Department of Health

Sustaining services, ensuring fairness

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

July 2013

Published to gov.uk, in PDF format only.

www.gov.uk/dh

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Executive summary

The case for change

1. In this global age, the UK is a uniquely connected country, with historical ties, economic activities and cultural attractions which draw people from all over the world. In 2012 London was the world's most popular tourist destination[1] and welcomed more than 15 million visitors[2]. People come here to settle permanently, to stay for a few years or to just visit for work, study, tourism or for family reasons. Evidence of this flow is seen in London's airports which, combined, are the busiest in the world. If our country is to remain competitive, we need to continue to welcome those who come here on holiday, to work and to study.
2. At the same time public services like the NHS are under increasing strain, coping with the demands of an ageing population and financial pressures. The NHS is and will remain free at the point of delivery for our residents, but it cannot continue as an international rather than a national health service.
3. Our health system is very generous to overseas visitors, perhaps one of the most generous in the world. We allow people who are living here temporarily to use the NHS and exempt many of them from charging, while any visitor, including a tourist, can visit a GP practice free of charge. These sorts of services are often not available for our citizens when they are abroad.
4. 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 and are able to avoid detection or payment.
5. In addition, the NHS struggles to identify and recover the cost from those not entitled to free treatment. NHS resources, both financial and clinical, are used to treat and care for people who have no long term commitment to our country and should contribute towards it. We urgently need to address this issue or the system is likely to become unsustainable.
6. We know that this is a significant problem, but to tackle it we need, for the first time, to understand just how large it is. We have commissioned a two-phase independent 'audit' of NHS use by visitors and temporary migrants. Reporting in the autumn, this work will use information gathered directly from staff on the frontline to estimate the scale of the challenge and the size of the financial burden.
7. The purpose of this consultation is to examine critically who should be charged in the future; what services they should be charged for; and how we can ensure that the system is better able to identify chargeable patients and recover costs. This consultation is looking specifically at how to address the challenges for the NHS in England. However, there will be engagement with the devolved administrations across the UK on these matters.

[1] http://newsroom.mastercard.com/wp-content/uploads/2012/06/MasterCard_Global_Destination_Cities_Index_2012.pdf
[2] http://www.visitbritain.org/insightsandstatistics/inboundvisitorstatistics/regions/regiontrends.aspx

8. A separate, parallel Home Office consultation looks at three specific elements of our proposals on a UK-wide basis: redefining qualifying residency; using a visa levy to ensure some migrants make a fair contribution; and extending charging to primary care services.

Who should be charged?

9. Everybody should have access to immediately necessary treatment[3] irrespective of their means or status. This consultation is not about changing the rules on universal access to a comprehensive healthcare system.

10. But we do think everyone should make a fair contribution. The NHS exists because, at its heart, is an agreement that taxpayers will pay for a comprehensive health service that is free at the point of delivery to all those who live here and are committed to our society.

Qualifying residency

11. The current qualifying test for free NHS treatment is whether a person is *ordinarily resident* (as defined by case law). *Ordinary residence* is a particularly generous test, satisfied almost immediately by many new and temporary migrants. It clearly does not accord with the principle that everybody makes a fair contribution. To tighten up on who is entitled to free NHS treatment, the Government propose to adopt a revised definition of qualifying residency that requires *current residence with indefinite leave to remain for non-European Economic Area (EEA[4]) migrants*. This proposal, although explained within this document, is being consulted on by the Home Office (http://www.ukba.homeoffice.gov.uk/policyandlaw/consultations/).

12. Expatriate UK citizens who move to reside abroad currently lose their entitlement to free NHS treatment. They regain this if they return to live in the UK permanently but usually not when returning to visit. In line with the principle that everybody makes a fair contribution, we propose to confirm the entitlement of any person who has previously paid at least seven years of National Insurance contributions.

Temporary migrants

13. Building on the principle that qualification for access to free NHS care should reflect a permanent relationship with the UK, we propose that non-EEA nationals who come for a limited period should make an explicit contribution to the costs of their healthcare unless or until they are given indefinite leave to remain.

14. This group of temporary migrants is defined, for the purposes of this consultation, as those who come to the UK under immigration controls to live for a period of up to five years (mainly

[3] Treatment which a patient needs: to save their life; to prevent a condition from becoming immediately life-threatening; or promptly to prevent permanent serious damage from occurring.

[4] The European Economic Area (EEA) comprises the countries of the European Union (EU), plus Iceland, Liechtenstein and Norway, those states having signed an agreement to participate in the EU internal market. Whilst not a member of the EEA, Switzerland has also signed up to EU legislation on the internal market and free movement of people. In this consultation, where the EEA is referred to, for simplicity, this will include reference to Switzerland.

students, workers and newly arriving family members of existing UK citizens), although some migrants can get indefinite leave to remain (ILR) before five years of residency.

15. To limit the administrative burden on the NHS, we propose that temporary non-EEA migrants should pay a migrant health levy on entry to the country that would be a fair contribution for access to any NHS services that they may subsequently require during their stay. We have also looked into the feasibility of recovering the healthcare costs of temporary migrants by requiring them to hold comprehensive healthcare insurance that could be used to pay for any NHS treatment. Our early analysis leads to a preference for the migrant health levy but we will consider views on other options, set out in the evidence document, as part of this consultation.

16. For some visa categories, those with private health cover will be able to waive their rights to free NHS care, and not pay the levy. If they require emergency treatment they would be charged in full.

17. The Home Office will be consulting on the proposed migrant health levy on a UK-wide basis (in parallel to this consultation). We will consider, as part of this consultation, whether to impose limited restrictions on expensive and specialised treatment.

Visitors from outside the EEA and other groups

18. Visitors (those here for less than six months) will continue to be charged directly at the point of use for hospital treatment. Health providers should (as now) make every effort to seek payment from patients' insurers or patients wherever possible. However, we will look at ways to improve how they are identified; in particular, how effective the NHS is in identifying health tourists who seek deliberately to obtain treatment without paying (see Chapter 5 - 'Making the system work in the NHS').

19. We will continue to charge illegal migrants (as defined in paragraph 3.55) in the same way as we charge other non-permanent residents and propose to extend such charges to include primary care and other treatment outside of hospitals. We will increase steps to identify and apply charges, while ensuring that immediately necessary treatment is provided and we maintain a comprehensive and robust population-wide strategy on protecting and managing public health.

20. We will retain all exemptions related to our humanitarian obligations and international obligations and agreements, and we will also simplify and reduce other exemptions so that they align to the key criteria of ILR, qualified ordinary residence and fair contribution.

What services should be chargeable?

Primary Care

21. Access to services provided by GP practices is a necessary part of comprehensive healthcare for any individual and should not be refused. If a short term visitor or other person who is not exempt from NHS charges, or has not paid the proposed migrant health levy (see Chapter 3: Who should be charged?), wishes to access primary medical care, they should be charged. The system must in future facilitate their charging both for primary medical care and on referral to hospitals or other specialist care services.

22. Those temporary migrants who have opted out of the migrant health levy and so waived their rights to free NHS care will not be expected to access routine NHS services, but if an emergency need arises, they will not be refused care but will be charged at the point of delivery.

23. We are considering further how we can best apply the principles of fair contribution to other primary care services (dentistry, ophthalmology, and prescription charges in community pharmacy) where charges already apply to most of the resident population.

Secondary Care

24. Elective (non-emergency) treatment in hospitals will be provided only after full payment of charges for those that are chargeable. Emergency treatment will not be delayed or denied but may be limited to what is clinically necessary, and payment will be sought after treatment. Measures will be adopted to improve the collection of these payments.

25. The proposal is that in future, subject to further consideration of dentistry, ophthalmology and prescription charges in community pharmacy, all NHS funded services (other than specified public health exemptions) should be chargeable for non-exempt individuals, irrespective of who provides the service or where the services are provided.

26. An appropriate and effective method of administering these charges needs to be developed with healthcare professionals and providers. Secondary care services in NHS hospitals are already chargeable for those who are not exempt.

Services that remain free of charge to all

27. Treatment of infectious diseases and sexually transmitted infections (STIs) is integral to protecting the public's health. Nobody should be charged for these and the existing exemptions for these services should therefore remain.

28. Currently hospital A&E services and emergency GP consultations are free to any patient, regardless of their residential status. This consultation asks a question about whether it is reasonable for a visitor to pay, possibly a fixed tariff, for such treatment, but we want to consider further what the clinical and operational implications of charging for emergency treatment would be.

29. We will examine what system improvements would be necessary and sensible to implement such charging without compromising patient access. A reliable system would be a pre-requisite for any introduction of charging at a later date.

Making sure we know who should be charged

30. Existing systems and processes through which the NHS applies and enforces the current charging rules are flawed. As a consequence, only a fraction of charges due are collected and this needs to be addressed. This need is heightened further by the proposed extension of charges to significantly more migrants and more services.

Registering new patients and tracking them through the system

31. Significant improvement is required to identify chargeable patients at the point that they first register with the NHS and subsequently track them through the system whenever they access hospital or other NHS services.

32. We want to work directly with GPs, practice staff, hospital managers and others to develop a system which meets their need for simplicity and ease of operation, incorporating further ideas and feedback from this consultation. We anticipate that improved technology will be a key longer term requirement. The design also needs to take account of the other principles we set out in this document, and clearly needs to be cost effective.

Implementation

33. The new system proposal is intended to operate from the first point of registration with the NHS, and so will impact only on people newly arriving from abroad. Consideration will be given at a later date to identify those who are already registered but who should be chargeable.

34. We also want to consider the case for establishing a legal gateway to formalise the sharing of personal information relevant to charging for NHS services between the NHS, relevant government departments and other involved agencies.

35. Such information transfers would be subject to the necessary protocols and controls (to protect confidential details of medical conditions, for instance) in respect of what information can and cannot be shared and how it is used. The consultation seeks views on these issues.

36. Any new rules and processes must enable the NHS to meet statutory duties to apply charges and to use its public funds appropriately, but must not compromise the efficient, cost-effective and safe delivery of healthcare. Regular patients should not be subject to repeated or intrusive eligibility checks.

Getting better at collecting the money

37. Work is currently underway in a number of London Trusts to see how the current system might be improved in a systematic fashion, from referral to admission, treatment, charging and recovery, and the roles of each party involved. We are currently working with these organisations to share their experience to develop this integrated best practice approach.

38. We must also address the existing disincentives which mean hospitals are discouraged from properly identifying all patients, because they remain liable for unrecoverable debts. We must also improve the rate of recovery from those who have been charged.

Recovering healthcare costs from the EEA

39. We will continue to apply EU legislation that governs the provision of healthcare to citizens of EEA Member States who either reside in or visit the UK, whilst taking action to improve the effectiveness and recovery costs for which the Member States may be responsible.

40. The biggest opportunity to increase recovery of income due from other countries is through the systematic capture of visitors' European Health Insurance Card (EHIC) details or other entitlement documents. Furthermore, some of the payments we make to cover the cost of

healthcare for UK citizens visiting or living in other EEA countries are more generous than EU rules require. We are proposing to end these payments.

Financial impact

41. We expect that the proposals to extend charging to temporary non-EEA migrants who were previously exempt, and to extend charging beyond just hospital services, will increase revenue. The level of revenue will depend on significant decisions, particularly on the level of charges for temporary migrants.

42. An improved enforcement system should also increase identification and recovery of charges from the health tourists who currently evade detection and/or payment, although it is important to recognise that it will also increase the reported level of unrecoverable debt, part of which at least is the inevitable cost of our obligations to provide immediately necessary treatment, as every country does.

43. We also need to consider further the potential impact on numbers of registered patients, and the costs of administering any new systems and processes.

Conclusion

44. The changes proposed in this document are designed to improve the sustainability and fairness of our health system while retaining the attractiveness of the UK as a destination for study, business and tourism. Without in any way restricting necessary access, we need to ensure everyone makes a fair contribution to the care they receive.

45. In developing our new proposals we have been mindful of four overarching principles for the new system that are set out in the box below.

