. The overwhelming reason given for this was concern that charges in this area could undermine services specifically designed to meet the needs of vulnerable people such as homeless people, destitute asylum seekers and refugees.

There were very specific concerns raised about charging for drug and alcohol treatment; charging for in-patient treatment in a hospital (e.g. for detoxification) could drive individuals to disengage from services and attempt a potentially fatal 'do it yourself' approach or an unmediated detoxification.

This question also brought up questions about the balance, or perceived 'unfairness', in the system which means that those that have broken the law and have been sent to a prison receive free rehabilitative care, as prisons are exempt, but someone who is sent to a court ordered community rehabilitation centre would have to pay for their treatment.

Those that agree with a health levy supported the idea that these services should be covered by the levy.

21. How can charging be applied for treatment provided by all other healthcare providers without expensive administration burden?

A substantial majority of respondents to this question expressed the view that it would not be possible to apply charging for treatment provided by other providers without significantly adding to the administrative burden and cost.

Concerns expressed in responses to Q20 were reiterated here; that it would disadvantage vulnerable groups as many small non-NHS services have been set up for the purpose of delivering services to vulnerable groups, e.g. refugees and asylum seekers, which would be less able to cope with the additional burden of putting charging mechanisms in place. In addition, this would entail sharing patient information with a greater range of agencies, which the respondents believe carries high risks of breaching data protection law and principles.

Of those offering solutions, the most commonly held view was that money generated by charging overseas visitors appropriately would make up for the administrative cost incurred. Specifically that modern and joined up IT systems should be used to deliver results; that it should be the concern of the provider and linked to their pay and that in any case it is not a great concern as private providers (e.g. BUPA) have their own administrative systems; that we should copy the US system; that the levy should cover such services; that overseas visitors should have to have health insurance to enter the country; and that 'pre-registration' services should be the access point to services not covered under insurance and/or the levy.

There were some special interest group responses that were opposed charging for these services as they would negatively impact vulnerable people (eg in terms of child protection) in the same way as they believe charging for NHS services would.

Making the system work in the NHS

22. How else could current hospital processes be improved in advance of more significant rules changes and structural redesign?

There were very mixed responses to this question, but with a very significant proportion of respondents believed that attention should be focussed on recouping the costs from EEA nationals before implementing any rule changes.

On the other hand, others were of the view that there is insufficient evidence that the cost of migrants/ overseas visitors to the NHS is enough to warrant putting new rules in place. Many were also concerned about any changes to the rules would encourage discrimination against certain patients, increase health inequalities, and make it more difficult to control infectious diseases prevalent in certain migrant communities e.g. HIV and TB.

There were also concerns about the concept of 'structural redesign' with the belief that the NHS had already been through enough change in recent years.

In terms of those who agreed and offered practical solutions to improve processes, many felt that IT systems would need to be improved and more clinical staff recruited to identify chargeable patients, to make any sort of useful difference. Better staff training on the issue and better communications campaigns to make staff aware of the their duties in this area were also important.

Some also suggested communications campaigns aimed at migrants and overseas visitors entering hospitals; making it the responsibility of the patient to ensure that they had the correct documentation/ paperwork with them on a visit to hospital and that people who failed to provide it should be charged. There was also a view that everyone without an NHS number should automatically be charged. For those in support of charging it was felt this should be done upfront – either via the levy or by putting a credit card machine in A&E; a few strongly advocated that relevant checks take place before a patient is treated. Some felt the NHS should be run 'like BUPA' and use their methods of recouping costs.

Many did not want the responsibility of checking a patient's status to rest with clinical staff and suggested that systems were better connected to Home Office information (for example via SPINE). The alternative was to have a 'tourism desk' in every hospital which dealt separately with anyone who was not a UK national, with a credit card machine available. For those who did feel that it was the responsibility of clinical staff or Overseas Visitors' Managers to check a patient's status, there was consensus that this would require a culture change within each Trust and the involvement of all staff. There were some practical examples from individual organisations.

In order to incentivise Trusts to properly carry out status checking, several respondents felt that hospitals should be allowed to recoup the costs associated with migrant/ overseas visitors use and reinvest them straight back into frontline services. Finally, one respondent made the suggestion that if hospitals were able to differentiate between different 'types' of debt accrued by migrants/overseas visitors then these statistics would be able to be used to assist in judging the scale of the 'health tourism' problem.

