Title: Visitor and Migrants NHS Cost Recovery Programme **IA No:** DH 3130 **Lead department or agency:** Department of Health **Other departments or agencies:**	**Impact Assessment (IA)** **Date:** 14th July 2014 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Secondary Legislation **Contact for enquiries**: nhscostrecovery@dh.gsi.gov.uk

Summary: Intervention and Options

RPC Opinion: N/A

Cost of Preferred (or more likely) Option				
Total Net Present Value	**Business Net Present Value**	**Net cost to business per year**	**In scope of One-In, One-Out?**	**Measure qualifies as**
£1,560m	**£0m**	£0m	No	N/A

What is the problem under consideration? Why is government intervention necessary?

NHS hospitals in England face significant challenges in terms of identifying, charging and recovering income from visitors and migrants due to inefficiencies and complexities in the current system. Visitors and migrants are currently able to access free NHS care immediately or soon after arrival in the UK, leaving the NHS open to abuse. Government intervention is necessary to ensure fairness in the system so that visitors and migrants make an appropriate contribution to their use of NHS healthcare services. Intervention is also necessary to improve information flows and improve the efficiency of processes in the system and thereby increase the recovery of income.

What are the policy objectives and the intended effects?

The NHS Cost Recovery Programme aims to: maximise cost recovery from European Economic Area (EEA) and non-EEA visitors and migrants and from EEA member states through short and long term projects; have regard for the Secretary of State's statutory duties, including the public sector equality duty, the duty to have regard to the need to reduce health inequalities and to maintain access to public health services; improve efficiency and sustainability by ensuring that the NHS becomes better at identifying those who are chargeable and recovering the costs which are due, in part through improved systems and processes; and to ensure everyone makes a fair contribution to the NHS.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

Option 1 – do nothing - no change to the current system of recovering costs (with health surcharge)

Option 2 (preferred option) – improve the current system and implement a process to better identify chargeable patients through a series of phased improvements for secondary care including toolbox for staff; training; communications and engagement; incentives and improvements to secondary care IT systems.

The specific impact of the interventions in this option is not well understood, it is critical that a formative evaluation of each element of the cost recovery programme is undertaken in order to learn lessons about what works in improving cost recovery (and the extent of the benefit realised) as the programme is being implemented. Decisions about progressing with the later phases of the Programme will be based on, and contingent upon, demonstrated achievements in the earlier phases.

Will the policy be reviewed? It will be reviewed

Does implementation go beyond minimum EU requirements?			No		
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	**Micro** No	**< 20** No	**Small** No	**Medium** No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** 0	**Non-traded:** 0	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: Jane Ellison Date: 14/07/14

Summary: Analysis & Evidence Policy Option 2

Description: Phased programme of system improvements

FULL ECONOMIC ASSESSMENT

Price Base Year 2014/15	PV Base Year 2015/16	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate:**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional	2	Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£56m		£7.4m	£130m

Description and scale of key monetised costs by 'main affected groups'

NHS – familiarisation cost £0.84m (PV)
NHS – admin cost £61m (PV)
DH – implementation / systems improvement cost £19m
DH – incentives £45m (PV)
UK residents – cost to prove residency £3.1m (PV)

Other key non-monetised costs by 'main affected groups'

N/A

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	3	Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£250m		£200m	**£1,690m**

Description and scale of key monetised benefits by 'main affected groups'

DH - Income from Phase 1 and Phase 2 improving the system in secondary care - £1,690m

Other key non-monetised benefits by 'main affected groups'

Increased information for patients to make better informed choices of treatment, avoidance of costs
Increased information and simplified procedures for frontline NHS staff
Increased efficiency in system which could result in deterrence of non-urgent care
Better data collection of actual use of healthcare services by visitors and migrants

Key assumptions/sensitivities/risks **Discount rate (%)** 1.5

The costs and benefits to visitors and migrants themselves are noted, but are not aggregated into the overall costs and benefits of the Programme. This is line with guidance from the Migration Advisory Committee;

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	Yes	IN/OUT/Zero net cost

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	Zero net cost

Evidence Base (for summary sheets) – Notes

References

- Creative Research Ltd (2013). Qualitative Assessment of Visitor and Migrant use of the NHS in England: Observations from the front-line. Prepared by Creative Research Ltd for the Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251908/Qualitative_Assessment_of_Visitor___Migrant_use_of_the_NHS_in_England_-_Observations_from_the_front-line_-_FULL_REPORT.pdf

- Prederi Ltd (2013). Quantitative Assessment of Visitor and Migrant Use of the NHS in England: Exploring the Data. Prepared by Prederi Ltd for the Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251909/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_FULL_REPORT.pdf

- Department of Health (July 2013). Sustaining services and ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210438/Sustaining_services__ensuring_fairness_consultation_document.pdf

- Department of Health (July 2013). Evidence to support review 2012 policy recommendations and a strategy for development of an impact assessment https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/210440/Sustaining_services__ensuring_fairness_-_evidence_and_equality_analysis.pdf

- Department of Health (30/12/2013). Sustaining services and ensuring fairness: Government response to consultation. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268630/Sustaining_services__ensuring_fairness_-_Government_response_to_consultation.pdf

- Department of Health (30/12/2013). Sustaining services and ensuring fairness: Implementation outline. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/269461/MigrantAccess_ImplementationPlan_Slide_Pack_January_2014.pdf

- Department of Health (30/12/2013). Equality Analysis: Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268632/Sustaining_services__ensuring_fairness_-_Government_response_to_consultation_-_Equality_Analysis.pdf

- HO Consultation: Controlling immigration: regulating migrant access to health services in the UK - response (Oct 2013)

  https://www.gov.uk/government/consultations/migrant-access-to-health-services-in-the-uk

- Home Office Impact Assessment: Immigration Bill Part 3 covers powers to regulate migrants' access to services. (October 2013)

  https://www.gov.uk/government/publications/immigration-bill-part-3-access-to-services

Evidence Base

A. Background

1. Over the summer of 2013, the Department of Health consulted on proposed changes to the existing system of visitors and migrants access and financial contribution to the NHS in England and considered options of how those who do not live here permanently should contribute towards the costs of their care.
2. 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.
3. The Government response was published on 30 December 2013 setting out initial decisions and next steps[1]. The Department is publishing an implementation plan alongside this impact assessment. This plan outlines the approach of the cost recovery programme over the next two financial years 2014/15 and 2015/16.[2]

Current system

4. The groups who are currently **in scope** of being charged include[3]:

   · Short Term visitors – uninsured EEA and non-EEA
   · Uninsured EEA non-permanent migrants, including students who are not ordinarily resident or exempt under the regulations;
   · Irregular migrants including: illegal immigrants, visa overstayers, failed asylum seekers
   · UK Ex-pats residing in both EEA and non-EEA countries returning to visit UK

   Those **out of scope** of charging include:

   · Individuals classed as Ordinarily Resident – currently many temporary migrants will be ordinarily resident immediately or soon after arrival;

[1] Department of Health (30/12/2013). Sustaining services and ensuring fairness: Government response to consultation. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268630/Sustaining_services__ensuring_fairness_-_Government_response_to_consultation.pdf

[2] https://www.gov.uk/government/publications/recovering-costs-of-nhs-healthcare-from-visitors-and-migrants

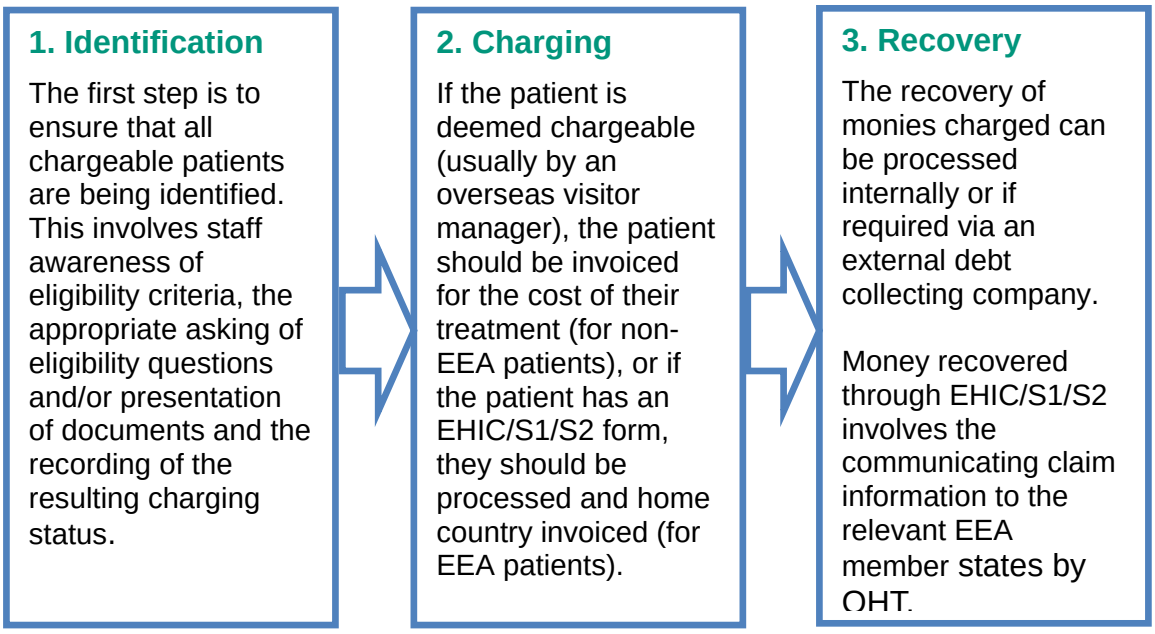
[3] Current system prior to implementation of the health surcharge

- Permanent residents and those with indefinite leave to remain (ILR);
- Those exempt on humanitarian grounds, e.g., asylum seekers, refugees, victims of human trafficking, etc;
- Those that fall within other exemptions in regulations, including insured EEA nationals.

5. Accident and emergency services (A&E), primary care and community health services are generally free at the point of use to all visitors and migrants and other services such as optometrists, dentistry and pharmacy incur charges in line with those which apply to residents.[4] There are also public health treatments and services which are not chargeable to ensure that the protection of individuals and those in the UK is safeguarded.[5]
6. The EEA process of income recovery from member states in terms of EHIC, S1 and S2 covers the whole of the UK and is processed by the Overseas Healthcare Team (OHT) at DWP. Non-EEA identification and recovery processes are devolved and this IA will cover England only for non-EEA patients.

Process

7. The process of recovering costs from those who are chargeable for NHS use can be split into three distinct and sequential stages:



An overview of the patient journey in the current secondary care system can be found at Annex E.

[4] Note that EEA countries can be charged for treating EEA nationals via EHIC process for A&E and primary care services

[5] See Charging Guidance under Regulation 6. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/254530/ovs_visitors_guidance_oct13a.pdf

Commissioned Research

8. In the absence of primary data, DH commissioned research in summer 2013 to better understand the impact of visitors and migrants on frontline NHS services and to begin to develop an evidence base of the costs to the NHS of providing care to visitors and temporary migrants. The first stage was to commission a qualitative market research study of observations from the NHS; the second stage was to commission a quantitative analysis based on population level data to model the estimated size of NHS costs for visitors and migrants.[6]

9. Since the publication in October 2013, more detailed work on EEA visitors and migrants has been completed on a UK wide scale. These updated figures will be used for the EEA analysis in the impact assessment. All EEA figures in this IA refer to the UK as the overseas healthcare team (OHT) currently process all UK claims on behalf of the DAs. Non-EEA figures represent England only (unless specified) as process for charging non-EEA visitors is devolved.

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

    - 550k are from EEA countries (UK wide)
    - 1,460k are from non-EEA countries (England only)
    - 80k are UK expats (residing in both EEA and non-EEA countries)
    - 580k are 'irregulars' (including failed asylum seekers liable to removal, people who have overstayed their visas and illegal immigrants

11. The research estimates the costs to the NHS per year of each of these groups as:

    - £340m for EEA visitors and non-permanent residents to the UK (excluding expats)
    - £1,070m for non-EEA visitors and temporary migrants to England (excluding expats & irregulars)
    - Over £100m for UK expats (residing in both EEA and non-EEA countries)
    - £330m for irregular migrants

12. The research 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

[6] 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 www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs

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 quantify because they are likely to make efforts to conceal their true eligibility status or are not flagged up in the system.

13. Overall, 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).

14. The total cost (UK) for EEA visitors and non-permanent residents and EEA based expats is around £340m; of which approximately £180m is potentially recoverable through the European Health Insurance Card (EHIC), with the remainder potentially recoverable through S1 (£60m) and other arrangements. It is estimated that the NHS recovered around £50m from EEA in 13/14, less than 20% of the total potentially recoverable amount.

15. EEA use of the NHS is currently recoverable via the EHIC, S1, S2 schemes.[7] There will be some individuals who are not part of their countries insurance or EHIC scheme and therefore would be chargeable directly for services (estimated to be approx. £8m) unless they are ordinarily resident in the UK or otherwise exempt from charging under the regulations.

16. For non-EEA visitors, temporary migrants and non-EEA expats the total cost (excluding irregulars and health tourists) 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 A&E and primary care and those individuals who are currently not chargeable due to being ordinarily resident or otherwise exempt under the regulations. At the time of the Prederi report publication, £23m was collected from non-EEA patients (less than 20% of potentially chargeable amount). Latest DH accounts show that in 13/14 £47m was recovered from non-EEA patients (30% of the potentially chargeable amount).

[7] EHIC: (European Health Insurance Card) A valid EHIC demonstrates that a visitor (including a student) is exempt from charge under EU Regulations and therefore entitled to free NHS treatment that is medically necessary during their visit.
S1: The S1 form is a European healthcare entitlement form for state pensioners living in a different European country to where their pension is paid. The S1 certificate of entitlement allows state pensioners access to the healthcare system in the European country where they have chosen to retire, and for that country to reclaim costs.
S2: The S2 form is a mechanism that entitles patients to state-funded pre-authorised treatment in another EEA country or Switzerland, with the treatment being provided under the same conditions of care and payment as for residents of that country.

Table 1: outline of visitors and migrants and estimated size of current stock of population in England[8] (daily equivalent, averaged across one year)**.**

EEA UK baseline	Estimated population (stock - daily equivalent)
Visitors (inc. retired visitors)	250k
Students (all duration)	210k
Retired (>3 months)	15k
EEA UK expats	45k
Economically inactive	30k
Total	550k
Non- EEA England baseline	
Visitors	170k
Temporary migrants < 12 months	55k
Migrants – working visas	634k
Migrants – family visas	
Students - visas	603k
Irregular migrants	580k
Non-EEA UK expats	34k
Total	2,076k

Wider work across government: Home Office Immigration Bill

17. In preparation for the introduction of the Immigration Bill (now the Immigration Act 2014), in a separate parallel consultation over the summer of 2013, the Home Office looked at three specific elements of the Department of Health's proposals on a UK-wide basis; redefining qualifying residency (ordinary residence), using a health levy (now called the 'health surcharge') to ensure some migrants make a fair contribution to the NHS. In their response[1] the Home Office set out proposals to redefine ordinary residency and 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.