1. **A system that ensures access for all in need** - everybody needs access to immediately necessary treatment irrespective of their means or status. In particular no person should be denied timely treatment necessary to prevent risks to their life or permanent health.
2. **A system where everybody makes a fair contribution to the NHS** – the NHS is under increasing pressure and it is right that in the future everyone who benefits from its services makes a fair contribution to ensure it is sustainable.
3. **A system that is workable and efficient** - any new rules and systems must enable the NHS to recover charges and to use its public funds appropriately. In doing so it must not compromise the efficient, cost-effective and safe delivery of quality healthcare or place undue burdens on staff. The role of NHS staff should not extend to immigration control, and clinicians should not be diverted from treating patients.
4. **A system that does not increase inequalities** - the Secretary of State has a duty to have regard to the need to reduce inequalities relating to the health service. In developing these proposals we shall ensure the needs and interests of vulnerable or disadvantaged patients are protected.

1. Introduction

Summary

This consultation seeks views on implementing a significant revision of the rules and circumstances under which new migrants and other visitors to the UK should be entitled to free healthcare through the NHS in England, and how those rules are enforced effectively.

It is not about denying necessary healthcare but rather about whether and how a fair contribution could be made to the costs of provision. This forms part of a wider cross-government consideration of migrant access to public services.

A major failing of the current system is the inability of the NHS to enforce the rules effectively (for reasons that are explained later). It is therefore essential that new rules, and particularly the systems and processes by which they are enforced, are practical and operable. We have therefore been working closely with the NHS, and will do so extensively throughout and beyond this consultation process.

1.1 The NHS will always provide a comprehensive service based on clinical need, not the ability to pay. It is a residency based system for England that is free at the point of delivery[5]. Powers to charge those not 'ordinarily resident'[6] have existed since 1949 and have been applied through regulations since the early 1980s, but those regulations currently only apply to hospital treatment (secondary care)[7].

1.2 Millions of people come to and from our country every year, ranging from single day visits to temporary stays to permanent immigration/emigration. These cross-border movements have been increasing for many years, driven by many factors. Healthcare is one of several facilities (usually but not always provided as a public service) that needs to be made available to any such visitor or migrant, but this creates specific challenges on how this should be done and where the costs should be borne.

1.3 Although this consultation goes much wider than health tourism, this is an issue that also needs to be addressed. Health tourists, whether those concealing a prior intention to access NHS services or those evading identification or subsequent payment, should be paying for treatment now.

1.4 Regulations introduced in 1982 have required non-residents to be charged for most hospital services, but there is little evidence that they have ever been applied rigorously and effectively across all hospitals. Since the 1980s, the charging regulations and operating guidance have been updated in a piecemeal and reactive

[5] "The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement…in the physical and mental health of the people of England" (Health and Social Care Act 2012)

[6] Living lawfully in the UK voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here that has a sufficient degree of continuity to be properly described as 'settled' (R v Barnet LBC Ex p Shah (Nilish) 1983 2AC 309HL).

[7] The NHS (Charges to Overseas Visitors) Regulations 2011, as amended [referred to in this document as 'the Charging Regulations']

manner leaving the overall system broadly unchanged and increasingly dysfunctional.

Background to consultation

1.5 A comprehensive review on migrant access to healthcare was undertaken by the Department of Health in 2012. That review confirmed significant weaknesses and failures in both rules and application, and put forward a range of options and recommendations, from basic process improvement to the radical redesign that now forms the basis of these proposals. It concluded that:

- the current system for making and recovering charges for treatment provided to overseas visitors contains major flaws
- the statutory duty is not being met and only minimal net income is being recovered, due to a number of contributory factors, relating to the eligibility rules themselves, how such patients are identified and how charges are recovered
- there are only limited opportunities to improve the effectiveness of the current charging rules.

1.6 The review proposed a number of discrete policy options that can be categorised broadly under the three elements of the system – eligibility, frontline implementation and cost recovery. It noted that an overall package addressing each of these issues would best meet the stated objectives and realise required benefits.

1.7 To maximise this potential, the recommendations of the review were to:

- replace the ordinary residence rule with a fixed residency threshold for non-EEA nationals
- reduce significantly (where justified) the current range of exemptions, particularly those from which large numbers are benefitting
- align incentives, including responsibility for unrecovered charges
- recover 'charges' by fixed pre-payment (on entry to the UK) for longer term visitors where possible
- improve the targeting of remaining short term visitors.

1.8 The 2012 review used a variety of sources to try and estimate the costs of NHS provision for non-residents and the extent of under-recovery of payment.

1.9 The small amounts of income recovered and the value of NHS debt written off is clear evidence of the need to change. However, there is less detailed data below this level. The NHS does not record the nationality of those to whom free treatment is currently provided.

1.10 In any changes we make we will be mindful of patients' rights in cross-border healthcare. The proposed changes will not affect the rights of European Economic Area (EEA) nationals who seek treatment, and pay in advance for such treatment, in accordance with Directive 2011/24 EU.

1.11 More detail on the context of the consultation is provided in the summary of the 2012 review, published alongside this consultation.

1.12 An evidence annex also accompanies this consultation. This builds on the 2012 review and sets out the evidence there is to support the policy proposals in the consultation.

Evidence underpinning the proposals for consultation

1.13 Due to the limited detailed information available, we have not been able to undertake an Impact Assessment at this stage. We have provided a summary of the evidence available to support the consultation, and will undertake a full Impact Assessment to accompany our response to the consultation.

1.14 To support the development of this Impact Assessment, we have commissioned an independent professional 'audit', to provide a more comprehensive assessment of the extent of NHS use and abuse by non-residents. While this will focus particularly on those who are inappropriately or fraudulently obtaining services without paying (abuse), it will also provide better data on the extent of NHS use by the groups we propose should become chargeable in the future.

1.15 The audit is running in parallel with this consultation and will report in September 2013. Its conclusions, together with the results of this public consultation and a full programme of NHS engagement, will inform final policy decisions and input to the final Impact Assessment that will accompany our Consultation Response. The full audit report will be published alongside that response.

What happens in other countries?

1.16 As part of the 2012 review, we conducted a comparison of other countries' healthcare systems and their approaches to charging overseas visitors for treatment.

1.17 Most healthcare systems we reviewed are insurance based, where the individual, or in some cases their employer, makes direct contributions for future potential healthcare needs. Individuals have an entitlement to a specified level of healthcare. Where state insurance provides a baseline service, individuals may choose or be compelled to purchase private health insurance to supplement this and entitlements vary.

1.18 In insurance based health systems the onus is on patients – whether resident or visiting – to prove that they are entitled to access state healthcare.

1.19 Residency based, tax-funded systems (eg UK and Spain) rely on identification of those who are not entitled rather than those who are, with the onus on staff to identify those who should be charged. Consequently provision of services to temporary migrants from their arrival appears generous when compared with that afforded to UK residents visiting countries with contribution or insurance-based healthcare systems.

1.20 There is more information on international provision in the evidence annex published with this consultation.

Cross-Government approach

1.21 In October 2012, an inter-ministerial group (IMG) was established to develop an integrated government strategy on migrants' access to benefits and public services. NHS healthcare is an important public service and forms a core component of this wider programme and its overall proposals that are being announced and taken forward collectively.

1.22 However, it is acknowledged within government that health is a distinct case, and any health proposals must continue to take account of health-specific drivers, particularly obligations to provide necessary

treatment and the protection of public health.

Legislative scope and approach

1.23 This consultation relates only to the NHS in England. However the issues described are interconnected with immigration and for a number of them the UK Government has responsibility across the UK. Accordingly, we will liaise with the devolved administrations across the UK.

1.24 The main potential changes that will be required to primary legislation concern the proposals for a migrant health levy or mandatory health insurance for temporary migrants, and the requirement for non-EEA nationals to have indefinite leave to remain before being entitled to free NHS care.

1.25 Those changes, if confirmed, will be made through the current Immigration Bill, and are addressed in the Home Office consultation that has been launched in conjunction with this consultation. (http://www.ukba.homeoffice.gov.uk/policyandlaw/consultations/)

1.26 Further changes to secondary NHS legislation that will enable detailed eligibility rules and system management processes will be implemented directly by the Department of Health during 2014**.**

Consultation purpose and approach

1.27 The purpose of this consultation is to invite comments on the proposed changes to regulations regarding charging of migrant access to NHS services in England and how they are enforced.

1.28 This consultation will inform and seek opinion from members of the public and interested bodies and organisations.

1.29 It also informs a parallel programme of essential direct engagement with the NHS, its workforce and its key stakeholders, focussing on key questions around the detailed design of an effective system to apply the proposed charging regime.

1.30 These parallel but complementary elements, together with the conclusions of the independent audit, will collectively inform our final proposals and consultation response.

Responding to the consultation

1.31 We welcome responses to the consultation by **28 August 2013**. We will take account of responses before confirming the changes we intend to make to current regulations.

1.32 We will ensure that any responses made to the specific questions on which the Home Office are also consulting on a UK wide basis are passed to them.

1.33 Further details on how to respond to this consultation are set out in Annex C: ‘How to respond to a consultation’.

1.34 We anticipate issuing a formal response to the consultation no later than the Christmas Parliamentary Recess.

2. Overarching principles

Summary

In developing our new proposals, we have been mindful of four overarching principles:

- **A system that ensures access for all in need** - everybody needs access to immediately necessary treatment irrespective of their means or status. In particular no person should be denied timely treatment necessary to prevent risks to their life or permanent health
- **A system where everybody makes a fair contribution to the NHS** – the NHS is under increasing pressure and it is right that in the future everyone who benefits from its services makes a fair contribution to ensure it is sustainable
- **A system that is workable and efficient** - any new rules and systems must enable the NHS to recover charges and to use its public funds appropriately. In doing so it must not compromise the efficient, cost-effective and safe delivery of healthcare or place undue burdens on staff. The role of NHS staff should not extend to immigration control, and clinicians should not be diverted from treating patients
- **A system that does not increase inequalities** - the Secretary of State has a duty to have regard to the need to reduce inequalities relating to the health service. In developing these proposals we shall ensure the needs and interests of vulnerable or disadvantaged patients are protected.

We shall also be mindful of the NHS's wider obligations and existing international health agreements.

A system that ensures access for all in need

2.1. Everybody needs access to immediately necessary treatment wherever they may be and irrespective of their means or status. No person should be denied timely treatment necessary to prevent risks to their life or permanent health. This is an essential principle for the Government.

2.2. This fundamental principle is underpinned by other legal safeguards. The UK Government remains a signatory to a number of international treaties, covenants and agreements on the provision of healthcare. The Universal Declaration of Human Rights includes a right to medical care and the International Covenant on Economic, Social and Cultural Rights requires states to take the necessary steps to create conditions ensuring access to healthcare for all (although it does not require such provision to be free of charge).

2.3. The UN Refugee Convention and the Council of Europe Convention on Action Against Trafficking in Human Beings provide for access to medical treatment for vulnerable migrants.

2.4. The NHS has a key responsibility to maintain the public's health, in particular through the early detection

and effective treatment of infectious diseases, and other proactive prevention measures. The effectiveness of these actions is dependent on a population wide approach that necessarily includes all persons who are present (ie everyone in the country regardless of their status as a resident, migrant or visitor).

A system where everybody makes a fair contribution to the NHS

2.5. The fundamental principle of the NHS is, and must remain, that it is free at the point of delivery for its citizens.

2.6. The NHS exists because, at its heart, is an unwritten social contract that taxpayers will pay for a comprehensive health service that is free at the point of delivery to all those who live here and are contributing to our society. The Government is strongly committed to this principle.

2.7. Until now we have extended this privilege to all who chose to come and live here on a temporary basis. This makes the NHS more generous than most other comparable systems and also open to abuse by those intent on cheating the system.

