Department of Health

Sustaining services, ensuring fairness

A consultation on migrant access and financial contribution to NHS provision in England

Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment

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Contents

Strategy for Impact Assessment development

This evidence document is to support the Department of Health's consultation on migrant access to the NHS. There are significant limitations in the information and data available which are summarised below:

1. There is currently insufficient evidence to support a definitive list of options to address the problem.

   An internal Department of Health review of charging for NHS services was undertaken in 2012. It confirmed existing anecdotal evidence and that there are significant weaknesses and failures in both the current rules and their application. It also put forward a range of options and recommendations, from basic process improvements to the radical redesign. This document draws together evidence on a number of proposals based on the review recommendations that included as part of the consultation. However, these should not be considered a comprehensive set of final options. We want to understand the feasibility of different options and will be engaging with stakeholders during the summer on system design and development.

2. There is no official data on migrant's use of the NHS. The NHS does not record the nationality of those to whom free treatment is currently provided. Nor does it routinely collect data on debtors or cases where individuals have sought to access free treatment inappropriately.

   There are significant inconsistencies around the estimates of migrant use of the NHS. The 2012 review estimated the nature of problem in the millions; however some external sources claims are much higher. The estimates that were presented in the 2012 review were based on a small survey of overseas visitor's managers and extrapolations of travel data/border movements and are therefore considered to be subjective rather than objective and unlikely to provide us with a true national picture. These sources include official migration statistics, data from the Office for Higher Education, Trust accounts, and others. All of these data sources come with limitations: they may lack accuracy, sometimes contradict each other and most of the time cannot be easily compared. That information is referenced where appropriate across this evidence document, but it is only to be considered as a likely illustration of the scope rather than providing us with a definite understanding.

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

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

early September. With the results of the consultation and the 'audit', we will be in a position to confirm final policy decisions and input to the final IA in the winter of 2013.

3. For the purpose of this evidence document, we have illustrated the income generation where ever possible. However, we have not undertaken any analysis to demonstrate the costs (including transition and on-goings costs) and have not projected the impacts of the proposed policy options for future years. This is because, (a) policy options are not confirmed; (b) policy development is in its initial stage; and (c) baseline data is not available to undertake the analysis. Through the consultation process and the parallel 'audit' work, we would aim to achieve these objectives and therefore will be able to provide a detailed cost – benefit/cost-saving analysis in the final IA, which is planned for publication in the winter of 2013.

Problem under consideration

There has been a long-standing recognition that current rules and practices relating to the charging of non-residents in the NHS are complex, inconsistently applied, and do not provide the right balance of fairness and affordability. Since the 1980s, the regulations and operating guidance have been updated on a piecemeal and reactive basis leaving the overall system broadly unchanged and increasingly dysfunctional.

In addition the current system in the UK is very generous, allowing people who are living here temporarily to use the NHS without contributing and also allowing any visitor, including tourists, to visit a GP free of charge. These sorts of services are rarely available for UK citizens when they are abroad.

The majority of people who visit, or reside here temporarily, make only occasional and necessary use of the NHS, but our current system also attracts 'health tourists' - people who take advantage of our current generous entitlements or are able to avoid detection or payment.

As a consequence 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. The consultation seeks to inform policy development to ensure the system remains sustainable.

For the purpose of ease in understanding the problem, we have classified the problem into two groups:

1. Generosity in the NHS

Definition of ordinary residents

The overseas visitor charging system places a statutory duty on NHS bodies to make and recover charges for hospital treatment from 'overseas visitors' (i.e. non-ordinary residents), where no exemption from charge applies. The power to charge overseas visitors for NHS care has not been enacted beyond secondary care. Since 1982 only those who are 'ordinarily resident' (OR) in the UK have been automatically entitled to access hospital services without paying, whilst some other groups have been exempted from charge by regulations.

The concept of OR has never been defined in legislation. To be deemed OR, a person must be in the UK lawfully but they do not need to have the right to reside permanently - OR can apply with immediate effect. In fact, it is extremely easy to pass an OR test and become entitled to free NHS hospital treatment. The vagueness of the definition also means that it is often difficult and onerous for NHS staff to screen eligibility.

The greater mobility of migrants and numbers of visitors to the UK in recent years combined with the ease of passing the OR test, means the NHS is facing a challenge of increasing demand for provision for free hospital care.

We have used the International Passenger Survey (IPS) data to estimate the likely number of short term visitors (<6 months) and OR (>6 months and <5 years) in England at any moment in time (i.e. full year equivalents) which is shown in the table below. The main categories of OR with less than five years of residence are students, workers and dependent family members. The current policy on overseas visitors requires short term visitors to pay for their NHS care while those who are OR would qualify for free NHS hospital care. We discuss the limitations involved with short term visitors' charges and recovery in the next section.

Table 1: Number of short-term visitors and ordinary residents in England at any moment in time

	Short term visitors		**Ordinary residents**		
	Category	Numbers	Category	Non-students	Students
2010	EEA	300,000	EEA	325,000	125,000
	Non-EEA	195,000	Non-EEA	600,000	370,000
2012	EEA	340,000	EEA	350,000	110,000
	Non-EEA	250,000	Non-EEA	650,000	300,000

Notes: Estimates derived from IPS. We might want to consider an indicative range of +/-25%.

Overseas visitors' charges do not apply beyond secondary care

The current overseas charging policy does not apply outside secondary care, i.e. access to primary care, including emergency GP consultations, other community care and Accident and Emergency Services (A&E) is currently free to overseas visitors.

Individuals who are not exempt are charged for any emergency treatment as an inpatient, including when admitted from A&E. However, this must not be delayed or denied if prior payment cannot be made for any reason.

2. Charging and recovery in the current system

Financial disincentive for the NHS to identify and charge overseas visitors

There is a fundamental financial disincentive for hospitals to identify and charge overseas visitors. This is because failure to identify overseas visitor has no impact on the Trust's income – they still receive payment from NHS commissioners who have no way of knowing that the patient was not entitled to free treatment. On the other hand, when a Trust identifies and treats a chargeable patient and the patient does not pay, the burden is no longer hidden and falls to the Trust itself. In such situations, the Trust must cover these costs from its own reserves. The 2012 review indicates that on average, Trusts identify between 30% and 45% of chargeable overseas visitor income and recover around 40% of all invoiced charges.

Weakness in income recovery

Hospitals have a legal duty to make and recover charges from overseas visitors who are not exempt from charges. From a cost recovery perspective, it is preferable for hospitals to demand and receive payment prior to incurring the costs of providing treatment.

However hospitals often feel they have limited room for manoeuvre because out of three categories of treatment i.e. immediately necessary, urgent, non-urgent, they are unable to

demand payment in advance of treatment for two of them – immediately necessary and urgent.[1] In light of human rights obligations that may be applicable, hospitals are told[2] to ensure that treatment which is immediately necessary is provided to any patient, even if they have not paid in advance.

Cost recovery is also compromised by the fact that undocumented migrants make up the largest group of chargeable overseas visitors – approx. 500,000, many of whom have few resources to pay charges incurred.[3]

Difficulties with defining and identifying means screening patients who are liable for charging can be difficult for NHS staff. Even if overseas visitors are identified and charged, the 2012 review identified that a significant number of patients simply refuse to pay following treatment. This is because once a patient is discharged the process of recovering charges from them is bureaucratic, time consuming and the chances of recovery diminish, particularly where patients leave the country or had given incomplete or false contact details. It was also evident that Trusts do not have expertise in chasing debts. Also patients are unable to afford high charges if they are not insured.

Similarly, there are weaknesses inherent in the identification and recovery of money from treating European patients. Residents of European Economic Area (EEA) states and Switzerland, including third country nationals are exempted from charges in certain circumstances, by virtue of European Union Rights arising under EU Regulations. UK can claim back the cost of treatment from the country where there patient is resident. Due to failure to identify these groups for the same reasons stated above and thereby failure to ask for EHIC card, there is poor recording in the web portals, a system by which UK claims money back from EEA. Based on Department of Work and Pensions (DWP) internal data, it is estimated that in 2012, only 60% of hospital trusts used the web portal on a regular basis to upload patient data.

Conclusion

Based on the observations above, it can be concluded that practices relating to identification and charging of 'non-residents' in the NHS are complex, generous and misaligned. This encourages 'free-riding', makes the NHS vulnerable to "health tourism" (where visitors come to

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[1] Immediately necessary: to save a life or prevent a condition becoming immediately life threatening; urgent – cannot wait until the patient can be reasonably expected to return home; non-urgent – routine elective treatment that could wait until the patient can return home.

