# Internal review of the overseas visitor charging system

*Part 2*

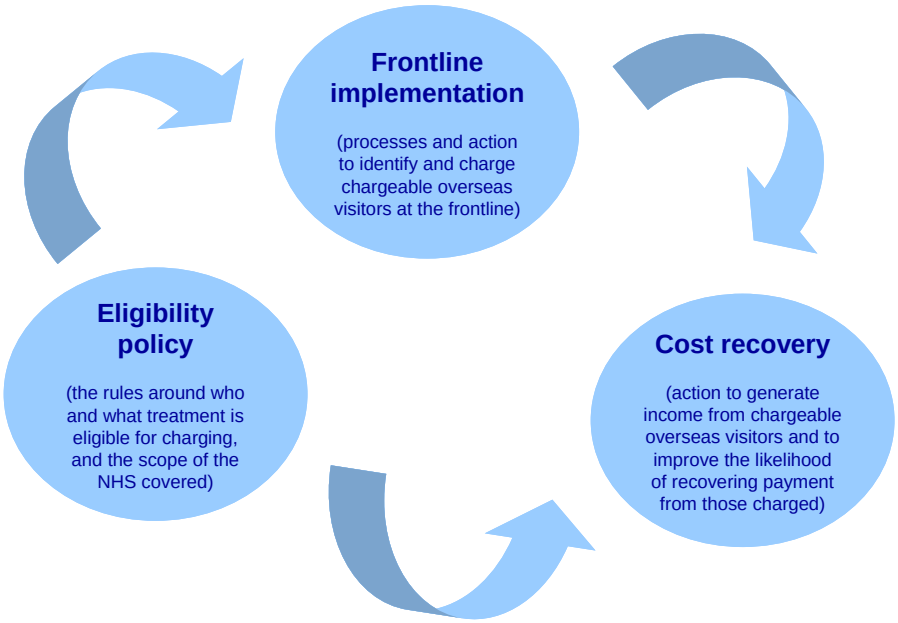
*Analysis of the overseas visitor charging system*

# Contents

## Introduction

1. Our analysis of overseas visitor charging policy focuses on three closely linked features of the system:

    - the eligibility rules
    - frontline implementation of those rules
    - cost recovery




2. Cost recovery is action to secure income from overseas visitors which, when successful, delivers the outcome of reducing pressure on the NHS budget and protecting resources for patients who are entitled to free NHS treatment. It is directly affected by the overseas visitor charging rules – for example a significant expansion of exemption categories would reduce the number of chargeable overseas visitor patients and therefore reduce the *potential* for income generation.

3. Eligibility policy determines how many people should be identified as chargeable overseas visitors. The diagram above depicts the impact of the rules on the frontline – for example, the more complex and burdensome the rules, the more difficulty Trusts will have in engaging with them.

4. And as NHS hospitals are solely responsible for identifying and charging overseas visitors, it is their frontline implementation of the rules that acts as the gateway, or gatekeeper, to income from overseas visitors.

5. Analysing the problems according to these three areas or themes will help us to identify where intervention could be worthwhile, and to keep in mind at all times that intervening in one area would have an impact on another.

## The eligibility rules

- Under current rules, NHS services provided outside NHS hospitals are free to all.
- Ordinary residence, which determines automatic entitlement to free NHS hospital treatment, is a confusing concept and difficult to apply. Despite this, it is a low threshold.
- The Charging Regulations exempt seven services and 33 categories of overseas visitor from charge – some exemptions could be viewed as needlessly generous.
- There is considerable overlap between ordinary residence and several exemptions from charge contained in the Regulations. This overlap reduces the need for hospitals to consider OR specifically in many cases, but makes any standalone proposal to tighten up the exemptions redundant.
- The Charging Regulations are not always compatible with EU Social Security Regulations, resulting in the UK missing out on reimbursement from other Member States.
- Ordinary residence and the Charging Regulations also appear to make redundant the European Free Movement Directive's requirement for economically inactive EEA nationals and family members moving to another member state to hold comprehensive sickness insurance in order to protect the host member state's health service.
- The scale and complexity of the Charging Regulations leads to confusion, disengagement with the policy, incorrect decision making and litigation threats.

### Introduction

6. The 1949 NHS (Amendment) Act created powers – now contained in Section 175 of the 2006 NHS Act – to charge people not 'ordinarily resident' in Great Britain for health services. The powers were first used in 1982 to make Regulations in relation to NHS hospital treatment (now consolidated as the NHS (Charges to Overseas Visitors) Regulations 2011[1].

7. Since 1982, anyone not ordinarily resident in the UK has not been entitled by right to free NHS hospital treatment. An exemption from charges within the Charging Regulations must apply to someone who is not ordinarily

[1] http://www.legislation.gov.uk/uksi/2011/1556/contents/made

resident in the UK, otherwise they will be liable for charges for NHS hospital treatment.

8. The overseas visitor eligibility rules, as contained in the Charging Regulations, govern the overseas visitor charging system and define which parts of the NHS can charge overseas visitors and which categories of people, treatments and services are exempt from charge. As such, it is these rules that determine the number of *chargeable* overseas visitors entering the NHS. The rules are also the focus of much criticism of the overseas visitor charging system for being overly complex or generous.

9. Further analysis of the exemption categories contained in the Charging Regulations is contained in Annex D, and in-depth analysis of the number of overseas visitors and the costs they impose on the NHS is found later in this section of the review.

**Scope of NHS treatment covered by the Charging Regulations**

10. Because Regulations have only been made to charge for NHS treatment provided in hospitals or by hospital employed or directed staff, NHS services provided elsewhere, including primary care (see section on primary care below) and services such as community care and costly NHS continuing care remain free to all by default. This is regardless of if the overseas visitor is here unlawfully, or on a short-term visit, whether they have the resources to pay or were chargeable for the treatment they received at an NHS hospital prior to their need for non-hospital treatment.

11. The Charging Regulations have not kept pace with changes to NHS provision in other ways too. The rules only apply to NHS bodies, since historically only NHS bodies provided NHS services. These days some independent bodies provide NHS services on behalf of the NHS, but the Charging Regulations do not allow charges to be made to patients who happen to receive NHS-funded hospital care from these independent bodies, regardless of where that patient resides or if they would have been charged for the same service provided at an NHS body. See Box 1 below for a case study reported to the DH overseas visitor helpdesk.

12. Therefore under the current scope of the charging rules, the same treatment could be chargeable or not, depending on which body provides it. As an example, Community Health Services once provided by PCTs are chargeable if they transferred to Foundation Trusts, but not where transferred to the third sector.

13. In addition, as health service provision evolves further as a result of the Health and Social Care Act (2012), Local Authorities will also have the power to provide or commission hospital treatment or treatment delivered by hospital staff in the provision of public health services. Without an amendment to the Charging Regulations such bodies will be unable to charge overseas visitors that are charged for those services now when provided at an NHS hospital.

***Box 1: Limited scope of the Charging Regulations***

A private hospital provided an overseas visitor with a joint replacement operation on the NHS. The patient had been in the country for a short time, had stated that they intended to stay in the country to get another joint replacement operation, and then intended to return to their home country.

The NHS commissioner challenged the hospital and attempted to withhold payment for the procedure, because the patient was not entitled to free NHS treatment under the Charging Rules and were liable for their own costs.

In this case the patient was indeed highly unlikely to meet an Ordinary Residence test or be covered by any exemption under the Regulations. However, as the hospital providing the treatment is not an NHS hospital, it is not covered by the Regulations and is therefore unable to apply charges. The treatment therefore had to be provided to the patient free, funded by the NHS.