2.8. This openness needs to be reconsidered; not just for economic reasons, but also to better reflect the concepts of equality and fairness on which the NHS is built. For this reason we propose to change the eligibility criteria to reflect a permanent relationship with the UK for persons from countries outside the European Economic Area (EEA). If and when they become permanent members of our communities they will become eligible for care that is free at the point of delivery.

2.9. The NHS still has to be funded and paid for. Like many other welfare services, healthcare provision for our citizens is governed by a social model that applies the principles of equity and shared risk. This means that those who can afford it will pay in more than others via their taxes, and those who have greater health needs are offset by those who remain healthier. These factors also apply across the individual life stages, where most people will need greatest access to healthcare at the start, and in later life.

2.10. However, this model was based on our established, permanently resident population that is fully integrated not just into healthcare but also the wider economy and society. Short term visitors, temporary migrants, and arguably those newly migrating on a long term basis from other countries are not integrated and require separate consideration.

2.11. Most significantly, migrants will have made no prior contribution to the UK exchequer during their previous working life. Even while here, those who are not workers will make only a limited contribution through indirect taxes.

2.12. Although many such migrants may make only limited use of healthcare, a minority could, without appropriate controls, access NHS services to a significant extent, attracted by it being free, more accessible and often better quality than in their own country.

2.13. To overcome this, the over-arching principle in future should be that ‘everybody makes a fair contribution’. Visitors and newly arrived migrants from non-EEA countries should contribute explicitly for NHS services until they are fully integrated in our residency system and its social provision.

A system that is workable and efficient

2.14. A significant conclusion of the 2012 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 NHS treatment. We therefore need to consider fundamentally different ways to apply and enforce the necessary rules and controls.

2.15. Any new system must be compatible with the structure and governance of the health and care system. The charging rules need to be applied across all designated NHS services and the full range of providers of those services.

2.16. In addition, the new system must not compromise the safe, efficient and cost-effective delivery of healthcare, particularly in critical front line services including Accident & Emergency and GP practices. Regular patients should not be subject to repeated or intrusive eligibility checks.

2.17. Staff across the system will clearly have a role in identifying chargeable patients, but the rules and systems should be as straightforward as possible. Clinicians are not expected to take on the role of immigration officials, but they are often well placed to identify visitors who are chargeable. The process we design will need to ensure there is no conflict with their professional obligations.

A system that does not increase inequalities

2.18. Given that the UK has a residency based healthcare system, it is likely that there will be differential access to some NHS services for non-residents compared with residents. However, in developing our new proposals, we have considered carefully issues of potential discrimination, along with legal obligations under the Equality Act 2010 and duties in respect of EEA nationals.

2.19. The Secretary of State also has a wider duty, to have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service. We will ensure that the detailed design of the new process does not undermine duties to reduce inequalities.

2.20. The new system also needs to be inclusive of all lawful residents, including homeless people, travellers, prisoners and other vulnerable groups, while also not denying immediately necessary or urgent care to unlawful residents.

2.21. We have developed our proposals so they do not have unjustifiable adverse impact on any protected groups, and it is important to note that no option proposes denying access to healthcare to any group. As part of this consultation process, we would welcome comments on any evidence to the contrary.

Other considerations

2.22. The NHS has a key responsibility to maintain a population based management of public health, in particular through the early detection and effective treatment of infectious diseases and other health risks.

2.23. Internationally, in its wider interests, the UK Government sometimes opts in to treaties and other international agreements that provide for reciprocated healthcare benefits, which may include providing free healthcare to their respective citizens. These extend healthcare benefits for UK citizens when they visit, or potentially reside in those countries, and ‘fund’ this by the UK Government

contributing to equivalent entitlements for the citizens of those countries who visit the UK.

2.24. Our membership of the EEA provides for a significant reciprocated healthcare provision between all EEA.

2.25. In general, health is a devolved matter in Wales, Northern Ireland and Scotland. The devolved administrations currently retain substantially the same legislative framework and almost all regulations on charging visitors. Given the connection between this matter and immigration generally it would be more effective and would reduce the risks of intra-UK border movements due to differential access and charging rules if broad principles could be adopted on an agreed UK wide basis.

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

Question 2: Do you have any evidence of how our proposals may impact disproportionately on any of the protected characteristic groups[8]?

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

3. Who should be charged?

Summary

Everyone needs access to immediately necessary treatment irrespective of their means or status. In particular, no person should be denied timely treatment necessary to prevent risks to their life or permanent health. The proposals set out in this section do not challenge the provision of universal access to a comprehensive health service, but pursue the principle that everyone should make a fair contribution to the services they receive.

To do this we propose to restrict entitlement to free NHS treatment to those non-EEA nationals with a permanent relationship with the UK. Building on this we propose that those who come for a limited period should make an explicit contribution to the costs of their healthcare unless or until they are given indefinite leave to remain. These temporary migrants might pay a migrant health levy on entry to the country, or be required to hold insurance to cover the costs of their NHS treatment.

We will continue to charge visitors directly at the point of use for hospital treatment. We will retain and simplify all exemptions related to our humanitarian obligations and international agreements.

Qualifying residency

3.1. The NHS is a residency based system, free at the point of delivery. The legal framework that underpins our current charging system defines what is meant by 'residency', and then determines which other groups of people who are not 'residents' should or should not be charged.

3.2. We propose to amend the residency rule to align with the principles set out in Chapter 2. This chapter discusses the implications of that change on different groups of migrants.

Permanent residents

Proposals relating to permanent residents are predicated on immigration rules and policies. The Home Office is consulting directly on these on a UK-wide basis. Responses to this consultation on this issue will be forwarded to the Home Office.

Proposal

To adopt a revised definition of qualifying residency for free NHS entitlement that requires a non-European Economic Area (EEA) migrant (who is subject to immigration control) to have *indefinite leave to remain* (ILR) before they can acquire the status of *ordinary residence*.

Discussion

3.3. At present, ordinary residence (OR) leads to automatic entitlement to free NHS care. OR is not defined in legislation but is based on case law and means, broadly, living in the UK on a lawful and properly settled basis for the time being, whether of short or long duration.

3.4. This vague definition means it can be very easy to pass an OR test so that those lawfully present in the UK for only a short period of time but intend to remain here may qualify and then be entitled to free NHS hospital treatment. This generous provision clearly conflicts with our proposed

principle of everybody makes a fair contribution.

3.5. In applying this principle, the qualification for receiving free NHS treatment should be having the permanent right of residence, ie ILR.

3.6. Any British national has a right of permanent residency. Similarly we must act in accordance with EU law that applies to all EEA citizens exercising their right of free movement and their family members (which may include non-EEA nationals). Such persons are not subject to immigration control. This new threshold of having ILR will therefore apply only to third country nationals – citizens from outside the EEA subject to immigration control.

3.7. We also want to explore how the ordinarily resident qualification can be better defined so that whether or not a person is properly settled here can be clearly and fairly assessed on a case by case basis, and would welcome any further comments or proposals on this issue.

Others with a right of permanent residence

Expatriates and other former UK residents

Proposal

We propose that those expatriates and former legal residents of the UK not subject to immigration control, who have paid National Insurance (NI) contributions for a significant period (we propose at least seven years), should also retain access to all NHS treatment free of charge, both when returning to live in the UK and when just visiting.

What happens now

3.8. An expatriate is a UK citizen who has previously resided in the UK but now lives abroad. Most are British nationals but they could have dual nationality. Many return to the UK on regular visits and eventually permanently.

3.9. Expatriates are not automatically entitled to free NHS treatment when they return to visit the UK as they are not 'ordinarily resident' here. However, if they live in an EEA state they will be entitled to treatment in accordance with the European legislation.

3.10. In relation to people entitled to a UK state pension, there are two separate exemption categories within the Charging Regulations that may apply. The first requires that the pensioner lives in the UK for six months or more each year and six months or less in another EEA member state without registering as a resident in that state.

3.11. These pensioners are fully entitled to free NHS treatment during the period they reside in the UK. In practice, they are also likely to be ordinarily resident or exempt under another category.

3.12. The second exemption requires that the person entitled to a UK state pension is a former resident of the UK or a UK crown servant of ten continuous years or more. These pensioners are entitled to free treatment on visits to the UK (from wherever in the world they live) when the need for the treatment arises during their trip, or for pre-existing conditions that need prompt treatment, but elective treatment is not included.

Discussion

3.13. Expatriates and other former legal residents of the UK are, and will remain, exempt immediately if genuinely returning to resume permanent residence (estimated to be around 75,000 expatriates each year).

3.14. Many argue they should be exempt due to their past payment of taxes and NI; indeed some may still be paying some UK tax. This accords with our principle that everybody makes a fair contribution. They should therefore retain eligibility for free NHS treatment when they require it.

3.15. Effective screening and subsequent application of the charging rules for expatriates is extremely challenging for hospital staff, in terms both of validating entitlement and of confronting the patient. Expatriates and former residents of the UK who have managed to stay registered with a GP (contrary to the Contract Regulations), may also access prescription drugs during short-term visits.

3.16. A small number of British nationals may never have lived in the UK – typically having British parents who emigrated before their birth. If they choose in later life to come to the UK they will be ordinarily resident and therefore qualify for free NHS treatment. This would not change under the new proposals.

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

Question 4: Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK? (Yes / No / Don't know)

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

Temporary migrants

Proposals relating to temporary migrants are predicated on immigration rules and policies. The Home Office is consulting directly on these on a UK-wide basis. Responses to this consultation on this issue will be forwarded to the Home Office.

Proposal

Temporary migrants – those non-EEA migrants subject to immigration control who do not have ILR – will in future have to contribute to their healthcare costs.

This contribution could be delivered through:

- **a new levy (the migrant health levy) on their entry visa. This payment will preclude the need to pay specifically for individual treatments at the point of use, with possible limited exceptions for expensive elective treatment.**
- **Mandatory health insurance top cover the costs of any NHS treatment**

Certain categories of temporary migrant may be given the option of not paying the health levy and therefore waiving the right to free NHS care, on the basis that they have comprehensive private medical insurance cover. They would be expected to access private medical care if needed, and would be charged for any emergency or other NHS treatment.

What happens now

3.17. The Home Office define a temporary migrant as somebody from outside the EEA enjoying a right of residency for a limited period. As such they can be differentiated from:

- a 'general visitor' who is present for a short period (maximum of six months) during which their main centre of interest remains in their own country
- a person with a permanent right of residence, defined in immigration terms as ILR.

3.18. Persons from outside the EEA who do not have ILR and who wish to enter the UK for more than six months are granted limited leave to remain subject to the circumstances of their request (eg a work contract or education course), but this will be for a maximum of five years, after which they may apply for ILR, if they meet the requirements of the immigration rules relevant to their visa category.

3.19. All temporary migrants irrespective of their country of origin (excluding those with EU residence rights) must apply for and obtain approved entry clearance (usually a visa) and all will be subsequently provided with a Biometric Residency Permit[9] (BRP).

3.20. The following visa categories of temporary migrant, and their dependants, where allowed, would be covered:

- Tier 1 – highly skilled workers and entrepreneurs
- Tier 2 – skilled workers
- Tier 3 – students
- Tier 4 – temporary workers eg entertainers & musicians
- Family migrants.

3.21. All of these groups are currently quickly entitled to free NHS services. They acquire this both through being ordinarily resident and sometimes through specific exemptions that are set out in the Charging Regulations.

Discussion

3.22. The new proposed charging policy applies to non-EEA temporary migrants who are subject to immigration control[10]. It is drawn directly from our core principle of everybody makes a fair contribution. They have not established the full ties and permanent relationships that justify inclusion in our social welfare model, as explained in Chapter 2, and should therefore contribute directly.

3.23. Although we have proposed in principle that temporary migrants should pay explicitly for their healthcare for up to five years, it may be fair and appropriate for these costs to be less than the full average cost of healthcare – a fair contribution may be less than a full contribution.

How we should charge

3.24. Applying direct charges for NHS treatment needs a mechanism to recover those charges. NHS hospitals are already required to charge some non-resident patients. Currently this is done by directly invoicing the patient at the point of hospital treatment.