18. The Immigration Act 2014 amends the meaning of 'ordinarily resident' in NHS charging provisions so that, for non-EEA nationals subject to immigration control, an individual cannot be deemed ordinarily resident unless they have acquired Indefinite Leave to Remain (ILR) in the UK. Building on this, the Act provides the power to require those non-EEA nationals subject to immigration control who are coming to the UK for more than 6 months to pay an 'immigration health surcharge' (surcharge) with their visa application fee. This is expected to be £150 per year for students and £200 per year for others and will be paid upfront for the duration of the visa granted. There will be some exemptions to the surcharge which are currently being decided and which the Home Office will set out in regulations including: Tier 2 intra-company transfers, asylum seekers and victims of human trafficking.

[8] Prederi Ltd (2013). Quantitative Assessment of Visitor and Migrant Use of the NHS in England: Exploring the Data. Prepared by Prederi Ltd for the Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251909/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_FULL_REPORT.pdf

19. Alongside the consultation response, the Home Office published an impact assessment which estimated the costs and benefits of the health surcharge as part of their overarching immigration bill impact assessment. This included the estimated costs to the economy of a potential reduction in temporary migrants coming to the UK.[9]

20. The effect of both of these changes will be that many of those who currently have free NHS care upon moving to the UK will instead be contributing towards the cost of any NHS care they need during their stay. Payment of the surcharge will provide access to the NHS on the same basis as those who are ordinary resident in the UK.

B. Problem under consideration

Issues in the current system

21. It has become clear from the independent commissioned reports and the responses to the Government consultations that despite the variation in practices, there are several consistent and significant inefficiencies when it comes to the process of identifying, charging and recovering monies from visitors and migrants. Trusts across England face a number of significant challenges when it comes to recovering costs from both EEA and non-EEA visitors.

22. An overarching problem reported was the challenge of interpreting the DH guidelines and the complex rules around the process of charging, with some Trusts interpreting them as non-compulsory altogether and others struggling to understand what exactly was required of them.

    - **Identification:** issues around the identification stage of the process are estimated to constitute the biggest loss of potentially recoverable costs for both EEA and non-EEA visitors. Patients are often not asked the appropriate charging related questions at any point during their admission or care. The fundamental disincentive in the current system lies at the point where a secondary care provider identifies a patient as chargeable.
    - Trusts are not currently sufficiently incentivised to identify such patients. The current system works in such a way that if the Trust identifies and charges a non-EEA patient, they are required to recover the income themselves. Therefore if patients are either unwilling or unable to pay, or are untraceable, the provider itself will make a loss. Conversely, if the patient is never charged, it is assumed that the patient was entitled to free treatment and the Trust receives the money for this patient from the local Commissioner, and the provider does not make a loss.

[9] Home Office Impact Assessment: Immigration Bill Part 3 covers powers to regulate migrants' access to services. (October 2013)https://www.gov.uk/government/publications/immigration-bill-part-3-access-to- services

  - For EEA patients, the current disincentive lies in the process of logging EEA patients on the web portal system linked to the OHT. Without this information the OHT cannot claim back income owed from member states.
  - In general, staff may not invoice patients because they are already perceived as being too difficult to pursue or to classify, and staff feel they have little time or resources to follow up all chargeable patients in an effective way.

- **Recovery:** The process of income recovery differs depending on whether it is from the individual (non-EEA) or via an EEA member state. There are problems in current recovery rates due to:
  - The patient being unable to or refusing to pay, or being impossible to track for payment;
  - The patients not being aware in advance of the cost of the treatment due to lack of information. Consequently patients are unable to choose to defer treatment and may be unable to pay the full cost.
  - For EEA visitors the cost of certain types of treatment should be recovered through the EHIC card (or other mechanisms). Problems include individuals not being in possession of an EHIC card due to lack of awareness or they are not insured in their own country

Costs

23. The quantitative report provides evidence of the significant financial costs to the NHS and pressures on staff in the current system; including an estimate that £388m spent each year on EEA and non-EEA patients who should be paying for their care but are not identified or charged. 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 report identified that the NHS recovered only around £73m in 12/13, less than 20% of chargeable costs. The latest DH accounts show that £97m was recovered in 13/14 from visitors and migrants.

C. Rationale for intervention

Statutory Duty

24. The NHS has a statutory duty to recover costs from all chargeable patients for secondary care services.[10]

Fairness

25. There is a perceived lack of fairness in the health care system in England as currently some migrants and visitors are immediately able to access free secondary care on arrival despite having made no contribution to the costs of that care. The majority of English based residents contribute via taxes and

[10] This is currently only enacted in secondary care

national insurance contributions in order to access free healthcare services at point of need.

Information barriers and inefficiencies

26. Since the 1980s, the regulations and operating guidance for charging visitors and migrants has been updated on a reactive basis, leaving the overall system broadly unchanged. However, over this time period, the demand for healthcare services has been increasing alongside an upward trend in visitor and migrants flows to the UK.

27. Under the current system there is a barrier to information between the visitor / migrant patient and the provider of healthcare (NHS) as to their chargeable status: we have a residency-based system of eligibility, but no ready means by which to officially prove our residency status. Consequently, NHS providers are generally unaware of a visitor or migrant's status. This can lead to abuse of the system (both implicit due to inefficiencies in the system and explicit via health tourism). Evidence shows[11] there are significant variations between practices/processes across Trusts which contribute to the system inefficiencies and lead to confusion for both patients and staff. This results in chargeable patients not being identified, resources not being allocated efficiently and the income which is potentially recoverable not being achieved.

28. Due to the inefficiencies in the system which stem from information barriers, there is an incentive for health tourism where people take advantage of the system or are able to avoid detection or payment. Thus, NHS resources, both financial and clinical, are used to treat and care for people who have either made no contribution or are not entitled to free care. These are limited resources which could be used to treat UK residents or generate an income from those who are chargeable.

D. Policy objective and intended effects

29. From 2014/15 the Department of Health will be implementing a Cost Recovery Programme targeted at visitors and temporary migrants using the NHS. The Programme will be implemented in phases over the next two financial years (14/15 and 15/16) when all components of the Cost Recovery programme will have come into effect. A DH Cost Recovery Team is leading this programme within the Department.

30. The overarching objective of the programme is to improve cost recovery from visitors and temporary migrants in England who are not entitled to NHS care that is free at the point of delivery in order to ensure that the NHS receives a fair contribution for the cost of the healthcare it provides.

[11] Creative Research Ltd (2013). Qualitative Assessment of Visitor and Migrant use of the NHS in England: Observations from the front-line. Prepared by Creative Research Ltd for the Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251908/Qualitative_Assessment_of_Visitor___Migrant_use_of_the_NHS_in_England_-_Observations_from_the_front-line_-_FULL_REPORT.pdf

31. In detail, the Programme aims:
    - To maximise cost recovery from EEA and non-EEA visitors and migrants and from the EEA member states, through short and long term projects;
    - Comply with the Secretary of State's statutory duties, including having regard to the need to reduce inequalities and maintain access to public health services
    - To improve the efficiency of the system overall, delivering additional benefits for staff e.g. reducing the work to establish chargeable status and where individuals are deterred from unnecessary use, reducing pressure on services
    - To ensure everyone makes a fair contribution to the NHS.

Cost Recovery Projections

32. Through a phased roll-out, it is estimated that the NHS could achieve a gross cost recovery of up to £500m by the middle of next parliament. This will be made up of £200m a year from health surcharge income (processed by the Home Office); £200m a year from better identification of EEA patients and recharging to their home countries; and £100m from better identification and recovery directly from non EEA patients. It is a significant improvement on the baseline of £73m recovered in 12/13 and £97m recovered in £13/14.

33. A significant amount of the recovered funds will come from the health surcharge for non-EEA migrants applying for visas of more than six months' duration. This provision is contained in the Immigration Act 2014. We expect the surcharge to be operational by the start of FY15/16.

34. **The surcharge income forms part of the baseline Option 1 (do-nothing) in this impact assessment, as implementation and collection of the surcharge is external to the cost recovery programme options.**

Equalities and Health Inequalities

35. We recognise the need to mitigate for any adverse impacts the proposals might have on particular groups and the implications for public health, equalities and health inequalities. This includes consideration of the needs of vulnerable resident populations (e.g. the homeless, gypsy travellers or people for whom English is not their first language), who could also struggle to provide evidence of eligibility for free care, and might therefore be assumed to be chargeable or might fail to seek necessary care.

36. In addition to the commissioned research, we published an equality analysis[12] with the consultation response. This built on a comprehensive literature review to identify any adverse or unjustifiable impacts on groups with particular

[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/268632/Sustaining_services__ensuring_fairness_-_Government_response_to_consultation_-_Equality_Analysis.pdf

protected characteristics.[13] It also considered the impact on vulnerable resident groups and confirmed that the changes could further disenfranchise groups such as the homeless or travellers. As a consequence we have ensured that the engagement programme includes working with organisations representing these groups, to better understand the impact and look at possible mitigating actions. DH will continue to have regard to the public sector equality duty and the Secretary of State's duties in respect of reducing inequalities and consideration of these duties will inform further development of policies and implementation.

37. DH is further considering if any amendments to the groups of overseas visitor that are exempt from charges in the Regulations are necessary, which will be informed by, amongst other things, equalities considerations.

38. The formative evaluation will include consideration of any impacts on equalities as well as health inequalities.

E. Description of options considered (including do nothing);

Option 1: Do-nothing – No change to the current system, with health surcharge

39. Do nothing to current system for recovering costs from visitors and migrants. Continue to charge short term visitors and migrants in current system for secondary care services with no changes to the process or system.

40. The health surcharge is part of the Immigration Act 2014. DH will receive the proportion of the surcharge income related to England based on the Barnett formula. This option assumes that there would be minimal implementation of the surcharge on frontline services in the NHS (the Home Office will collect the surcharge from visa applicants). In particular, it assumes no use of the information that the surcharge has been paid.

[13] As defined in the Equality Act 2010.

Option 2: Implement phased improvements to the current system for cost recovery in secondary care

41. This option represents maximising the efficiency of identification, charging and recovery of costs from EEA and non-EEA visitors and migrants within the current system through a **phased programme of improvements**.

42. **Phase 1 of this option** includes creating a toolbox for system improvement, training and outreach, communication and engagement activities and implementing financial incentives.

43. **Phase 2 of this option** includes the introduction of a more robust NHS identification process which would aid better identification of potentially chargeable individuals from 2014/15. This would improve the way that visitors and migrants can be identified by NHS providers in secondary care so that charging rules can be applied or entitlement exemptions confirmed.

44. This phase of the new process would amend and enhance the NHS SPINE system to hold an individual's chargeable status based on immigration status provided by the Home Office (for temporary migrants on surcharge) or by individuals themselves (for short term visitors). This could then be used by frontline staff in secondary care, including overseas visitor managers, to validate and check whether an individual was chargeable. This would cover the registration and processing of temporary migrants who are covered by the health surcharge and also visitors from EEA and non-EEA.

45. **Option 2 is the preferred option.** Estimates of the costs of each of the phases of Option 2 are presented in the analysis below. Also presented is a discussion of the range of possible benefits arising from implementation of these phases. Since the specific impact of the interventions making up each of these phases is not well understood, **it is critical that a formative evaluation of each element of the cost recovery programme is undertaken in order to learn lessons about what works in improving cost recovery (and the extent of the benefit realised) as the programme is being implemented. Decisions about progressing with the later phases of the Programme will be based on, and contingent upon, demonstrated achievements in the earlier phases.**

46. The formative evaluation will provide an interim report in March 2015, with the final report being published in August 2015. These will provide a formative evaluation of the early implementation and impact of the programme.

47. **This impact assessment will cover only the changes which will be implemented for Phases 1, 2 and 3 in secondary care as part of the visitor and migrant cost recovery programme. The cost benefit analysis of the options around extending charging to primary and community care will be analysed in a separate impact assessment which will be published by the end of the FY14/15.**

Assumptions

The following assumptions have been made in estimating the costs and benefits of the Cost Recovery Programme:

- The costs and benefits to visitors and migrants themselves are noted, but are not aggregated into the overall costs and benefits of the Programme. This is line with guidance from the Migration Advisory Committee[14];
- The numbers of overseas visitor managers and related staff are based on the commissioned survey ('Qualitative Research' undertaken by Creative Research);
- Familiarisation costs are based on average wage rate of an overseas visitor manager. It is assumed that OVMs would share any new information / processes with staff as per normal procedures.
- Estimates of time taken to process patients have been based on evidence from the commissioned survey ('Qualitative Research' undertaken by Creative Research);
- Assumptions have been made for use of secondary care services by overseas visitors and migrants based on the use of these services by the resident English population aged 15-64[15] (using this age group takes into account the lower use of healthcare services by visitors and migrants as evidenced in literature);
- Costs of enhancements to NHS information systems have been estimated by the Health and Social Care Information Centre (HSCIC), and are based on assumptions made by HSCIC;
- All costs and benefits are in FY
- All costs and benefits have been presented in constant prices with 14/15 base year (Year 0). This is based on HMT GDP deflator December 2013.
- Assumed current identification rate of visitors and migrants is 50% and recovery rate of 50%
- The incentive modelling is based on following assumptions:

  EEA

  - Analysis is based on non-UK-resident EEA patients who hold a valid EHIC card issued by the EEA country who is 'competent' for their healthcare
  - Does not cover EEA patients who are not entitled to hold an EHIC from their 'home' member state.
  - EEA EHIC income is based on 2013/14 DH accounts
  - The volume of claims is based on 2013/14 web portal entries for all countries (formula, waiver and portal)
  - Incentive payments are applied uniformly across all countries whether they are portal, or formula / waiver agreements

[14] Migration Advisory Committee (Jan 2012) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257235/analysis-of-the-impacts.pdf

[15] HES data 2011/12

Non EEA

- Analysis applies only to chargeable non-EEA patients (excluding surcharge payees and patients exempt from charging for other reasons)
- Analysis based on the patient paying the full invoice. Other scenarios (part paid bills, payment plans etc.) are not considered in detail.
- Analysis is based on an estimate of total chargeable amount for non-EEA patients from independent commissioned research.