23. How could the outline design proposal be improved? Do you have any alternative ideas? Are there any other challenges and issues that need to be incorporated?

The responses varied from concerns that migrant groups should not be charged and that everyone, regardless of immigration status, should access healthcare, to others with strong views that charges should be levied upfront, in as non-discriminatory way as possible.

There were also those who expressed concern that such a proposal might create additional bureaucracy on NHS staff and that the burden should not fall on GPs or any other clinician. A number of responses seemed to support the registration system or some form of ID cards, as well as linking indefinite leave to remain (ILR) with health records and a way of reviewing (or challenging) person's status. On UK residents, some respondents felt that residents might find the idea of re-registration unacceptable.

There were some views respondents who felt there is a need for more facts and figures, without which there is no way of accurately saying how big the problem of migrants' access to care services is. Transparency was mentioned in the form that copies of all proposals should be provided in different languages.

Some responses opposed an "IT system" for charging migrants on the grounds that it would be too costly to implement in addition to expense of the on-going maintenance, technical support and training required for users. There were also a number of responses relating to the sharing of data. Concerns about the collection of data relating to immigration status and NI contributions might be seen as a breach of Data Protection were balanced by those that felt that if well developed, such a system could be key to the success of this proposal.

24. Where should initial NHS registration be located and how should it operate?

Of those who responded, a clear majority felt that NHS registration should remain within the NHS – most felt that this should be in primary care or the first point of contact with the NHS, which it was recognised, might sometimes be A&E.

Many respondents argued that this would be less bureaucratic and burdensome since it is how registration works now. Some argued that separating registration from an NHS setting could delay access to healthcare. As well as scepticism at the cost and bureaucracy of setting up a new system or provider of registration, there were concerns about the potential problems associated with outsourcing.

> *"It would lead both to delays in people accessing healthcare and to mistakes being made, as we know from Home Office outsourcing to Serco, Capita, G4S."*

However a substantial proportion of those arguing for registration to be located in GP practices were arguing for a continuation of the status quo; not supportive of a new registration system to check people's eligibility status in case linking healthcare with immigration status should deter people from seeking healthcare.

> *"NHS registration should remain with GP practices, in line with the principle of meeting patients' immediately necessary health needs. If someone is required to register with an external agency completely separate form health services, prior to visiting a GP, there is a risk they will not get to see a doctor and these needs will not be met in a timely way."*

Of those who suggested another location for registration, approximately two-thirds felt that a centralised point would be most effective, and a variety of non-NHS suggestions were made including post offices, town halls, schools or online. Some of those responses argued that this could reduce the administrative burden on GPs or other NHS staff and to prevent any interference with their professional duties. Others felt that an external central registration process would offer an opportunity to establish a system in which staff could be appropriately trained, with the skills, expertise and knowledge.

> *[It is] essential that any arrangement for the charging of individuals or the checking of eligibility is removed from the sphere of the personal interaction between the clinician and the patient. For that reason, aside from any administrative capacity arguments, we agree that alternatives to the individual GP practice should be found to handle any initial NHS registration process.*

The remaining third supported the idea of an NHS registration process that linked to border control and/or visa processes. They felt it was important that NHS registration happened before people entered the UK, to ensure that accurate information about eligibility would be recorded.

> *"NHS registration should take place as part of a visa application. NHS numbers should be given with the first visa received."*

Some respondents answered this question by stating their opposition to short-term visitors or non-residents being able to register at all.

Suggestions of how initial registration should operate were limited, but the use of NHS numbers, to record people's eligibility or chargeable status was frequently mentioned, potentially alongside use of central databases like the SPINE. Others flagged the complexities of the charging rules which mean that people's chargeable status would change frequently – an initial registration as chargeable, or not, might need to be regularly reviewed.

> *"One inherent problem with the proposed system is that charging status would change over time (due to marriage, divorce, refusal of asylum application, transition from temporary to indefinite leave to remain) and there would need to be a constant adjustment to registration status"*

Another issue identified were the potential unintended consequences for groups who may find it difficult to prove their status and eligibility, including homeless people.

> *" [We are] also concerned about the impact of this proposal on those who are awaiting a Home Office decision who have had to send in their papers while a decision is made…with some waiting over 12 months."*

25. How can charges for primary care services best be applied to those who need to pay in the future? What are the challenges for implementing a system of charging in primary care and how can these be overcome?