[2] Guidance on implementing the overseas visitors hospital charging regulations (Chapter 4, Para 4.3) at https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations

[3] The EU funded CLANDESTINO project provides a good overview of estimates proposed since 2000 (which range from roughly 150,000 to 1m for the UK): http://irregular-migration.net/index.php?id=169; all of the estimates need to be adjusted to reflect England only.
Düvell, Franck 2007, in: Triandafyllidou, Anna and Ruby Gropas (eds.) (2006): European Migration: A Sourcebook, Aldershot: Ashgate – best estimate: 240,000.
Gordon, Ian et al 2009: Economic impact on the London and UK economy of an earned regularisation of irregular migrants to the UK, London, London School of Economics – best estimate: 618,000;
Migration Watch UK (2005): The illegal Migrant Population in the UK, Briefing Paper, London: Migration Watch UK – best estimate: 670,000.

the UK specifically to use NHS services they are not entitled to access for free) and impose loss to NHS revenue.

With unprecedented financial demands on the NHS's budget and increased mobility of migrants and numbers of visitors to the UK, there is a need for the government to intervene to regulate health provision and ensure that scarce resources are targeted at those who are, or who should be, eligible and that NHS can generate revenue from non-eligible patients.

We considered the equality implications of the proposals as far as possible at this stage. This is set out in Annex 2, Equality Assessment.

Government legislation, guidance and principle sources of evidence

Key government policy(ies) include:

1. Health and Social Care Act 2012.
2. National Health Service (Charges to Overseas Visitors) Regulations 2011
3. New Immigration Rules 2011
4. NHS Charges (Overseas Visitors) Regulations, SI 2011/1556
5. The Cross-border Healthcare Directive 2011

Sources of evidence used:

1. Internal DH Review of Overseas Visitor Charging Policy 2012
2. Migration committee paper
3. Home Office statistics
4. Office of National Statistics
5. Higher Education Statistics Agency

International evidence

As a parallel work to the consultation, we are conducting a comparison of other countries' health care systems and their approaches to charging overseas visitors for treatment. The intention is to find out if there are any lessons, and to establish the relative generosity of the provision of free treatment to overseas visitors exempt from charge in the NHS, compared with that provided free by other countries to visiting UK residents. See Annex 1 for detailed findings, which should be considered as a working draft. In summary:

General conclusions:

Most healthcare systems that were reviewed are insurance based (either private or social/state systems – such as Germany or France), where the individual, or in some cases their employer, makes direct contributions for future potential healthcare needs. Examples include United States of America, Belgium, Czech Republic, Finland, Hungary, Switzerland, Netherlands, Australia, and others. In such cases, temporary migrants will be able to buy into the state system, but short-term visitors (other than intra-EEA) and students would be required to pay (as demonstrated in Australia, New Zealand, and United States of America). This typically means demonstrating adequate insurance to cover the cost of treatment, including urgent medical attention and/or emergency hospital treatment.

In most countries, the onus is on patients – whether resident or visiting – to prove that they are entitled to access state healthcare. This typically means demonstrating adequate insurance to cover the cost of treatment, even if the insurance is provided by the State and funded through taxation. In the majority of countries, a medical card provides this proof.

Some health systems are fully integrated with social security information systems enabling automatic, efficient and reliable verification of entitlements.

Although there was very limited information on access to healthcare by illegal immigrants, those that reported concluded that there are difficulties in charging and recovering chargeable income from them and in most cases the burden falls on the state.

Country specific details are as follows:

In many EEA countries, visitors are required to arrange for health insurance prior to their visa. The insurance policy must cover all Schengen countries, and the minimum policy coverage is €30,000 which usually covers for medical treatment and emergency repatriation (e.g. Denmark, France, Italy, Sweden, Luxembourg, Netherlands and others).

While in Australia, premiums for visitors vary from Basic Cover $79.99 (equivalent to £48.73) which meets visa requirement and covers for in hospital services to Executive top $350 (equivalent to £213.17) which meets visa requirement and offers highest level of in hospital and outpatient cover.

In some other countries, visitors are entitled to healthcare which is absolutely and urgently necessary (Germany, Italy).

In most EEA countries, a requirement for visitors is that the representative office of the insurance company must be located in Europe. Also in Australia, there are over 40 private health insurance funds registered by the Australian Government.

Health insurance is a prerequisite condition for a potential temporary visa holder or limited term resident and the visa will not be granted unless a visa processing officer is satisfied that the applicant has made adequate arrangements to obtain and maintain the appropriate health cover. E.g. Australia, United States of America.

In Australia, where public hospital services are provided to ineligible persons, including emergency services, they are generally charged an amount as determined by State and Territory governments. For example, in New South Wales (as of June 2012), ineligible patients are charged $120 (equivalent approx. £76) for all non-admitted occasions of service in a metropolitan hospital. Where ineligible patients are admitted, they are charged daily accommodation fees of $2,575 (equivalent approx. £1,626) as 'critical care' patient and $1,035 (equivalent approx. £654) as inpatient (other than critical care) patients. Ineligible persons are identified through non-possession of a Medicard.

Temporary migrants in most EEA countries are required to arrange for their own health insurance or pay directly to providers (Portugal, Luxembourg, and Slovenia).

While in some countries, residents -person that has acquired a residence or a fixed place of abode, are entitled to healthcare benefits (Denmark, United Kingdom, Italy, and Sweden).

In Czech Republic, any person can be insured within the public health insurance system regardless of his or her nationality provided he or she meets the conditions of participation, i.e. permanent resident and employment. Resident is also a criterion for accessing free health care Portugal.

Students:

In Finland, students who are in the country for less than 2 years, must have private insurance which primarily covers the costs of medical treatment up to EUR100,000.

In Australia, students are required to take out Overseas Student Health Cover, which cover the costs of medical and hospital care - include visits to doctor, some hospital treatment, ambulance cover and limited pharmaceuticals. The average cost of Overseas Student Health Care is $360 (equivalent approx. £231.66). The insurance is provided by a selected number of suppliers; students cannot purchase cover from an overseas provider.

In New Zealand, students are required to have compulsory health insurance of around NZ $295.50 per semester and NZ $585.00 for one year (equivalent approx. £158.16 and £313.11 respectively).

Policy Area to be consulted on: **Who should be charged?**

Qualifying residency

The core principle of the proposed new system is that everybody makes a fair contribution. Visitors and newly arrived migrants should contribute explicitly for NHS services until established as residents.

Based on this principle, the proposal aims to redefine the eligibility criteria so that 'ordinary residence' is replaced as the 'core' way of being entitled to free NHS treatment with being a permanent UK resident. By permanent residents, we mean UK residents who have lived in the UK for a minimum of five years, or who have indefinite leave to remain in the UK.

In this way, the threshold for free access to the NHS will be raised, i.e. limited to only permanent residents and to exempt categories. The 2012 review indicated that there were at any moment in time, approx. 1.4million ordinary residents in England (including EEA ordinary residents) and their associated treatment costs in secondary care was approx. £610m (including treatment costs for EEA ordinary residents).

If eligibility criteria were to change from 'ordinary residents' to 'permanent residents', non-EEA ordinary residents (approx. more than 700,000) will no longer be eligible for free NHS care, unless specifically exempted. The review advises extreme caution about the numbers as they were based on subjective inferences from hospital Trust managers, extensive extrapolation and assumptions based on travel trend/border movements data, length of stay and expected healthcare consumption. The report suggested use of +/-25% range on this estimate.

In 2011, tighter immigration rules were introduced with respect to entrepreneurs, workers and students. Subsequently new immigrants have been reduced in each of these categories. As reported in the Home Office website, in 2012, there were 3% fall in work related visas compared with 2011; and 20% fall in study visa in 2012 compared with 2011.

Our internal analysis has indicated that the number of ordinary residents at any moment in time in 2012/13 has remained more or less the same. i.e. approx. **1.4m ordinary residents** (including both EEA and non-EEA ordinary residents) and the expected hospital treatment costs is approx. **£590m.**

Although there is an increase in number of EEA and non-EEA ordinary residents, there is a reduction in the number of students both for EEA and non-EEA. Therefore, rise in the treatment costs for non-students is offset by a fall in the treatment costs for students. For details on numbers and costs for ordinary residents, see Table 2 on page 14.

Table 2: Number of ordinary residents at any moment in time, including students and non-students in England.

	Category	Non-students (Number/treatment costs in secondary care, £)	Students (Number/treatment costs in secondary care, £)
2010/11	EEA	325,000 (approx. £140m)	125,000 (approx. £49m)
	Non-EEA	600,000 (approx. £270m)	370,000 (approx. 150m)
2011/12	EEA	350,000 (approx. £149m)	110,000 (approx. £43m)
	Non-EEA	650,000 (approx. £280m)	300,000 (approx. £118m)

Notes: Number estimates are derived from various data source such as IPS, Home Office, Higher Education Statistics Agency; Cost estimates are based on average cost per person estimated by the DH Resource Allocation Branch (for the purpose of calculating PCT allocations). However, we take into consideration that different groups of overseas visitors are younger, on average, than the average population and use appropriate average cost estimates.
We might want to consider an indicative range of +/-25%.