Data used in the estimation of costs and benefits are presented below:

Table 2

Description	Value Low	Value Central	Value High	Source/reason
On costs for wage rates		30%		As per DH guidance – Standard Cost Model
Hourly OVM wage rate	£10.42	£22.38	£25.90	NHS band wage rates, Creative Research estimates that OVM fall within Band 3 to Band 7, with the majority around Band 4/5.
Number of OVMs per trust	1	1.5	2	Creative Research Qualitative Study
Average working week (hrs/week)		37.5		NHS standard contract hours
EO	£21,438	£23,437	£25,436	DH salary min – max at this level 2012/13
Number of trusts in England		160		NHS data
Health surcharge payment	£150 students		£200 Other visa tiers	Home Office
Estimated use of secondary care services by additional migrant group (%)	10%	15%	20%	Based on use of secondary care services by English resident population (age range 15-64 years old)
Discount rate		1.5%		DH standard process (see economic value section at the end of this IA)

Detailed Option Appraisal

Option 1: Do nothing – no change to the current system for cost recovery, includes health surcharge

48. Do nothing to current system and continue to charge visitors and migrants in line with current practices, with no improvements to the processes but with the implementation of the surcharge (by the Home Office). The system would retain the current inefficiencies and consequently the NHS in England would maintain recovery of a very low proportion of income due from chargeable visitors and migrants. The current disincentives on Trusts to identify visitors and migrants and incentives for possible abuse by health tourists would also remain.

Option 2: Implement phased improvements to the current system for cost recovery in secondary care, with the health surcharge

49. This option represents maximising the efficiency of identification, charging and recovery of costs from EEA and non-EEA visitors and migrants within the current system through a **phased programme of improvements**. Phase 1 seeks to implement improvements to the current system and processes for recovering costs; Phase 2 introduces changes to the NHS registration process and the inclusion of immigration information on NHS Spine information system.

50. Each of the phases of option 2 are discussed in more detail below with analysis of the costs and benefits. The transition period for Option 2 is from 2014/15 to 2016/17 (2 years).

Option 2, Phase 1: Improve the current system for cost recovery in secondary care

51. **Phase 1 of Option 2** represents maximising the efficiency of identification, charging and recovery of costs from EEA and non-EEA visitors and migrants within the current system through a programme of improvements. These include: creating an NHS-facing toolbox for system improvements, training and outreach, communication and engagement activities and implementing incentives and sanctions. As well as this, DH will also be running various pilots to test some of the tools and potential roll out of EHIC collection in emergency care settings.

52. Both the qualitative research commissioned and the responses to the DH consultation found that practices within the current system are varied, but identified consistent and significant inefficiencies in the process of identifying, charging and recovering from chargeable patients. The system improvements in this phase seek to address those inefficiencies which are most commonly reported.

53. The elements of this phase were developed after a scoping and feasibility assessment by DH policy and analytical teams alongside an NHS Reference Group of stakeholders and consultation with relevant external organisations and stakeholders. The activities presented in this phase represent the final recommended elements of the programme to be implemented during the financial year 2014/15.

54. The various programme elements outlined would be complementary to one another. The full detail of all of the elements considered for implementation in this phase can be found in Annex B.

55. The following **groups** could be impacted: NHS staff including overseas visitor managers and frontline NHS staff (clinicians, receptionists and administration staff); visitor and migrant patients,[16] Department of Health, NHS England and the Overseas Healthcare Team at DWP.

56. The programme elements making up this phase of Option 2 cover four overarching themes;

    a) Toolbox for system improvement;

    b) Communications and engagement activities;

    c) Training and outreach activities (including the national intensive support team);

    d) Incentives and sanctions programme for NHS provider trusts

57. The **benefits** of Option 2, both Phases 1 and 2 will be considered together on page 34

58. The **costs** of Phase 1 are detailed below[17].

Costs of Option 2, Phase 1

a) Toolbox for system improvement.

59. This element seeks to create a "toolbox" for NHS frontline staff to improve their understanding of the complex rules of overseas visitor and migrant charging, enable the sharing of best practice and better inform patients. This will involve;

- Updating and simplifying the current formal guidance;
- Publishing new data sharing guidance;
- Publishing new ordinary residence guidance;
- Promoting mechanisms to share best practice between NHS trusts;
- Exploring the viability of developing a "decision tree" tool for NHS staff that could provide a quick, easy and objective indication of whether or not a given patient is chargeable based on a series of standard questions;
- Developing a series of patient-facing letters for use by overseas visitor managers, based on current best practice and developed with behavioural insights and legal expertise. This will include "patient

[16] The costs and benefits to visitors and migrants themselves are noted, but are not aggregated into the overall costs and benefits of the Programme. This is line with guidance from the Migration Advisory Committee.

[17] A detailed explanation of costs for Phase 1 can be found in Annex C.

estimate letters" to inform patients of the likely cost of elective care prior to receiving treatment.

- Testing via a randomised control trial the impact of response rates through using different letter types.

Cost to NHS:

60. All one-off costs to the NHS in the toolbox refer to familiarisation costs, which involve the time spent by overseas visitor managers (OVMs) to familiarise themselves with the new information / rules and distribute this, where relevant, as per normal processes to other staff.

61. It is assumed that this would be applicable to 1.5 OVMs per trust, across 160 trusts (240 FTE OVM time). It is assumed that this would take 1.5hours at average hourly rate of £23.33.

62. The specific details of all other costs outlined below are found in Annex C.

    A summary of the costs for the 'Toolbox' element of this option are shown below:

Table 3: Toolbox costs (14/15)

	One off costs to NHS	Average Ongoing costs to NHS (per annum)	One off costs to DH	TOTAL in 14/15
Updating current guidance	£28,000	-	-	£28,000
Gathering and sharing best practice	£8,400	-	-	£8,400
Data sharing guidance	£2,800	-	-	£2,800
Ordinary residence guidance	£2,800	-	-	£2,800
Decision tree (scoping and – if possible, creation and implementation)	£2,800	-	£10,000	£12,800
Patient estimate letters (OVM time taken)	-	£150,000	-	£150,000
TOTAL	**£44,800**	**£150,000**	**£10,000**	**£204,800**

b) Communications and engagement activities

63. This element covers improvements to communications and engagement activities which aim to improve NHS staff and patients awareness of the rules around charging overseas visitors and migrants and associated processes. This will cover:

- An internal awareness raising programme with NHS staff involving the development of appropriate collateral, guidance and events.
- A targeted external awareness raising programme in the public domain, communication to potential chargeable patients who are more likely to use the NHS within England.
- Digital content on existing websites

Table 4: Communications and engagement cost summary:

	Total in 14/15
Internal communications	£300,000
External communications	£750,000
TOTAL	**£1,050,000**

c) Training and outreach

64. This element covers training for NHS staff around the rules of overseas visitor and migrant charging. This includes;

- Voluntary e-learning modules for a range of staff within a hospital around the rules of overseas visitor and migrant charging
- Senior leadership engagement events by DH policy teams
- National Intensive Support Team - to support NHS organisations to redesign their internal processes for more effective implementation and cost recovery. This would be modelled on the successful Emergency Care Intensive Support Team (ECIST) currently working with A&E departments, which will provide a short-term resource of clinical and managerial experts to assist in the roll out of any new systems and processes. The cost of this element has been based on the emergency care support team. It is estimated that this programme's team would require less resources in terms of staff and a smaller hospital / trust coverage than ECIST. It is expected that this programme would run for the first two years of the transition period (14/15 and 15/16) at a cost of £500,000 per year.

Table 5: Training and outreach cost summary (one-off costs):

	14/15	15/16
NHS staff training (e-learning module creation)	£16,000	£ -
Senior leadership engagement events	£12,500	£ -
National Support Team	£500,000	£500,000
TOTAL	**£528,000**	**£500,000**

d) Incentives

65. Issues around the identification stage of the charging process are estimated to constitute the biggest loss of potentially recoverable costs for both EEA and non-EEA visitors. **The fundamental disincentive in the current system lies at the point where a secondary care provider identifies a patient as chargeable.** The aim of the incentive schemes is to increase identification and recovery rates of EEA and non-EEA chargeable patients, leading to an increase in the income that UK can recover from EEA states and in England from non-EEA visitors. Additionally, improved identification rates would also establish a robust baseline of actual use of NHS healthcare by visitors. This is data that is currently very limited. Improved data on actual use will enable DH to review current policy and inform the evidence base for future policy development.

66. Incentive payments are already used in a number of contexts within the NHS. For example, Best Practice Tariffs, implemented in 2010/11, seek to reduce variation in clinical quality and ensure that best clinical practice is as widespread as possible. Best practice tariffs (BPTs) have been designed to change care settings (for example from inpatient to day care), to streamline the pathway of care (for example by reducing outpatient appointments after surgery) and to encourage Trusts to treat patients with high quality care based on the best evidence available. A review of BPTs by the Audit Commission found that although they have a variable impact, they can bring about a significant improvement in the quality and cost-effectiveness of healthcare.[18]

67. Several options were considered for both the EEA and non-EEA incentives, the final recommendations are presented below. An outline of all the options can be found in Annex D.

    - **EEA incentives**

      Recommended Option: Provider continues to be paid 100% of national tariff for an EHIC patient by the relevant commissioner (CCG or NHS England) plus receive an additional payment worth 25% of national tariff for every EHIC entry on the web portal to encourage behaviour change. This 25% would be paid to the provider by DH, and the policy would be reviewed after the first year to ensure its productivity. The costs and benefits have been modelled over a 2 year implementation period. After this, the 25% will be reviewed and could be reduced.

Costs

Costs to DH

68. The 25% incentive level would be paid on all EHIC web portal entries[19], and the Department would not gain any additional income from those countries with

[18] 'Best Practice Tariffs and their impact', November 2012, Audit Commission.

[19] There are 3 types of EEA agreements: waiver agreements where countries do not charge the UK and we do not charge them; formula agreements where the UK receives a fixed amount per annum; actual treatment costs (portal countries) recovered from EEA countries with which we have neither waiver nor formula agreements

whom the UK has a set agreement (35% of portal entries in 2013/14 related to countries holding these agreements). At break even, 25% of the additional activity is income generating. Therefore an increase in portal activity does not translate directly to an equivalent gain to the Department.

69. As a worst case scenario, if the incentive did not change behaviour and there was no increased identification the scheme would cost approx. £2m in the first full year of implementation. To note that if the 65% increase is achieved there will still be a short to medium term cost to the Department as we await payment from EEA states. It is expected that there is a 1-2 year time lag on recovering income from EEA member states. In cash terms DH will not break even in year 1 due to this time lag.

70. To break even at a 25% incentive level (additional costs to DH = additional income), there needs to be a 65% increase in EHIC portal entries assuming that current visitor levels remain the same. This increase is assumed to be spread evenly across waiver, formula and portal countries. We would begin increasing our actual income if the reporting activity went beyond this additional 65%.

71. In terms of number of claims that would have to be identified and reported, this would represent an additional 3,250 to the current levels (5,000) to a total of 8,250.

Additional costs, with 65% increase in total EEA portal activity			
Total EEA current activity identified 13/14	65% additional activity identified	Potential total EEA activity identified at breakeven	Costs = 25% incentive of total activity identified
£8.33m	£5.41m	£13.75m	£3.44m

Cost to Overseas Healthcare team (OHT)

72. There will be an admin cost to the OHT of processing any additional EEA claims as a result of the incentives. OHT have estimated that in 2013/14 it took an average of 7.4 minutes to process an EEA claim from the web portal, which in monetary terms is approx. £1.44 per claim (central estimate). The table below outlines the estimated admin cost for an increase in identification rates as modelled. Due to the low rate of current identification, it is expected that by the end of 15/16, identification rates and web portal entries will be significantly higher as a result of the incentives.

Table 6

	Low	Mid	High
Hourly wage rate for EO (£)	£10.99	£12.02	£13.04
Cost of processing per EEA web portal entry	£1.32	***£1.44***	£1.57

	by 15/16 scenarios		
	Low	Central	High
Increase in identification (%)	200%	450%	600%
Additional no. of entries (compared to baseline)	10,000	22,500	30,000
Additional admin cost (£)	***£14,423***	***£32,451***	***£43,268***

Benefits

73. **Income -** Note the additional income will be included when considering the total benefits for Option 2 on page 34.

74. Additional income at a 65% increase in identification rates yields an increase in income of £3.44m compared to current levels. (At this level of increase in identification, additional income would equal additional costs). Identification rates above 65% will generate an additional income for DH over the cost of paying the incentives. The difference between additional activity identified and additional income is due to the fact there are some countries which would not be income generating.

75. **Better data -** Improved identification rates would also establish a robust baseline of actual use of NHS healthcare by EEA visitors. This is data that is currently very limited. Improved data on actual use will enable DH to review the formula / waiver agreements on a country-by-country basis and if the actual reporting activity becomes more advantageous in cash terms to the Department renegotiate current arrangements.

76. Due to the low rate of current identification, it is expected that, after 1.5 years of implementation, by the end of 15/16, identification rates and web portal entries will be significantly higher as a result of the incentives. This is based on implementation date in autumn 14/15. We have then assumed an increase of 450% on current web portal identification levels in as the central scenario which would represent an additional approx. 23,000 entries and a total of £23.7m income for portal country claims.

77. It is expected that the current reporting levels for these countries are very low. The actual income generated via the portal was £5.3m in 13/14.

78. Using the central scenario identification rate for 1.5 years implementation provides the below costs and income stream. Note that the income is included in the overall benefits of this option presented on page 34.

Table 7

	By 15/16 (1.5 years of implementation)	16/17 (due to delay in income from member states)
Assumption of identification increase (from baseline level)	450%	Review incentive policy
Cost of incentives (DH)	£11.5m	Review
Income from additional identification	-	£23.7m

Net (in year)	*-£11.5m*	*+£23.7m*

- **Non-EEA**

79. **Recommended incentive** - This would involve a 75% tariff rate paid to the provider by the commissioner on identification of a chargeable non-EEA patient (underwriting debt recovery) and the provider charging the patient 150% of tariff. The provider splits the recovered income between itself and the commissioner.

80. If there is full recovery of costs this would cancel out the commissioner's initial payment and leave the provider in a positive position of 50% gain over Tariff (having received two payments of 75% of tariff). This option would involve changing regulations to enable 150% tariff fee to be charged to patients. The earliest regulations could be laid would be autumn 2014, to come into force in April 2015, at the beginning of the next financial year.

Benefits

81. **To the overall system –** there would be an overall benefit of additional income into the system which would be dependent on the recovery rate. At a 60% identification and 55% recovery rate (scenario B) there would be new income to system of £31m.