[9] The Biometric Residence Permit is the standard form of immigration document issued to non-EEA nationals granted leave to remain in the UK for more than 6 months. It takes the form of card containing the holder's photograph, basic biographical details and immigration status, including periods of leave and any conditions of stay.

[10] Non-EU family members of EU nationals who are exercising free movement rights in the UK are not subject to the Immigration Rules.

3.25. However, the 2012 review confirmed that this process is inefficient and ineffective, leading to low levels of recovery and significant unpaid debts. More fundamentally, the review concluded that "the NHS is not set up structurally, operationally or culturally to identify a small subset of patients and charge them for their NHS treatment".

3.26. This consultation proposes a significant increase in the number of people requiring identification and charging. This could multiply the risks of non-identification and non-recovery and represent a significant administrative burden on the NHS. A radically different approach is therefore proposed.

3.27. We therefore considered two new options:

- a healthcare insurance scheme whereby any temporary migrants would be required to buy into specific insurance schemes set up between the NHS and insurers (this was based on a similar scheme for students and workers which operates in Australia)
- a specific payment on entry to the UK for all temporary migrants – the migrant health levy, that would then entitle the person to any necessary NHS treatment without further charge.

3.28. Detailed consideration of these options is provided in the accompanying evidence annex.

3.29. This analysis suggests that the levy option would be the easiest to administer and would provide most migrants with a better level of health cover at a lower cost. Our preference is therefore is for the migrant health levy. However; we welcome further comment on the relative merits of all of the options.

3.30. We are also mindful that a few individuals who come to the UK for a limited time, particularly highly skilled professionals and entrepreneurs, may want their healthcare needs to be met by private healthcare. Indeed, this may form part of their employment package.

3.31. Where temporary migrants have comprehensive private medical insurance or personal funds sufficient to cover the cost of private medical care, and therefore do not intend to make any use of NHS care, they may wish to waive their right to free NHS access in return for not paying the migrant health levy. If they do need access to emergency or other treatment that is not available from their private provider, they will be charged in full.

3.32. We recognise that universities, employers or others may have other ideas on how the costs of their students' or workers' healthcare could be provided and welcome any such proposals.

Migrant health levy for temporary migrants

How it would work

3.33. A temporary migrant would pay a single fixed fee for the right to access all NHS services for the duration of their visit. The fee payment would be a condition of receiving entry clearance (including visas) to reside. The migrant's Biometric Residency Permit would be endorsed to show that they are entitled to NHS treatment without further charge.

3.34. When the patient registers with a GP and subsequently accesses treatment, the aim is to set up an NHS system so that their record will show entitlement to access all services (primary and secondary care) without further charge for the

duration of the visa period. The system will record when the visa period is due to expire. The NHS does not have to administer further payment or charge recovery (subject to any exclusions that may be applied, see paragraph 3.40).

How much should the levy be?

3.35. 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.

3.36. Appropriate factors to be taken into consideration may include:

- recognising the wider economic value of students
- considering whether older migrants should contribute to the likely higher costs of their immediate future healthcare considering whether migrants overall will be more healthy and access healthcare less than their regular age cohort
- recognising that temporary migrants may not spend all year in the UK and may access elective treatments in their own country.

3.37. The full annual costs of healthcare average around £1,600 per person and range from under £700 to over £6,000 for the very elderly. Further detail is given in the evidence annex.

3.38. The average cost for a person aged 15-44 is £700. The Home Office are consulting on the level of charges, starting at no less than £200 per year (£600 for a 3-year visa), but an appropriate charge might be higher than this and might vary for different groups.

What should the migrant health levy provide for?

3.39. The intention is that the migrant health levy would be set at a fair and appropriate level to cover all anticipated healthcare needs during the individual's stay.

3.40. It may be appropriate to build in a very limited set of excluded treatments for which specific charging should still apply. These might include any or all of the following:

- IVF treatment
- cosmetic surgery
- organ transplantation (subject to further clinical consideration)
- services for pre-existing pregnancies.

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

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

a) A health levy paid as part of the entry clearance process

b) Health insurance (for NHS treatment)

c) Other – do you have any other proposals on how the costs of their healthcare could be covered?

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

a) **£200 per year**

b) **£500 per year**

c) **Other amount (please specify)?**

Question 8: Should a migrant health levy be set at a fixed level for all temporary migrants? Or vary according to the age of the individual migrant?

a) **Fixed**

b) **varied**

Question 10: Should some or all categories of temporary migrant (Visa Tiers) be granted the flexibility to opt out of paying the migrant levy, for example where they hold medical insurance for privately provided healthcare? ? (Yes / No / Don't know)

Question 11: Should temporary migrants already in the UK be required to pay any health levy as part of any application to extend their leave? (Yes / No / Don't know)

Visitors from outside the EEA

Proposal

We will continue to charge short term visitors directly at the point of use for hospital treatment, and will improve the effectiveness of how the NHS identifies and charges them.

We have no immediate plans to review individual international reciprocal healthcare agreements but will seek to ensure that the NHS only provides treatment for free to the extent that the agreements require.

What happens now

3.41. General visitors are defined by the Home Office as those staying lawfully in the UK less than six months. They include tourists and those visiting friends and relatives. These nationals from other countries may require a visa but whether requiring a visa or with unrestricted entry, they may stay for a maximum of six months.

3.42. A few hospital services are exempt from charges for any individual, including a short term visitor. These are addressed later in this chapter.

3.43. All other (non-EEA) visitors are chargeable and should pay the full cost of other treatment provided in NHS hospitals.

3.44. In late 2011, the Home Office introduced a new immigration rule that provides that any person with outstanding debts of over £1,000 for NHS treatment may be refused further entry into the UK to encourage payment of charges that are due.

Discussion

3.45. We are not aware of any country that provides full healthcare to all visitors without any form of charge or other direct payment, including through insurance (though many will have reciprocal agreements with some other countries).

3.46. Charges should cover the full cost of treatment including direct clinical costs and a reasonable contribution

to other overheads, including charging administration.

3.47. We have considered mandating health insurance for all visitors. However, the enforcement of such a scheme at our borders would be prohibitive, especially as visitors from many countries do not require a visa for short visits.

3.48. However, the majority of visitors do hold basic insurance, usually as part of travel insurance**.** NHS hospitals could adopt a more systematic approach to first requesting insurance details from identified chargeable patients, and contacting the insurers to seek reimbursement. They may subsequently revert to charging the patient direct if this is unsuccessful.

How much should we charge?

3.49. Primary legislation allows for charges to be made for treatment on any appropriate commercial basis.

3.50. Current regulations do not provide any detailed direction on this. The 2012 review research suggests that most NHS institutions currently charge direct treatment costs, with some applying an additional administration cost.

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

Reciprocal agreements

3.51. We exempt visitors from a number of countries[11] with which the UK has reciprocal healthcare agreements may form part of wider social and economic agreements that meet other Government objectives. The most significant of these is with the EU with regard to EEA citizens.

3.52. The healthcare exemption covers any treatment needed during the course of their visit - any treatment that can wait until they return home should not be provided without charge. Determining such necessary treatment is a clinical decision.

3.53. Reciprocal healthcare agreements, where no charges are made do simplify administration as well as providing extended benefits to both countries' citizens (at a cost to both exchequers).

3.54. Most existing reciprocal agreements only provide for 'needs arising' treatments and not for other elective treatments. The NHS could enforce these limits better.

[11] Anguilla; Armenia; Australia; Azerbaijan; Barbados; Belarus; Bosnia and Herzegovina; British Virgin Islands; Falkland Islands; Georgia; Gibraltar; Iceland; Isle of Man; Jersey; Kazakhstan; Kyrgyzstan; Macedonia; Moldova; Montenegro; Montserrat; New Zealand; Russia; Serbia; St. Helena; Tajikistan; Turkmenistan; Turks and Caicos Islands; Ukraine; and Uzbekistan

Other Groups

Those who are living here illegally

Proposal

We should continue to charge illegal migrants who present for treatment in the same way as we charge visitors at full cost directly at the point of use.

What happens now

3.55. Illegal migrants are those who are present in the UK with no leave to remain. They include:

- those who have entered illegally and not declared themselves or been detected
- those who have failed to return home at the end of a period of lawful presence
- those who have sought asylum and been refused to the extent that all appeal rights have been exhausted. Those still in the process of seeking asylum are not 'ordinarily resident' but are exempted from charges under the regulations.

3.56. As illegal migrants are not ordinarily resident or otherwise exempted, they are chargeable in full for all hospital treatment with the exception of exempted services (mainly infectious diseases and treatment in an Accident & Emergency department).

3.57. A small number of Home Office supported failed asylum seekers and human trafficking victims are exempted under the Charging Regulations.

Discussion

3.58. The Government's starting point those persons who are here unlawfully should not remain and should have no entitlement to benefits or public services but essential healthcare must be provided. Providing this access to necessary treatment needs to take account of a number of factors.

3.59. The illegal 'population', while fluctuating, inevitably represents a more established cohort whose health needs will therefore be higher than for short-term visitors, who are here for only a limited period.

3.60. Although some will have few healthcare needs, others are likely to be vulnerable, living in conditions typically associated with greater individual health needs. They may also be destitute with no means to pay. It would not, however, be right to exempt the whole group on the grounds of probable destitution.

3.61. While here, undocumented migrants (unless they have the means to seek private treatment), have no alternative to the NHS to meet their immediate health needs. While some are registered with GPs, others find registration difficult or do not approach a practice for fear of disclosure.

3.62. Failure to identify and treat early symptoms promptly risks delayed emergency hospital admission as well as public health risks. In the main, this group are unable to pay charges levied for urgent treatment and figure significantly in debts to Trusts.

3.63. The 1966 UN International Covenant on Economic and Social and Cultural Rights provides for 'the right of everyone to the highest attainable standards of physical and mental health', and 'the creation of conditions which would assure to all medical services and medical attention in the event of sickness'.

3.64. The 2008 World Health Assembly endorsed an international commitment to 'migrant sensitive health policies and equitable access

to services'. How these commitments apply to illegal migrants has never been tested. We believe they should not commit signatory countries to providing free healthcare.

3.65. However, we will continue to ensure that immediately necessary treatment is not delayed or denied.

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

Other exemptions to allow free treatment

Proposal

Exemptions should be simplified around the key principles and their manifestation through the new residency qualification and past contribution and ties with the UK or other special circumstances.

Discussion

3.66. We currently have over thirty separate exemptions that provide eligibility for free treatment, separate from the base qualification of ordinary residence (listed in Annex A).

3.67. These exemptions have been added piecemeal over time and add to both the generosity and complexity of the current system.

3.68. As far as possible the core principles of residency and previous ties should define our policy. As a consequence temporary non-EEA migrants will now not be exempt. There will however be some other key criteria (such as humanitarian obligations) that need specific definition. We therefore propose to streamline current exemptions as shown in the table.

Streamlining current exemptions

We will remove any exemption categories that will be superseded by a new proposed exemption for ex-residents based on previous National Insurance contributions so that qualification would be based solely on the new proposal, namely:

- UK state pensioners who previously resided in the UK for 10 years or more, or had 10 years continuous service as a UK Crown Servant (needs arising treatment only)
- UK state pensioners who live 6 months or more here and 6 months or less in another EEA member state without registering as resident in that member state
- former UK residents of 10 years or more now employed overseas for up to 5 years
- missionaries overseas for UK-based missions
- former UK residents of 10 years or more now living in a non-EEA country with which the UK has a reciprocal healthcare agreement (needs arising treatment only)

Whilst the following groups would also likely meet the new NI payment exemption, for the avoidance of doubt **we will retain** specific exemptions for:

- those receiving UK war/war widows' pensions or armed forces compensation scheme payments
- members of Her Majesty's UK forces
- UK crown servants working abroad
- British Council/Commonwealth War Graves Commission staff overseas
- UK Government financed posts overseas
- The spouse / civil partner and dependent children of all of the above.