**Ordinary residence**

14. The primary, or 'core' way in which people are entitled to free NHS hospital treatment is by being ordinarily resident (OR) in the UK. The concept of ordinary residence appears in many areas of law, but it has never been defined in legislation. Instead, it takes its meaning from case law – see Box 2 below – and means, broadly, living in the UK on a lawful and properly settled basis for the time being.

***Box 2: Case law relating to ordinary residence***

The context for the 1982 case of *Shah v Barnet LBC* was education, but Lord Scarman's decision is recognised as having wider application. He said:

"'Ordinarily resident' refers to a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration.

"There is, of course, one important exception. If a man's presence in a particular place or country is unlawful, e.g. in breach of the immigration laws, he cannot rely on his unlawful residence as constituting ordinary residence."

*YA v Secretary of State for Health* in 2009 considered whether asylum seekers and failed asylum seekers could be considered ordinarily resident in the UK. The Court of Appeal (Lord Justices Ward, Lloyd and Rimer) found that they were not:

"[Asylum seekers'] residence by grace and favour is not ordinary. The words must take some flavour from the purpose of the statute under consideration and […] the purpose of the NHS Act is to provide a service for the people *of* England and that does not include those who ought not to be here. "

15. The vagueness of the definition means that it is often very difficult and onerous for NHS staff to determine – and for patients to prove – ordinary residence, given the lack of absolutes within its definition. A person must be in the UK lawfully but they do not need to have the right to reside permanently, so immigration status is of limited relevance.

16. They must be properly settled and not simply visiting from their real abode, but this can be very difficult to determine or prove without a time frame to follow or if they do not work, or attend courses, or if they do not acquire accommodation or pay bills in their own right to demonstrate "settledness". A person must be here voluntarily so, in theory, children might often fail an ordinary residence test since the extent to which they have independently chosen to be here may be limited.

17. Yet despite this difficulty it can be extremely easy to pass an ordinary residence test and become entitled inalienably to free NHS hospital treatment (OR is also the test for entitlement to a UK-funded EHIC and to group 1 entitlement to a donated organ).

18. OR is not linked to nationality or a particular immigration status. A person does not have to have a positive right to reside in the UK, nor do they have to have resided for a particular period of time – OR can apply with immediate effect – or intend to reside here for a particular period of time. The purpose for them being in the UK, whilst needing to be a settled one, can be as slight as 'merely love of the place' (*Shah v Barnet LBC*). The threshold at which OR will apply is therefore very low.

19. The following are illustrative examples of people who would pass an OR test and be legitimately entitled to free NHS hospital treatment under the current rules (see pen pictures in Annex F for further, more detailed examples):

    - A non-EEA woman coming to the UK on a marriage visa to marry a UK resident is 6 months pregnant when she arrives and will need maternity treatment and to deliver before the wedding. She is OR on arrival.

    - A non-EEA man visiting family in England on a visitor's visa has a stroke and accesses health treatment, for which he is charged. He applies to UKBA for leave to remain so that his family can care for him. From the point of making the application he could pass an OR test, making further treatment free.

    - A non-EEA woman with multiple health needs exercises rights under the European Free Movement Directive to move in with her EEA passport-holding daughter who lives and works in the UK. On arrival the mother would pass an OR test and be entitled to free hospital treatment.

20. However, despite ordinary residence having a low threshold, tentative estimates suggest that most people considered ordinarily resident in the country are, indeed, long-term residents (see analysis section later in this report).

***Box 3: The Habitual Residence Test***

Ordinary residence is not the only residency test in operation across government. The Habitual Residence Test[2] was introduced in 1994 in response to concerns about "benefit tourism". The test is applied to all people (unless they fall into one of the exempt categories, such as for refugees or working EEA nationals) who have recently arrived in the country – including returning British nationals – and who make a claim for certain means-tested social security benefits, or seek housing assistance from a local authority.

Like ordinary residence, the term 'habitually resident' is not defined in legislation, but through domestic and EC case law. This has established that DWP and Local Authority 'decision makers' can take into account factors including:

- The length and continuity of residence
- The person's future intentions
- Their employment prospects
- Their reasons for coming to the UK
- Where the person's 'centre of interest' lies

Case law has established that the main factors in deciding whether someone is habitually resident are whether they have a 'settled intention' to reside, and whether they have actually been resident here for an 'appreciable period of time'. EEA nationals who have worked in an EEA state may, depending on their circumstances, be accepted as habitually resident immediately on arrival. For others, a period of actual residence is likely to be required, but this may be relatively short (there is no set minimum period; it could even be a matter of weeks).

From May 2004 people have had to satisfy an additional test – the "Right to Reside" Test – in order to be considered habitually resident. Any person who does not have a right to reside automatically fails the Habitual Residence Test.

**Short-term visitors and others not ordinarily resident**

21. The Charging Regulations define an overseas visitor as "a person not ordinarily resident in the United Kingdom". Therefore OR and overseas visitor are mutually exclusive terms and a person should not be able to be both at once. Under the current rules, anyone not ordinarily resident can

[2] Information in this text box is taken from the Commons Library's 2011 Standard Note on the Habitual Residence test, http://www.parliament.uk/briefing-papers/SN00416

only be entitled to free NHS hospital treatment by being exempt under the Charging Regulations. The Charging Regulations are very lengthy and offer exemption from charges to seven services and 33 categories of overseas visitor[3].

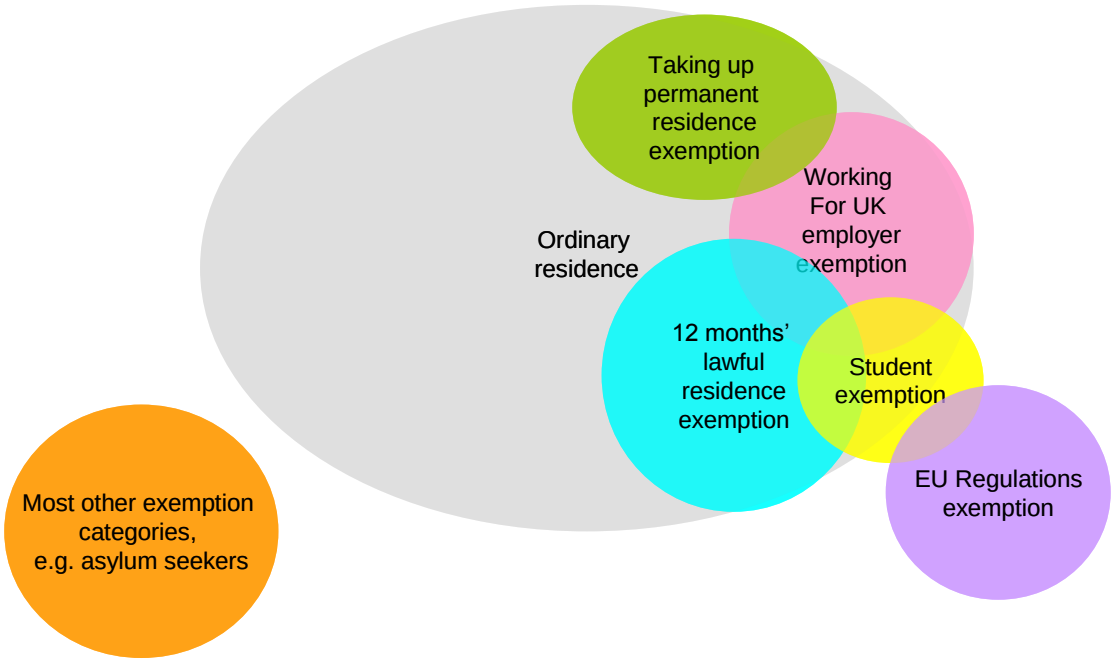
**The exemption categories' interplay with ordinary residence**

22. As noted above, a person should not be able to be both ordinarily resident and an overseas visitor at once. However, in reality there is a lot of overlap between ordinary residence and many of the exemption categories, such as for those who:

- have resided lawfully in the UK for at least 12 months;
- are working for a UK-based employer;
- are studying full time on a course of at least six months in duration;
- are taking up permanent residence in the UK.