82. **To providers** - The aim of this incentive is to encourage the provider to identify non-EEA visitors and to recover the debt due to extra payment they will receive. By including the commissioner it reduces the provider's debt liability to 25% of tariff, helping to remove the disincentive brought by fear of bad debt to identify and charge the patients. The provider gains a payment of 75% tariff initially and keeps half of what it recovers. Therefore the income for the provider is dependent on the identification and recovery rates. Table 9 outlines various scenarios and income levels. At a 60% identification and 55% recovery rate there would be income to provider of £67.8m.

83. **To the CCG** – Incentivising the provider to identify non-EEA visitors rather than bill the CCG as if they are England resident patients, the CCG will reduce the income it flows to provider for these patients.

Costs

84. **To commissioners** – Initially the commissioner (CCG) compensates the provider for identification of a non-EEA patient at 75% tariff rate. It then receives half of what is recovered by the provider. For the commissioner to break even, the incentive would need to drive change for both identification and recovery rates. The relationship between the two rates varies in value in order for the commissioner to break even under this proposal. For example at an identification rate of 50%, the recovery rate needs to equal 100%, whereas at an identification rate of 60% the recovery rate required drops to 66% of the invoiced total. This is due to the shift in responsibility for debt between the commissioner and the provider where previously the commissioner was paying for unidentified chargeable patients (as if they were UK residents). Commissioners will pay for

patients from whom trusts will never be able to recover costs (and so will never see their 'underwriting' repaid).

85. **To the provider** - The proposal increases the risk of debt for both providers and commissioners. Providers could end up with more visible debt that they have been unable to recover at higher fee levels.

Overall summary

86. Table 8 outlines what the recovery rate would need to be for the commissioner to break even at different identification rates (that is, the benefit from paying for fewer "UK residents" equals the cost of the incentive payments).

87. Overall – there is no cost to the overall system as a result of non-EEA incentives. The additional income to the system is included in the overall option benefits outlined on page 34.

88. The risk within this element is outlined in risks section (page 37). The commissioner would be at a net loss if recovery of income does not enable them to break even.

Table 8 - Scenarios for commissioner to break even

				Provider income	Provider debt (cost)	Commisoner cost of incentives	Benefit to commissioner of better identification	Net income to system
				(relative to Baseline: charging at tariff, 50% identification, 50% recovery)				
	a.	50% identification	100% recovery	£78m	-	-	-	*£39m*
	b.	60% identification	65% recovery	£77.2m	(£9.4m)	(£24.2m)	£ 24.2m	*£31m*
	c.	70% identification	68% recovery	£98.2m	(£14.2m)	(£26.6m)	£27.3m	*£37m*
	d.	100% identification	72% recovery	£161.7m	(£27.7m)	(£33.3m)	£33.5m	*£56m*

Sanctions for non-EEA scheme

89. Sanctions will be implemented alongside the non-EEA incentives to ensure that providers continue to follow up on recovery of income owed after the identification of an individual. This is likely to involve an audit of the provider where clear documentation would be required for any who have not been charged. The details of the sanctions are currently being worked up. Any costs to providers of being fined as a result of not adhering to the process have not been included in analysis as this represents a penalty. There could be additional costs of

implementing the sanctions, but the details of this element have not yet been worked up.

Non-monetised cost to visitors and migrants

90. As a result of making the system more efficient in terms of identification and charging, there could be a deterrence effect for some visitors and migrants who are put off accessing NHS services due to the increased likelihood of being charged. This could potentially have an impact on the individual's health and subsequent treatment required in future.

91. The costs to visitors and migrants themselves are noted, but are not aggregated into the overall costs and benefits of the Programme. This is line with guidance from the Migration Advisory Committee.

Summary of Monetised Costs for Option 2, Phase 1:

Table 9

Summary of Costs	14/15	15/16
One off		
NHS – Toolbox	£54,800	£ -
DH - Communications and engagement	£1,050,000	£ -
DH - Training and outreach	£28,500	£ -
DH – National Support Team	£500,000	£500,000
DH – incentives	£11,500,000	
Ongoing		
NHS – Toolbox	£150,000	£150,000
TOTAL	**£1,780,000**	**£12,140,000**

Evidence of non-monetised benefits of Option 2, Phase 1

92. The monetised benefits will be outlined alongside Phase 2 on page 34. As both relate to improving the system the additional income generated will be a combination of both phases.

93. Some providers already use some of the elements in Phase 1 as part of their visitor and migrant process. One Trust that has introduced pre-attendance forms in A&E has seen the total amount recovered from chargeable patients increase by 12% in one year. There was a 110% increase in identified chargeable patients, indicating a large improvement in identification processes and awareness of the charging rules. The total amount invoiced in the department fell by approximately 50%, indicating that chargeable patients were opting out of more expensive elective treatments. On balance it appears that this Trust experienced both an increase in recovered income alongside reduced costs resulting from increased patient awareness.

94. Two large London Trusts have provided recovery data from before and after implementing pilot schemes of elements included in Phase 1.

95. One Trust improved their identification processes and awareness of the charging rules in A&E by introducing pre-attendance forms. This led to a 110% increase in

identified chargeable patients. The total amount invoiced fell by approximately 50% but the amount recovered increased. Overall this resulted in the doubling of the percentage recovered (the amount recovered / the amount invoiced) from chargeable patients for A&E in this Trust.

96. A second Trust improved their identification processes specifically in the maternity department, which led to an increase of over 100% in the number of chargeable patients identified. In this instance however there was little change in the amount of money recovered meaning that the percentage recovered dropped.

Option 2, Phase 2: aid better identification of chargeable patients in secondary care (manual validation of immigration and charging status through NHS 'Spine')

97. **Phase 2 of Option 2** includes the introduction of a process which would aid better identification of potentially chargeable individuals in secondary care from FY2014/15. The aim of this would be to improve the way that visitors and migrants in the UK can be identified by NHS providers so that charging rules can be applied or entitlement exemptions confirmed.

98. This phase of work would complement the Phase 1 elements previously outlined, enabling visitors and migrants to be identified in a consistent an systematic way across secondary care services.

99. Development of the new process will involve the Health & Social Care Information Centre (HSCIC) scoping and enhancing the existing PDS (personal demographics service) record on the NHS Spine. This will enable storage of information on the potential charging status of patients linked to their NHS record. Overseas Visitors managers and other trust staff will be able to 'look up' a patient as part of their entry on the PDS record on the NHS Spine.

100. Currently the default in the system is that a patient has to prove that they are resident in the UK / or exempt from charging to be entitled to free care. This default will not change under this option, however it will enhance the system to enable better identification of chargeable individuals.

101. This phase will cover the following groups of visitors and migrants in secondary care:

- The surcharge cohort of temporary migrants non-EEA: This group requires data sharing between the Home Office and the HSCIC. A pre-registration process will supply all individuals who have entered the country on a visa with an NHS record, which will be flagged with their chargeable status. The costs of issuing BRPs and aligning surcharge and visa processes has been considered in the Home Office Impact Assessment.
- The non-EEA visitor cohort: This group would be captured on first contract with NHS services. The system would identify the majority as chargeable as they would not have an NHS number (the current default of the system).
- The EEA visitor cohort: This group would be captured on first contract with NHS services and the PDS record on the Spine would be enabled to capture their EHIC card details for charging if relevant.
- EEA students: This group are able to use their EHIC cards for the duration of their course in the UK. This group would be captured on first contract with NHS services and the PDS record on the Spine would be enabled to capture their EHIC card details for charging if relevant.

102. The new identification process (and the supporting IT) will not apply retrospectively, i.e. there will be no requirement to trace and record people who arrive in the UK before the start date of policy. While this would technically be possible, it is likely that there would involve significant work and costs to establish the correct status for c. 60M existing records. The new system is expected to be

implemented via a staged process from FY2014/15. It is expected that the group of individuals who are not covered by the new system will fall and steady state will occur after five years (the maximum duration of a visa to the UK before renewal is required.)

103. Annex F provides an outline of how the improved identification process would work for patients in this system – both UK residents and visitors and migrants.

104. The following groups could be impacted:

- Staff in the Department of Health
- Staff in the Health and Social Care Information Centre
- NHS frontline staff – including OV Managers, clinicians and reception staff
- Home Office & Border Agency staff
- NHS England
- Small minority of UK resident population who do not have NHS number
- Visitor and Migrant patients[20]

Cost to Department of Health

Systems Implementation Cost (one-off and ongoing)

105. The system improvements outlined in this phase would be implemented and run by the Health and Social Care Information Centre (HSCIC). It is assumed that this system would be rolled out across 160 provider Trusts in secondary care in England. The HSCIC has provided costings for each strand of the work. These have been based on an understanding of the requirements of the system at this stage of the process prior to roll out.

106. The cost estimates provided include:

- Receipt of files submitted from Home Office containing records for entrants and data updates
- Creation/update of patient records (including NHS Numbers) on the NHS Spine
- Design, elaboration, planning, development, testing, assurance and deployment of different phases of work for surcharge and visitors cohort
- Displaying entrant information when patient record is viewed by NHS organisations using the SCRa portal
- Management of the service as part of NHS Spine Services
- HSCIC resources required for each type of activity
- Contingency of 20% of estimated cost except for certain small-scale activities

107. It is not anticipated there would be any requirement to have biometric residency permit (BRP) card reader at hospitals as all information linked to the surcharge would be included in the updated SPINE system. NHS frontline staff

[20] See assumptions – not being included in aggregate costs and benefits

could ask an individual to see BRPs as a second form of identification or checking if relevant.

Table 10: Implementation Cost (one off)

System / Implementation	FY14/15
Scoping and development	£62,700
Delivery	£228,090
Additional for Visitor work	£30,000
Privacy IA	£12,500
Hardware costs (additional processor 'node')	£18,000
VAT	£70,258
Total implementation cost	**£421,500**

Table 11: Admin cost for HSCIC (ongoing per year)

Recurring activities/elements	Average annual from 15/16
Database licences	£11,000
Query tool licensing	£53,500
Security penetration testing	£3,000
Service management/support	£27,000
TOTAL	**£94,500**

Data sharing with Home Office

80. The above costs do not include the costs of data sharing with the Home Office to share the surcharge cohort immigration status. This is currently being worked up with HO, DH and HSCIC and costs will be dependent on the data required and processes agreed.

Costs to NHS

Familiarisation cost (one off, direct cost)

81. Staff would require time to familiarise themselves with updated elements of the SPINE system. It is assumed that the OVMs (or equivalent) per trust in England (160) would be trained and would distribute the relevant information to the rest of the staff as per normal processes.

82. It is assumed that this would require 240 FTE OVM time at an hourly rate of £23.33. The estimated familiarisation costs for this is £5,600.

Administration Costs

e) Admin Costs

108. It is expected that the changes outlined in Phase 1 and 2 will result in more visitor and migrants being identified and therefore charged. It is assumed that visitors and short term migrants will be charged as per the current process of invoicing and recovering income. As the numbers increase, this will require additional administrative time and costs for frontline staff / OVMs.

109. The administration costs have been split into: time taken to identify additional patients from both the EEA and non-EEA and time taken to recover money from those who are chargeable. Not all individuals who are asked the identification questions will be chargeable. It is assumed that for 100% of EEA visitors and non-permanent residents the cost of their care will be recoverable for secondary care services and 20% of non-EEA individuals will be chargeable in the central scenario case.[21]

110. The recovery part of the process for EEA visitors will be relatively straightforward if they have documentation such as EHIC, S1 forms. For non-EEA patients, or those without an EHIC will require more time for frontline staff to recover. This will be particularly relevant for non-EEA patients as trusts are responsible for recovering income and any income not recovered will be classed as bad debt on the trusts books. The time taken to recover money is very dependent on the patient, circumstance, some patients pay for their treatment on the spot whilst others are harder to track once they have left the hospital and / or unable to pay. The impact on frontline staff of the increase in identification and therefore recovery required will be investigated through the formative evaluation.

[2121] Only some non-EEA individuals identified would be chargeable and require recovery element of process (notably visitors)

Table 12

Ongoing Admin cost – NHS	From 14/15		
	Low	**Central**	**High**
Population of migrants and visitors (stock daily equivalent) Includes expats, irregular, inactive		3,300,000	
Estimated use of secondary care services by V&M group (%)	10%	15%	20%
Number of potential users of NHS services – EEA	51,000	77,000	102,000
Number of potential users of NHS services non-EEA	210,000	315,000	420,000
% already identified (baseline)	*40%*	*50%*	*60%*
% now identified due to policy	55%	40%	25%
% not identified	5%	10%	15%
Additional number identified due to policy	143,000	157,000	130,000
Additional admin time: identification of additional patients	5mins	10 mins	15mins
Additional admin time: chasing / recovery (of those identified EEA)	15mins	20mins	30mins
Additional admin time: chasing / recovery (of those identified non-EEA) hrs	30mins	1hr	3hr
Assumed % of chargeable non-EEA individuals (due to type of service used and OR status)	15%	20%	25%
Admin cost per person EEA	£3.62	£11.67	£20.25
Admin cost per person non-EEA	£ 4.53	£27.22	£87.75
Total Admin Cost	**£280,000**	**£1,530,000**	**£3,530,000**

Source: Prederi Quantitative study, Creative Research qualitative study, Hospital Episode Statistics 11/12,

UK residents without an NHS number

111. There would be a potential cost to those who are legally resident in the UK and entitled to free care, yet do not have an NHS number. This system will identify more chargeable individuals than under the current system. This could affect a very small proportion of the resident population who do not have an NHS number if they have to spend time proving that they are resident in the UK. This might require a short follow up discussion with an OVM.

112. There is a lack of evidence about the size of the population without an NHS number. We have estimated the proportion of the resident population in England who do not have an NHS number to be in the range of 2-4%. This is a high estimate.

113. In order to estimate the costs of the new identification process to this group, we assume that the percentage of these individuals who would use secondary care services would be low (2-4%) as they have never used NHS care previously. The burden cost to these individuals has been measured in terms of time (equivalent wage) given up to prove they are eligible for free care. This is equivalent to the current minimum wage (£6.31).[22]

114. The current default in the system is if you do not have an NHS number on identification you require follow up and could be chargeable. It is assumed that 50% of people are identified under the current system; therefore this cost would be applicable to anyone over and above this level that is identified due to the enhanced system in place.

Table 13: Cost to UK residents (ongoing)

	Low	Central	High
England population - mid 2012 estimate[23]		53,500,000	
Estimated number of English based residents without NHS number (2 – 4%)	1,070,000	1,605,000	2,140,000
Assumption of those already identified under current default	40%	50%	60%
Use of NHS England services (secondary care) by this group (%)	2%	3%	4%
Estimated use of secondary care NHS England services (population size)	21,400	48,150	85,600
Estimated time to prove residency (hrs)	0.25	0.5	1
Total cost of proving identification (per year)	**£ 14,000**	**£76,000**	**£324,000**

Non-monetised costs

115. There could be a group of visitors who are not flagged as chargeable in the new system but who actually are chargeable - visitors who have used the NHS on a previous visit to the UK and already have an NHS number. The size of this group is has not been quantified as there is no data on the numbers affected, however it is expected to be minimal.