We will retain all exemptions (ie free NHS care) related to our humanitarian obligations:

- those who have been granted refugee status under section 3(2) of the Immigration Act 1971
- those seeking asylum, temporary protection or humanitarian protection under those same rules
- failed asylum seekers receiving section 4 or section 95 support
- children in Local Authority care
- victims (and suspected victims) of human trafficking in the UK
- those that the Secretary of State for Health decides there are exceptional humanitarian reasons to exempt and certain conditions are met

We will retain other exemptions under international obligations and agreements:

- those covered under EU law and
- those visiting from non-EEA countries with which the UK has a reciprocal healthcare agreement
- nationals of countries who are contracting parties to the European Convention on Social and Medical Assistance 1954 or the European Social Charter 1961 and without resources to pay (needs arising treatment only)
- NATO personnel and their spouse / civil partner and dependent children, stationed in the UK

We will retain the exemption for prisoners and detainees due to the fact that they do not have the option to return to their home country for healthcare but we will remove the specific exemption for their family members who may continue to reside here.

We will remove other miscellaneous exemptions that are not consistent with the new eligibility principles and have no other obvious legal or other justification, for example:

- Overseas visitors employed on UK registered ships

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

EEA citizens in the UK

Proposal

We will apply EU legislation that governs the provision of healthcare to citizens of EEA Member States who either reside in or visit the UK, whilst taking action to improve the effectiveness and recovery of costs for which other Members States are responsible.

Discussion

3.69. European Union (EU) legislation on the co-ordination of social security systems requires each Member State to cover the costs of its citizens and their family members (including non-EEA nationals) accessing state-provided healthcare in other European Economic Area (EEA) countries in the following main circumstances:

- visitors (usually up to three months) and students, using the European Health Insurance Card (EHIC formerly known as the E111) for all necessary care during their visit. Treatment costs are reimbursed by their home state
- any EEA citizen who moves to another Member State to work, including self-employed or actively seeking work, becomes the responsibility of that State for the provision of healthcare (and social security). They are entitled to the same conditions as any other resident. This means that in the UK context they are entitled to full free access to the NHS
- state pensioners, and their dependents, who have moved abroad receive full access to healthcare in that state. Treatment costs are reimbursed by the state that pays their state pension
- a person who has been authorised to undergo a planned medical treatment in another member state: costs are paid by the member state that has referred them.

3.70. We do not propose changing these entitlements but we will be looking to improve the effectiveness of cost recovery from other Member States (see Chapter 6).

3.71. We will continue to monitor and evaluate access to the NHS by economically inactive migrants, including through our current 'audit', and will explore any possible solutions that are within the parameters of EU law.

4. What services should we charge for?

Summary

This chapter considers what services should remain free to all, and proposals for extending charges to other services currently free to all. It is important to note that exemptions for public health remain in place.

Primary care, and in particular access to a general practitioner, is recognised as a necessary part of comprehensive healthcare for an individual and should not be refused. However, visitors and others who are not exempt from charging should be charged for primary medical services. Temporary migrants who have paid the migrant health levy (Chapter 3) would be able to access primary medical services on the same basis as a permanent resident. The practicalities of ensuring chargeable migrants and visitors are charged in full for primary dental services, ophthalmic services and prescription charges in community pharmacy are being considered further.

In secondary care, emergency treatment will not be delayed or denied, but may be limited to what is clinically necessary and payment sought after treatment. Otherwise treatment will be provided only after payment has been received, as is already the case in the NHS in England. Measures will be adopted to improve the collection of these payments.

We also propose that in future all NHS services (other than specified public health exemptions) should be chargeable for non-exempt individuals, irrespective of who provides the service or where the services are provided. An appropriate and effective method of administering these charges will be developed with healthcare professionals and managers, providers and commissioners (Chapter 5).

Introduction

4.1. This chapter sets out the services that will remain free to all, and proposals for extending charges to services which are currently free.

4.2. Because this consultation is about developing a fair and effective system for charging, it is important to confirm at the outset that the NHS will continue to guarantee access to a range of services. So, whether free or charged for, the NHS in England will continue to provide a comprehensive healthcare service, including primary care (GPs; dentistry; ophthalmic services; and pharmacy), and continuing care.

4.3. Although the National Health Service Act 2006 permits charges to be made to non-residents for any NHS service, 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 Trusts and NHS Foundation Trusts). They do not cover the same secondary care services if they are provided by any other commissioned NHS provider (eg private sector companies, social enterprises).

4.4. Significant services including primary medical services, community-based care and continuing care are currently free to all even if the person is chargeable for NHS hospital treatment, because there are currently no regulations that permit charging for these services. This consultation seeks to determine whether charges should be extended

to any or all of these settings, services and treatments.

4.5. In addition a few specific services and treatments are free to all users, even for a person who is deemed to be chargeable for NHS hospital treatment.

Exempt treatments

Proposal

Exemptions for infectious diseases and sexually transmitted infections (STIs) are integral to protecting the public's health. These exemptions should therefore remain.

Discussion

4.6. No charges (other than some prescription charges) are made in respect of specified infectious diseases, including all STIs. No charge is made for those detained for treatment by the Mental Health Act 1983 or treatment imposed by a Court Order.

4.7. These exemptions are to ensure population-wide protection of public health. Failure to treat infectious disease promptly increases the likelihood of spread through direct or indirect personal contact.

4.8. Access to treatment without charges (that may deter some disease carriers from presenting) is central to the NHS's duty to protect public health on a population-wide basis. Exemptions from charging should not, however, extend to any other conditions that a patient may have.

Primary care - General Practitioners (GPs)

The Home Office are consulting on a proposal that a principle of charging for all healthcare, including GP services, is applied on a UK-wide basis. Responses to this consultation on this issue will be forwarded to the Home Office.

Proposal

Access to services provided by GPs is the cornerstone of a comprehensive health service.

Registering with a GP practice, and creating a healthcare record (NHS Number), must allow us to differentiate between those who will be chargeable for NHS services and facilitate the sharing of this information to subsequent healthcare providers that they may be referred to.

Any chargeable migrant or visitor should, in future, be charged for GP services, but not for registering with a GP practice.

What happens now

4.9. GP practices provide consultation, diagnosis and treatment of registered patients. Treatment, based on clinical diagnosis, may include prescribing drugs or referral to hospitals or other service providers for elective (or emergency) care. Such services should remain available subject to a new process to support charging where appropriate.

4.10. Currently any person can request registration with a GP practice. If the need is for less than three months they may be recorded as a 'temporary migrant'. A GP practice cannot refuse to register a patient who is living in the practice catchment area, if its list is open, unless there

are exceptional circumstances. No charges can be levied for registering with a GP practice.

4.11. Powers to charge people not ordinarily resident have not been enacted in respect of GP services, so currently no one can be charged for GP services.

4.12. GP practices are also obliged to provide emergency treatment for up to 14 days for patients they do not register and also for any accident or emergency that occurs in their practice area.

Discussion

4.13. The service provided by GP practices is a fundamental part of the healthcare system. Immediate access and on-going doctor/patient relationships provide for effective management of chronic and other existing conditions, and prompt diagnosis and treatment of new health problems. This provides obvious health benefits for the patient, potential cost savings for the NHS, and supports population centred public health protection, including preventing the spread of disease. Thus every individual present in the country for any period needs this service.

4.14. Individuals with chronic conditions may need access to on-going primary care services, even if they are only staying for a short period, but most such visitors should only require access to an emergency consultation.

4.15. There is no determination of eligibility for free secondary care when registering with a GP practice, and there is no obligation on a GP practice to provide information relating to potential chargeability when referring to secondary care. This enables some patients to evade detection on admission to hospitals and leads to them not being charged appropriately for hospital treatment.

4.16. The principle of everybody making a fair contribution means that where a migrant is required to contribute directly to their healthcare costs this should include primary medical services. The costs of GP services are less than £200 per year, so compared to secondary care should not be a significant burden.

4.17. The proposed migrant health levy for temporary migrants will cover all regular health needs, including GP services.

4.18. There are a number of challenges to surmount in applying charges for short-term visitors. Charging per visit may deter necessary consultations which could carry public health risks. There are also administrative costs in charging and a particular risk is that these costs could exceed the recoverable revenue. These issues need to be taken into account in detailed process design, and are addressed in general terms in 'Making the system work in the NHS' (Chapter 6).

4.19. As well as considering public opinion, we will engage extensively with the NHS on these questions.

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

Other primary care services

4.20. In addition to GP services, primary care services also include community pharmacy (dispensing of NHS prescriptions other than to hospital inpatients), and the provision or primary (high street) dental and ophthalmic services. While GP services are free to everybody, these other services have more complex rules on charging and exemptions that currently apply to residents and visitors.

4.21. Our initial consideration of these areas has highlighted some significant practical challenges to applying the principles of fair contribution. These are set out below and we seek views, comment and ideas that can inform continued evaluation of these areas.

Prescription charging

4.22. Prescriptions are orders for drugs or appliances written by a health professional, usually by a GP, but also by others such as a nurse or dentist, and are usually dispensed in community pharmacies. Some drugs are dispensed directly through other routes, such as out of hours services or walk-in centres.

4.23. Drugs or appliances supplied by the NHS are subject to a prescription charge (which is currently £7.85) unless one of the existing exemptions applies to the individual: age (those under 16, 16-18 and in full time education, and 60 and over), income (such as through the receipt of certain benefits) or medical condition. The prescription charge does not change if the actual cost of the drug or appliance to the NHS varies; it is a flat co-payment contribution.

4.24. We have given initial consideration to whether chargeable migrants and visitors should be required to pay prescription charges for all NHS drugs or appliances, regardless of whether they meet the eligibility requirements for the prescription fee exemptions. Although it might seem right that this group should be required to pay, there are significant challenges that would need to be overcome to ensure this is achievable. For example, a mechanism for determining chargeable status and communicating this between all relevant healthcare professionals, who either prescribe or dispense drugs and medical appliances, would need to be developed.

4.25. This would require significant investment, including changes to prescribing IT systems. Whilst the level of demand for prescriptions by this group is unknown, the cost of the required system changes may far exceed any revenue generated.

4.26. We will consider these challenges in conjunction with related appraisal and development of the integrated NHS process for registering and tracking new migrant access to healthcare, as set out in Chapter 5, but would welcome views as to whether newly regulating their eligibility for free prescriptions is something that should, and could practically be pursued, or any alternative proposals.

Ophthalmic services

4.27. NHS sight tests and optical vouchers are available to defined eligible groups. There is no residence requirement and if a chargeable migrant or visitor is within one of the eligible groups and an ophthalmic practitioner thinks there is a clinical need for a sight test then the optometrist may provide that free of charge. If the person is also eligible for an optical voucher then following an NHS sight test they would also be issued with an optical voucher based on the prescription issued.

4.28. There are no patient charges for NHS sight tests and the optical voucher is used to help with the cost of an optical appliance prescribed following the sight test. Eligible patients are those aged under 16, 16-18 and in full time education, on qualifying benefits, aged 60 and over and patients who have diabetes or glaucoma or are at risk of glaucoma.

4.29. However, if a chargeable visitor or migrant is referred for further tests or treatment within a hospital, usually the ophthalmic inpatient department, they will be liable for charges for that treatment, in the same way as for any other secondary hospital care.

4.30. We have given initial consideration to whether overseas visitors who fall within the eligible categories for NHS sight tests and optical vouchers should be required to pay a charge for these services or receive a lesser amount of support.

4.31. It may be that specific charges or restrictions on their eligibility for optical vouchers could be introduced for chargeable migrants. However, it is not clear how much revenue this would raise as the numbers of cases are not known. In addition a mechanism for determining those who are chargeable would be needed that would be accessible to and operable by all high street ophthalmic contractors.

4.32. We will consider these challenges in conjunction with related appraisal and development of the integrated NHS process for registering and tracking new migrant access to healthcare set out in Chapter 5 but would welcome views as to whether new migrant charges for ophthalmic services are something that should, and could practically be pursued, or any alternative proposals.