The majority of respondents to this question were opposed to the idea of charging for primary care in any way, stating that *'universal primary care services are vital for individual and public health*' and pointing out that it is necessary to assess the broadest range of health needs in order to determine any response. Many suggested that to charge for primary care, in particular, would be against the spirit of the NHS and would therefore be unethical. There were also concerns that charging for primary care would place unnecessary pressure on A&E services for both the seriously ill and those with less critical needs, whose needs might become urgent, more costly and potentially fatal if not treated in a timely manner.

There were concerns expressed that the current system of charging for secondary care was not working as well as it could be; that the Department of Health's focus should be on improving the current system rather than beginning something new.

Of those responses that considered the challenges, many believed that the greatest would be GP resistance, either because they would feel uncomfortable undertaking such checks themselves or because it would be a poor use of their time. Some respondents commented that primary care staff may disagree with charging on ethical grounds and would not wish to participate. GP buy in to the process was felt to be the key in overcoming this. Other suggestions included local CCGs providing an individual at reception at each surgery whose

role it is to carry out checks and a centralised system for new patients, rather than adding extra burdens onto reception staff, nursing staff and GPs. It was also suggested that this role could be taken on by a pre-registration centre.

A significant challenge, articulated by a number of respondents, was how to avoid discrimination. There was a lot of concern that checks would only happen to those who 'appeared' foreign due to their characteristics such as name, race, physical appearance, and accent or language skills. It was felt the only way to avoid this would be to 'check' whole communities.

A substantial number of respondents stated that they felt that having a credit card machine in GP surgeries where people would have to pay from a standard tariff to see a clinician had potential. However, in light of concerns over public health and impact on inequalities, there were suggestions that people should be entitled to a certain number of visits without being charged.

Looking more widely, there were concerns that it shouldn't be left to the NHS alone to ensure that bona fide migrants are legitimately able to access care. That more must be done to ensure that people had adequate insurance at the border (should the decision be made to take this forwards), that airlines are not scrupulous enough in ensuring that pregnant woman are able to fly and that there should be a clear advertising campaign and information given to people when they are applying for a visa to reside for any length of time in this country.

26. Do you agree with the proposal to establish a legal gateway for information sharing to administer the charging regime? What safeguards would be needed in such a gateway?

The majority of responses were not supportive of the proposal to establish a legal gateway for sharing information. This response was not only from the campaign organisations but also the professional bodies, trade unions, refugee and migrant groups. Many questioned whether any such system of sharing sensitive personal data could be set up without contravening data protection principles.

However, those working on the frontline in the NHS were almost universally in favour of establishing a legal gateway for information sharing. Of those in favour, most respondents recognised that any such proposal would have to take account of data protection issues, in particular safeguarding patient medical records, and confidentiality. The system would also need to be extremely secure, with a high level of protection in place to ensure that the system could not be infiltrated by hackers.

There were some practical suggestions around how this might be done in terms of IT. The need for eligibility information to be easily accessible to relevant staff by integrating it into existing systems (for example Personal Demographic Service, PDS) rather than staff being required to log onto a separate system.

Those who responded on behalf of organisations supporting the rights of migrants and asylum seekers were strongly opposed to the proposal and questioned whether any such system of sharing sensitive personal data could be set up without contravening data protection principles. The BMA, and other professional organisations, while acknowledging that work to develop the specifics of any system had not yet been articulated, raised concerns in a number of areas, including patient confidentiality, breakdown of trust between clinicians and patients and the engagement of migrants and their dependents with the NHS.

The Royal College of General Practitioners (RCGP) were particularly concerned about the impact of this proposal on doctor patient relationships. They also raised specific concerns about resident but vulnerable UK groups, such as homeless people, travellers and gypsies, and individuals with chaotic lives may be deterred by the checks involved. This was echoed by a

number of other groups, and on behalf of other vulnerable groups, notably illegal migrants such as failed asylum seekers liable to removal.

Recovering Healthcare Costs from the European Economic Area (EEA)

27. Do you agree that we should stop issuing S1 forms to early retirees and stop refunding co-payments and if not, why?

A minority of respondents answered this question and the majority of the responses suggested that many had misunderstood it or chosen to answer it from a personal perspective; advocating entitlement to free NHS hospital treatment for UK pensioners as a benefit of paying national insurance contributions for extended periods.