Benefits of Option 2, Phases 1 and 2

116. The additional income generated from this option includes the benefits from both phases 1 and 2 outlined above. It is estimated that by 17/18 there will be additional income of £200m compared to the baseline year 13/14 (£100m) as a result of the cost recovery programme. The initial £300m estimated total chargeable income for the programme was based on the independent commissioned research by Prederi. The benefits and potential income were also estimated based on informal modelling and information collected from providers

[22] Minimum UK wage at end February 2014

[23] Census data – Office of National Statistics population estimate

who have implemented similar elements of the programme already voluntarily. The incentives element of phase 1 have been modelled with monetary income and outlined in this impact assessment. These phases have been considered together in terms of the additional monetary income which could be generated as they are being implemented in complement to one another and one cannot isolate the impacts of the different elements.

117. The majority of the additional EEA income will be derived from an increase in EHIC identification rates from an extremely low base and S1 form processing and awareness. The collection of better data on actual use of NHS services by EEA patients will enable the UK to consider the formula agreements it holds with other countries and renegotiate towards the end of the programme as the income received from these arrangements is estimated to be lower than if it was based on actual use. Current (13/14) EEA income is £50m, it is estimated by the independent research that this could be up to £180m.

118. Non-EEA additional income will primarily be derived from better identification of these individuals via the 'improved system tools' and enhanced IT system which should enable a systematic approach across trusts. Additionally, the incentives and sanction element will begin a process whereby trusts are checked and fined if they are found to not be identifying non-EEA patients. The latest income data in 13/14 from non-EEA individuals was £47m.

119. The formative evaluation which has been independently commissioned will be considering the impact (including the benefits and income) as part of their reporting and feeding this information back to the team.

Table 14

Benefits in terms of additional income	**12/13 income**	**13/14 actual income** (baseline)	**By 15/16**	**By 17/18**
EEA Incentive income estimate *(this will contribute to the total additional income generated from the programme)*		-	£25m *(from 1.5 years of implementation at 460% identification increase)*	review
Non-EEA incentive *(as above)*		-	£30m *(scenario B low estimate)*	review
Additional income (compared to 13/14 baseline)		-	-	+£200m
Total income from phases 1 and 2	£73m	£97m	-	**£300m**
- From EEA	*£50m*	*£50m*	**	*£200m*
- From non-EEA	*£23m*	*£47m*		*£100m*

** Note that the income estimates have not been broken down by year as it is not possible to attribute individual elements to each year based on evidence

Option 2 also could generate the following non-monetised benefits:

- Efficiency and financial
    - Deterrence of chargeable patients from non-urgent care.
    - This option could lead to patients making more informed choices. Better information provision could enable chargeable patients to choose whether to proceed with non-urgent elective care and pay, or seek the treatment elsewhere. It is expected that this would lead to some chargeable patients choosing not to have the treatment through the NHS, leading to cost savings.
    - The raised awareness and increased efficiency of the identification process would be expected to deter some deliberate health tourists from entering the country with the intention of accessing free NHS services. These benefits have not been quantified as it is difficult to identify the numbers who would be deterred.
    - Clearer information for NHS staff on eligibility criteria and the rules around charging overseas visitors and migrants could make the process itself more efficient, with less NHS staff time taken on the eligibility decision
    - Increased levels of public confidence as a result of the NHS increasing identification and charging of those individuals who should be contributing to their use of NHS healthcare services

Summary of Option 2, Phase 2

120. A summary of the estimated costs of Option 2, Phase 2 and benefits of Phase 1 and 2 is presented below:

Table 15

Summary of Option 2 Costs	14/15	15/16
One off		
DH - Implementation Cost	£425,000	
NHS - Familiarisation Cost	£5,600	
Ongoing		
NHS – admin costs (both phases)	£1,530,000	£1,530,000
DH – Admin costs for HSCIC	-	£94,500
UK residents	£76,000	£76,000
TOTAL one-off	£428,000	-
Total ongoing	£1,606,000	£1,700,500
TOTAL	**£2,034,000**	**£1,700,500**

Financial value and economic value

121. All the monetary values, both costs and benefits, in the main body of this Impact Assessment are expressed in terms of financial values. These represent the actual monetary values of the both the costs of elements of the Cost Recovery Programme and the actual income recovered or to be recovered from chargeable visitors and migrants.

122. In order to understand the economic or opportunity costs and benefits of the Programme, it is necessary:

- first, to convert these financial values into the quantity of Quality-Adjusted Life Years (QALYs) that could be bought with the resources spent on the Programme and with the benefits realised (including income recovered); As per DH guidance, it is assumed that £15,000 will buy one QALY;
- then, to multiply the resultant quantity of QALYS by the DH economic value of a QALY, assumed to be £60,000.

123. Table 17 presents a summary of the costs & benefits from the two phases of Option 2 (both one-off and ongoing costs and benefits) in terms of **financial** values.

124. Table 18 presents a summary of costs and benefits from the two phases of Option 2 in terms of **economic** costs. **These figures have been used in the summary sheets for this impact assessment.**

125. In both Table 17 and Table 18, the present value figures over 10 years are calculated using a discount rate for both costs and benefits of 1.5%. This results in a higher estimate of the costs, and thus a more conservative estimate of the net present value, over the 10 year time period, than if the costs are discounted at 3.5%.

126. All the losses and gains in this analysis have been assumed to impact the NHS. This too leads to a conservative (i.e. low) estimate of the net benefit as the opportunity cost to those outside the NHS is lower than within the NHS; and were costs outside the NHS to be considered, they would be discounted at 3.5% and thus have a lower present value over ten years.

Table 16

Summary of Financial costs & benefits from the phases of Option 2

	One-Off	Annual Average	Total (Present Value over 10 years)
Costs			
Phase 1			
DH – Toolbox	£0.05m	£0.2m	£1.6m
DH - Communications and engagement	£1.1m	-	£1.1m
DH - Training and outreach	£0.03m	-	£0.03m
DH national support team	£1.0m	-	£1.0m
DH- incentives	£11.5m	-	£11.5m
Phase 2			
DH – HSCIC Implementation Cost	£0.4m	£0.09m	£1.3m
NHS – familiarisation cost	£0.01m	-	£0.01m
UK residents – identification cost	-	£0.1m	£0.8m
NHS admin cost	-	£1.5m	£15.4
Total Costs - all phases	**£14m**	**£1.9m**	**£33m**
Benefits			
Income from Phase 1 and 2	£250m	£200m	£1,666m
Total Income	**£250m**	**£200m**	**£1,690m**
NPV			**£1,658m**

Discount rate 1.5% for all costs and benefits

Price base year 14/15

GDP deflator Dec 2013

10 year time period

Base year for income 13/14

Might not sum due to rounding

Table 17

Summary of Economic costs & benefits from the phases of Option 2

	One-Off	Annual Average	Total (Present Value over 10 years)
Costs			
Phase 1			
DH – Toolbox	£0.2m	£0.6m	£6.3m
DH - Communications and engagement	£4.2m	-	£4.2m
DH - Training and outreach	£0.1m	-	£0.1m
DH national support team	£4.0m	-	£4.0m
DH- incentives	£45.9m	-	£45.9m
Phase 2			
DH – HSCIC Implementation Cost	£1.7m	£0.4m	£5.1m
NHS – familiarisation cost	£0.02m	-	£0.02m
UK residents – identification cost	-	£0.3m	£3.1m
NHS admin cost	-	£6.1m	£61.7m
Total Costs - all phases	**£56.2m**	**£7.4m**	**£130m**
Benefits			
Income from Phase 1 and 2	£250m	£200m	£1,690m
Total Income	**£250m**	**£200m**	**£1,690m**
NPV			**£1,560m**

Base year for income 13/14

Discount rate 1.5% for all costs and benefits

Price base year 14/15

GDP deflator Dec 2013

10 year time period

Might not sum to rounding

Monitoring and Evaluation

127. Currently, the NHS cannot provide an accurate assessment of its performance in recovering payments due from those overseas visitor patients who are chargeable for their treatment. In order to be able to monitor progress in maximising the recovery of costs incurred through the treatment of chargeable visitors and migrants who use the NHS, it will be necessary to measure, by Trust, the following metrics (for visitors and migrants):

- Invoiced income
- Actual cash recovered
- Bad debt – provision
- Written-off debt

128. A full evaluation of the Cost Recovery Programme will be undertaken both during implementation and after the Programme are complete. The formative evaluation will take place during the next two years, while the different phases are being implemented, to learn lessons about what works in cost recovery as the evidence emerges. The post-implementation evaluation will be undertaken to understand the extent to which the Programme's objectives have been achieved, and whether the costs and benefits are in line with expectations. Staff attitudes and stakeholder opinions about the Programme will be monitored, providing a baseline and regular updates which will feed into the evaluation.

Risks to a successful outcome

129. There are a number of risks associated with the Programme.

Risks - Option 1: Do nothing, with health surcharge

i. The current low levels of recovered income will continue;

ii. The current levels of abuse or health tourism will continue, along with a perceived lack of fairness or may increase as other countries tighten up their own systems/processes;

iii. The health surcharge will be implemented later than planned; this risk will be mitigated by working closely with the Home Office;

iv. Those wishing to access low cost healthcare will do so by applying for visa; the rigour of the visa application process makes this a low risk;

v. Those who have paid the health surcharge access healthcare to a higher level than they would previously; the impact of this is likely to be low, since the groups who require visas, and thus will pay the surcharge, in general are less likely to use healthcare services overall;

Risks - Option 2: implement a phased programme of system improvements

(Risks iii, iv, v above relating to the surcharge will also apply to this option)

i. A more efficient charging process deters those who pose a public health risk to the population from seeking the appropriate treatment; this risk will be mitigated by allowing everyone to continue to have free access to GP and nurse consultations in primary care to prevent risks to public health such as HIV, TB and sexually transmitted infections;

ii. Maternity services are always considered to be immediately necessary and will be provided whether the woman has paid in advance or not. This is justified on the basis of the possible risk to mother and child.

iii. A more efficient charging process deters from seeking early treatment those who subsequently require more costly healthcare from the NHS; to mitigate everyone will continue to have free access to GP and nurse consultations in primary care;

iv. There is a lack of engagement from the NHS frontline; to mitigate a programme of engagement, training and outreach activities with the NHS will seek to mitigate this risk;

v. The rates of identification of chargeable patients do not increase and projections for recovered income are not be met; to mitigate support will be provided to the NHS front-line (see Phase 1, toolbox elements, National Support Team);

vi. The NHS improves the identification of chargeable patients but this does not translate into increased recovered income; support will be provided to the NHS front-line (see Phase 1, toolbox elements, National Support Team);

vii. The proposed changes to information systems do not happen as planned or do not deliver the anticipated results; we will work closely with the Health and Social Care Information Centre to mitigate this risk;

viii. Unintended adverse impacts on vulnerable groups (e.g. homeless) occur; we have ensured that the engagement programme includes the NHS to raise awareness. We will also include in guidance for the NHS advice on how to address these issues and steps to help individuals to prove their residency status.

ix. The engagement programme also specifically includes working with organisations representing vulnerable groups, to better understand the impact of the proposed changes and to consider mitigating actions.

Incentives

x. If the growth in identification levels is below the breakeven level the EEA incentive scheme will cost the Department more than income generated.

xi. However, any growth will means an improvement of the data on actual healthcare use and this will support a beneficial renegotiation of the formula and waiver agreements with other EEA states.

xii. If the increase in reporting activity did not occur based on current patterns but was disproportionately higher for patients from countries with waiver or formula agreements, we would need more than the additional 65% to

break even. If a disproportionate increase came from reporting linked to patients from ‘portal’ countries, we would need less than the proposed 65% to break even.

xiii. Those visitors without EHIC card would not be identified and processed in the system, providers would not receive 25% incentives payment. They would be charged at the tariff rate. This option would be undertaken in conjunction with an awareness information campaign about bringing your EHIC when visiting the UK. This is included in the other elements of the cost recovery programme.

xiv. Time lags in recovery from other EEA member states delay achievement of breakeven points and value for money

xv. Non-EEA patients with limited financial means may choose to avoid seeking healthcare rather than be charged. This is amplified when the patient is unknowingly carrying communicable disease, which then becomes a public health risk.

xvi. NHS providers seek to prioritise chargeable patients over regular NHS patients as the former could represent increased income to the Trust.

xvii. Clinical treatments could be made for financial reasons where providers stand to make a profit.

xviii. The increase in identification and associated debt for non-EEA patients could cost more to providers than the guaranteed 75% of tariff provided by commissioners.

xix. Where providers have been historically very successful at identifying chargeable patients, their commissioners could end up paying more (through the 75% underwriting) than they have done.

xx. Providers continue to avoid identification and charging, preferring to bill the commissioner at 100% tariff (as per a standard patient) and risk the sanction rather than identify the patient and have the risk underwritten only to 75% by the commissioner along with the additional administrative burden of cost recovery.

xxi. The incentives scheme proves too difficult to adapt to patients reimbursing their costs of healthcare via a multi-year payment plan.

xxii. The scheme only succeeds in incentivising the identification element rather than identification and cost recovery by providers.

xxiii. Increased risk of debt for both providers and commissioners. Trusts could end up with more visible debt that they have been unable to recover and

commissioners will pay for patients from whom trusts will never be able to recover costs (and so will never see their ‘underwriting’ repaid).

xxiv. Commissioners require significant additional financial support from the ‘centre’ to be able to afford the risk.

xxv. Time lags in recovery delay achievement of breakeven points and value for money

xxvi. These risks will be addressed and mitigated through a programme of monitoring and evaluation (see Post Implementation Review Plan below).

Annex A: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. If the policy is subject to a sunset clause, the review should be carried out sufficiently early that any renewal or amendment to legislation can be enacted before the expiry date. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

Basis of the review:

The visitor and migrant cost recovery programme implementation plan includes a commitment that there will be a post implementation review.

Review objective:

The review will take place both during programme implementation and once the programme is complete.

The objectives of the review are to:

- learn lessons on what works and initial impacts in cost recovery through formative evaluation, focusing on each phase of the recommended option
- understand the extent to which the Programme's overall objectives have been achieved
- determine whether the costs and benefits are in line with expectations and, if not, reasons for any differences.