23. It is difficult in reality to see how the majority of people being considered exempt from charges in these ways could not have passed an ordinary residence test in the first place, and therefore not be subject at all to the Charging Regulations.

***Figure 1: Overlap between ordinary residence and exemption categories***




[3] Five categories of overseas visitor who are exempt from charge limit free treatment to that the need for which arises during the visit, i.e. treatment that is needed promptly during the visit, and not pre-planned treatment.

24. Furthermore, there are limitations and conditions in place within this ‘secondary’ way of entitlement to free NHS hospital treatment that are not within the ‘primary’ way of entitlement, i.e. ordinary residence. For instance, to benefit from the ‘taking up permanent residence’ exemption, a person needs to have the right to live permanently in the UK (eg indefinite leave to remain). A person claiming to reside here who has not been given that right of permanent residence can instead rely on ordinary residence, for which there is no such requirement. This means the condition of permanence laid out in the Regulations is redundant.

25. The fact that the above exemption categories exist might suggest that policy makers assumed them necessary because persons who have not been in the UK for long, or who are subject to immigration control, should not be able to be considered ordinarily resident. Any such assumption could have been on moral grounds, or, erroneously, legal grounds, since, as has been shown, OR can have a very wide application. Alternatively, policy makers may have felt these exemptions necessary to put the position of workers, students etc beyond doubt. OR could not be relied upon to do that job due to the lack of clarity within the definition and the resulting differences in application between one NHS body and another when faced with an almost identical patient.

26. However, all this suggests that the relationship between ordinary residence and exemption from charges within the Charging Regulations is not working properly. It adds to the general confusion and results in an unwieldy and confusing system for the NHS and the public. The complexity risks incorrect decision making by the NHS or decisions that may be challenged by litigants seeking to exploit the flexibility of ordinary residence and push its definition beyond its limit. A case recently came to the attention of the Overseas Visitors Policy Team where a legal firm known for litigation in this area was acting on behalf of a client who at the time of treatment was in the UK on a visitor’s visa. The legal firm stated that the client was OR simply because they were lawfully in the UK and intended to remain here for the time being, even though they had not applied for permission to live here. They asked the Trust to declare that the patient was OR and so withdraw the charge.

27. It also means that policy makers cannot properly manage entitlement to free NHS hospital treatment, since removal of an exemption category from the Regulations may still leave a route of entitlement through ordinary residence. Any standalone proposal to tighten up the exemptions would be effectively redundant.

## The exemption categories[4]

28. Whilst some of the exempt services are on sound public health grounds, such as treatment for infectious diseases, others do not have such obvious benefits to the general public. One exempt from charge service is for all accident and emergency treatment provided in an A&E unit until the patient is admitted as an inpatient (emergency treatment provided after admission is not free to all). This is regardless of if that overseas visitor has funds to pay the A&E charge or has health insurance. If they go on to incur costs for treatment beyond admission, the cost for the A&E episode cannot be added to their bill. Since, unlike primary care, it is well known that A&E unit treatment is free to all, this may lead to added pressure and inappropriate use of the A&E unit by overseas visitors who would be better treated by a GP.

29. Some of the exempt from charge categories of overseas visitor are due to our humanitarian obligations, such as those seeking asylum whilst their applications are being processed and the victims of human trafficking. However, other exemption categories might be seen as needlessly generous, such as:

    - former residents who emigrated up to five years previously as long as they are currently employed overseas;
    - employees on UK-registered ships; and
    - missionaries working for a UK based mission, even if they have never been a resident of the UK.

30. In addition, a person moving to the UK to take up permanent residence is entitled to free NHS hospital treatment immediately, regardless of any connections to the UK or any high cost specialist health needs they may have.

31. The exemption for family dependants means that in most cases whenever a person is exempt from charge, so too is their spouse/civil partner and children under the age of 16 (or under the age of 19 if still in education). For the most part, the exemption only applies if the family member is living on a lawful and permanent basis with the principally exempt person.

32. This exemption is problematic in a number of ways (see Annex D for in-depth consideration of this issue). It can be a difficult exemption category for the NHS to get right because it is often unclear if the family member is in the UK on a permanent basis with the principal exempt person. If the family member cannot benefit from the exemption as they have not been in the UK with the principal exempt person for a sufficient time, the NHS also has to consider whether they are exempt from charge in their own right or indeed whether they can pass an ordinary residence test. In

[4] This section contains high-level analysis of the Regulations and exemptions – see Annex D for in-depth consideration of each exemption.

addition, the family dependants exemption does not apply to the family of a person who is ordinarily resident in the UK.

**European Union Social Security Regulations**

33. A person can be entitled to free NHS hospital treatment by virtue of rights arising under EU Social Security Regulations (EC) 883/2004 and 987/09 – the EU Regulations. These rights have direct effect but are also written into the Charging Regulations at regulation 9.

34. An insured resident of a European Economic Area (EEA) Member State or Switzerland is entitled to free NHS treatment when it is medically necessary to provide it to them during their temporary visit to the UK to prevent them from having to return home sooner than planned for medical treatment, or when they are formally referred here for pre-planned treatment. They need to provide a valid European Health Insurance Card (EHIC) or E112/S2 respectively to receive this treatment free of charge. The UK can then be reimbursed by the home member state if details from those documents are recorded by the NHS and reported to the Department of Work and Pensions' Overseas Healthcare Team.

35. Again, there is overlap between two forms of entitlement. Students from the EEA/Switzerland would generally remain insured in their home member state and have a valid EHIC from that country to cover them for anything medically necessary during their stay in the UK, which could be for several years. The UK can then be reimbursed for all of that treatment. However, if that student does not bother to carry their EHIC, they will nevertheless receive free NHS hospital treatment by virtue of the Charging Regulations if their course is of at least six months' duration (or, indeed by passing an ordinary residence test). This means that the UK misses out on being reimbursed by the student's home country. This is likely to also be the case for some posted workers sent to the UK from their employer in another EEA member state.

**European Free Movement Directive and Comprehensive Sickness Insurance**

36. Another way in which European law appears to be working in conflict with ordinary residence and the Charging Regulations is in residence entitlements arising from the European Free Movement Directive. The Directive provides that EEA citizens have an initial right to reside in other member states for three months, after which their right to reside is dependent on them exercising an 'EU Treaty right' as either a worker, a self-employed person, a job-seeker[5], a student or a self-sufficient person. These rights extend to the family members of the EEA national exercising the Treaty right, including non-EEA family members. Once an EEA national has exercised an EU Treaty right continuously for five years they

[5] Romanians and Bulgarians cannot exercise the job-seeking Treaty right.

can then reside without any restriction (equivalent to indefinite leave to remain) and gain a right of permanent residence here.

37. For those who are economically inactive (i.e. students and the self-sufficient) the right of residence only applies if they have comprehensive sickness insurance (CSI) cover in the host member state and are not a burden on the social assistance system of the host member state. A private health insurance policy or an entitlement under the EU Regulations where the UK can be reimbursed (eg a valid EHIC) satisfies the CSI requirement. However, because of the way that our domestic legislation is framed, this safeguard to protect member states from the undue burden of nationals from other member states going to live in their countries is lost when it comes to healthcare. Anyone taking up permanent residence in the UK is entitled under the Charging Regulations to receive free NHS hospital treatment. If that person cannot demonstrate permanence, they can instead rely on ordinary residence, again meaning that they are entitled to free NHS hospital treatment.