Once again, these are initial high-level estimates based on a number of assumptions, such as ordinary residents being identified, charged and costs recovered. However, in the real world, even with the introduction of compulsory payment for non-EEA ordinary residents and recovery of money from EEA patients, there will be element of “un-insured” patients and non-identification and loss of recovery from EEA patients, which will lead to failure in full recovery of treatment costs. Also evidence suggest that immigrants use less health care services than natives and the immigrant population is generally younger than the native-born population as a whole.[4][5] [6] [7]As such, it is important to note that there is significant uncertainty around these figures.

We expect to get a better understanding of the numbers with the commissioned independent ‘audit’ report findings.

Expected benefits may include:

1. Clear eligibility definition and new registration system would enable NHS staff to identify and process the required details quickly thereby save staff time.
2. Money recovered can be used in providing better quality care to patients.
3. It would ensure fairness in the system.

[4] "Facts About Immigrants' Low Use of Health Services and Public Benefits". *Immigrants' Rights Update.* 20 (5). 29;

[5] "Sharing the Costs, Sharing the Benefits: Inclusion is the Best Medicine". Immigration Policy Center. 22.

[6] "Immigrant health care in the United States: What ails our system?" *Journal of the American Academy of Physician Assistants*, 22 (4): 33–37.

[7] “Impact of migration on the consumption of education and children’s services and the consumption of health services, social care and social services”, *National Institute of Economic and Social Research*, 2011.

Risks:

1. The new proposal might deter students and other groups from coming to the UK.
2. Administrative burden (involved in identifying and charging) may outweigh the benefit, as we understand from 2012 review that the share of all treatments to non-permanent residents is below 2% of NHS treatment expenditure. Furthermore, one needs to consider how much of this revenue can be realistically raised (e.g. patients may not be able to pay, there may be reciprocal agreements with other countries, etc.).

Widening scope to exempt some expatriates and other former UK residents

An expatriate is a UK citizen who has previously resided in the UK but is no longer resident here. Most will be British nationals but they could have dual nationality.

Currently, expatriates are not automatically entitled to free NHS treatment as they are not 'ordinarily resident' here. Expatriates are exempt immediately if genuinely returning to resume permanent residence (estimated to be around 75,000 expatriates each year)[8].

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

On the principle that everybody makes a fair contribution the proposal is to regularise the entitlement of expatriates and other former UK residents not subject to immigration controls.. The policy proposes that those who have paid National Insurance contributions for a significant period (propose at least 7 years) should also retain the right to free treatment whilst returning to the UK on a visit. It is not proposed to limit this to 'needs arising' treatment.

Most people in receipt of UK state pensions who reside abroad will qualify for treatment under the NI exemption.

The 2012 review indicated that at any moment in time there are around **100,000 visiting expatriates** and the likely treatment costs is around **£15m**. This number needs to be treated with caution as we do not know for certain the proportion of expatriate using the NHS and proportion of expatiate getting identified and charged.

It is to be noted here that recovery of income was proving anyway difficult from the expatriates group in the current charging system because they can often avoid detection. With the new proposed policy to exempt this category from NHS charges, we expect the NHS to continue to provide NHS care for free and incur greater loss if more ex-pats return to access free NHS care. In considering these costs, we need to consider the payments made to the EEA countries for treating UK expatriates. By negotiating better payments (refer EEA income

[8] Internal review of the overseas visitor charging system, 2012, Department of Health.

recovery - Annex IV below) with EEA countries, such as the proposal to join Annex IV, may result in net savings rather than costs in treating expatriates. We will explore such impacts in the final IA.

Other benefits may include:

1. Better payment negotiations with EEA may potentially save money to the NHS. For instance UK including the EEU Annex IV clause may potentially save money. For details on Annex IV, refer section Recovering Healthcare Costs from EEA.
2. The proposal will lead to fairness in the system based on the principle that everybody makes a fair contribution.

Risks:

1. There are currently more that 5 million expatriates living abroad (more than 2 million in EEA and more than 3.5 million in non EEA countries). By making the NHS entitlement free to expatriates, there is a danger that more expatriate may come in the future to access free NHS care.

How to charge

This consultation proposes a significant increase in the number of people requiring identification and charging, that could multiply the risks of non-identification and non-recovery and a significant burden on the NHS.

We considered three options for securing the payment contributions:

Direct payment by the individual at the point of treatment

This is the current system for short term visitors (those coming to the UK for less than 6 months) are already administered. It requires NHS hospitals to identify each such patient at the point of treatment, charge them the full cost of treatment, and subsequently secure that from them, often after they have left hospital. As our consultation documents explain this is highly inefficient as many are not identified and many more fail to pay.

Applying this principle to up to 500,000 newly chargeable temporary residents would magnify those inherent problems (although we do have new proposals to improve the process of tracking chargeable patients). This problem is magnified as we are also intending to apply charges across all areas of the NHS in including primary care.

More importantly for those students and workers, it would expose a small number, to significant financial risk, and the consequences of non-payment are currently that visa extensions would be refused (this is already in the Immigration Rules to target visitors who fail to pay). This in turn could lead those students and workers who would have a higher risk of healthcare costs due to any underlying health condition to decide not to come here.

This approach is also predicated on paying the full cost of treatment. We have said that a fair contribution for this group should be (significantly) less than the full cost. To implement this principle under direct payment would require a complicated process of hospitals applying an agreed level of reduced charges and receiving ‘central’ recompense for the remainder.

Direct payment through Insurance at the point of treatment

Temporary residents would be required (as a condition of visa entry), to hold comprehensive health insurance that would be used to fund any treatment they require through the NHS.

The insurer would pay the NHS provider (eg hospital) directly for the treatment. For this to be manageable, we envisaged establishing a list of approved insurers that migrants could sign up with.

This approach is based on the model in use in Australia and New Zealand, both of whom require migrant students and workers to pay for their healthcare in this way as a condition of entry.

This significantly reduces the risks of non-payment for the NHS. It also benefits the impacted migrants, as the insurance packages could provide premiums that pool risk (rather than individual premiums based on health screening). Premium costs could also be spread over the period of stay.

However, on more detailed consideration there are significant challenges and disadvantages:

- Most fundamentally it is clear that fully comprehensive insurance for a person who is present in the UK for a significant period will be expensive. Early estimates suggest premiums would be in the thousands of pounds, even for students, as they need to cater for all on-going requirements including chronic conditions (to provide the same level of care as the NHS). This is much more extensive cover than tourists will obtain as travel insurance where known conditions are typically excluded, and most will delay accessing all but emergency treatment until they return home. The low cost insurance (around £250 per year) offered to students in Australia is only basic cover with significant limitations, such that they are advised to take out additional top up private health insurance. This could at least double the cost (and more for those with any existing health conditions).
- To reduce such costs would require the Government or the NHS to subsidise by accepting some of the risks of higher take up of healthcare. We want, in any case, to subsidise charges in line with our fair contribution principle.
- Establishing and managing such a scheme would still require significant administration by the NHS at the point of each treatment, to identify the chargeable person, and to secure payment from the insurer. This will be further complicated by the likely need to differentiate included and excluded treatment. The likely need to charge for excluded treatment brings back the challenges already noted for direct patient payment, including the visa refusal risk for those who fail to pay
- These challenges would be magnified significantly for similar cover to be provided to older migrants, particular those migrating to join already resident family and who may have significant age-related health needs
- Migrant adherence to having and maintaining insurance would need to be checked and monitored to ensure that it is in place. There is a significant risk of non-compliance that would result in the person being uninsured at the point of treatment and liable for its costs. This monitoring burden is likely to fall to some or all of the Border Agency, employers or universities, and the NHS.

Contribution through Migrant Health Levy

Migrants to pay a fixed charge linked to their visa application (but separate from the current visa application fee) in advance of entry. This fee will be deemed to pay for their access to any subsequent healthcare needs during their stay, with the possible exception of a few excluded high cost non-essential treatment (such as IVF, Cosmetic Surgery) and/or pre–existing pregnancy or conditions requiring transplants or other high cost intervention. We are consulting on this.