Review approach and rationale:

Details of the review have not been finalised but it is expected to focus on cost recovery, system changes and cultural change, particularly within NHS England healthcare system. A logic model is being developed for the programme which identifies inputs, outputs, outcomes and impacts, as well as how activities are expected to achieve the programme objectives.

Staff attitudes and stakeholder opinions about the Programme and how these effect implementation and delivery will be monitored, providing a baseline and regular updates which will feed into the evaluation. The Cabinet Office Implementation Unit will be involved in this phase of the review. Information will be collected from Trusts to determine the extent to which costs are recovered. There will also be consideration of any unintended consequences, such as whether people are being deterred from seeking care necessary to prevent the spread of infectious diseases.

Formative evaluation will take place during the next two years, while the different phases are being implemented. Impact evaluation will take place after the programme has been implemented, which is expected to be in 2016/17, and once the programme has bedded in.

Baseline:

Currently, the NHS cannot provide an accurate assessment of its performance in recovering payments due from those overseas visitor patients who are chargeable for their treatment. In order to be able to monitor progress in maximising the recovery of costs incurred through the treatment of chargeable visitors and migrants who use the NHS, we will be measuring, by Trust, the following metrics (for visitors and migrants):

- Invoiced income
- Actual cash recovered

- Bad debt – provision
- Written-off debt

The new collection of data will allow the Department and the NHS to monitor in-year quarterly forecasts, and hold annual audited accounts of the actual cash recovered by Trusts from chargeable NHS overseas visitors.

The baseline year is 2013/14 when total recovered income is projected to be £100m.

Success criteria:

The overarching objective of the programme is to improve cost recovery from visitors and temporary migrants in England who are not entitled to NHS care that is free at the point of delivery in order to ensure that the NHS receives a fair contribution for the cost of the healthcare it provides.

The programme aims:

- To maximise cost recovery from EEA and non-EEA visitors and migrants and from the EEA member states, through short and long term projects;
- To take account of the Secretary of State's statutory duty to equalities and to have regard to the need to reduce health inequalities and maintain access to public health services ;
- To improve the efficiency of the system overall, delivering additional benefits for staff e.g. reducing the work to establish chargeable status and where individuals are deterred from unnecessary use, reducing pressure on services;
- To ensure everyone makes a fair contribution to the NHS.

The programme will be judged on how far these objectives are met as part of the post implementation review.

Monitoring information arrangements:

A staff survey is being developed to collect information on awareness, attitudes and current practices. This survey would be repeated to identify changes over time. The Cabinet Office is involved in this part of the review. A mechanism for collecting financial information from Trusts will be developed. Other organisations including NHS England and Monitor will be involved in this element.

Reasons for not planning a review:

N/A

Annex B

Table summarising full list of options considered for Phase 1

Category	Element	Central cost estimate (one-off unless indicated)	Evidence/Feasibility	Recommended for implementation ?
Toolbox	Updating current guidance	£27,000	Both independent qualitative research and a survey of OVMs has highlighted the need for simplified guidance	Yes
	Gathering and sharing best practice	£8,000	Examples of best practice pilots that have already been implemented have demonstrated efficiency savings and some increased revenue	Yes
	New data sharing guidance	£2,700	Evidence from qualitative research and OVM community has highlighted need for clarity when reconciling their work with data protection legislation	Yes
	New ordinary residence guidance	£2,700	Evidence from qualitative research has identified the need for DH guidance to better define “ordinary residence” for NHS staff	Yes
	Decision Tree	£12,700	Reference group, clinicians and OVMs have been involved in developing solution to simply process. Initial conversations indicate strong feasibility for implementation	Yes – to be further scoped
	Patient estimate letters	£150,000 per annum	Anecdotal evidence from London Trusts suggests that providing better information to patients about their treatment costs can lead to more informed choices and suitable payment plans	Yes

Communications and engagement	Internal communications programme	£300,000	The qualitative research indicated that currently there is a lack of consistency and clarity over the rules around charging for NHS staff.	Yes
	External communications programme	£750,000	Evidence from both the qualitative and quantitative research indicates that some groups of chargeable patients are more likely to use the NHS, and an external communications programme therefore be targeted about rules and processes	Yes
	Information web pages	Not yet quantified	There will be a need for all of the information to be available in one place (for both staff and patients). The costs of this element have not been quantified as they will depend on range of information and tools and where the pages would be hosted. Feasibility discussions ongoing	Yes – to be further scoped
Training and outreach	NHS staff training	£16,000	Training would help to clarify the rules and support NHS staff, as indicated above (internal communications)	Yes
	Senior leadership engagement	£12,500	Anecdotal evidence from Trusts indicates that the higher the level of support for staff and the charging process, the more successful the Trust is in cost-recovery	Yes
Data flows	Existing risk-checking model of chargeable status rolled out across Trusts	£tens of millions	Scoping of this element has highlighted the high costs and it could be made redundant by phase 2 of recommended Option 2	No
	Developing new model to check risk of chargeable status	Not quantified	As above	No

	Automatic EHIC referral to DWP portal	Not quantified	Very low feasibility because of architecture of the IT systems in Trusts	No
	Debtor data sharing portal (centralised so that Trusts can see “hospital hoppers”.)	Not yet quantified	Could reduce potential for “hospital hopping”. Currently being scoped and legal issues being considered.	To be further scoped
Additional resource	Increasing helpdesk support	£17,250	Extending a phone/email facility during the period of change would allow clarification of the rules and support for NHS staff and patients	If required in future could implement
	Additional centrally-funded resources for Trusts	£3.5 million per annum	Would involve subsidising extra costs for a limited time. However would not be sustainable long term and too expensive centrally	No
	Centralised debt recovery processes (allowing one central body to undertake debt recovery)	Not yet quantified	Feasibility currently being scoped	To be further scoped
	National support team (to go into Trusts on request)	£1 million	Similar models have been successful in other NHS areas to help Trusts solve problems on certain issues	Yes – to be further scoped

Annex C: Detailed Option 1 Costs

All one-off costs for NHS toolbox phase outlined in the main body for Phase 1 represent familiarisation costs for frontline overseas visitor manager (OVM) staff, based on the following assumptions.

Familiarisation costs for NHS staff (one-off)	Low	Central	High
OVM hourly wage	£10.87	£23.33	£27.00
Estimated number of OVMs	160	240	320
Familiarisation Time (hr)	1	1.5	2

Toolbox

Costs to the NHS: One-off familiarisation

Description	OVM Time	Cost
Updating the current guidance	5 hours	Estimated to be between £12,000 and £31,000 with a best estimate of £27,000
Gathering and sharing best practice	1.5 hours	Estimated to be between £3,750 and £9,000 with a best estimate of £8,000
New data sharing guidance	0.5 hours	Estimated to be between £1,250 and £3,000 with a best estimate of £2,700
New ordinary residence guidance	0.5 hours	Estimated to be between £1,250 and £3,000 with a best estimate of £2,700
Decision Tree	0.5 hours	Estimated to be between £1,250 and £3,000 with a best estimate of £2,700

Costs to NHS: On-going

- Patient estimate letters: 0.25 hours of OVM time taken to process the letter for each patient (by determining potential cost of patient's treatment). Estimated £3 per patient letter based on OVM salary, for 50,000 elective outpatient appointments for chargeable patients per year (based on Prederi quantitative assessment alongside English resident use of NHS services). Best estimate £150,000.

Costs to DH: One-off

- Decision tree: Estimated by the DH digital team to be between £5,000 and £15,000 with a best estimate of £10,000, for creating and initially implementing the tool.

Communications and Engagement

Costs to DH: One-off

- Internal communications programme: Based on similar DH internal communications campaigns previously implemented, it is estimated that this would cost approximately £300,000 for 1 year. This would include creation and production of necessary materials and distribution.
- External communications programme: Based on similar DH external targeted communications programmes previously implemented, it is estimated that this would cost approximately £750,000 for 1 year. This would include creation and production of necessary materials and distribution.
- Information web pages: The number of pages required and their content is not yet known, therefore it is not possible to quantify this cost, though it will involve one-off and on-going costs to DH, both expected to be minimal.

Training and outreach

Costs to DH: One-off

- NHS staff training: Cost details from Health Education England indicate that the production of e-learning modules of around 30 minutes in length would cost £4,000 each as a best estimate. Based on an anticipated 4 modules, costs are estimated at £16,000.
- Senior Leadership engagement: Based on similar events run by DH a best estimate of £2,500 per event gives a total of £12,500 for an anticipated 5 events. There are also expected to be costs of DH members visiting Trusts which are currently not quantifiable but are expected to be minimal.

Annex D – Incentives – further detail and options

It is clear from these independent commissioned reports and the responses to the Government consultation that despite the variation in practices, there are several consistent and significant inefficiencies when it comes to the process of identifying, charging and recovering monies from visitors and migrants. The current system includes major disincentives for secondary care providers to identify chargeable patients, both in the EEA and non-EEA process. EEA visitors' treatment costs are recovered from their member states if they are eligible for an EHIC card (having paid in necessary insurance payments). If an EEA individual is not eligible for an EHIC card, they are chargeable individually. Non-EEA visitors are chargeable individually and will either pay themselves or recover money via their insurance.

Stakeholders have emphasised the need to alter the current system to:

- Encourage providers to identify more actively chargeable non-EEA patients and systematically declare the costs of healthcare provided to EEA visitors holding a European Health Insurance Card (EHIC;
- Encourage commissioners to participate more actively in better invoice verification and more efficient contracting with their providers.

Issues around the identification stage of the charging process are estimated to constitute the biggest loss of potentially recoverable costs for both EEA and non-EEA visitors. Currently, for non-EEA patients, if a provider identifies a chargeable patient, they are required to recover the income themselves. Any income that they are unable to recover, either because patients are unwilling or unable to pay, or are untraceable, will result in the provider itself making a loss and the bad debt being on the providers' book. Conversely, if the patient is never identified and charged, it is assumed that the patient was entitled to free treatment and the provider receives the money for this patient from the local Commissioner, and does not make a loss.

The fundamental disincentive in the current system lies at the point where a secondary care provider identifies a patient as chargeable. In order to change behaviour and culture of NHS staff and incentivise providers to identify chargeable patients it will be necessary to introduce a wide range of incentives that are behavioural, operational and financial in nature. These would be introduced alongside a package of measures designed to improve the current system by removing process hurdles, give additional support, share best practice and introduce a better identification system for visitors and migrants.

Incentive payments are used in a number of contexts within the NHS. For example, Best Practice Tariffs, implemented in 2010/11, seek to reduce variation in clinical quality and ensure that best clinical practice is as widespread as possible. Best practice tariffs (BPTs) have been designed to change care settings (for example from inpatient to day care), to streamline the pathway of care (for example by reducing outpatient appointments after surgery) and to encourage Trusts to treat patients with high quality care based on the best evidence available. A review of BPTs by the Audit Commission found that although they have a variable impact, they

can bring about a significant improvement in the quality and cost-effectiveness of healthcare.[24]

In 2013, NHS England[25] reviewed the use of incentives, rewards and sanctions within the NHS. These included the Quality and Outcomes Framework (QOF), the Commissioning for Quality and Innovation framework (CQUIN) and the Quality Premium, amongst others. Although the review identified limitations and variations in the practical operation of various incentive schemes, it did recognise the importance of these schemes in enabling the transformation of care towards the highest quality.

Aim of incentives

The aim of the incentive schemes is to increase identification and recovery rates of EEA and non-EEA chargeable patients resulting in:

- **Increased income** – these incentives are designed to encourage providers to identify and report EHIC information on the web portal, leading to an increase in the total amount the UK is able to invoice and recover from EEA states for the costs of healthcare; or to identify and invoice non-EEA patients.
- **Better data** - Improved identification rates would also establish a robust baseline of actual use of NHS healthcare by visitors. This is data that is currently very limited. Improved data on actual use will enable DH to review current policy and inform the evidence base for future policy development.

1. Outline of options

Several options which outline the possible ways to implement incentives in the system have been modelled. There are different options for EEA and non-EEA patients as they follow different processes.

The options are:

EEA

1) **Do nothing** – maintain current system with low levels of identification and web portal processing
2) **25% incentive payment for 1 year (pilot) then review impact**
   a) For all EEA country entries – **Recommended Option**
   b) For only portal EEA country entries
3) **Admin fee**
4) **Flat fee**
5) **Sanctions**

[24] 'Best Practice Tariffs and their impact', November 2012, Audit Commission.

[25] Outcome of the review of incentives, rewards and sanctions by NHS England', October 2013, NHS England Board paper.

Non-EEA

1) Do nothing – Maintain current system
2) 75% Tariff / 75% Tariff
3) 75% Tariff / 75% Invoiced amount

Other elements to be run in parallel

a) Sanctions
b) Piloting

2. Assumptions

EEA

- Analysis is based on non-UK-resident EEA patients who hold a valid EHIC card issued by the EEA country who is 'competent' for their healthcare
- Does not cover EEA patients who are not entitled to hold an EHIC from their 'home' member state. This category of patient is chargeable directly.
- EEA EHIC income is based on 2013/14 DH accounts
- S1 and S2 income is not included in the analysis
- The volume of claims is based on 2013/14 web portal entries for all countries (formula, waiver and portal – see description below)
- Incentive payments are applied uniformly across all countries whether they are portal, or formula / waiver agreements

Non EEA

- Analysis applies only to chargeable non-EEA patients (excluding surcharge payees and patients exempt from charging for other reasons)
- Analysis based on the patient paying the full invoice. Other scenarios (part paid bills, payment plans etc.) are not considered in detail
- Baseline assumptions - 50% identification rates, and of those identified 50% recovery rate
- Analysis is based on an estimate of total chargeable amount for non-EEA patients from independent commissioned research[26]

3. EEA Option Analysis

Background

For EEA cost recovery, the onus is on the provider to identify an EEA patient, request EHIC details from the patient and enter these onto a web portal for the Overseas Healthcare Team (OHT) to process[27]. There is currently no advantage for providers in identifying EEA patients as chargeable and entering them onto the web portal, as the Commissioner pays the provider for non-identified EEA patients'

26 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251909/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_FULL_REPORT.pdf

27 Note that activity refers to entry of claims onto the web portal

healthcare. Without the provider's investment in time/resource to enter these details, the OHT is unable to bill the EEA member state, and the UK is unable to reclaim money owed for the patient's healthcare costs. Currently, there is no charging applied in primary care or emergency care.

The EEA charging process varies depending on the patient's resident country. There are waiver agreements where countries do not charge the UK and we do not charge them, based on the premise that there are similar numbers of visitors between countries; formula agreements where the UK receives a fixed amount per annum, independent of the actual healthcare use by visitors, which is based on IPS data. The remaining EEA income is based on actual treatment costs (portal countries) recovered from EEA countries with which we have neither waiver nor formula agreements.[28]

The independent research estimated that there is approximately £220m which is potentially recoverable through the European Health Insurance Card (EHIC). In 2013/14, £23.8m income was received through formula agreements (80% of EEA visitor income) and £5.3m (20%) through actual portal entries. This represents less than 15% recovery rate of estimated potential visitor EHIC income.