Of those working in the NHS there was nearly unanimous support for the proposal. Comments suggested that it seemed appropriate to maximise income from the EEA and this appears to be administratively straightforward. There was a note of caution however, with concerns about safeguarding those UK pensioners who decide to have the entirety of their healthcare needs provided in another EEA country, where the S1 seems to work very well. Reducing payments to other Member States assumes that UK expatriates will always return home for treatment, some may not wish or be able to.

Of those that did answer the question, a small number who supported the proposal did so on the basis that because many pensioners elect to have treatment in the UK whilst living abroad the UK is effectively paying twice. They felt the proposal is in line with the majority of other EU countries, though it was noted that EEA retirees coming to live in the UK have no knowledge of the S1 form. One respondent suggested that UK pensioners should be given the option to opt into the NHS for their hospital care, but with the proviso that they wouldn't be entitled to free treatment in the country in which they were living.

One legal group response opposed the proposal, suggesting that these steps may deny British citizens, who move to another Member State, the benefits of migration. They also expressed the view that, as there is no evidence that the sums involved are significant, the amounts gained would be insufficient to justify such a significant change in the principles on which the NHS is founded.

There were a number of responses from individuals who have retired outside the EEA, the majority in Turkey, who, perhaps as might be expected, felt the UK should continue to look after its citizens no matter where they lived.

Professional bodies and migrant groups had no comments to make on this question

Annex B: List of organisational respondents

Academy of Medical Royal Colleges
Advisory Group Hepatitis
African Health Policy Network
Aire Centre
Alma Mata Global Health Network
Amnesty International
Anti-Trafficking and Labour Exploitation Unit
Association of British Insurers
Asylum Support Appeals Process
Asylum Welcome
Barnardo's
BHA for Equality
Bliss
Blue Dart Couriers
BMA
Bolton NHS Foundation Trust
Brighton and Sussex University Hospital NHS Trust
Bristol CCG
British Association for Sexual Health and HIV
British HIV Association
British Pregnancy Advisory Service
British Red Cross
Bupa
Catholic Bishop's conference of England and Wales
Centrepoint
CfBT
Children's Commissioner
Children's Society
CHIVA and the Children and Young People HIV Network
Churches Refugee Network
City of Sanctuary Bradford
Chief Nursing Officer, BME Advisory Group
Coalition of Latin Americans in the UK
Coram Children's Legal Centre
Crisis
Definitive Immigration Services
Derby Hospitals NHS Foundation Trust
Diabetes UK
Diocese of East Anglia Justice and Peace Commission
Discrimination Law Association
Doctors of the World
DrugScope
East and North Hertfordshire NHS Trust
Easton Family Practice Bristol
Emirates Airline
Epsom & St Helier NHS Trust
Faculty of Public Health
First Milk Ltd
Foundation Trust Network
Freedom from Torture
Friends, Families and Travellers
Gateshead College Students' Union
Gateshead Health
Gloucestershire Hospitals NHS Foundation Trust
Gospel Literature Outreach
Great Ormond Street Hospital
Great Western Hospitals NHS Foundation Trust
GuildHE
Guy's and St Thomas' NHS Foundation Trust
Healthwatch Southwark
Helen Bamber Foundation
Hill Dickinson LLP
Hillingdon Hospitals NHS Foundation Trust
Homeless Healthcare Team
Homeless Link
Horn of Africa Health & Wellbeing Project
Hull and East Yorkshire Hospitals NHS Trust
Immigration Law Practitioners' Association
Institute of Psychiatry at King's College London
Imperial College Healthcare Trust
Imperial College London
InterHealth
Isle of Wight NHS Trust
Japanese Chamber of Commerce and Industry in the UK
Jesuit Refugee Service
Joint Council for the Welfare of Immigrants
Kalayaan
Keep Our NHS Public
King's College London
Kingston Hospital NHS Foundation Trust
Latin American Women's Rights Service
Leicester City Council
Leicester Faiths Support Group for Asylum Seekers and Refugees
Lewisham NHS Trust
Liberty
Limehouse Practice