There are significant advantages to this approach:

For the student or worker

- We anticipate a single cost for all students and for all workers that pools their health risks including comprehensive cover. The cost would be lower as no insurer profit margin or risk factor element. Actual cost to be determined through consultation and further cross-government agreement
- It is easy for us to reduce the cost further in line with the fair contribution principle.
- No risks of additional bills and associated risk of debt related visa exclusion

For the NHS (and other institutions)

- All temporary migrants must obtain the permission of the Home Office by seeking 'entry clearance', before they travel. This means that the Home Office is ideally positioned to collect the levy from all temporary migrants as part of the entry clearance process.
- Removes the considerable risk of non-payment for excluded treatment that typical insurance policies will still create
- The health risks of temporary migrants are pooled, so those with existing health conditions are not disadvantaged, eliminating the discriminatory risk associated with other approaches.
- Overall costs to the individual will be lower as there will be no profit margin in the annual charge.
- Minimal front line administration, in terms of both monitoring individual 'compliance' (being covered for healthcare as required) and subsequent processing of treatment and recovery of charges. We envisage that the payment of the charge would be recorded on the migrant's Biometric Residency Permit that will act as evidence of eligibility

There are some but fewer and less fundamental disadvantages:

- Payment for the specified visa period is likely to have to be and up-front lump sum. This will be more significant if the annual fee is high
- There is a risk that some, having paid an up-front charge, may seek to maximise their use of available healthcare and increase capacity and financial demands on the NHS. Similarly a few may be attracted to seek visas under the available categories with a main aim of securing cheap healthcare.
  While this cannot be discounted we should recognise that these groups currently have full free access to the NHS while present so if the current risk should actually reduce
- Requiring all such migrants to pay this levy for NHS treatment is unfair on those (mainly highly skilled workers and entrepreneurs) who hold comprehensive healthcare insurance, either individually are more likely through employers for privately provided healthcare.

We propose addressing this by providing an opt out from the levy for such persons that also excludes them from access to any free NHS treatment.

We also considered whether both options should be available to each temporary resident, but concluded that this would not be practical because:

- The administrative burdens for the NHS, as well all institutions required to check and monitor compliance, would remain, indeed having separate categories would make this even more difficult
- Such an option would lead to a distorted distribution with those who are healthier opting for insurance and those with greater health needs opting for the Levy, thus increasing the NHS cost burden

The proposal is to introduce a health levy as a condition of receiving entry clearance (including visas) to reside. The health levy would be registered on an immigration record. When the patient accesses treatment, their record will show entitlement to access without further charge. The Home Office are consulting on the principle and details of the Health Levy as this would be a specific immigration power.

It is estimated that in 2012 there were approximately **950,000 temporary migrants** in England at any one time and the estimated treatment costs in secondary care was approximately **£398million**.

If the option of health levy is introduced as an effective mechanism of income recovery for non-EEA residents, it could be expected that a significant proportion of treatment costs for non-EEA patients would be recovered while considering factors such as humanitarian and legal obligations, equalities duties and potential discriminations issues, and public health.

A significant feature of the NHS access charge option is that the level of charge can be varied to an appropriate level in line with the principles of fair contribution or other factors. The full cost of healthcare varies according to age, ranging from £700 (age group 0-4 years) to £6,000 (age group 75+) as indicated in Table 3.[9]

[9] 2011-12 age healthcare cost spend summaries, estimates based on Nuffield G&A and Mental Health age cost indices and scaled to 2011 ONS Census population and spend from the 201-12 DH Annual Report & Accounts.

Table 3: 2011-12 age- health care costs summary

Common Age Bands	Average HCHS[1] Cost / head 2011-12	Average Prescribing[2] Cost / head 2011-12	Average PMS[3] Cost / head 2011-12	HCHS + Mental Health + Prescribing + PMS £s/head	ONS 2011 Census based population (000s)	2011-12 Spend by Ageband (£000s)
0_4	489	24	210	722	3,329	2,403,519
5_14	457	28	56	540	6,058	3,274,101
15_44	559	66	88	714	21,511	15,348,081
45_64	1,213	193	152	1,558	13,480	21,006,649
65_74	2,993	401	253	3,647	4,592	16,748,065
75+	5,377	517	388	6,281	4,137	25,988,460
Total	**1,295**	**155**	**146**	**1,596**	**53,107**	**84,768,874**

Source: Estimates based on Nuffield G&A and Mental Health age cost indices and scaled to 2011 ONS Census population and spend from the 2011-12 DH Annual Report & Accounts.

Benefits may include:

1. Cost savings to the NHS as costs of treatments are pooled by all temporary migrants. In this way patients with pre-existing conditions are not disadvantaged.
2. As the payment will be administered at the visa processing stage, there will less administrative burden on the part of the NHS.
3. Increase coverage and protection for those who would have otherwise delayed or avoided protection.
4. Visitors with identifiable pre-existing conditions will not be excluded.

Macroeconomic impacts:

1. Due to the introduction of a fixed charge, there is a likelihood that immigration would fall slightly. This could have an impact on wider economic impacts such as gross domestic product and employment. However, a study on OECD countries suggest that estimates of fiscal impact of immigration tend to be very small in terms of GDP and are around zero on average across the OECD countries. It is also understood from the same study that the impact whether positive or negative, rarely exceeds 0.5% of GDP in a given year.[10]

Risks:

1. Increase administrative burden on the part of the visa processing departments.
2. There is a risk that a few prospective migrants with significant health conditions will seek temporary residency to access major treatments for a relatively small insurance fee.

[10] http://www.keepeek.com/Digital-Asset-Management/oecd/social-issues-migration-health/international-migration-outlook-2013/the-fiscal-impact-of-immigration-in-oecd-countries_migr_outlook-2013-6-en

Policy Area to be consulted on: **What services should we charge for?**

The NHS Act permits charges to be made to non-residents for any NHS services. However, the necessary powers to define and implement such charges have only ever been applied to hospital treatment (secondary care) and then only in those hospital bodies defined by the Act (NHS Trust and NHS Foundation Trusts).

Significant services including primary care, community-based care and continuing care are free to all. This disparity is considered generous and therefore the consultation considers whether charges should be extended to any or all of these services.

No charges are made in respect of specified infectious diseases and sexually transmitted infections. Treatment at sexual health clinics is also universally free. These exemptions are to ensure population-wide protection of public health and do not extend to any other conditions that a patient may have. There are no proposals to reduce or remove these exemptions.

Primary care (GP) services

The consultation recognises that primary care is a necessary part of the healthcare of any individual resident in the country, whatever their status, so access should not be restricted. However, where the individual is determined not to be exempt from healthcare charges, these charges should include provision of GP services.

The new process of registration and creation of a healthcare record (linked to the NHS number) must differentiate those who will be chargeable for NHS services and facilitate the disclosure of this information to subsequent healthcare providers

Other Health care settings

Other settings include community-based treatment; elective secondary care provided by alternative commissioned providers, including independent treatment centres, social enterprises or other commercial organisations; and continuing care outside hospitals (e.g. rehabilitation).

There are no current powers for charging in any of these treatment settings. The proposal is to include all services to be charged for non-exempt individuals, irrespective of who provides the service.

Emergency treatment (via GP or Accident and Emergency Department)

Hospital A&E services and emergency GP consultations are currently free to all. Individuals who are not exempt are charged for any subsequent inpatient emergency treatment, including when admitted from A&E.

There is no question of treatment being denied and would be a recognition that some individuals would be unable to pay or refuse to pay.

Income generation with introduction of charges in wider NHS settings

Based on our 2012 review estimates, we have derived an indicative estimate of demand by **overseas visitors and ordinary residents** across different NHS settings in England which are shown in the table below - these estimates should be considered as an illustration of likely scope rather than a precise estimate. If charges are introduced in these different settings and with the introduction of the Health Levy if payments are made, there is a possibility that a proportion of these healthcare costs from these different settings can be recovered. The amount of money recovered will depend on overseas visitors being identified, charged and income recovered and in the case of ordinary residents, the amount charged as health levy. Also one needs to consider the factors such as humanitarian and legal obligations, equalities duties and potential discriminations issues, and public health.

Table 4: Treatment costs in other settings, including A&E, Prescriptions in primary care, Primary care, community based services, 2012

Other settings	**Overseas visitors/£millions**	**Ordinary residents/£millions**
A&E	approx. £8m	approx. £34m
Prescriptions in primary care	approx. £23m	approx. £132m
Primary care	approx. £21m	approx. £138m
Community based services	approx. £36	approx. £200m

Notes: Number estimates are derived from various data source such as IPS, Home Office, Higher Education Statistics Agency; Cost estimates are based on average cost per person estimated by the DH Resource Allocation Branch (for the purpose of calculating PCT allocations). However, we take into consideration that different groups of overseas visitors are younger, on average, than the average population and use appropriate average cost estimates.
We might want to consider an indicative range of +/-25%.

Policy Area to be consulted on: **Making the system work in the NHS**

Improving the current system in hospitals

The 2012 review concluded that, while there was a clear case to revise the rules on who should be charged and introduce more radical ways of administering them, there was also a significant opportunity to improve current practices in NHS hospitals, providing an earlier opportunity to improve compliance and increase recovered income from charges. This also incorporates the opportunities set out in the next section to improve the income recovery from EEA patients.

The 2012 review estimated that there are approximately195,000 short term visitors from non-EEA countries at any one time. Based on the survey response (included as part of the 2012 review), it is estimated that the cost of treating chargeable overseas visitors could be around **£125m**. This figure could be a significant under estimate, as it takes no account of those patients who have avoided detection and charging in first place. For instance, although it is difficult to estimate the number of undocumented migrants, various sources suggest around 500,000 at any one time[11]. This group are usually unable to pay charges levied for treatment and contribute significantly in debts to Trusts.