38. Therefore, despite the possession of CSI being a requirement of residence here after three months for an economically inactive EEA/Swiss national, they will not then have to use it to pay for their healthcare since, by having it, they are entitled to NHS hospital treatment for free. The UK's domestic legislation effectively makes the requirement for CSI to protect a member state's health service redundant.

39. This creates a very confusing situation – for the NHS and the public – and most NHS hospitals do not ask to see evidence of CSI from an economically inactive EEA national claiming to be residing here since if they had it they would then be entitled to free NHS hospital treatment anyway. Most economically inactive EEA nationals who can demonstrate some settled residence here or claim to have moved here are therefore provided with free NHS hospital treatment, regardless of if they have CSI.

40. This creates a risk of EEA nationals and their families choosing to move to the UK because of instant access to free treatment, which they might not be entitled to in their home country if that country requires them to pay contributions for healthcare and they have not done so. Such a risk would obviously place a burden on the UK which is contrary to the European Free Movement Directive. This situation could only be rectified by replacing or refining ordinary residence and some of the exemption categories under the Charging Regulations.

**Exemptions from charge under reciprocal healthcare agreements**

41. Reciprocal healthcare agreements are in place with 28 non-EEA countries whereby visitors from those countries receive largely free healthcare when visiting. They include Australia, New Zealand and Caribbean countries, plus a cohort of ex-Soviet and other eastern European countries. The reciprocal agreements in effect extend healthcare to UK citizens who travel abroad at a cost of providing free treatment to visitors from those

countries. See Annex E for further consideration of the reciprocal agreements.

**Conclusion**

42. There are multiple issues with the eligibility rules governing the overseas visitor charging system, not least the fact they are complex and difficult to implement. The rules provide free treatment to many people who may be able to pay, or who may not live, or have never lived, in the UK. This could risk the UK being targeted by those seeking free treatment and contribute to a belief that the NHS will treat anybody for free. And, as the international comparison work conducted as part of this review shows (see Annex I), this generosity is often not afforded to UK residents when they are in need of healthcare overseas.

## Primary care

- There is no legislation or extant DH guidance relating to overseas visitors and primary care. The concept of 'ordinary residence' has no relevance.
- In primary medical services GPs have discretion to accept overseas visitors' applications to join their patient lists (whether fully registered or as a temporary resident).
- However there is strong anecdotal evidence of confusion and differing approaches among GP practices including discriminatory cases of deregistering patients who are believed to be 'ineligible' in some way.
- GPs have no duty, or incentive, to establish entitlement for free NHS secondary care treatment, or identify a patient's likely status, when making referrals.
- Residence status is also irrelevant for optical, dental and prescriptions policy, which means, for instance, that anyone over 60 visiting from anywhere in the world is entitled to a free NHS prescription.

43. As described above, the legislative power to charge overseas visitors for NHS treatment has not been enacted beyond services at, or by staff employed to work at, or under the direction of, an NHS hospital. There is currently no legislation or DH guidance on foreign nationals' or overseas visitors' access to primary care (services provided by GP practices, dental practices, community pharmacies and optometrists).

44. Primary care services account for around 90% of people's contact with the NHS[6]; and the vast majority of those who use primary care services will be diagnosed and treated without being referred to secondary care.

45. With no legislation or extant guidance covering primary care, there are therefore no 'rules of entitlement' for overseas visitors – the rules are exactly those that apply to the resident population. The concept of 'ordinary residence', which underpins overseas visitor charging policy in NHS hospitals, has no relevance for primary care in England – indeed the term 'overseas visitor' has no meaning in the primary care setting[7].

### Primary medical services

46. NHS primary medical services in England are provided by around 36,000 primary medical care contractors (GPs) working in around 8,200 GP

[6] http://www.dh.gov.uk/en/Healthcare/Primarycare/index.htm

[7] However when the term is used in this review in relation to primary care, we mean those people who would be deemed as overseas visitors were the definition within the secondary care charging rules to be applied in primary care – i.e. those not ordinarily resident.

practices, which provide approximately 300 million general practice consultations a year[8]. NHS General Medical Services (GMS), Personal Medical Services (PMS)[9] and Alternative Provider Medical Services (APMS) contracts with GPs cover medical services to NHS patients. Through an entitlement to undertake private work GPs can provide the same general practice services on a private, paying basis, as long as those patients are not also registered on the practice list.

47. GP practices have an overriding contractual duty to provide emergency and immediately necessary treatment free of charge for any accident or emergency that takes place within their practice area. In addition, where a GP practice turns down a patient wishing to register, the GP must provide, free of charge, any immediately necessary treatment for up to 14 days.

***Preventative and public health role of primary medical services***

48. Primary medical services play a key preventative role. Higher continuity of care with a GP is associated with lower risk of emergency and unplanned hospital admission – which is important, given the disruption such admissions cause to planned interventions and the high unit costs of emergency admission to hospital compared with primary care[10].

49. The King's Fund[11] states that GPs are well placed to actively manage patients with ambulatory care sensitive conditions, thus preventing acute exacerbations and reducing the need for emergency hospital admission.

50. Primary medical services are also ideally placed to take on an active public health role, such as providing advice and information and contributing to the delivery of vaccination and screening campaigns. A 2010 study commissioned by the King's Fund to inform the Inquiry into the Quality of General Practice in England[12] states that "general practice and GPs are often regarded as the basic building blocks of public health, and primary care is seen as a logical location for local public health activities". The Royal College of GPs' curriculum statement on health promotion[13] underlines the importance of GPs having a good understanding of public health knowledge and skills, and encourages GPs to be proactive in consultations.

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[8] http://www.dh.gov.uk/en/Healthcare/Primarycare/PMC/index.htm

[9] As governed by The NHS (General Medical Services Contracts) Regulations 2004, http://www.legislation.gov.uk/uksi/2004/291/contents/made, and The NHS (Personal Medical Services Agreements) Regulations 2004, http://www.legislation.gov.uk/uksi/2004/627/contents/made

[10] See for example the review of research evidence commissioned by the King's Fund and published in December 2010, *'Avoiding hospital admissions: What does the research evidence say?'*, http://www.kingsfund.org.uk/publications/avoiding_hospital.html

[11] http://www.kingsfund.org.uk/current_projects/gp_commissioning/ten_priorities_for_commissioners/acs_conditions.html

[12] King's Fund 2010, A pro-active approach: Health Promotion and Ill-health prevention, www.kingsfund.org.uk/document.rm?id=8743

[13] Royal College of General Practitioners 2007, Healthy People: Promoting health and preventing disease, http://www.rcgp-curriculum.org.uk/PDF/curr_5_Healthy_people.pdf

***Registering new patients for primary medical services***

51. Under the terms of their contracts GPs have discretion to accept applications to join their patient lists (either as fully registered or – for those in the area for more than 24 hours and less than three months – as a temporary resident) and to treat them without charge under the NHS. There is no minimum period that a person needs to have been in the UK before a GP can register them, and practices *can* accept someone living outside of the practice area. There is no legislation preventing a practice from registering any person, but under the Contract Regulations people leaving the UK with the intention of being away for at least three months should be removed from the list.

52. GP practices therefore have extensive discretion to register an overseas visitor either as a temporary resident or, if their stay is for more than three months, as a permanent patient. Indeed where a person is staying within the practice area and the practice list is not closed, practices have very limited discretion not to do so (because they can only refuse someone on reasonable, non-discriminatory grounds).