In 13/14 there were approximately 5,000 EHIC claims entered onto the web portal for all EEA countries (all agreements). This amounted to £8.33m in terms of logged income (average claim £1,670).

NHS staff can enter EHIC details of formula or waiver countries onto the portal but this will not determine the income for the UK as the default is the set agreement. Therefore it is expected that the current reporting levels for these countries are low. Additionally, for the reasons described previously, it is expected that portal country reporting is also low as providers have no gain from entering the details. The actual income generated via the portal is £5.3m.

Type of agreement	No. of countries	13/14 Income
Portal	17	£5.3m
Formula	7	£23.8m
Waiver	6	£0m
Total	**30**	**£29.1m**

[28] Note that the UK also receives S1 and S2 income from EEA countries which has not been included in this analysis

2013/14 web portal activity reporting levels are summarised below:

EEA Portal Activity 2013/14 (20% of total EEA income)	Portal reporting	% of total portal reporting
Total waiver country activity identified	£696k	8.4%
Total formula country activity identified	£2.35m	28.2%
Total portal country activity identified	**£5.29m**	**63.4%**
Total EEA activity identified	£8.33m	100%

S1 & S2 Incentives

The proposed EEA incentives scheme in this paper cover only incentives for EHIC reporting. The costs and benefits of incentivising reporting of S1 (state pensioner) and S2 (pre-arranged treatment) schemes are not discussed. However, the Secretary of State will mention these in his upcoming letter to the Home Affairs Committee to signal intent. The Department of Health will then provide figures specific to these two schemes for a final decision to be made.

Option Analysis (EEA)

1) **Do nothing** – maintain current system with low levels of identification and web portal processing
2) **25% incentive payment for 1 year (pilot) then review impact**
   For all EEA country entries – **Recommended Option**
   For only portal EEA country entries
3) **Admin fee**
4) **Flat fee**
5) **Sanctions**

2a) 25% incentive payment For all EEA country entries

The provider receives the standard tariff rates from their commissioner to cover the costs of care (as per current rules) plus an additional payment from the Department worth 25% of tariff for each case where a patient's EHIC information is collected and added to the web portal. This payment would be made once the portal data entry had been verified, rather than at the point of cost recovery from the EEA State. The level of incentive would be reviewed after one year.

This option would be done in conjunction with an awareness campaign about bringing your EHIC when visiting the UK. This is included in the other elements of the cost recovery programme.

Benefits

Benefits to DH/NHS - This option is designed to encourage providers to identify and report EHIC information on the portal, leading to an increase in the total amount we are able to invoice and recover from EEA states for the costs of healthcare.

Additional income at a 65% increase in identification rates, yields an increase in income of £3.44m compared to current levels. (As discussed below, at this level of increase in identification, additional income would equal additional costs). Identification rates above 65%, will generate an additional income for DH over the cost of paying the incentives. The difference between additional activity identified and additional income is due to the fact there are some countries which would not be income generating. This is outlined in the next section.

65% additional activity identified	Additional income from portal countries
£5.41m	£3.435m

Improved identification rates would also establish a robust baseline of actual use of NHS healthcare by EEA visitors. This is data that is currently very limited. Improved data on actual use will enable DH to review the formula / waiver agreements on a country-by-country basis and if the actual reporting activity becomes more advantageous in cash terms to the Department renegotiate current arrangements.

Costs

Costs to DH - The 25% incentive level would be paid on all EHIC portal entries, and the Department would not gain any additional income from those countries with whom the UK has a set agreement (35% of portal entries in 2013/14 related to countries holding these agreements). At break even, 25% of the additional activity is income generating. Therefore an increase in portal activity does not translate directly to an equivalent gain to the Department.

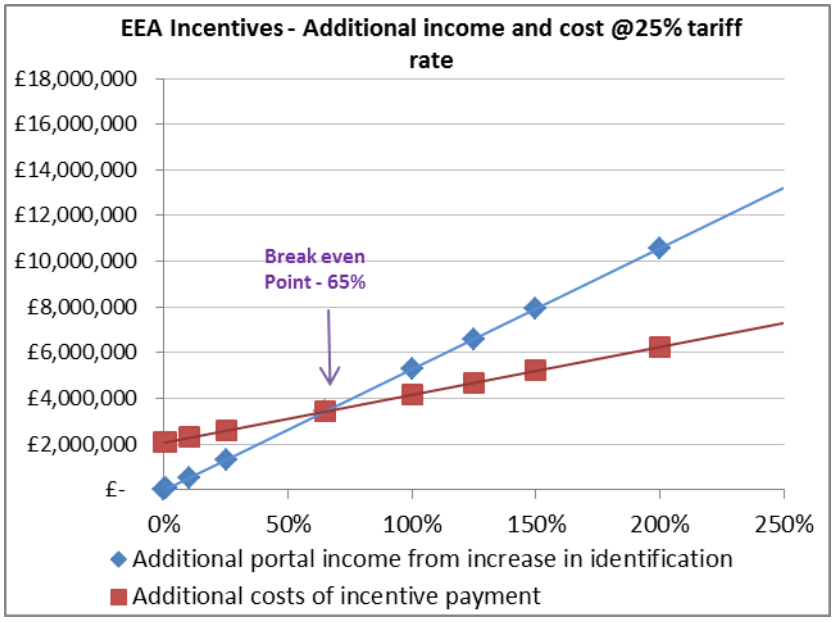
As a worst case scenario, if the incentive did not change behaviour and there was no increased identification the scheme would cost approx. £2m in the first year. To note that if the 65% increase is achieved there will still be a short to medium term cost to the Department as we await payment from EEA states. It is expected that there is a 1.5-2 year time lag on recovering income from EEA member states. In cash terms DH will not break even in year 1 due to this time lag.

Additional costs, with 65% increase in total EEA portal activity			
Total EEA current activity identified	65% additional activity identified	Potential total EEA activity identified	Costs = 25% of total activity identified
£8.33m	£5.41m	£13.75m	£3.44m

Breakeven

To break even at a 25% incentive level (additional costs to DH = additional income), there needs to be a 65% increase in EHIC portal entries for the first year. This increase is assumed to be spread evenly across waiver, formula and portal countries. We would begin increasing our actual income if the reporting activity went beyond this additional 65%.

In terms of number of claims that would have to be identified and reported, this would represent an additional 3,250 to the current levels (5,000) to a total of 8,250.



The table below shows the additional income and cost at different identification rates for a 25% incentive level.

Percentage increase in identification	Total income with percentage identification increase (formula + portal)	Additional portal income from increase in identification	Costs of incentive payment
0%	£29.1m (baseline)	£0	£2.1m
10%	£29.6m	£529k	£2.3m
25%	£30.4m	£1.3m	£2.6m
65% **(Break even point)**	£32.5m	£3.4m	£3.4m
100%	£34.4m	£5.3m	£4.2m
200%	£39.7m	£10.6m	£6.3m
300%	£45.0m	£15.9m	£8.3m

A 25% incentive level on tariff rate has been modelled based on the premise that in order to change behaviour and generate attention to the policy, a strong credible signal would need to be sent to providers. Gathering views from stakeholders, they felt the level of incentive payment would be key to changing behaviour and increasing identification and portal reporting. This level would be set for the first year only, and would be reviewed after the pilot year to determine the impact and the feasibility of future year's incentive levels.

A lower incentive level (less than 25%) would require a lower level of identification to break even. However, a 65% level of identification (at 25% payment) and beyond is likely to be achievable, as currently there are Trusts in some geographical areas which have very low levels of reporting to the web portal. The number of claims in 13/14 (5,000) was lower than expected when compared to the volume of visitors to the UK. In 2012, there were 20.6m visits to the UK from the EU[29], and the independent research estimated that the daily equivalent population of EEA visitors in England was 170,000. It is anticipated that in time, the incentive payment, would ultimately be maintained at a level lower than 25% above tariff and more akin to a fee that reflected admin compensation.

[29] ONS travel trends (IPS data) 2012

Incentive level	Increase in identification required to break even	Cost if no behaviour change
20%	46%	£1.6m
25%	65%	£2.1m
30%	90%	£2.5m

Risks

- If the growth in identification levels is below the breakeven level the EEA incentive scheme will cost the Department more than income generated. However, any growth will means an improvement of the data on actual healthcare use and this will support a beneficial renegotiation of the formula and waiver agreements with other EEA states.
- If the increase in reporting activity did not occur based on current patterns but was disproportionately higher for patients from countries with waiver or formula agreements, we would need more than the additional 65% to break even. If a disproportionate increase came from reporting linked to patients from 'portal' countries, we would need less than the proposed 65% to break even.
- Those visitors without EHIC card would not be identified and processed in the system, providers would not receive 25% incentives payment. They would be charged at the tariff rate. This option would be undertaken in conjunction with an awareness information campaign about bringing your EHIC when visiting the UK. This is included in the other elements of the cost recovery programme.
- Time lags in recovery delay achievement of breakeven points and value for money

2b) Incentives on portal countries only

This option would not be viable operationally in the system. Knowing that only a proportion of visitors would generate additional income providers would be less incentivised to identify all EEA patients and enter the details on the system. Currently only 20% of the EEA income is from portal countries. If the provider did identify the patients, they would have to spend time determining where the patient was from and deliberately failing to report those from formula and waiver countries.

There would also be a high risk of leading to perverse incentives where patients from portal countries would be prioritised in terms of treatment.

3) Admin fee – per entry

This option represents paying a fee to cover the admin costs for an EEA portal entry. It is assumed that this would take an overseas visitor manager (OVM) approx. 15 minutes to enter data in the system per claim. At an average wage rate for an OVM is £22.40 per hour this would represent approx. **£6 per entry.**

This option is not recommended as this level of payment is estimated to be too low to change behaviour from the current processes. Engagement with stakeholders has suggested that for an incentive scheme to work and generate change there needs to be a strong signal in the first year, £6 is a low amount, particularly considering the low identification levels (5,000 entries in 2013/14.) It is anticipated that in time, the incentive payment, would ultimately be maintained at a level lower than 25% above tariff and more akin to a fee that reflected admin compensation.

This would generate additional income for providers of £6 per claim.

In terms of costs to DH, this would represent approximately £30,000 in the first year if there was no change in behaviour based on number of claims of 5,000. Any increase in identification rates would increase the cost based on £6 per claim rate. At a 65% increase in identification this would be an additional £19,500. These costs are minimal.

The benefits would be the same as those outlined in option 2.a) and would be dependent on the level of identification increase, if any.

4) Flat fee - £20

Similar option to above but paying a fee of £20 per entry to incentivise bigger behaviour change.

In terms of costs to DH, this would represent approximately £100,000 in the first year if there was no change in behaviour. At a 50% increase in identification this would be an additional £65,000. This option is not recommended**.** As for option 3, these costs are minimal

The benefits would be the same as those outlined in option 2.a) and would be dependent on the level of identification increase, if any.

It is anticipated that in time, the incentive payment, would ultimately be maintained at a level lower than 25% above tariff and more akin to a fee that reflected admin compensation.

5) Sanctions Option

We have limited data on the actual use of healthcare by visitors and migrants and therefore limited data on a baseline of entries for providers. It would thus be extremely difficult to set sanctions, for example, fines for lack of identification of EEA patients. In parallel with more positive incentives and once data integrity has improved, it might be possible to develop “sticks” to hold Trusts to account. This would, however, only work through increased commissioner scrutiny and intervention.

4. Non-EEA

Background

For patients coming from non-EEA countries who are identified as chargeable, the debt risk is carried by the healthcare provider who has to recover the cost of treatment from the patient or, on occasion, their insurer. There is estimated to be a low rate of recovery in the current system, particularly where the individuals themselves are charged. From anecdotal evidence, the scale of under-reporting of chargeable patients is likely to be significant.

Process

- If patient is identified as chargeable, debt risk = 100% provider held until payment received from patient
- If patient is not identified as chargeable (either through lack of information, effort or wilfully) = cost = 100% commissioner held

The independent commissioned report estimates that the total chargeable amount for non-EEA visitors and migrants was approximately £156m.[30] DH accounts show that in 2012/3 we recovered approximately £40m from overseas patients. This represents less than 25% of the estimated chargeable income from patients. There are two steps in the process of generating the £40m recovered amount; amount identified / invoiced and recovery rate of the invoiced amount. We do not have data on what in practice these two levels are, as we currently do not know the scale of under-reporting in the system. This is the reason behind designing an incentives scheme. The baseline assumptions used for the current system are 50% of chargeable patients are identified and of their costs, 50% are recovered.

Current system process and assumptions:

- Non-EEA patients charged at tariff level;
- Provider identifies and invoices 50% of total chargeable amount - £78m;
- Provider does not identify 50% of total chargeable amount and invoices CCG as UK resident patients - £78m;
- CCG pays provider for the 50% not identified (as UK resident patients) - £78m;
- Provider recovers 50% of the invoiced amount - £39m;
- Provider has bad debt of 50% of invoiced amount (not recovered) - £39m

Option Analysis

1) Do nothing – Maintain current system
2) 75% Tariff / 75% Tariff
3) 75% Tariff / 75% Invoiced amount

[30] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251909/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_FULL_REPORT.pdf

4) Other elements to be run in parallel
   a. Sanctions
   b. Piloting

We are recommending tariff/tariff option 2 plus sanctions option of targeted growth rates. The modelling, data and stakeholder views exercise caution with this recommendation. The recommendation is based on Ministerial decision as the strong preferred option.

2) 75% tariff / 75% tariff

This option would involve a 75% tariff paid to the provider by the commissioner on identification of a chargeable non-EEA patient (underwriting debt recovery) and the provider charges the patient 150% of tariff. The provider splits the recovered income between itself and the commissioner. If there is full recovery of costs this would cancel out the commissioner's initial payment and leave the Trust in a positive position of 50% gain over Tariff (having received two payments of 75% of tariff). This option would involve changing regulations to enable 150% tariff fee to be charged to patients. The earliest regulations could be laid would be autumn 2014, to come into force in April 2015, at the beginning of the next financial year.

Process

- Non-EEA patients charged at 150% of tariff;
- Providers receive half of the amount charged ("75% tariff") at identification stage *(from commissioners);*
- Providers receive 75% of tariff at full recovery (= half the amount recovered at full recovery); & half of the amount recovered at less-than-full recovery
- Commissioners receive half of the amount recovered at recovery stage

Benefits

Benefits to the overall system – there would be an overall benefit of new income into the system which would be dependent on the recovery rate.