Table 5: Number of short term (<6 months) visitors at any moment in time, England

	Categories	**Numbers**
2010/11	EEA	300,000
	Non-EEA	195,000
2011/12	EEA	340,000
	Non-EEA	250,000

Notes: Number estimates are derived from IPS. We do not any evidence on how these total costs are split across the various chargeable groups to generate what level of costs. We might want to consider an indicative range of +/-25% .

It is also indicated that Trusts currently invoice between £35m and £55m to chargeable overseas visitors, and recover about 40% of all invoiced charges (£15m - £25m).

A number of factors make it difficult for Trusts to recover costs from patients, which are discussed in the above section on problem under consideration. The improvement proposal would systematically aim to address the whole process from referral to admission, treatment, charging and recovery, roles of each involved party, and the incentives and disincentives underlying them. The Diagram 1 sets out the current system and how it operates.

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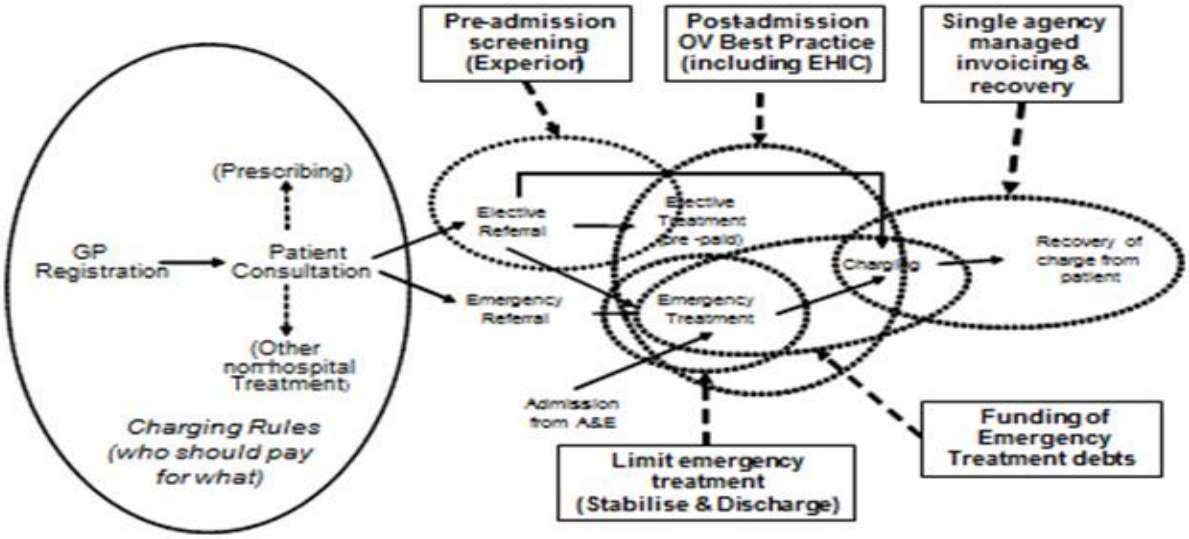
[11] The EU funded CLANDESTINO project provides a good overview of estimates proposed since 2000 (which range from roughly 150,000 to 1m for the UK): http://irregular-migration.net/index.php?id=169; all of the estimates need to be adjusted to reflect England only.
Düvell, Franck 2007, in: Triandafyllidou, Anna and Ruby Gropas (eds.) (2006): European Migration: A Sourcebook, Aldershot: Ashgate – best estimate: 240,000.
Gordon, Ian et al 2009: Economic impact on the London and UK economy of an earned regularisation of irregular migrants to the UK, London, London School of Economics – best estimate: 618,000;
Migration Watch UK (2005): The illegal Migrant Population in the UK, Briefing Paper, London: Migration Watch UK – best estimate: 670,000.

Diagram 1



NHS England is currently considering the potential of a managed pilot in the London region that has the highest density of visitors and other migrants and is also where the main identified current innovations are located. Some of the specific areas of improvement are as follows which have been piloted in some hospitals across the London region:

- *Pre-admission screening*: all referred elective patients will be screened for eligibility before admission using proven commercial system tools. Identified patients will be withdrawn from treatment or pay as required before it proceeds.

- *Limit Emergency Treatment (stabilise and discharge):* urgent treatment in advance of payment is limited to that necessary to safeguard the patient's immediate health.

- *Post Admission Best Practice:* gather, evaluate, share and combine other local best practices in screening admissions (elective & emergency) and applying charges. Includes identification and recovery of EEA patient costs through EHIC cards.

- *Commissioner funding of Emergency Treatment:* Trusts are legally required to provide emergency treatment but funded only by those charges they are able to recover from patients. It is proposed that they are funded in full for such treatment by commissioners, possibly subject to conditions. This should result in greater compliance with duty to identify such patients.

- *Agency Managed Invoicing & Recovery:* currently each Trust undertakes its own charging and recovery. Local practices vary in effectiveness, and lack both systems and expertise to recover, particularly when patients have left the UK. A centralised process should provide the capability to increase recovery.

The 2012 review indicates that some of the currently chargeable income is being collected albeit only about £20m (40%). We understand from the review that much will remain unrecoverable (from illegal migrants which constitute one of the biggest categories of chargeable patients). Our initial understanding is that improved NHS initiatives might recover up to £40m of that over time.

Expected benefits may include:

1. Clear rules regarding screening will bring more clarity in the system and may increase efficiency in the NHS.
2. Agency managed invoicing and recovery would bring economies of scale to the NHS and reduce administrative burden in each Trusts.

Risks:

1. The treatment costs for overseas visitors are a small fraction of the overall NHS treatment expenditure (less than 2%). With cost involved in operating the overseas visitor charging system, one needs to carefully weigh the benefits against cost.

Developing a new NHS wide system

Under the current system, chargeable migrants are not screened and identified until they access hospital treatment, often as part of emergency admission.

The new system would aim to improve the identification, charging and recovery of income through a number of core components, as set out below, which is by no means an exhaustive list:

- Initial registration of a person new to the NHS should include a full review of their eligibility for free treatment based on the new rules
- Relevant information is accessible from other government agencies
- NHS numbers and related personal records should differentiate chargeable and exempt persons. They may also differentiate temporary migrants who may have time limited eligibility through the new Health Levy, and EEA citizens for whom reimbursement may be claimable from their home country
- The initial ‘NHS registration’ could be separate from and ideally precede registering with a specific GP Practice
- Eligibility information linked to the personal record/number should be accessible by all subsequent providers of treatment, in particular elective referrals from GPs and emergency hospital admissions
- There should be an appropriate and integrated set of new financial and other contractual incentives to maximise the number of patients who are appropriately charged, and to maximise revenue recovery from appropriately charged patients. In particular hospitals (and in the future other providers) should not be liable for unrecoverable costs of providing emergency treatment.
- The process of recovering charges from visitors could be managed on a pooled basis taking advantage of more professional systems and expertise.

There would be costs, including transition and annual costs to the NHS and other government agencies such as the Home Office. These costs will be identified once the full set of proposals

are agreed through the consultation and will be outlined in the full IA. The Home Office are consulting on the principle and details of the implementation framework.

Expected benefits may include:

1. Revenue generated as temporary migrants who was exempt from NHS charges under the old system will now have to pay.
2. A centralised screening system connected through visa/entry clearance will reduce administrative burden on the part of the NHS.
3. Information will be shared across a number of bodies, thus making the new system transparent and efficient.

Risks:

1. Treatment in an emergency or for public health needs may get compromised or delayed.

Policy Area to be consulted on: **Recovering healthcare costs from the EEA**

The UK operates an extensive reciprocal agreement with EEA countries which co-ordinates the provision of healthcare under the Free Movement Directive that results in financial obligations between member States. Under this EU legislation, UK can claim back the costs of providing healthcare to EEA citizens. However, this is dependent on Trusts identifying such patients at the frontline, the patient presenting a valid EHIC, and Trust reporting details via a web portal.

Although they are governed by EU, there are opportunities to optimise our net financial position by being fairer and more effective.

Greater use of web-portal to identify EEA visitors

When an EEA patient requires necessary treatment and presents their EHIC to the NHS, the details are up-loaded onto the Overseas Visitors Web Portal. Claim information is sent for processing and reimbursement by the Member State (not the individual receiving the treatment).

Department for Work and Pension (DWP) information suggests that only around 60% of hospital trusts use the Web Portal on a regular basis, which means the UK is missing out on income owed by other EEA member states. There is no direct incentive to upload claims onto the Web Portal as NHS can recover treatment cost under internal funding arrangements. The money, once claimed, is directed back into the Department of Health's EEA budget.

Regional analysis of NHS reporting shows a significant decline. For example:

- One area reported only £159,000 in 2012 (33% of hospital trusts in this region reporting) in comparison to over £318,000 in 2012 ; and
- Another area reported £146,000 in 2012 (40% of hospital trusts in this region reporting) compared to £307,000 in 2012 .