53. Where a GP refuses to register a person, that person can request that the PCT assign them to a provider of essential medical services. If approached in this way the PCT has no alternative to comply with this request. However, this information is not in the public domain and the Department does not routinely give this information out. The Department's current policy in relation to registering overseas visitors for primary medical services, as described in Box 4, was published as an information annex in the 2010 consultation on overseas visitor policy in relation to secondary care.

54. Prospective patients wishing to register with a GP practice must provide details such as name and address, date of birth, NHS number and previous GP if relevant. Some GP practices will also ask to see proof of identity (such as passport or driving licence) and proof of address (such as utility or council tax bill) [14]. This is not a legal requirement, and would only be considered non-discriminatory if asked of every person wishing to register. A GP practice should not refuse to register someone because they cannot provide proof – this would be unlikely to be considered 'reasonable grounds'. The BMA[15] advises practices to use their discretion and consider the individual circumstances of an overseas visitor who cannot provide documents that would normally be required for patient registration.

[14] NHS Choices, http://www.nhs.uk/chq/Pages/1095.aspx?CategoryID=68&SubCategoryID=158

[15] http://www.bma.org.uk/images/gpcoverseasvisitnhsprimarymedservfeb2011_v3_tcm41-204281.pdf

***Box 4: Current DH policy regarding the registration of overseas visitors for primary medical services[16]***

Those seeking registration with a primary medical care contractor do so by applying directly to the contractor (normally by attending the practice premises).

GPs are self-employed and have contracts with the local PCT to provide services for the National Health Service. Under the terms of those contracts, GPs have a measure of discretion in accepting applications to join their patient lists. However, they cannot turn down an applicant on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

Other than that, they can only turn down an application if the PCT has agreed that they can close their list to new patients or if they have other reasonable grounds.

In applying to become a patient of a particular contractor there is no formal requirement to prove identity or immigration status. However, there are practical reasons why a GP might need to be assured that someone is who they say they are. Consequently, it can help the process if a patient offers relevant documents. Many asylum seekers offer to show their 'Application Registration Card' (ARC) or official documents that confirm their status.

Where a patient applies to register with a general practice and is subsequently turned down the GP must nevertheless provide, free of charge, any immediately necessary treatment that is requested by the applicant for a period of up to 14 days (this can vary according to circumstances). There is no formal definition of 'immediately necessary treatment' within the GP's contract – we expect the doctor to exercise sensible professional judgement on a case-by-case basis.

Where a person has difficulty in registering for National Health services with a primary medical services contractor they should get in touch with their local PCT (directly or via the local Patient Advice and Liaison Services) to discuss what assistance might be available locally.

Under section 83 of the NHS Act 2006 the PCT has a duty "to the extent that it considers necessary to meet all reasonable requirements, exercise its powers so as to provide primary medical services within its area, or secure their provision within its area".

In fulfilling this duty the PCT must have regard to the Government's responsibilities under Human Rights Law, EU Law and other treaty obligations (such as reciprocal arrangements) as well as complying with relevant primary and secondary legislation, including any relevant directions issued by the Secretary of State.

[16] This was published as an annex for information in the 2010 DH consultation *'Review of Access to the NHS by Foreign Nationals'*, http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_113233

***Box 5: Significance of GP patient lists[17]***

The GMS and PMS Contracts Regulations place an obligation on PCTs to prepare and keep up to date a list of patients accepted by each GP contractor. This obligation will be transferred to the NHS Commissioning Board from April 2013.

GP patient lists form the basis for certain payments to GP contractors. Typically, at least half of the money that a practice receives is in the form of the 'global sum' paid under the GMS contract for core service delivery. Each quarter, the resources for England that are shared out are calculated by multiplying the total number of registered patients on GMS lists in England by the price per patient figure (£64.59 in 2010-11). Global sum payments to GMS practices in England in 2009-10 totalled some £1.7 billion.

GP registrations also feed into the calculation of PCT allocations, and will continue to be a key element in the allocations formula for clinical commissioning groups. In this context however patient list numbers are constrained to ONS population statistics to ensure that PCTs' total allocations are not over-funded as a result of inaccurate GP patient lists (therefore certain numbers of overseas visitors appearing on practice lists would be excluded). GP patient list numbers exceed ONS population data by some 2.5 million people[18].

Inaccurate lists reduce allocative efficiency and cause inequities in the funding of GP practices. Active list management by PCTs is essential to seek to maintain accurate GP patient lists through the removal of inappropriate patient records such as those for deceased patients, 'gone-aways' and duplicates.

The Audit Commission undertakes a regular National Duplicate Registration Initiative (NDRI). The 2009-10 NDRI resulted in the deduction of over 95,000 patient registrations, 10% of which were for asylum seekers registered on GP lists who had since been removed from the UK.

55. Given that GP patient lists form the basis for certain payments to GP practices, and that the global sum payment contains an element for temporary residents, GP practices appear to have an incentive to register overseas visitors, even those visiting for a short time. However it is feasible that the growing emphasis on maintaining accurate patient lists may moderate this incentive. A 2006 study in Newham[19] considered that

[17] http://www.dh.gov.uk/en/Healthcare/Primarycare/PMC/Funding/index.htm
[18] September 2011 written evidence from the DH Permanent Secretary to the Public Accounts Committee on the accuracy of GP patient lists, http://www.publications.parliament.uk/pa/cm201012/cmselect/cmpubacc/1502/1502we03.htm
[19] Newham PCT commissioned research from Imperial College's International Health Unit, *'The identification and charging of Overseas Visitors at NHS services in Newham: a Consultation'*, June 2006, http://www.lho.org.uk/Download/Public/11948/1/IHU%20Entitlement%20Report%2006.pdf

the use of primary medical services by temporary migrants has implications for practice targets, particularly under the QOF.

56. When presented with an overseas visitor patient who the practice deems able to pay, the incentive may be stronger for the GP practice to treat them on a private basis (and so receive a consultation fee, on market rates which might be from £30 - £60) rather than registering them on the practice list. GP practices would need to act with caution, and should not offer private treatment to a patient who wished to register as an NHS patient.

57. However it is plausible that some visitors in the country as holidaymakers would fully expect to pay for their primary care treatment. This can combine with GPs' own ethical viewpoints; anecdotal evidence from a GP in East London reported that local GPs hold firmly to the practice of providing free primary care to overseas visitors from less developed countries, but advising short-term tourists from wealthy nations to attend a private clinic.

58. Nevertheless, when patients are not treated privately but register for the first time with a GP practice, even as a temporary resident, they are likely to receive an NHS number. Even if GP practices wished to identify chargeable overseas visitor patients, there is no mechanism for them to record such identification on primary care patient records, even the Spine. Despite registration with a GP or having an NHS number being irrelevant for the question of entitlement to free NHS hospital treatment, a chargeable overseas visitor with a number is far more likely than one without to evade identification and access free NHS hospital treatment to which they are not entitled (see section on frontline implementation by NHS hospitals, below).

***Confusion, leading to inconsistent and inequitable practice***

59. There is strong anecdotal evidence of confusion among GP practices. In many cases this includes a prevailing, incorrect, belief that a person must be ordinarily resident in the UK in order to qualify for primary medical services. Calls to PCTs and DH reveal strong anecdotal evidence of GP practices either referring to the withdrawn Health Service Circular 1999/018 (see Box 6 below), or believing that Regulations exist governing the registration of overseas visitors for primary medical services. Although DH's 2010 consultation, *Access to the NHS by foreign nationals*, did not consider the rules relating to primary care, many respondents stressed the need for clear guidance from the Department of Health on the primary care entitlement issue.