Dental services

4.33. NHS charges are levied for most primary dental services. These charges are a contribution to the cost of NHS dental provision and are collected by dentists on behalf of the NHS. Some patients are exempt from charges (those under 18 (19 if in full-time education), those who receive specified income related benefits, and women who are pregnant or have given birth in last 12 months).

4.34. As with the rest of primary care, the lack of residency rules means visitors or migrants, if taken on for NHS dental care, receive the same subsidised, if subject to NHS charges, or free, if in an exempt category, provision as UK residents.

4.35. We need to look further at the different types and levels of charges that might be applied to visitors and migrants that would be consistent with ‘fair contribution’. As with pharmacy and ophthalmic services, a key challenge is a mechanism for determining those who are chargeable as migrants or visitors that would be accessible to and operable by all high street dentists. A further consideration for dentistry is the potential impact of any changes on local dental access.

4.36. We therefore need to consider these challenges in conjunction with related appraisal and development of the integrated NHS process for registering and tracking new migrant access to healthcare set out in Chapter 5 but would welcome views as to whether new migrant charges for dental services is something that should, and could practically be pursued, or any alternative proposals.

Question 16: Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs? (Yes / No / Don't know)

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

Hospital care

Proposal

To improve the existing processes for identifying, charging and recovering debt from referral to admission

What happens now

4.37. Regulations introduced in 1982 have required non-residents to be charged for most hospital services but there is little evidence that they have ever been applied rigorously and effectively across all hospitals. Since the 1980s, the regulations and operating guidance have been updated in a piecemeal and reactive manner leaving the overall system broadly unchanged and increasingly dysfunctional.

Discussion

4.38. Good practice in identification and collection of charges exists in a number of places, especially some of the larger hospital trusts. The intention is to build on this to streamline the processes, maximise net income recovered, and form a basis for design and implementation of new processes (Chapter 5).

Emergency treatment (via GP or A&E Department)

Proposal

We want to consider further the possibility of charging for emergency treatment, and to examine what system improvements would be necessary and sensible to implement charging without compromising patient access.

4.39. This section concerns the provision of immediate treatment to visitors and other temporary migrants who are not exempt from charges for routine healthcare, including:

- attendance at a hospital A&E Department
- consultation with a GP as an unregistered patient.

What happens now

4.40. Hospital A&E services and emergency GP consultations are free to all. Individuals, who are not exempt are, however, charged for any inpatient emergency treatment, including when admitted via A&E, but this must not be delayed or denied if prior payment cannot be made.

Discussion

4.41. In accordance with international, legal and humanitarian obligations, the NHS provides emergency treatment to anybody who requires it regardless of their status or ability to pay.

4.42. There are strong competing arguments over charging for these services. There is no question of treatment being denied and there is recognition that some individuals might be unable, or refuse, to pay. However, many visitors expect to pay for such treatments, either personally or via their own insurance.

4.43. It therefore seems reasonable to charge a visitor or tourist a basic fee

potentially ranging from £20 to £100 (for major A&E treatment), as is the case in Australia.

4.44. However, there are arguments against charging:

- Charging may deter some patients from seeking timely immediately necessary treatment, risking their long term health as well as the likelihood of later more extensive and expensive emergency treatment
- There would be an increased administrative burden in both A&E and GP practices in identifying those who should be charged
- Vulnerable residents, such as homeless people or travellers, may wrongly be charged if they cannot prove their eligibility
- Processing delays could impact on A&E patient flows, and there are risks of wholesale switching between GP and A&E care if there were differential charging regimes.

4.45. We want to examine these arguments further, particularly with clinicians and other front line NHS staff. We need to determine whether a simple fee collecting process is operationally feasible without compromising the safe and efficient flow of patients through highly pressured A&E departments and GP practices.

4.46. We anticipate that if charging is deemed appropriate in principle, it could not be introduced unless or until robust new systems were able to support a streamlined process of screening and charging.

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

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

Organ transplantation

Proposal

We will consider further whether the criteria for allocating an organ from a deceased donor needs to be amended in light of the changes to entitlement to free NHS care that is proposed in this consultation.

Discussion

4.47. Currently anybody who is ordinarily resident in the UK has equal priority when it comes to the allocation of organs for transplant. The decision on who receives an available organ is based on clinical need.

4.48. Following this consultation, we will consider the final proposals, in particular any implications of the change in the ordinary residence rule that will exclude anybody who does not have indefinite leave to remain (ILR).

Other healthcare settings

Proposal

NHS services should be chargeable for non-exempt individuals, irrespective of who provides the service or where the services are provided. An appropriate and effective method of administering these changes needs to be developed.

What happens now

4.49. NHS treatment is provided in a range of settings other than NHS hospitals, including:

- community-based treatment provided by NHS organisations, primary care providers, independent, voluntary, charitable or social enterprise organisations, Care Trusts, GP led services and other providers
- hospital or elective care services provided by non-NHS providers
- continuing care outside hospitals, such as rehabilitation (often provided by non-NHS commercial or not for profit bodies) or NHS continuing healthcare (packages of care for people with complex ongoing healthcare needs).

4.50. There are no current powers for charging in any of these treatment settings.

Discussion

4.51. It is anomalous that charges apply in NHS hospitals but not in the other settings identified, particularly as the same treatment provided to different patients may or may not be charged depending on where the patient is referred.

4.52. However, if charges do apply to non-NHS bodies, then process solutions will need to minimise burdens of administration and debt recovery on independent and community providers.

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

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

5. Making the system work in the NHS

Summary

The NHS struggles to identify and recover the cost from those currently chargeable. Work is underway in a number of London Trusts to improve the workings of the current system, and we will work with the NHS to enable these organisations to share their experience to develop an integrated "best practice" approach.

We will also address the existing disincentives which mean hospitals are discouraged from properly identifying all chargeable patients, and improve rates of recovery from those who have been charged.

Significant improvement is required to identify chargeable patients at the point that they first register with the NHS and subsequently track them through the system whenever they access hospital or other services. The new system proposals are intended to operate from the first point of registration with the NHS, and so will impact only on people newly arriving from abroad.

This Chapter suggests a number of core components and operational constraints for an effective system. Any new rules and processes must enable the NHS to meet statutory duties to apply charges and to use its public funds appropriately without compromising the safe, efficient and cost-effective delivery of healthcare.

This consultation is also seeking views on the case for establishing a legal gateway to formalise the sharing of personal non-medical information relevant to charging for NHS services between the NHS and other bodies.

Introduction

5.1. This chapter sets out some of the requirements and suggests an outline process as to how a better system might operate.

5.2. For many reasons, the NHS is not applying the current regime effectively. Extending the requirement to charge to more migrants and more services would clearly be a further major challenge.

5.3. Designing, implementing and subsequently managing an effective system needs to be led and managed by the NHS, with input from NHS England and support from the Department of Health on regulatory changes.

5.4. A key part of this consultation is to engage extensively with NHS staff and other key stakeholders to design the new system and identify the requisite statutory provisions and other system components, including IT infrastructure.

5.5. In the short term we think there are opportunities to improve current charging processes in hospitals but ultimately a more comprehensive new NHS wide system is needed.

Improving the current system in hospitals

5.6. The Department of Health's 2012 review concluded that, while there was a clear case to revise the rules on who should be charged, and introduce new ways of administering them (both of which would require statutory changes), there was also a significant opportunity to improve current practice in NHS hospitals, providing an early opportunity to increase recovered income.

What are the problems?

5.7. We estimate that less than half of potential chargeable patients are identified, largely because of practical difficulties in identifying elective patients referred by GPs and emergency admissions.

5.8. Hospitals face significant financial disincentives if they identify and charge such patients, as they are unable to claim from NHS commissioners for the cost of treatment and must instead recover the full cost direct from the chargeable patient. Given that some debt from such charges is inevitable, they incur significant losses that are eventually manifested in the written off debts in their accounts.

5.9. Based on Trusts' accounts and our survey of Trusts, we estimated that Trusts currently invoice between £35m and £55m to chargeable overseas visitors, and only manage to recover about 40% of those invoiced charges.

5.10. All of these figures could be significant under-estimates, and of course take no account of those patients who have avoided detection and charging in the first place. We are expecting the new independent audit to provide a more robust assessment of the problem.

5.11. A number of factors make it difficult for Trusts to recover costs from patients that they invoice. In particular:

- the duty to provide all immediately necessary or urgent treatment regardless of receipt of payment leads to inevitable unrecovered costs. The likelihood of recovery diminishes rapidly after discharge, particularly where patients leave the country or give incomplete or false contact details
- a large share of costs is borne by a small number of individuals with high bills. This makes it more likely that these individuals may simply not be able to pay (notably some undocumented migrants)
- NHS Trusts do not have expertise in chasing debts. Many use specialist debt recovery companies at some point but even these have limited success and Trusts lose up to half of any such recovered income in fees
- the overall process of invoicing, and follow up recovery (including individual case handling) is time consuming and expensive. Trusts rarely recover these additional incurred costs.

Improvement opportunity

5.12. The 2012 review, and other policy research, did identify a number of innovative practices in individual London hospitals and concluded that collectively these initiatives (together with other untapped good practice) should support development of a comprehensive best practice model across the entire patient pathway.

5.13. These initiatives variously address the whole process systematically from referral to admission, treatment, charging and recovery, and the roles of each involved party. They are explained in more detail in the evidence annex accompanying this consultation.

5.14. None of these initiatives requires any change in regulations or other statutory or contractual provisions. They are therefore within the current remit of the NHS itself. However, the whole system approach will require a coordinated and managed approach.

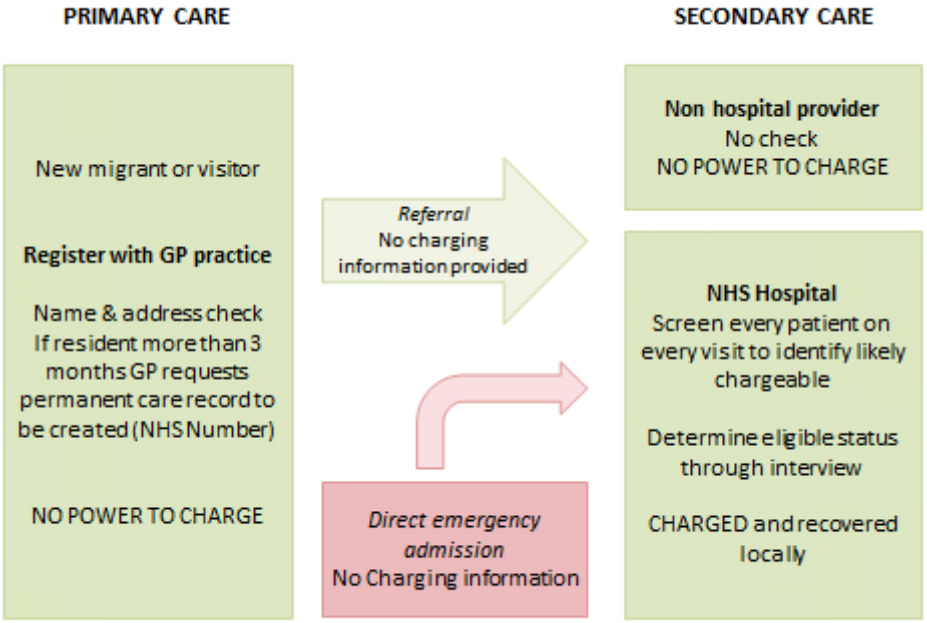
5.15. We are currently working with these London trusts to share their experience to pilot this integrated best practice approach.

5.16. These pilots may also provide the opportunity for participating hospitals and commissioners to input in to the more systematic redesign of migrant registration and tracking, as set out later in this chapter.

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

Developing a new NHS wide system

How the current system works



Current system weaknesses

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

5.18. There are no requirements or supporting systems for referral from a GP or other primary care services to indicate chargeable status. The main patient identifier – the NHS number – contains no record of an individual's chargeable status or information to support identification for charging.