EEA state pensioner registrations

Under EU rules, a state pension is exportable and includes healthcare provision as a benefit in kind. The UK clearly exports vast numbers of UK state pensioners who decide to retire to other EEA countries, but it is also the case that state pensioners retiring here from EEA countries must also have their healthcare funded by their home country.

The system works on the same principle as the EHIC, with a form 'S1' being issued to state pensioners wishing to move abroad. For every 'S1' registered in the UK, the UK would be entitled to claim approximately £4000 per year for each individual. This figure represents a lump sum figure and is claimed regardless of the level of healthcare used. The UK has a process in place for registering the forms, which is managed by the Overseas Healthcare Team within the DWP but relatively few are received.

The assumption is that the majority of the 'S1' forms are 'lost' within the NHS, and may be attached to patient records. We believe that there is a loss of around **£12million** (a conservative) per year from EEA member states.

Early retirees

This process is applicable to UK nationals, who are not in paid employment, and are residing in another EEA member state. The form (E106) was introduced in 1982, primarily to provide healthcare cover for pre retirees, allowing them 2.5 years of healthcare cover and time to integrate into their new country of residence.

Forecasts indicate that the UK pays out around **£3.6million** a year for this entitlement. However, Residual E106 is not required under EU Regulations and the Department of Health could save £3.6million per year by removing the entitlement and also remove the operational costs involved in the processing of the forms.

Co-payments

Under EU Regulations EEA visitors are entitled to receive treatment in another Member State on the same basis as a resident of that country. Many EU countries operate a co-payment system where the patient is required to cover a percentage of the cost, as the UK does for prescriptions and dental treatment.

Since 2009 the UK has refunded 100% of all state treatment provided in another member state, including dental treatment. The co-payment element is refunded directly to the customer, whereas reimbursement of the state element is managed member state to member state.

The rationale for this policy approach was a ruling of the European Court in 2008, which upheld that an individual requiring treatment in another member state should not be financially disadvantaged, and receive treatment on the same basis as in their Member State of residence. This decision has subsequently been overruled which means the UK is not legally obliged to reimburse co-payments and could save around **£2.7million** per year by ceasing this arrangement.

UK state pensioners returning to the UK from another EEA country

Under EU law state pensions are transferrable and contain healthcare provision as a benefit in kind. This means that EEA countries are required to cover the health costs of their state pensioners, wherever they live in the EEA (EU Regulation 883/04).

Such state pensioners are, by definition, not resident in the UK, meaning they are not entitled to the full range of NHS services. However, if a country opts to join Annex IV of the Regulation, it extends the full provision of health services to state pensioner's resident abroad within the EEA. So, a UK state pensioner, resident in Spain could have an elective procedure at a UK hospital.

Currently, the UK is not listed under Annex IV, but if it were to join, we would open the NHS to approx.150,000 individuals. This would bring about an obvious cost to the NHS (falling on the NHS as and where the patients present themselves) but it is likely to prove popular given the general desire shown by UK citizen's resident within the EEA to return to the UK for significant treatment.

The benefit to the UK of joining Annex IV would be a discount of 5% from payments to all countries using the same method for charging other countries for providing healthcare to their

citizens. Using current spend levels as a guide, this would result in the following savings against the EEA budget:

Table 6: Savings that would be generated if UK had been in a position to join Annex IV

Financial year	Member state claims/millions	With Annex IV -5 % discount (Member state claims)
2011/12	approx.£766m	approx.£721m
Net savings in 2011/12 if UK had been in a position to join Annex IV	**approx.£45m**	

Source: Department of Health, EEA medical costs: resource outturn totals, 2013.

Annex 1: International evidence

Country	General Access Rules	Limited Term Residents	Visitors	Illegal	Emergency
Australia	All permanent residents have access to national public health system which includes free public hospital treatment and either free or subsidised out of hospital treatment. Individual states and territories are responsible for policies for the ineligible.	Health insurance is recommended. Students required to take out Overseas Student Health Cover which is offered by Australian private health insurers for an average cost of $360.	Travel health insurance required for visa, including health examination.	Chargeable. Matter for state or territory.	Chargeable. Matter for state or territory.
Austria	All persons required to have compulsory social health insurance, mainly through employment.	Compulsory social health insurance for those who are employed, otherwise private health insurance.	Travel health insurance is required, with coverage of minimum €30,000, for duration of stay.	No information available	Chargeable. If payment is not received, doctors/hospitals must cover the cost.
Belgium	No information available	Medical insurance required.	Travel health insurance is required, with coverage of minimum €30,000, for duration of stay.	No information available	No information available
Canada	No information available	Medical examination is required for permanent residence applications and for employment visas.	Travel health insurance is required.	No information available	No information available
Czech Republic	Public insurance system (premium payments) for those who have permanent residence or are employed in the Czech Republic.	Public insurance system (premium payments) for those who are employed in the Czech Republic. Private insurance required for those who are not.	Travel health insurance is required, with coverage of minimum €30,000, for the duration of stay.	Chargeable.	Chargeable either to public insurance system or to individual.
Denmark	All residents registered on Civil Registration system is entitled to healthcare.	All residents registered on Civil Registration system is entitled to healthcare.	Travel health insurance is required, with minimum of $30,000 coverage, in order to obtain a visa. Must be valid for same period as visa.	Entitled to emergency treatment free of charge. Entitled to continued hospital treatment free of charge if not reasonable to refer patient to home country or for patient to pay.	Free of charge to all in hospitals. Continued treatment is chargeable.
Estonia	No information available	Health insurance is required.	Travel health insurance is required, with coverage of minimum €30,000, for duration of stay.	No information available	No information available

Finland	All permanent residents are covered by a decentralized system of mixed funding, including an obligatory National Health Insurance and a public municipal system.	Health insurance is required in order to obtain a residence permit. Students must also prove health insurance cover.	No information available	No information available	No information available
France	All legal residents are covered by public health insurance, funded by compulsory social health insurance contributions from employers and employees.	All residents are covered after three months of residence if in a regular situation with regards to residence and work. Students are affiliated to Student Social Service.	Travel health insurance is required to obtain a visa, with coverage of minimum €30,000, for duration of stay. Insurance companies must have a representative office in Europe. Emergency treatment and hospitalization covered by state.	No information available	Emergency treatment and hospitalization covered by state
Germany	All persons required to take sickness insurance either with statutory or a private health insurance fund. Social assistance schemes are available for the destitute.	No information available	Travel health insurance is required, with coverage of minimum €30,000, for duration of stay. Insurance companies must have a representative office in Europe. All visitors entitled to emergency treatment.	Entitled to emergency treatment	All persons entitled to emergency treatment.
Hungary	No information available	Mandatory health insurance for those residing for longer periods.	Travel health insurance is required, with coverage of minimum €30,000, for duration of stay. Insurance companies must have a representative office in Europe.	No information available	No information available
Italy	Healthcare provided for anyone within state soil for a long period and those in very poor conditions	Residents register with National Health System and pay through taxes. Otherwise private health insurance is a choice.	Travel health insurance is required and must be shown on entry.	No information available	Chargeable if can pay, otherwise free for the poor.
Latvia	No information available	No information available	Travel health insurance is required, with coverage of minimum €30,000, for duration of stay. Insurance companies must have a representative office in Europe.	No information available	No information available
Lithuania	No information available	State health insurance available.	Travel health insurance is required for duration of stay.	No information available	No information available

Luxembourg	All persons required to have health insurance. Health insurance automatic if involved in professional activity. Others can obtain voluntary insurance. Children are covered by the state.	Health insurance is required. If longer than three months, have to pass a compulsory medical examination and lung x-ray to obtain authorisation to stay. In urgent cases, social offices of place of residence may cover costs.	Travel health insurance is required for duration of stay. If staying for up to three months for family reasons, a financial responsibility certificate must be made by Luxembourg resident. If emergency care is needed and there are no means for the individual to pay, the state covers this.	Chargeable.	Chargeable. If no means for individual to pay, costs are recovered either from family members or the state.
Malta	No information available	No information available	Travel health insurance is required, with coverage of minimum €30,000, for duration of stay.	No information available	No information available
Netherlands	No information available	Health insurance is required for all residents and expatriates.	Travel health insurance is required, with coverage of minimum €30,000, for duration of stay. Emergency treatment to all, with state covering if individual cannot pay.	No information available	No information available
New Zealand	No information available	Health insurance is required for international students and working holiday makers. Preferred insurance providers. Cost approx. NZ$585 per year. Those over 60 years of age must provide medical evidence to Vero before cover can be accepted.	Travel health insurance advised. Emergency treatment covered by Accident compensation scheme.	No information available	No information available
Norway	No information available	Health insurance is required and can be condition for being granted a residence permit only for au pairs.	No information available	No information available	No information available
Poland	No information available	No information available	Travel health insurance is required, with coverage of minimum €30,000, for duration of stay. Insurance companies must have a representative office in Europe.	No information available	No information available