***Box 6: Withdrawn guidance***

Health Service Circular (HSC) 1999/018, 'Overseas visitors' eligibility to receive free primary care' – was issued by the NHS Executive in February 1999. It covered all areas of primary care but clearly linked the question of eligibility for primary medical services with the concept of ordinary residence, stating that the NHS is primarily for the benefit of people who live in the UK so eligibility to receive free medical treatment should relate to whether a person is ordinarily resident. It also encouraged GPs to treat foreign nationals on a private, paying basis, stating: "it would be particularly appropriate to offer private medical treatment if it appears that the patient has come to the UK specifically to obtain treatment".

However, as the legislative powers to charge those not ordinarily resident for access to the NHS were never enacted for primary care, DH withdrew HSC 1999/018 when it was a decade old, amid concerns about its accuracy. However no formal statement was made and the Circular is easily found on the internet. The guidance has not been replaced, however the Department recently advised all SHA primary care leads of the correct position.

60. The current confusion and lack of clarity among GP practices is resulting in highly inconsistent approaches. Some practices are acting in a discriminatory way, or taking a more restrictive approach than that applicable in secondary care (e.g. refusing to register asylum seekers, when this group is entitled to free hospital treatment under the Charging Regulations).

61. There is evidence of GP practices attempting to identify whether patients are ordinarily resident as the deciding factor in whether to register them, and failing to register (or de-registering) patients who they believe to be 'ineligible' in some way. Solicitors and other groups representing migrants regularly take up cases of those refused access to a local GP practice and there have been several threatened judicial reviews of practices which have refused to register a person due to their immigration status.

62. A 2006 study looking at the charging of overseas visitors for primary care services in Newham[20] researched procedures employed for registering this patient group and the views of health care providers. The researchers conducted a survey which was completed by 92 doctors from 53 practices. 55% of respondent GPs reported "having systems in place to identify and charge overseas visitors requesting registration".

63. In July 2011 the medical weekly publication 'Pulse' reported[21] results of its survey of GPs on the issue of registering asylum seekers. 29% of the 290

[20] *'Charging Systems for Migrants in Primary Care: The Experiences of Family Doctors in a High-Migrant Area of London'*, Journal of Travel Medicine, 15: 13–18, http://onlinelibrary.wiley.com/doi/10.1111/j.1708-8305.2007.00161.x/full

[21] http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/12426580/gps-treating-asylum-seekers-unfairly-targeted-by-pcos

respondents said they restrict free access to care for asylum seekers and non-UK migrants, while one in four said guidance from their local PCT places restrictions on care. Two-thirds of GPs said they did not believe non-UK migrants should have access to NHS care. The same article reported information obtained from 85 Primary Care Organisations (PCOs) under the Freedom of Information Act. One in 10 PCOs said they would investigate GPs who decided to treat failed asylum seekers, with two PCTs claiming that GPs who "knowingly registered ineligible patients" would be investigated by counter fraud officials.

***Box 7: Registering those without leave to remain in the country***

The confusion and inconsistent practice in primary medical care is particularly rife when it comes to the issue of registering overseas visitors who do not have leave to remain in the UK.

In December 2011 'Pulse' reported[22] the case of a Nigerian family which registered with a GP practice in Essex. When the practice attempted to make a referral to the local hospital, the hospital wrote back saying the family were not here legally and were not entitled to treatment. The practice checked with UKBA, which confirmed that the family's application for asylum had been refused twice. After the family confirmed this, the practice removed the two adults, but not the children, from its list. Following intervention by human rights lawyers Pierce Glynn the PCT advised the practice to re-register the couple.

A briefing[23] by Pierce Glynn and the Migrants' Rights Network includes a case study based on the real circumstances of an undocumented migrant. 'Jane', 26 weeks pregnant and feeling unwell, was unable to register with a local GP and was told her details would be passed to the Home Office. The PCT supported the GP practice's stance, and said Jane could not access primary care unless she had 'leave to remain' in the UK for more than 6 months. Jane decided that she could not risk enforced removal from the UK, so avoided further contact with the authorities and give birth to her baby at home. The briefing concludes that the GP and PCT in this case acted unlawfully, and urges migrants' rights campaigners and advocates to make greater use of the law to ensure that GPs do not deny migrants access to primary care.

### *GPs' ethical concerns*

64. There is evidence of conflicting views among GPs – particularly fears that GPs might be expected to turn 'immigration police'. This issue was heightened following the Department's 2004 consultation on the introduction of overseas visitor primary care charging (see Box 8, below), which took place amid concerns about the introduction of identity cards.

[22] http://www.pulsetoday.co.uk/main-content/-/article_display_list/13234713/gps-forced-to-register-illegal-immigrants-after-threat-of-legal-action
[23] http://www.migrantsrights.org.uk/files/Access-to-Health-Care.pdf

The BMA's Annual Representative Meeting in 2005 approved the motion that it is not appropriate for medical staff to act as proxy immigration officers in seeking to determine the immigration status of people presenting for care and treatment[24].

65. Some suggest that charging overseas visitors for primary care undermines the ethical code underpinning the doctor-patient relationship,[25] which focuses on the primacy of patient care as well as trust and confidentiality. There are also fears (e.g. expressed in the BMA's responses to Government consultations on charging) that decisions regarding eligibility for care may be required to take place in the context of clinical consultation. The same concerns exist with regard to the secondary care charging rules, as described in the section on frontline implementation by NHS hospitals, below.

66. This overriding view that clinicians' sole concern should be for patient care is strong, however the BMA's opposition to charging still holds even if the process to determine a patient's chargeable status never impinged on the consulting room and was carried out only by practice administrators.

67. However, there are clearly conflicting views as the survey[26] referred to in paragraph 58 above suggests that a majority of GPs do not believe overseas visitors should have access to NHS care.

***Box 8: 2004 consultation on primary medical care***

In May 2004, the Department of Health consulted on proposals to introduce charging system for overseas visitors accessing NHS primary medical services[27], with rules aligned as closely as possible with those for hospital care.

The responses to the consultation were mixed, with both very strong support for tightening up the rules and strong support for allowing certain groups (e.g. asylum seekers, failed asylum seekers and undocumented migrants) to continue to have access to free primary care. The consultation highlighted a range of sensitive and difficult issues including asylum, migration, citizenship, public health, identity cards and equality, and Ministers failed to reach a decision on how to take it forward.

[24] British Medical Association Annual Representative Meeting, http://www.bma.org.uk/ap.nsf/Content/ARMAgenda05Wed (accessed March 2006 and as referenced in http://www.lho.org.uk/Download/Public/11948/1/IHU%20Entitlement%20Report%2006.pdf).

[25] See for example *'The duties of a doctor registered with the General Medical Council'*, http://www.gmc-uk.org/guidance/ethical_guidance/7162.asp

[26] http://www.pulsetoday.co.uk/newsarticle-content/-/article_display_list/12426580/gps-treating-asylum-seekers-unfairly-targeted-by-pcos

[27] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4082726

***Referring overseas visitor patients to secondary care***

68. GP practices act as both the gateway to and coordinator of patient access throughout their care pathway, and as such are the conduit for a significant proportion of the overseas visitors seeking secondary hospital care. Feedback from NHS Trusts and Foundation Trusts suggests there are real concerns that under current arrangements GPs are not acting as a *gateway or gatekeeper* to free secondary care services for overseas visitors, but as an open door. However GPs currently have no role or duty – or indeed incentive – to establish a patient's entitlement for free NHS secondary care treatment when making referrals.

69. The BMA's February 2011 guidance on overseas visitors accessing NHS primary medical services[28] advises GPs to avoid making any judgements about the likelihood of a patient being charged for secondary care and to refer whenever clinically appropriate. However the DH Charging Guidance for hospitals suggests hospitals encourage GPs to identify in their referral letters any patient whom they believe may be an overseas visitor. Many hospitals have built up successful arrangements with local GPs to that effect (though it remains the hospital's duty alone to establish entitlement.)