At a 50% identification and 50% recovery rate there would be new income to system of £20m.

Benefits to providers - The aim of this option is to encourage the provider both to identify non-EEA visitors and to pursue the debt due to extra payment they will receive. By including the commissioner it reduces the provider's debt liability to 25% of tariff, helping to remove the disincentive brought by fear of bad debt to identify and charge the patients.
The provider gains a payment of 75% tariff initially and keeps half of what it recovers. Therefore the income for the provider is dependent on the identification and recovery rates. The table in the overall section outlines various scenarios and income levels.

At a 50% identification and 50% recovery rate there would be an additional income to provider of £48.8m.

This options also aims to incentivise the commissioner to hold the Trust to account regarding its debt recovery.

Costs

Costs to commissioners – Initially the commissioner (CCG) compensates the provider for identification of a non-EEA patient at 75% tariff rate. It then receives half of what is recovered by the provider.

For the commissioner to break even, the incentive would need to drive change for both identification and recovery rates. The relationship between the two rates varies in value in order for the commissioner to break even under this proposal.

For example at an identification rate of 50%, the recovery rate needs to equal 100%, whereas at an identification rate of 60% the recovery rate required drops to 66% of the invoiced total. This is due to the shift in responsibility for debt between the commissioner and the Trust where previously the commissioner was paying for unidentified chargeable patients (as if they were UK residents).

Commissioners will pay for patients from whom trusts will never be able to recover costs (and so will never see their 'underwriting' repaid).

Costs to the provider - The proposal increases the risk of debt for both Trusts and commissioners. Trusts could end up with more visible debt that they have been unable to recover at higher fee levels.

Overall summary

The table below outlines what the recovery rate would need to be for the CCG to break even at different identification rates (that is, the benefit from paying for fewer "UK residents" equals the cost of the incentive payments).

Scenarios for CCG to break even

				Provider income	Provider debt (cost)	CCG cost of incentives	Benefit to CCG of better identification	Net income to system
				(relative to Baseline: charging at tariff, 50% identification, 50% recovery)				
	a.	50% identification	100% recovery	£78m	-	-	-	£39m
	b.	60% identification	65% recovery	£77.2m	(£9.4m)	(£24.2m)	£ 24.2m	£31m
	c.	70% identification	68% recovery	£98.2m	(£14.2m)	(£26.6m)	£27.3m	£37m

	d.	100% identification	72% recovery	£161.7m	(£27.7m)	(£33.3m)	£33.5m	£56m

Additional scenarios where CCG does not break even

		Provider income	Provider debt (cost)	CCG cost of incentives	Benefit to CCG of better identification	Net income to system
50% identification	50% recovery	£48.8m	(£19.5m)	(£29.3m)	-	£20m
60% identification	55% recovery	£69.8m	(£24.2m)	(£31.6m)	£7.8m	£26m
70% identification	60% recovery	£92m	(£26.5m)	(£32.8m)	£15.6m	£33m

Risks

- Highly sensitive to recovery and identification rates of which there is limited evidence for baseline
- Could lead to a lower recovery rate as providers are recovering a higher fee level from patient
- The proposal increases the risk of debt for both Trusts and commissioners. Trusts could end up with more visible debt (since they are charging 150% of tariff) that they have been unable to recover and commissioners will pay for patients from whom trusts will never be able to recover costs (and so will never see their 'underwriting' repaid). CCGs therefore could have increased costs and budgetary pressures in a challenging financial climate
- Risk to relationship between NHS England, CCGs and providers
- Risk of CCG not having sufficient 'cash flow' to finance increase in upfront payments (particularly in areas where Trusts have historically been better at chargeable patient identification)
- Risk of complication if patient repays costs on a payment plan over a number of months/years.

3) 75% Tariff / 75% Amount invoiced

This option would involve a 75% tariff paid to the provider by the commissioner on identification of a chargeable non-EEA patient (underwriting debt recovery) and the provider charges the patient an amount up to 150% of tariff. The provider then keeps 75% of the fees recovered and the commissioner gets 25% of the total fees. This option would involve changing regulations to enable 150% tariff fee to be charged to patients.

Process

- 75% tariff is paid to the provider by the commissioner on the identification of a chargeable non-EEA patient and the provider is allowed to set its own level of fees to charge the patient within parameters set by Secretary of State. After financial modelling, we do not recommend this as it is not financially viable.
- Non-EEA patients charged *up to* 150% of tariff;
- Providers receive 75% of tariff at identification stage (from commissioners);
- Providers receive 75% of fee at full recovery (= 75% of the amount recovered at full recovery); 75% of the amount recovered at less-than-full recovery
- Commissioners receive 25% of the amount recovered at recovery stage

Financial modelling indicates that in order for the CCG to break even, fees of approximately 300% would be required to be charged to patients. Although the Secretary of State may set parameters for charges on a commercial basis, any profit element must reasonable. It is considered that charges of 300% would amount to an unreasonable level of profit and are not legally viable.

Other elements which could be run in parallel

As outlined previously the preferred option is **tariff/tariff option 2 plus the sanctions option of targeted growth rates**.

a) Sanctions

- **Spot Check / Audit**
  A general process of audit could be carried out on Trusts by commissioners. This is likely to be a spot check / dip sample. If breaches were found then the commissioner could then apply the sanction. Sanctions could be based on the severity of the audit outcome or per case. It is likely that the level of sanction would be mandated by DH.
  Issues
  - In practice commissioners would need to develop expertise and capacity to do this, as a parallel, though not as extensive, system to the system currently in providers;
  - Is this a high enough priority for CCGs to spend time / resources on? CCGs would have to send in auditors to count the number of patients in the hospital on that day vs. the number of non-EEA declared;
  - Unlikely to change behaviour;
  - Is there sufficient capacity/scope to implement by commissioners?
  - Issues between relationships with CCGs and providers;
  - There are possible presentational aspects with this option. We would have to announce not only that we will charge non-EEA patients 50% more than they cost; but that we seek to fine Trusts for not doing so.

- **Data sharing and high level assessment**

  High level analysis on UK visitor numbers could be used to compare with invoiced and recovered amount from providers. Commissioners could then take this data and benchmark it against previous identification rates and their overall expectations for identification. This would allow them to consider sanctions at a high level, applied in a band approach rather than per case. This could involve a process where commissioners can set a target for improvement year on year and sanction for failures.

  Issues

  - We do not have data on the identification rates in specific areas. We only have a population top down estimate of the potentially chargeable income for non-EEA patients in England. This is not actual use, or by area in England.
  - The IPS UK visitor data we have provided on target areas is based on a self-declared survey question which asks the individual where they intend to primarily visit in the UK. This gives us a rough estimate of where people are thinking of going and therefore a very rough idea of where tourists cluster. However, it would not be robust to build a sanction process on this data.
  - Using the number of chargeable patients identified already would not capture the non-identified group. Therefore, if this was used to create the sanctions, it could incentivise providers to identify even less than they do now so that their baseline is lower.

- **Recovery Rate Sanction**

  There is an alternative approach: that of using penalties on Trusts which faili to seek to recover costs with sufficient vigour. This could simply look at the overall recovery rate and apply sanctions if it is too low. Alternatively it could focus on specific aspects of the process and sanction Trusts where:

  - they have failed to attempt charging before treatments;
  - they have not gathered sufficient information to chase the debt properly;
  - they have failed to advise the Home Office of outstanding debt;
  - treatment has been provided in advance of payment that was not strictly necessary;
  - they have provided regular/accurate information to commissioners on cost recovery or made prompt payments to commissioners for the funding recovered.

  Issues

  - Is there sufficient capacity/scope to implement by commissioners?
  - Issues between relationships with CCGs and providers.

- **Target Growth Levels**

  In this proposal DH would require Trusts to demonstrate growth in identification rates. Trusts would agree a reasonable rate of increase in identification rates for the coming year with the commissioner. DH could

recommend a minimum figure for reasonable growth. If a Trust failed to reach this target, the commissioner would then be able to look to see if there are systematic failures. The commissioner could require the Trust to demonstrate what they have done over the year to drive increases and outline developments for the coming year. The commissioner could consider whether this was appropriate and apply sanctions (at rates mandated by DH) if needs be or issue the threat of sanctions for the coming year.

Issues

- Providers could be incentivised to report initial low levels of identification as their baseline rate to avoid fines
- Lack of current data / evidence to determine baseline rates and target rates
- Issues around local level target rates
- Resources required by CCG

- **Commissioner flexible approach**

  Under this principal the sanction levels could be established by DH but commissioners could be allowed to develop their own methodologies for checking identification is being carried out. This effectively establishes the principal that sanctions are acceptable under specific circumstances, but allows commissioners to use it as they see fit.

5) **Piloting**

We have considered the possibility of piloting the non-EEA financial incentive in a discrete geographic area such as London. However, we do not currently have the legal powers to do so and as such, this would require additional secondary legislation.

Issues

- If piloting took place in London, it would be as efficient to roll out the pilot everywhere as London makes up the majority of visitors; and DH would have to lay regulations to charge 150% fees for pilot for any geographical location.

6) Central Risk Pooling

This option involves having a centralised debt recovery or risk pooling system, where the Department would underwrite the non-EEA debt for Trusts. Finance colleagues have assessed this but believe that it would not achieve its stated objectives and would be too costly to the department for implement and maintain. As such, it has not been pursued further.

Other elements of cost recovery programme to complement incentives

The cost recovery programme also recognises that Trusts face significant practical hurdles to managing the process and work is underway to correct this. This includes the work as part of Phase one, the better identification process and the introduction a National Intensive Support Team to help implement best practice for cost recovery:

- The deployment of a national intensive support team currently in development to drive best practice in cost recovery by Trusts and commissioners.
- Toolbox
- Better identification
- Targeted engagement programme - a programme of targeted trust visits is being initiated. This will cover 20 Trusts nationally and will be led by Sir Keith and the Director and Deputy Director for the programme. The visits will seek specific feedback on the processes and challenges faced by the Trusts in managing identification and cost recovery.

5. Financial Assessment

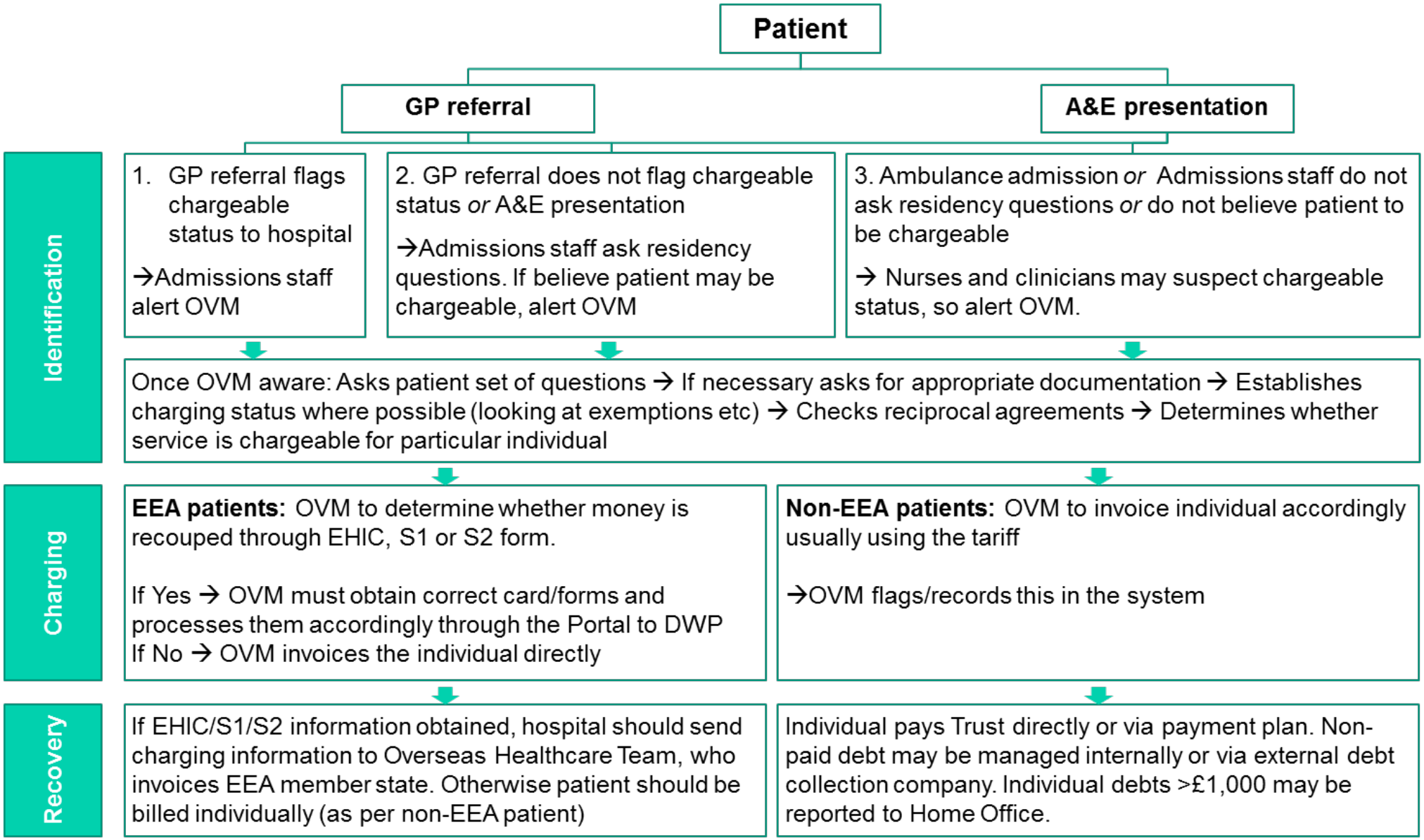
On affordability, our assessment is that the EEA scheme is affordable in year one, even taking lags in recovery of income from EEA states into account. Even if there were little or no change in behaviour, which seems unlikely, the cost would be some £1-2m in year one, which can be managed at risk within existing DH central budgets.

The non-EEA scheme has overall net benefits to the system, particularly as recoveries improve. However it also runs the risk of additional costs to commissioners, if identification is below 60% and recovery rates are below 65%. This would add to the pressures faced by commissioners in a challenging financial climate. There are also risks around additional provider bad debt.

The EEA scheme does not appear to be novel and contentious given its relatively small financial scale and that it is initially time limited for one year. An upfront incentive and associated affordable investment is considered necessary to change behaviour.

The non-EEA scheme also appears within the range of reasonable charging policies open to the Department given SoS powers under the legislation to charge on a commercial basis.

Annex E – Patient Journey



Annex F – Option 2 "Aiding better identification"