5.19. There is no mechanism for recognising European Economic Area (EEA) nationals with EHIC cards to enable recovery from their Member States for primary care services, or to alert hospitals for secondary care services that could also include diagnosis.

Core components of an effective new system

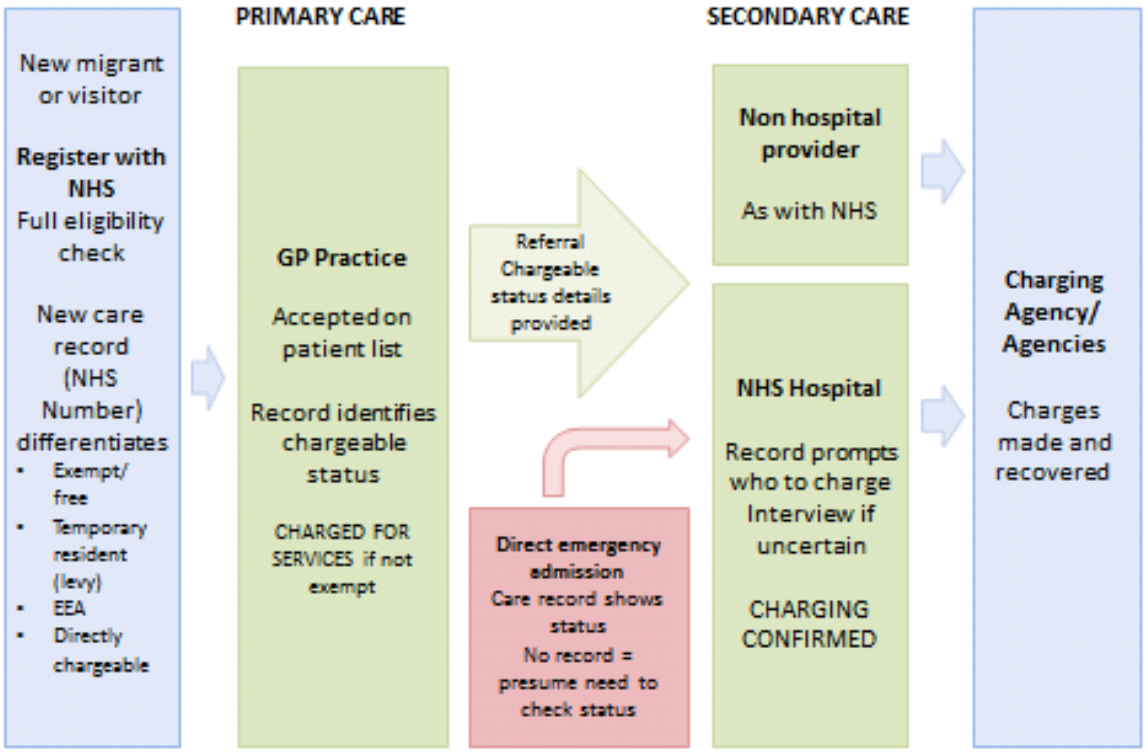
5.20. There are a number of core components, set out below, that are required to ensure the new system is effective and efficient. This list is not exhaustive but likely to include:

- 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 migrant 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, dentists 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.

How the future system might work



Operational considerations

5.21. For any new system to be fully adopted by the NHS, some key constraints must be observed:

- treatment in an emergency or for public health need should not be denied
- the needs and interests of vulnerable or disadvantaged patients including the homeless, travellers and those who are lawfully resident but may not have documentation should be protected and not be charged
- lawfully resident patients should not be subject to frequent and intrusive checks
- screening and checking must be smart and efficient
- clinicians' time must not be diverted wholesale from clinical matters
- administrative costs must be minimised without compromising effective enforcement
- identification and screening processes must be non-discriminatory.

5.22. These proposals are intended as a starting point for detailed design led by NHS managers and users. All elements are open to constructive challenge.

Key decisions in the new system design

Which body(s) should handle initial NHS registration?

5.23. We recognise that individual GP practices may not have the capacity or systems to undertake such checks. We therefore want to consider whether there are better alternatives for this critical process.

5.24. Possible bodies could include:

- The NHS care record function, supported by some additional data from GP practices
- local hospital (where there is current expertise)
- NHS England or DH hosted centre
- an external agency
- others.

How should primary care charges be made?

5.25. If people required to contribute to their healthcare costs should do so for primary care as well as hospital treatment, we need to determine how this could be applied in practice.

5.26. Temporary migrants paying the migrant health levy would have access to primary care without further charge. However for other short term migrants who request non-emergency access (perhaps to monitor current chronic conditions while visiting, or for illegal migrants) a direct charge would need to be levied.

5.27. In such cases should this be by:

- payment per consultation or other service
- an annual service fee
- other standard fixed fee.

5.28. A further consideration is whether a proportion of those charges should be transferred or retained by GP practices (to cover any administration costs).

5.29. We have discounted the option for such patients to be registered and charged as private patients because of the need to maintain a

comprehensive, fully accessible health service, subject only to charges where applicable.

Accommodating full scope of charging across NHS provider settings

5.30. The new system needs to be able to accommodate:

- charging across all types of NHS care - primary care, hospital care, community health services and continuing healthcare
- charging different migrant groups in different ways – short term visitors by direct charge and temporary migrants by the migrant health levy.

5.31. Decisions about some elements of the system may in turn influence final decisions on whom to charge and for which services.

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

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

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

Legal gateway for data sharing

5.32. Managing and tracking patients across the healthcare pathway requires the collection, storage and sharing of information. An expanded and more robust charging system will increase the amount of information to be shared and the number of bodies and agencies involved.

5.33. In particular we will be linking some decisions and actions taken by the NHS with information initiated by the Home Office, and may need links with other government departments or agencies (eg to validate NI records).

5.34. We recognise that there is a particular need to take account of patient confidentiality whereby information about a patient's health is not shared. These legal gateways may need to be reaffirmed and formalised.

Transition

5.35. When new rules come into force a significant number of people already residing may become chargeable. A decision is therefore needed as to whether, and if so how, charges could be applied to them.

5.36. These decisions may have a cross-government dimension (given that other benefits and public service entitlements may also change) but we need to consider the specific factors for health, taking account of impact on the individual and the impact on the NHS (feasibility and cost).

5.37. The changes to the charging system may mean that a temporary migrant who was ordinarily resident and so

entitled to free NHS treatment under the old system, should now have to pay (because they do not have ILR and have not paid the health levy). Fairness suggests that they should not have to start to paying, at least while their current visa remains valid.

5.38. Current health registration records do not contain data that would enable us to filter out those individuals who in future may need to be charged and/or registered differently. We would therefore need to review primary care registration for the whole population. This would be an enormous administrative burden as well as a huge imposition on a large number of UK residents.

5.39. The current proposal is therefore not to extend charges to people who hold visas before the new charging regime comes into force for the duration of that visa.

5.40. However, we may look at ways of identifying those who should be chargeable on an exception basis so that their records could be corrected over time. This would be applicable in the main to repeat visitors who may have registered previously (and illegal migrants).

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

Next Steps

5.41. The ideas, options and questions in this chapter will form the basis for direct engagement with NHS frontline staff and other groups to develop and design the overall system. We expect to do this through working groups and wider engagement events.

5.42. A robust new system is likely to require some new technology, and delivery of effective administration processes is likely to happen progressive over the next few years.

5.43. Feedback from wider public consultation will input into final decisions, particularly on policy issues, principles and safeguards.

6. Recovering Healthcare Costs from the European Economic Area (EEA)

Summary

Under EU rules Member States reimburse each other directly for the costs of healthcare provided to their respective citizens under particular circumstances.

The UK pays out considerably more than it receives because many more of our citizens visit other EEA countries and many more UK state pensioners reside in other EEA countries than happens in reverse. But we can do more to reduce our net payments. We therefore propose to:

- Improve the recording of NHS treatment provided to EEA citizens via their European Health Insurance Cards (EHIC) or pensioner registration (S1) forms, as part of the NHS system improvement;
- Cease reimbursement of co-payments, and the funding of initial healthcare costs for early retirees. These payments to our citizens exceed our obligations under EU law;
- Reduce our payments to other Member States for the healthcare costs of our state pensioners to reflect their having retained entitlement to NHS treatment on returning home.

Introduction

6.1. The EU countries plus Norway, Iceland, Liechtenstein (the non-EU EEA Member States) and Switzerland co-ordinate the provision of social security including healthcare under Regulation (EC) No.883/004. The Regulation includes rules on the reimbursement of costs between Member States in the following main circumstances:

- for visitors (including students) using the European Health Insurance Card (EHIC, formerly known as the E111) for all necessary care during their visit
- for state pensioners and their dependents who have moved abroad, the state that pays their state pension is responsible for paying the costs of their healthcare, either through an annual average cost payment or actual incurred costs
- for a person who has been authorised to undergo a planned medical treatment in another Member State, costs are paid by the Member State that has referred them
- for a dependent (usually a spouse or child) of someone who lives in another EEA Member State or someone from another EEA Member State working in the UK.

6.2. The reimbursement arrangements do not cover working age citizens who move from one EEA country to another to take up work, for whom the NHS provides free treatment.

Opportunities for improving cost recovery

EEA visitors

Proposal

In addition to raising awareness of how to record EHIC details we propose to include the systematic capture of EHIC details across all NHS providers as part of the new registration system. A key part of the improved system will be appropriate incentives for hospitals and others to collect and process EHIC details.

Current process in UK

6.3. For visitors from EEA countries the costs of their treatment are borne by the social security body of the home country and reimbursement is managed using the details held on the patient's European Health Insurance Card (EHIC). The cost of treatment can only be recovered if the patient's EHIC number is recorded. The NHS does not do this systematically.

6.4. Since October 2009, if a patient on a visit from the EEA requires necessary medical treatment and presents an EHIC to the NHS, the treating institution reports the EHIC details onto the Overseas Visitors Web Portal. This information can then be used by the UK to present a claim for reimbursement to the patient's home country. The process is extremely simple and the portal can be accessed via secure internet. Formula agreements are in place with some countries to reimburse estimated costs.

Weakness with current position

6.5. Only 60% of hospital trusts in England use the web portal on a regular basis, and it is clear that the UK is missing out on income owed by other EEA Member States as a result. There appears to be a lack of incentive to identify and record EEA patients as Trusts are reimbursed regardless via internal mechanisms and resource allocations.

6.6. There is currently no mechanism to capture treatment costs outside hospitals. Furthermore, there are no mechanisms to capture systematically the healthcare costs of EEA students, for whom there is an EU wide agreement that their treatment needs should be covered by an EHIC for the duration of their study.

EEA State Pensioner Registrations

Proposal

We propose to develop a more robust process for identifying newly arriving EEA state pensioners and capturing their S1 details as part of the new registration system design.

6.7. The UK has a process in place for registering the forms and triggering the payments, but relatively few are received. We believe that forms are 'lost' within the NHS, as the significance of the form is often not understood by the GP practice or hospital trust to whom the EEA pensioner may first pass it. A conservative estimate is a loss of around £12 million per year in additional income from other EEA Member States.

Payments the UK is not legally required to make

Early retirees

Proposal

We propose to stop issuing residual S1 forms from 1 April 2014.

Current Process

6.8. The UK issues form S1 for non-state pensioners, outside the requirements of the Regulations. This process is applicable to UK nationals, who are not in paid employment, and are residing in another EEA member state. The form was introduced in 1982, primarily to provide healthcare cover for early-retirees, allowing them time to integrate into their new country of residence. It provides them with health cover for up to 2.5 years.

6.9. Forecasts indicate that the UK pays out around £4 million a year in relation to citizens in receipt of a residual S1.

Weakness in the current process

6.10. Residual S1 (formally known as an E106) is not a requirement of EU Regulations. The UK is the only Member State to make such payments and could save around £4 million per year by removing the entitlement. There would also be additional savings to be drawn from the current administrative costs of the scheme.