70. At the very least, it is helpful for GP practices themselves to understand that being registered with a GP, or having an NHS number, have no bearing on patients' entitlement to free NHS hospital treatment, and to inform patients on referral that they *may be* liable to charging for their hospital treatment. Improved co-ordination could avoid the current situation where secondary care providers tell us that chargeable overseas visitor patients regularly claim to be surprised when they are informed that they are required to pay charges, because no mention was made of this by their GP.

71. The lack of any role whatsoever for primary medical care to identify potentially chargeable overseas visitor patients, combined with the misconception that holding an NHS number entitles someone to free hospital treatment, is exacerbating weaknesses in the overseas visitor charging system.

72. The creation of Clinical Commissioning Groups (CCGs) could possibly present an opportunity of realigned incentives as CCGs will be directly responsible for commissioning budgets and commissioning services they consider appropriate to meet reasonable local needs. In the future GPs may be incentivised to identify chargeable overseas visitors and inform hospitals when making referrals as this would help hospitals to identify and charge overseas visitors, relieving pressure on the CCG commissioning budget.

[28] http://www.bma.org.uk/images/gpcoverseasvisitnhsprimarymedservfeb2011_v3_tcm41-204281.pdf

## Other primary care services

### *Prescription charges*

73. The power to introduce prescription charges dates back to the 1949 NHS (Amendment) Act – the same Act that introduced the power to charge those not ordinarily resident in the UK for NHS treatment. However, charges were not first introduced until 1952.

74. The current prescription charge arrangements are relatively straightforward to administer within the present infrastructure of around 11,000 community pharmacies in England. The NHS reimburses pharmacies for the cost of the drugs they dispense to patients, less any prescription charge they have collected. Pharmacies also receive a fee.

75. The number of items dispensed in the community in England rose from 886 million items in 2009 to 926.7 million items in 2010. The average number of prescription items per head in England was 17.8 in 2010.

76. The current prescription charge is £7.65 per item. The prescription charge is a flat rate charge that has no bearing on the cost of the item prescribed, or the cost to the NHS of dispensing the item. Patients are able to purchase a prescription prepayment certificate (PPC) covering a 3 or 12 month period. Prescription charges raise around £450 million a year from items dispensed in the community (includes prescription pre-payment certificate revenue).

77. If a patient is prescribed a drug or appliance the prescription charge rules apply and the person will be charged a prescription charge per item at the time dispensing takes place, unless they hold a valid exemption.

78. If a private prescription form is presented, the pharmacist can decide if they will dispense against the form and determine the cost to the patient of that transaction.

79. In 2009, 94% of prescription items were not charged for at the point of dispensing in the community. Most of this (around 90%) is due to prescribing to people exempt from prescription charges (but the percentage also includes items dispensed to patients possessing a PPC).

80. Exemptions cover three main groups: age, income and medical condition. The age exemptions do not require a declaration from the patient as the prescription form (in most cases) carries the patient's date of birth and/or age.

### *Overseas visitors' access to prescription charges and charge exemption*

81. In the absence of any overseas visitor charging rules in primary care, overseas visitors (assuming that they have been accepted on to a GP practice's list, either fully registered or as a temporary resident) are subject to the same rules as any other patient on the list with regard to prescription charges. If the patient is issued with an NHS prescription form, they pay the NHS prescription charge per item at the time dispensing takes place, unless they hold a valid exemption. This means, for instance, that anyone over 60 visiting from anywhere in the world, even for a short time, is entitled to a free NHS prescription.

82. In practice, it may be difficult for overseas visitors to access the non-age based exemptions. For example, overseas visitors are highly unlikely to be able to access free prescriptions through the benefits system. However they would be able to apply to the NHS Low Income Scheme or for a maternity exemption or a medical exemption certificate (assuming they had one of the qualifying medical conditions). We do not have data on the numbers of overseas visitors applying to these schemes, but it might be safe to assume the numbers are low, and short-term visitors in particular are unlikely to apply.

83. Unlike primary medical services, DH does not receive queries from pharmacists about entitlement where a person who is an overseas visitor has submitted an NHS Prescription form for dispensing. The Department receives the occasional query about whether prescription charges should apply to overseas visitors but – as noted above – this issue hinges only on whether the GP practice accepts the person onto the patient list.

84. It is unclear what the benefits would be of removing overseas visitors' coverage by NHS prescription charging rules, particularly if this entailed moving the responsibility for providing access to NHS prescriptions away from the GP.

### *General Ophthalmic Services*

85. General Ophthalmic Services (GOS) encompass NHS funded sight tests carried out by optometrists and ophthalmic medical practitioners, and the NHS optical voucher system.

86. Expenditure on NHS sight tests and optical vouchers is demand-led, driven by the numbers of eligible patients who visit their optician for NHS-funded sight tests and the numbers of optical vouchers issued as a result of the tests. Total GOS expenditure in 2009/10 was £467.6m (within this sum sight tests cost around £254m and optical vouchers around £209m).

### *NHS funded sight tests and optical vouchers*

87. Opticians who provide NHS funded sight tests currently receive £20.70 per test from their PCT. Eligibility for NHS funded sight tests is targeted at

specific groups. People can receive a free NHS funded sight test if the optician is satisfied that there is a clinical need and the person falls into one of the eligible groups relating to age, income and condition.

88. Some patients also receive an NHS optical voucher, which they can use to meet (in whole or in part) the cost of any glasses or contact lenses required. Eligibility for optical vouchers is targeted at those under 16 years of age, students, and those on low incomes. The optician who dispenses the glasses or contact lenses redeems the value of the voucher from their local PCT.

***Overseas visitors' access to General Ophthalmic Services***

89. Optometric contractors do have discretion to reject an application for a sight test but only where they have reasonable, non-discriminatory grounds. They are also required to satisfy themselves that the sight test is clinically necessary.

90. Given the lack of rules relating to overseas visitors' access to primary care, overseas visitors under 16 years of age are able to receive free sight tests and glasses on the NHS, and overseas visitors aged 60 or over can receive free sight tests. It is less likely that overseas visitors are able to meet the eligibility criteria related to the receipt of income support or similar benefits. And the optometrist can refuse an application if they are not satisfied that there is a clinical need for a sight test.

91. However, we have no data relating to the demand placed by overseas visitors on General Ophthalmic Services. DH receives occasional queries about entitlement, generally from contractors who believe that the former HC 1999/018 guidance still applies and therefore that 'ordinary residence' can form part of the eligibility criteria.

***Primary dental services***

92. As commissioners of local NHS health services PCTs identify need and agree levels of dental services with dental service providers. Patients seeking dental treatment find a dental practice with an NHS contract which is taking on new NHS patients. There is no requirement for patients to register with a dentist, nor are there any criteria (based on catchment or otherwise) that dictate which practice patients can attend.

93. Finding an NHS dentist taking on new patients continues to be an issue in some areas. According to the GP Patient Survey, nationally 92% of those who have tried to get an NHS appointment in the last two years say they have succeeded. However, when this is broken down to those looking for a new practice (i.e. those without an existing dentist) the percentage falls to 78%.

94. Dental treatment can be provided under the NHS where a dentist feels it is clinically necessary in order to maintain and improve a patient's oral

health. In England, primary dental care services make up the largest element of dental services, with total gross expenditure in 2010-11 of £2.8bn.