Liverpool Heart and Chest Hospital NHS Foundation Trust
London Borough of Tower Hamlets Council
London Health Inequalities Network
Maternity Action
Malling Health
Medact
Mental Health in Immigration Detention Action Group
Merlin
Migrant and Refugee Communities Forum
Migrant Voice
Migrants Resource Centre
Migrants Rights Network
Migration Watch
Mind
Moorfields NHS Foundation Trust
National Aids Trust [Endorsed by The Cara Trust & The Food Chain]
National Board of Catholic Women
National Childbirth Trust
National Children's Bureau
National Union of Students
National Voices
Newcastle upon Tyne NHS Foundation Trust
NHS Brighton & Hove CCG
NHS England
NHS Protect
NHS Sheffield CCG
Norfolk & Norwich NHS Trust
North East London FT Mental Health
North East Migrant Health and Wellbeing Group
Nottingham and Nottinghamshire Refugee Forum
Norfolk & Norwich University Hospital NHS Foundation Trust
North and East London Commissioning Support Unit
North West London Hospitals NHS Trust
Nottingham University
Nottinghamshire Healthcare NHS Trust
Oldham Unity
Optical Confederation
Park Surgery
Pathway Charity
Pharmacy Voice
Platform One Medical Practice
Portsmouth Hospitals NHS Trust
PositivelyUK
Praxis
Public Health England
RAK Academy
Refugee Action
Refugee Children's consortium
Refugee Council
Refugee Support Devon
Regional Asylum Activism Project, North West Region
Rights of Women
Royal College of GPs
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians & Gynaecologists
Royal Pharmaceutical Society
Sandwell and West Birmingham CCG.
Save the Children UK
Second Step
Scottish Refugee Council
Sheffield City Council
Sheffield Health & Social Care Foundation Trust
Sheffield Local Medical Committee
SIM International UK
Slough Immigration Aid Unit
South East Strategic Partnership on Migration
South Tees NHS Trust
South West Directors of Public Health
South West Migration Partnership
South Yorkshire Migrant & Asylum Action Group
Southend Hospital
Southwark Forum for Equalities and Human Rights
St Mungo's
St Thomas C of E Church, Werneth, Oldham
Still Human Still Here
TB Alert
Terence Higgins Trust
The Big Life group
The City College of Further Education
The Dover Detainee Visitor Group
The Dudley Group NHS Trust
The Royal College of Surgeons of Edinburgh
The Royal Wolverhampton NHS Trust
The Sophia Forum
The Whittington NHS Trust
Trades Union Congress [endorsed by British Dietetics Association & Prospect]

UCLG
UK Council for International Student Affairs (UKCISA)
Unison
Unite the union
Universities UK
University College Hospital London
University Hospitals Coventry and Warwickshire NHS Trust
University of Oxford
University of Sussex
West London Medical Centre
Women's Health and Equality Consortium'
Women's Resource Centre
Wrightington Wigan and Leigh NHS Foundation Trust

Annex C: Data summary table[8]

EEA	Total (£m)
Total gross cost for EEA visitors, non-permanent residents and expats	**305**
Total Recovered / Recovery Rate	**50 (16%)**

Non-EEA	Total (£m)
Total gross cost for non-EEA visitors, temporary migrants and expats	**175**
Of which	
Visitors	*76*
Temporary migrants (>3 months, <12 months)	*49*
UK expats	*50*
Total gross cost for groups who would be covered by the new immigration health surcharge[9]	**951**
Of which	
Temporary Migrants (>12 months)	*521*
Students (Tier 4 visa-holders)	*430*
Total Gross Cost for Non-EEA and UK expats *(excluding health tourism increment and illegal migrants)*	**1,126**
Total currently potentially chargeable - to individuals[10]	**156**
Total Recovered / Recovery Rate	**23 (15%)**

Total gross cost of illegal migrants (including failed asylum seekers liable to removal, illegal entrants and people who have overstayed their visas)	**£330m**
Total gross cost of health tourism increment	**£70m - £300m**

[8] Figures based on initial findings from independent research study. Further work will be undertaken to determine actual costs to be recovered.
[9] Note this is the cost for the **stock** of the groups covered. The immigration health surcharge will apply to the **flow** of temporary non-EEA migrants.
[10] Note the distinction between the gross **cost** of NHS services and the **total amount chargeable**. Some NHS services (such as A&E) are currently not chargeable.