Portugal	All citizens are covered by National Health Care System	Health insurance is required to obtain a residence permit. Students also require insurance. Otherwise, have to pay directly to provider.	Travel health insurance or pay directly to provider.		All persons entitled to emergency treatment.
Romania	Obligatory social health insurance payments	Proof of payment of social health insurance is required for right to temporary stay.	Health Insurance required in order to obtain a long or short stay visa	Chargeable	Free of charge for treatment deemed emergency. Continued treatment is chargeable.
Slovenia	All persons required to have compulsory health insurance, issued either on the basis of employment or residence. Socially endangered groups are granted exemptions. Those not covered are entitled only to urgent treatment.	No information available	Travel health insurance or pay directly to provider.	Accommodated in Centre for Foreigners. Covered by state.	All persons entitled to emergency treatment. Covered by state.
Sweden	All residents are covered by the Swedish national health care system.	All residents staying longer than a year are covered by Swedish national health care system. Students and other migrants staying less than a year must have valid health insurance in order to obtain a visa.	Travel health insurance is required in order to obtain a visa.	No information available	No information available
Switzerland	All persons in residence required to take out basic health insurance policy. Each household member must be insured separately.	All persons in residence required to take out basic health insurance policy within three months of residence.	Travel health insurance or pay directly to provider.	No information available	Chargeable. Must provide a commitment to provide cover of insurance to provider later.
United States	Government funded healthcare covers only eligible senior citizens, the very poor, the disabled and children. Everyone else is required to pay.	No information available	Travel health insurance is required, with coverage of minimum $50,000.	No information available	No information available

Annex 2: Equality analysis

Title: 'Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to the NHS provision in England'

Relevant line in DH Business Plan 2011-2015**:** Better Value – providing better quality care by improving productivity and ensuring value for money for the taxpayer

What are the intended outcomes of this work?

The objective is to assess the proposals set out in this consultation to amend the rules and associated practices governing which overseas visitors and migrants are charged for NHS care and how they will be charged, to see whether the proposals will have an adverse and unjustifiable impact on any group with protected characteristics.

The current Charging Regulations apply to everyone who is not an ordinary resident of the UK, i.e. overseas visitors (or non-residents), irrespective of age, disability, ethnicity, sex, gender identity, religion or belief, sexual orientation or socio-economic status. They currently exempt, and will continue to exempt, some specific groups such as refugees, victims or suspected victims of human trafficking, asylum seekers and supported failed asylum seekers as before on humanitarian grounds.

With increased demands on the NHS budgets, the rise in mobility of migrants and number of visitors to the UK, there is an expectation this will increase further placing greater pressure on services and impacting negatively on the resident population. It is reasonable that the Government should take steps to ensure that those who use its services (with clear exceptions as mentioned above) contribute towards the costs of their care. The proposed changes in this consultation seek to ensure that those coming to the country for a limited period either as visitors or temporary residents contribute to the cost of their healthcare and to improve the effectiveness of the identification and charging of those non-residents. These changes will apply to individuals within these groups, again irrespective of their age, disability, ethnicity, sex, gender identity, religion or belief, sexual orientation or socio-economic status.

We recognise that different policy options may impact on these groups differently but at this point we do not have this level of detail. Following the consultation process we will be in a position to undertake a detailed equality impact assessment of the final policy options (if required) which will accompany the response to the consultation.

Who will be affected?

Some patients will be affected if the proposals are accepted in that some visitors and migrants to the UK that were previously, through other mechanisms, entitled to free NHS treatment may in the future be required to pay for it directly or contribute towards the cost of their healthcare needs during their stay.

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment. For more information, see the current DH Transparency Plan.*

What evidence have you considered?

The Department has considered equality issues in its previous, recent work on charging visitors and migrants for NHS care. In 2011, equality analysis statements were compiled for work on consolidating regulations and guidance and immigration sanctions for those with unpaid debts to the NHS. They can be found here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127064/EqIA-2.pdf.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127063/EqIA.pdf.pdf

However, there is little data available on the impact on the individual equality groups. In any system that restricts a particular benefit to certain cohorts of people so that some people do not enjoy the benefit, there is an inevitable level of inequity. In the case of entitlement to free NHS healthcare in England, since the UK has a residence based healthcare system, this inequity is based on residence status. Resources for healthcare are finite, and cannot be spent on those from outside the UK without diminishing, perhaps significantly, the resources that are available for UK residents.

It is already the case that free NHS hospital treatment is reserved only for lawful, settled residents in the UK, and certain clearly defined groups of people who are not UK residents. Our proposals seek to reserve all free NHS care for:

i) UK/EEA nationals who are properly settled in the UK,

ii) Non-EEA nationals with indefinite leave to remain in the UK who are properly settled here, and

iii) those others who must, or who we consider should, be exempt from charge due to humanitarian or international obligations or because of a clear record of past UK National Insurance contributions.

Currently, only hospital-based secondary and tertiary NHS treatment is charged for. There are proposals to extend charging to all or most NHS services including primary care, for those visitors or migrants that are, or will be chargeable.

Background

The Department of Health undertook a major review into the rules and procedures on charging visitors and migrants to the UK for NHS care England in 2012. The evidence from this review has informed the proposals for change put forward in this consultation. The review identified the generosity that England affords to those people who are living in the UK on a temporary basis, who have not, yet, made a significant contribution to our society or economy, in providing them with free NHS care immediately upon moving here. Another significant conclusion of the review was that the NHS is not set up structurally, operationally or culturally to identify a small subset of patients and charge them for their treatment and recover such charges from them. Therefore we estimated that less than half of potential chargeable patients

under the current rules were identified, and when they were identified and charged, trusts only managed to recover about 40% of those invoiced charges.

The Department of Health does not believe that our proposals would directly discriminate against any of the groups with protected characteristics in law amongst visitors and migrants to the UK. The proposed strengthening of the requirement to be a permanently settled resident of the UK along with strengthened systems to identify those who are not, does not prevent anyone from being entitled to free NHS treatment based on their ability or disability, sex, race, age, gender reassignment, sexual orientation or religion or belief.

There is potential for indirect discrimination against some protected characteristic groups (see disability and age, below) but this can be justified by the fact that we cannot afford a healthcare system that is free to all comers. Nor would that be a fair or reasonable system for those tax payers that fund the NHS. The Government believes that everyone should make a fair contribution to their healthcare, so those visiting or newly moving to the UK should either pay directly for their healthcare or make a payment towards it.

Given the lack of available evidence, we will ask those responding to the consultation to provide any evidence they have that our proposals would discriminate against protected characteristic groups within the visitor/migrant populations.

We will then provide a further equality analysis on final proposals as part of the future full impact assessment.

Disability

People with disabilities have the same rights to be a resident of the UK and therefore entitlement to free NHS care. Under the proposals set out in the consultation they would be eligible for access to free NHS care as a temporary resident upon payment of the health levy, or benefit from the exemption from charge categories (where appropriate).

Currently, only secondary hospital care is charged for. The proposals being consulted on envisage charging those migrants that are chargeable for other NHS services such as primary GP services and other non-hospital secondary/tertiary care. It is possible that some people who are or will be chargeable for NHS care, have certain disabilities that mean they are more likely than those without the disability, to need to access those services that are newly charged for. Whilst there is insufficient data to confirm this, if it were the case, then this could amount to indirect discrimination. However, we consider this is justified because of the need to ensure that visitors and chargeable migrants, who are not lawfully or ordinarily resident in the UK, make a fair contribution to the NHS services they access.

Sex.

Men and women are treated equally within our proposals. They are able to be a resident of the UK entitled to free NHS care, or have access to free NHS care as a temporary resident upon payment of the health levy, or benefit from the exemption from charge categories.

Race

A person of any race is able to be a resident of the UK entitled to free NHS care, or have access to free NHS care as a temporary resident upon payment of the health levy, or benefit from the exemption from charge categories. In terms of the application of the rules of entitlement and identifying those liable to pay, it is important that non-white people or people for whom English is not their first language are not targeted to demonstrate entitlement due to speculation or assumption that they are not resident here. To do so would be clearly

unacceptable, and longstanding guidance to the NHS has advised that each patient must be treated the same in assessing for charges. In order to protect against this possible discrimination further, the Department updated Guidance in 2011 to reiterate and strengthen a section titled *Avoiding discrimination in establishing if charges apply*, pointing out NHS bodies' legal equality duties and advising that staff involved in assessing for charges are trained in how to exercise those duties. Such an approach will continue to be necessary by whichever body is assessing for entitlement/liability for charges.

Our proposals seek to establish a simpler system, whereby a person's entitlement status, once established, is tracked around the healthcare system, allowing NHS staff to identify easily those who must pay and reduce the need to establish this at each stage. This should reduce the risk of people being targeted to establish entitlement based on their race or appearance.