UK state pensioners returning to the UK from another EEA country

6.11. UK state pensioners living in another EEA country are not currently entitled to the full range of NHS services, as would be afforded to an individual who is ordinarily resident. In particular if they return for a visit they may be charged for elective treatment.

6.12. Anecdotal evidence suggests that many already return for some treatment and few are actually detected and appropriately charged.

6.13. The benefit to the UK of allowing state pensioners to return for their planned treatment would be a discount of 5% from payments to all countries to whom we make lump sum annual payments for our pensioners. That discount reflects the fact that the NHS is still providing a proportion of their healthcare. Using current spend levels as a guide, we estimate that this could reduce our payments by up to £40m per year. This will be offset by some increase in NHS expenditure on those who do return for treatment, but we believe that many are already doing so and not being detected and charged.

Co-payments

Proposal

We propose to stop refunding co-payments from 1 April 2014.

Current process

6.14. Under EU law an EEA visitor is 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.

6.15. Since 2009 the UK has refunded 100% of all state treatment provided in another Member State, including co-payment contributions. The co-

payment element is refunded directly to the individual.

Weakness in the current process

6.16. The UK is not legally obliged to reimburse co-payments and could save around £3 million per year by ceasing this arrangement. The current system of repaying co-payments opens the door to patients seeking fully reimbursed treatment in another Member State to avoid any charges that might apply in the UK (eg dentistry). Individuals would claim instead through their travel insurance.

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

Summary of questions

Overarching principles

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

Question 2: Do you have any evidence of how our proposals may impact disproportionately on any of the protected characteristic groups[12]?

Who should be charged?

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

Question 4: Should access to free NHS services for non-EEA migrants be based on whether they have permanent residence in the UK? (Yes / No / Don't know)

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

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

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

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

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

a) **£200 per year**
b) **£500 per year**
c) **Other amount (please specify)?**

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

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

c) Fixed
d) varied

Question 10: Should some or all categories of temporary migrant (Visa Tiers) be granted the flexibility to opt out of paying the migrant levy, for example where they hold medical insurance for privately provided healthcare? ? (Yes / No / Don't know)

Question 11: Should temporary migrants already in the UK be required to pay any health levy as part of any application to extend their leave? (Yes / No / Don't know)

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

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

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

What services should we charge for?

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

Question 16: Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs? (Yes / No / Don't know)

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

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

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

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

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

Making the system work in the NHS

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

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

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

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

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

Recovering Healthcare Costs from the European Economic Area (EEA)

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

Annex A: Overseas visitors exempt from charging

Full list of exempt from charge overseas visitor categories under the Charging Regulations

1. Anyone who has been lawfully living in the UK for twelve months immediately prior to treatment (a temporary absence of up to 182 days is allowed)
2. Anyone who is working in the UK for an employer who is based in the UK
3. Anyone self-employed in the UK
4. Any unpaid worker with a voluntary organisation offering services similar to those of a Health Authority or Local Authority social services department
5. Any full time student: i) on a course of at least 6 months duration, or ii) a course substantially funded by the UK Government
6. Anyone who has come to take up permanent residence in the UK
7. Anyone covered by EU Regulations/Rights*
8. Anyone covered by a reciprocal healthcare agreement with the UK*†
9. Refugees
10. Asylum seekers whose applications are still being considered
11. Failed asylum seekers receiving section 4 or section 95 Home Office support
12. Children in the care of the Local Authority
13. Those identified, or suspected as being, victims of human trafficking (as determined by the UK Competent Authority)
14. Anyone granted exemption by the Secretary of State for exceptional humanitarian reasons
15. Diplomatic staff working in embassies or Commissions in the UK
16. Serving NATO personnel, posted in the UK, who are not using their own or UK armed forces hospitals
17. UK state pensioners who have lived lawfully in the UK for 10 continuous years at some point, who now live for not more than 6 months each year in another EEA Member State (and are not registered as resident there) and not less than 6 months each year in the UK
18. Anyone who receives: i) a UK war pension, or ii) an armed forces compensation scheme payment
19. Members of Her Majesty's UK armed forces
20. UK Civil Servants working abroad who were recruited in the UK and employed by Her Majesty's Government

21. Anyone recruited in the UK who works abroad for the British Council or the Commonwealth War Graves Commission
22. Anyone who is working abroad in a job financed in part by the UK Government in agreement with the Government or a public body of some other country or territory
23. Anyone who has lived legally in the UK for ten continuous years but now working (including self-employment) abroad for the first 5 years away
24. Missionaries working overseas for an organisation principally based in the UK
25. Prisoners
26. Those detained by the Immigration Authorities in the UK
27. Anyone employed on a ship or vessel registered in the UK
28. UK state pensioners with ten years lawful residence in the UK, or employment as UK Civil Servant*
29. Anyone who has lived legally in the UK for 10 continuous years but now living in the EEA or a country with which the UK has a reciprocal healthcare agreement*
30. Anyone from a country that is a signatory of the European Convention on Social & Medical Assistance or the European Social Charter and without means to pay
31. An authorised child or companion of a person under 14, above
32. The family members (spouse/civil partner and children under 16) of all but numbers 14, 30 and 31 of the above categories.

* *Exemption may have limited scope. For all others the exemption covers all treatment*.

The Statutory Instruments for the Charging Regulations can be found at:

http://www.legislation.gov.uk/uksi/2011/1556/made

http://www.legislation.gov.uk/uksi/2012/1586/contents/made

Annex B: How will different groups be affected?

Resident British nationals

No change - will continue to have automatic entitlement to free NHS services and will not be subject to extensive entitlement checks and challenges.

Expatriates

All expatriates who return to reside in the UK will resume automatic qualification to free NHS services. Some but not all will benefit from exemptions if they return on a visit. We intend to extend this entitlement to any expatriate or former UK residents who has an extensive record of National Insurance contribution, and for this to cover their full medical needs.

Visitors from the EEA

No change. Visitors (usually here for up to three months) and students will continue to use the European Health Insurance Card (EHIC) for all necessary care during their visit, with costs reimbursed by their home state.

Residents from the EEA

No change. Any EEA citizen who moves to another member state to work becomes the responsibility of that state for the provision of healthcare. They are entitled to the same healthcare as any other permanent resident.

Non-EEA temporary migrants

In the future, all temporary migrants (student, workers and newly arriving family members or dependents) who do not have indefinite leave to remain will contribute to the cost of their healthcare through a new migrant health levy, linked to their visa. This will be set at a fair level reflecting their contribution and value. The Home Office are currently consulting on this.

High value workers may waive payment of the migrant health levy and access to the NHS in favour of privately provided healthcare.

Non-EEA visitors/ tourists

No change. We will continue to charge visitors directly at the point of use for hospital treatment. However, this would be extended to include primary care and other treatment outside hospitals.

Illegal migrants

We will continue to charge illegal migrants who present for treatment in the same way as we charge other non-permanent residents. This would be extended to include primary care and other treatment outside hospitals. However, urgent and necessary care will not be delayed or withheld pending payment.

Annex C: How to respond to a consultation

Responding to the consultation

We would welcome responses to all of the questions above as well as any additional comments that you would like to make. An online response form can be found alongside this document on our website. Please use this to record your responses and comments. Alternatively, you can use the Word response form on our website or email your responses to:

migrantaccess@dh.gsi.gov.uk

If you do not have internet or e-mail access, then please write to:

International Healthcare Team
Department of Health
3rd Floor
Wellington House
133-155 Waterloo Road
London SE1 8UG

Please submit your responses to the questions and any other comments that you have by 5pm on **28 August 2013**.

If you wish to do so, you can request, via the online / Word response form on our website, that your name and/or organisation be kept confidential and excluded from the published summary of responses. Please mark e-mail or postal responses in a similar way in order to ensure confidentiality.

Please note that we may use your details to contact you about your responses or to send you information about our future work. We do not intend to send responses to each individual respondent. However, we will analyse responses carefully and give clear feedback on how we have developed the regulations as a result.

Commenting on the consultation process

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds, LS2 7UE

e-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

If you would like any part of the content of your response (as distinct from your identity) to be kept confidential, you may say so in a covering letter. We would ask you to indicate clearly

which part(s) of your response are to be kept confidential. We will endeavour to give effect to your request but as a public body subject to the provisions of the Freedom of Information legislation, we cannot guarantee confidentiality.

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Summary of consultation responses

A summary of the responses to this consultation will be made available and will be placed on the consultations website at:

http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Glossary of terms

Accident and Emergency (A&E) services	These are services that are needed immediately in an emergency situation and under current rules are free of charge to all overseas visitors, whether provided at a hospital accident and emergency (or casualty) department, a minor injuries unit, a walk-in centre, or elsewhere, up until the point that overseas visitor is accepted as an inpatient or given an outpatient appointment. Emergency treatment that is given after admission to the hospital (e.g. intensive care or coronary care) is chargeable to a non-exempt overseas visitor.
All medically necessary treatment	Treatment of all emergency, urgent and chronic conditions including the routine monitoring of them. It only applies to those visitors from the European Economic Area (EEA) and Switzerland who have valid European Health Insurance Cards or have Provisional Replacement Certificates for them.
Asylum seekers	Anyone who has made a formal application with the Home Office to be granted temporary protection, asylum or humanitarian protection which has not yet been determined. Formal applications are those made under the 1951 UN Convention and its 1967 Protocol and also any other request for humanitarian protection, such as some claims made on protection from serious harm grounds under Article 3 of the European Convention on Human Rights.
British National/Citizen	British nationality is defined in law. Whether a person has a claim to British nationality can be determined by applying the definitions and requirements of the British Nationality Act 1981 and related legislation to the facts of their date and place of birth and descent. The most acceptable evidence of British citizenship is a British passport.
Community services	Services delivered in the community rather than at a hospital.
Co-payment	A contribution to the full cost of a medical service.
Dependents	A spouse or civil partner and children under the age of 16 or up to 19 if still at school and receiving child benefit.
European Economic Area (EEA)	Countries of the European Union (EU), plus Iceland, Liechtenstein and Norway, those states having signed an agreement to participate in the EU internal market. Whilst not a member of the EEA, Switzerland also signed up to EU legislation on the internal market and free movement of people. In this consultation, where EEA is referred to, for simplicity, this will include a reference to Switzerland.

European Union (EU)	An economic and political union established in 1993 after the ratification of the Maastricht Treaty by members of the European Commission.
Expatriate (Expat)	A British national no longer resident in the UK. Non-UK nationals may also be former residents of the UK and former contributors of UK National Insurance Contributions.
Failed asylum seekers	A person who has had their asylum/humanitarian protection application and all appeals rejected becomes a 'failed asylum seeker'. They will become liable for charges for new courses of NHS hospital treatment at that point, even if they have been here for more than one year. However, failed asylum seekers who are being supported by the Home Office under 'section 4' or 'section 95' of the Immigration and Asylum Act 1999 are exempt from charges. Section 4 support is given to those failed asylum seekers taking reasonable efforts to leave the UK but for whom there are genuine recognised barriers to their return home.
Health tourism/tourist	Health tourism is difficult to define, with any definition predicated on the actual rules of entitlement at the time. The common view is that any unpaid debts for chargeable NHS treatment constitute 'health tourism'. The different circumstances under which income due to the NHS from chargeable visitors is not realised include: visitors who conceal a prior intention to access NHS services that they are not entitled to access for free, with the intention of avoiding detection or, if charged, payment; visitors who, when receiving unexpected treatment, seek to evade identification or payment; those who are residing here unlawfully and who receive emergency treatment but have no resources to pay for this.
Immediately necessary treatment	Treatment which a patient needs: to save their life; to prevent a condition from becoming immediately life-threatening; or promptly to prevent permanent serious damage from occurring.
Indefinite leave to remain (ILR)	The permanent right of residence for a non-EEA person
NHS charged patients	Overseas visitors who are liable for charges as NHS patients.
Non-European Economic Area (non-EEA)	Any country other than EU Member States, Norway, Iceland, Liechtenstein and Switzerland.
Non-urgent treatment	Routine elective treatment that could wait until the patient can return home.

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