Annex D: Glossary[11]

Accident and Emergency (A&E) services	These are services that are needed immediately in an emergency situation and under current rules are free of charge to all overseas visitors, whether provided at a hospital accident and emergency (or casualty) department, a minor injuries unit, a walk-in centre, or elsewhere, up until the point that overseas visitor is accepted as an inpatient or given an outpatient appointment. Emergency treatment that is given after admission to the hospital (e.g.intensive care or coronary care) is chargeable to a non-exempt overseas visitor.
All medically necessary treatment	Treatment of all emergency, urgent and chronic conditions including the routine monitoring of them. It only applies to those visitors from the European Economic Area (EEA) and Switzerland who have valid European Health Insurance Cards or have Provisional Replacement Certificates for them.
Asylum seekers	An asylum applicant is a person who either: (a) makes a request to be recognised as a refugee under the Geneva Convention on the basis that it would be contrary to the UK's obligations under the Geneva Convention for him to be removed from or required to leave the UK, or (b) otherwise makes a request for international protection.
British National/Citizen	British nationality is defined in law. Whether a person has a claim to British nationality can be determined by applying the definitions and requirements of the British Nationality Act 1981 and related legislation to the facts of their date and place of birth and descent. The most acceptable evidence of British citizenship is a British passport.
Community services	Services delivered in the community rather than at a hospital.
Co-payment	A contribution to the full cost of a medical service.
Dependents	A spouse or civil partner and children under the age of 16 or up to 19 if still at school and receiving child benefit.
European Economic Area (EEA)	Countries of the European Union (EU), plus Iceland, Liechtenstein and Norway, those states having signed an agreement to participate in the EU internal market. Whilst not a member of the EEA, Switzerland also signed up to EU legislation on the internal market and free movement of people. In this consultation, where EEA is referred to, for simplicity, this will include a reference to Switzerland.

[11] This glossary is not designed to provide official definitions of immigration terms

European Union (EU)	An economic and political union established in 1993 after the ratification of the Maastricht Treaty by members of the European Commission.
Expatriate (Expat)	A British national no longer resident in the UK. Non-UK nationals may also be former residents of the UK and former contributors of UK National Insurance Contributions.
Failed asylum seekers	A failed asylum seeker is an individual whose application for asylum and other forms of protection has been refused and who has exhausted their appeal rights. They will become liable for charges for new courses of NHS hospital treatment at that point, even if they have been here for more than one year. However, failed asylum seekers who are being supported by the Home Office under 'section 4' or 'section 95' of the Immigration and Asylum Act 1999 are exempt from charges. Section 4 support is given to those failed asylum seekers taking reasonable efforts to leave the UK but for whom there are genuine recognised barriers to their return home.
Health tourism/tourist	Health tourism is where people have travelled to England with an intention of obtaining free healthcare to which they are not entitled. This can either be by 'flying in and flying out' to access specific services or through existing registration (eg through family connections or previous residency). By their very nature, health tourists are difficult to identify and then quantify because they are likely to make efforts to conceal their true eligibility status or are not flagged up in the system.
Immediately necessary treatment	Treatment which a patient needs: to save their life; to prevent a condition from becoming immediately life-threatening; or promptly to prevent permanent serious damage from occurring.
Indefinite leave to remain (ILR)	Indefinite leave to remain (often known as 'ILR' and 'settlement') is permission to remain in the UK without any time restrictions on the length of stay.
Irregular migrant	Someone who is either a failed asylum seeker and not supported by the Home Office, overstayed the terms of their visa or is an illegal migrant. The term 'irregular migrant' is used in the qualitative and quantitative research into the extent and costs of migrant and overseas visitor use of the NHS.
NHS charged patients	Overseas visitors who are liable for charges as NHS patients.
Non-European Economic Area (non-EEA)	Any country other than EU Member States, Norway, Iceland, Liechtenstein and Switzerland.

Non-urgent treatment	Routine elective treatment that could wait until the patient can return home.
Ordinary residence (OR)	OR is not defined in legislation but is based on case law, and can be defined as a person living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, whether they have an identifiable purpose for their residence here and whether that purpose has a sufficient degree of continuity to be properly described as “settled”.
Permanent resident	Any individual, living in the UK, with the right, or permission, to do so permanently.
Primary Care	Care provided by GP practices and other providers who act as the main first point of consultation for patients. This includes dental and ophthalmic services.
Secondary Care	Secondary care is defined as a service provided by medical or dental specialists who generally do not have first contact with patients.
Social enterprise	Social enterprises are social mission driven organisations which apply market-based strategies to achieve a social purpose.
Temporary migrant	A non-EEA national who is in the UK for a time-limited period (usually between 6 months and 5 years).
Urgent treatment	Treatment which clinicians do not consider immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to return home.
Visitor	A non-EEA national in the UK for a short period (maximum of six months), such as tourists and those visiting friends and relatives, during which their main centre of interest remains in their own country.