Age

As now, some of the exemption from charge categories we propose to retain are dependent on a person's age. The children of exempt overseas visitors are also exempt in certain circumstances, since it would be unreasonable to expect them be apart from their parent, whilst children in the care of the Local Authority are also exempt since they are clearly vulnerable.

When a child is not entitled to free NHS hospital treatment, the person liable is their parent or guardian. This will also be the case for other treatments if charging is extended to primary GP and other services.

Currently, those in receipt of UK state retirement pensions can benefit from certain exemptions that younger people cannot. This is no different from other welfare benefits eg pension payments itself, tax rules etc. However, we propose to remove the exemption from charge categories for UK state pensioners and replace them with one based on the former payment of UK National Insurance contributions, thereby removing that possible indirect discrimination.

Currently, only secondary hospital care is charged for. The proposals being consulted on envisage charging those migrants that are chargeable, for other NHS services such as primary GP services and other non-hospital secondary/tertiary care. It is possible that some older visitors or migrants who are or will be chargeable, are more likely to need to access some of the newly charged for services, for instance GP services. This could amount to indirect discrimination. However, we consider this is justified because of the need to ensure that visitors and chargeable migrants, who are not lawfully or ordinarily resident in the UK, make a fair contribution to the NHS services they access.

Gender reassignment (including transgender)

Under the proposals, transgender and transsexual people are able to be a resident of the UK and therefore be entitled to free NHS care, or have access to free NHS care as a temporary resident upon payment of the health levy, or benefit from the exemption from charge categories.

Sexual orientation

Under the proposals heterosexual, bisexual, lesbian and gay people are able to be a resident of the UK and therefore be entitled to free NHS care, or have access to free NHS care as a temporary resident upon payment of the health levy, or benefit from the exemption from charge categories.

Religion or belief.

As for race, it is important that people whose religion can be assumed by their appearance are not targeted in demonstrating entitlement due to speculation or assumption that they are not resident here (see race).

Currently, missionaries are exempt from charge, which is not an exemption category that could be enjoyed by a person of no belief. We propose to remove that exemption and replace it with one based on the former payment of UK National Insurance contributions, thereby removing that possible discrimination.

Other identified groups

- **Pregnancy and maternity**

  Whilst, as now, maternity services will not be free to all, we do not propose to change current guidance that maternity services always be considered immediately necessary[12] and provided to any woman regardless of if she has already paid in advance or not.

- **Carers**

  Under the proposals, carers are able to be a resident of the UK entitled to free NHS care, or have access to free NHS care as a temporary resident upon payment of the health levy, or benefit from the exemption from charge categories. They do so in their own right, not as a consequence of their caring responsibilities.

- **Non-EEA temporary migrants**

  The Government's proposal to require those non-EEA nationals on a temporary basis to pay a health levy to access NHS care rather than being entitled to it free of charge under the current ordinary residence rule may have an impact on those of a lower income. We are mindful of this in the consultation and will work to set the levy at an affordable rate which will not necessarily reflect the average cost of care that an individual might be expected to need.

Engagement and involvement

Was this work subject to the requirements of the cross-government Code of Practice on Consultation? (Y/N)

How have you engaged stakeholders in gathering evidence or testing the evidence available?

As part of the 2012 review the Department engaged with stakeholders on the frontline of the NHS, the BMA and migrant support groups. Subsequently we have had discussions with key delivery partners on the intentions of the policy proposals in this consultation.

[12] Treatment which a patient needs, to save their life or that of their unborn child; to prevent a condition from becoming immediately life threatening; or promptly to prevent permanent serious damage from occurring. Guidance on implementing the overseas visitors hospital charging regulations (Chapter 4, Para 4.7) at https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations

In advance of the launch of this consultation we have engaged with:

- Professional bodies - RCGPs, BMA, Academy of Medical Royal Colleges; National Association of Primary Care
- NHS organisations – NHS England, NHS Confederation, NHS Trust Development Authority,
- Public Health England
- Migrant support groups - Still Human, Still Here, Doctors of the World
- Migration Watch UK

During the consultation process we will be engaging with a range of stakeholders including those listed above. Opportunities to do this through the Department's established partnership arrangements will be maximised and the proposals will be on the agenda for discussion at:

- the National Stakeholder Forum [partners across health and social care]
- the Strategic Partners Forum [voluntary and third sector organisations]

We are also engaging directly with the Department of Health Social Partnership Forum [NHS employers and employees/unions]

We will also be working closely with frontline NHS staff and managers, with NHS England and other NHS bodies to discuss the detail of the proposals and ensuring that the new system is practical and workable for the NHS in particular. We will also be asking them to identify any relevant evidence during this process.

How have you engaged stakeholders in testing the policy or programme proposals?

We have met or spoken to key stakeholders and outlined the content of the proposals for consultation.

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

- NHS England, NHS Confederation, NHS Trust Development Authority, and Public Health England have seen the consultation document and had an opportunity to comment on proposals,
- RCGPs, BMA, Academy of Medical Royal Colleges; National Association of Primary Care have either met or spoken on the phone to officials to discuss the proposals and will be engaged specifically during the consultation process

Summary of Analysis.

The Department of Health does not believe that our proposals would directly discriminate against any of the groups with protected characteristics in law amongst visitors and migrants to the UK.

The proposed strengthening of the requirement to be a permanently settled resident of the UK along with strengthened systems to identify those who are not, does not prevent anyone from being entitled to free NHS treatment based on their ability or disability, sex, race, age, gender reassignment, sexual orientation or religion or belief.

It does however seek to ensure, on the principle of everyone making a fair contribution, that

those who are not permanently settled in the UK contribute to the funding of the NHS.

Eliminate discrimination, harassment and victimisation

We believe that creating a system whereby a person's entitlement to free treatment is recorded on their health record and tracks them around the healthcare system will lead to less direct questioning of individuals at each stage of their care, which may reduce any current unacceptable targeting of people for questioning based on their race or appearance.

Advance equality of opportunity.

None identified

Promote good relations between groups.

We believe that the fact that everyone will make a fair contribution to the costs of their healthcare in the future will promote better relations between residents and visitors/migrants, as it will make the system fairer, more transparent and simpler to explain. It may reduce any current hostility or misconception about what visitors and migrants receive at the expense of the taxpayer.

What is the overall impact? None identified

Addressing the impact on equalities.None identified

Action planning for improvement.

We will review available evidence and ask consultation respondents to provide any relevant evidence they may have.

Please give an outline of your next steps based on the challenges and opportunities you have identified. Next steps:

1. Active engagement programme during the period of the consultation – including detailed consideration of system design with NHS staff and organisations, including any monitoring requirements to evaluate impact on groups affected
2. Independent 'audit' of the NHS use by visitors and temporary migrants
3. consideration of further evidence as proposals are developed with stakeholders
4. Full impact assessment [with an updated Equality Analysis] to accompany the response to the consultation in Autumn 2013

For the record
Name of person who carried out this assessment: Craig Keenan
Date assessment completed: 2nd July 2013
Name of responsible Director/Director General: Kathryn Tyson, Director of International Health and Public Health Delivery
Date assessment was signed: 2nd July 2013

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation	During the consultation process we will be engaging with a range of stakeholders including those listed above. Opportunities to do this through the Departments established partnership arrangements will be maximised and the proposals will be on the agenda for discussion at: • the National Stakeholder Forum [partners across health and social care] • the Strategic Partners Forum [voluntary and third sector organisations] We are also engaging directly with the Department of Health Social Partnership Forum [NHS employers and employees/ unions] We will also be working closely with NHS England and other NHS bodies to discuss the detail of the proposals and ensuring that the new system is practical and workable for the NHS in particular.	End August 2013	David Pennington, Public Health Directorate

Data collection and evidencing	Commissioned independent 'audit' of the extent of use and abuse by visitors and migrants of the NHS. The first phase is a qualitative piece of research working with frontline NHS and immigration officials to establish the best estimate across England.	End- August 2013	David Pennington, Public Health Directorate
Analysis of evidence and assessment	The second phase of the independent 'audit' will be a quantitative piece of work [currently out to competitive tender]. This will provide : • An estimated cost of the current use of the NHS in England by visitors (including health tourists) and non-permanent residents (temporary residents including workers students and others), split by EEA and non-EEA residents • An estimate of the future costs to the NHS if the current overseas visitors charging system continues. • How these estimates will change in the future alongside changing composition of migrant users in the identified sub-groups and impact of external factors For each group the analysis will need to consider utility in primary care, secondary care and accident and emergency.	mid-September 2013	David Pennington, Public Health Directorate
Monitoring, evaluating and reviewing	This will need to be addressed as part of the work with the NHS to develop the new system.	Autumn 2013	David Pennington
Transparency (including publication)	Following the consultation process we will be in a position to undertake a detailed equality impact assessment of the final policy options (if required) which will accompany the response to the consultation		