### *NHS dental charges and exemptions from charge*

95. Patient charges depend on the treatment needed. Patients pay one charge for each complete course of treatment – either Band 1 (£17), Band 2 (£47) or Band 3 (£204). If patients need to be referred to another dentist for another, separate course of treatment, they can expect a second charge. Some minor treatments are free.

96. Patients do not have to pay for NHS dental treatment if they qualify for exemptions broadly based on age and income.

### *Overseas visitors' access to NHS dental services*

97. Overseas visitors' entitlement to NHS primary dental services is as it is across primary care (i.e. there are no rules of entitlement), so overseas visitors are able to pay NHS charges to access NHS subsidised dental treatment. Overseas visitors meeting the above exemption criteria will be exempt from dental charges (though it is less likely that overseas visitors would be able to meet exemption criteria related to the receipt of income support or similar benefits).

98. Although dental treatment carried out at an NHS Hospital is exempt from NHS dental charges, the overseas visitor Charging Regulations supersede this. In these cases the hospital has a duty to identify patients who are not ordinarily resident in the UK, determine if they are exempt from charge and, where charges apply, charge for the costs of the NHS services and recover the cost.

99. There is no record of numbers of overseas visitors using NHS primary dental care services. The issue of whether they are entitled to access arises occasionally as a query to DH dental policy teams, but PCTs generally manage this issue locally and none has flagged to the Department that it is a concern.

100. It is considered unlikely that the existing problems relating to capacity / resources would be abated if overseas visitors were unable to access NHS dental services or were charged at a rate separate from the existing NHS patient charge rates for accessing for NHS dental services.

## UK expatriates

101. As discussed earlier, only those ordinarily resident in the UK are automatically entitled to free NHS hospital treatment, and there is no link between a person's contribution to funding the health system and their access to services. This has particular consequences for British expatriates settled in other countries, and others who have a right to permanent residence but who no longer live here.

102. Research on British expatriates[29] has found there to be 5.6 million British nationals living overseas permanently – with around another 500,000 living abroad for part of the year. The biggest ex pat populations are in Australia (more than 1 million), Spain, the US, Canada and France. British emigrants tend to move abroad primarily to work, but an increasing number of British pensioners are living abroad – 9.2% in 2009. Many ex pats stay overseas for relatively short periods, with more than half of Britons returning in 2008 having been away for only one to four years.

103. We estimate that, at any moment in time, there are up to 100,000 ex pats visiting England, of whom around 15,000 are UK state pensioners. As such they feature significantly among chargeable overseas visitors.

### Current rules

104. The Charging Regulations specifically disregard any period of temporary absence of up to 182 days. This means UK residents who spend significant chunks of the year abroad can be absent for up to six months before they risk being chargeable for hospital treatment. This period was increased from three months as part of the changes made to the Charging Regulations in 2011, in recognition of increased mobility.

105. In addition, there is an exemption category for those taking up permanent residence in the UK, which includes ex pats returning from abroad to resume permanent residence. We estimate that in addition to the visiting ex pats mentioned above, around 75,000 ex pats each year return to take up residence in England.

106. Ex pats can also qualify for more than 10 of the 33 other exemption categories in the Charging Regulations. The most likely are:

- UK state pensioners living abroad, who have previously lived in the UK for at least ten years, can receive free treatment for needs arising during any temporary visit to the UK, but not for existing conditions or elective needs;

[29] IPPR's 2010 report *Global Brit: Making the most of the British diaspora,* http://www.ippr.org/images/media/files/publication/2011/05/Global%20Brit%20summary_1783.pdf

- Anyone who has lived legally in the UK for 10 continuous years but now works (or is self-employed) abroad is exempt from charges, including elective free treatment, during their first five years away;
- Crown servants, HM armed forces, or anyone working abroad in a job financed by the UK Government is exempt from charge on return visits.
- Ex pats who have lived legally in the UK for 10 continuous years and now live in the EEA, or in non-EEA countries which have a reciprocal healthcare agreement in place with the UK can receive free treatment for needs arising during their visit (and such other care as covered by the terms of the agreement).
- In addition, former UK residents living and insured in the EEA have the right under EU Regulations to receive all clinically necessary healthcare when they visit the UK on production of their European Health Insurance Card (funded by the other EEA State).

107. Ex pats who cannot benefit from an exemption in the Charging Regulations are required to pay for most NHS hospital services when they return to the UK on short term, or even longer-term, visits.

108. As mentioned earlier in this review, the concept of 'ordinary residence' has no relevance in primary care, but under the Contract Regulations people leaving the UK with the intention of being away for at least three months should be removed from GP patient lists. There is a strong focus on removing inappropriate patient records such as 'gone-aways' from patient lists to reduce inequities in funding GP practices. However, an ex pat who manages to stay registered with their GP – contrary to the Contract Regulations – could access prescription drugs during short-term visits, or even referred care.

**Ex pats' views**

109. The rules for ex pats are longstanding and clearly articulated, but are either not widely known, or where understood, deeply controversial among those affected. It is clear (from correspondence and ex pat forums online) that many ex pats strongly believe that they should have a right to access NHS services for free, because of their previous tax and national insurance contributions. Some may in fact still be contributing to funding the NHS through their liability to UK tax on their pensions, other personal income or assets. Box 9 below contains an extract from correspondence received by DH in the last few months – the views expressed are not uncommon.

***Box 9: Common ex pat views expressed in recent correspondence***

"Retired British citizens who opt to live outside the UK for more than six months of the year are denied all but emergency service from the NHS if we visit the UK. This, despite the fact that we have paid our National Insurance contributions in full until retirement and, in my case, despite the fact that I continue to pay UK tax at normal rates. […]

"Despite paying NI all my life, the obvious solution would be that I pay again by taking out healthcare insurance here [in Turkey]. However, as I am over 65 years old with pre-existing health problems, I am unable to obtain any kind of private health insurance. Thus, like many others here, I am obliged to pay privately for all my medical care and medication. [This] is extremely expensive and will most likely erode my modest savings over time. […]

"In short, we are worse off than Turkish nationals here, and much worse off than either Turkish nationals living legally in the UK (for whom health care is free of course) and normal British citizens in the UK. In view of this, I wonder if you can appreciate why many of us here feel rather let down by our country? […]

"What feels so unfair is that treatment is denied to British citizens who have contributed fully to the NI scheme and, in many cases, still pay UK tax, simply on the basis of where they choose to live. It would not be an exaggeration to say that many of us feel like we are being "punished" for not residing in the UK. […]

"How does the British government justify regarding people like me as "resident" when it comes to liability for UK tax and apparently "non resident" when it comes to access to health services?"

**Key issues**

110. There is anecdotal evidence, from NHS overseas visitor managers (OVMs) and other sources, of chargeable ex pats returning to access NHS healthcare, including maternity services – in effect this is 'health tourism'.

111. Trusts can experience difficulties in identifying chargeable ex pats at the frontline. Many are able to hide their true residential status, particularly if they retain property or have other domestic links to the UK. They may also claim to be returning permanently to the UK. OVMs highlight major problems with this group, telling us that ex pats can be among the most difficult and hostile patients to approach to discuss charging issues. These issues sometimes lead OVMs to take the patient's word at face value.

112. As a result, although difficult to quantify, it is likely that the NHS is funding, to a significant extent, the healthcare of ex pats who are not entitled to access the NHS for free.

113. In the case of UK state pensioners the burden may be exacerbated. This is because the UK already statutorily funds the provision of healthcare for its state pensioners who reside permanently in another EEA country. If this group accesses free treatment on a visit to the UK we are in practice paying twice for their healthcare.

**Conclusion**

114. Many ex pats are angry that they are not entitled to something which they feel they paid for throughout their working lives. The perceptions and consequent behaviour of ex pats, combined with the difficulties in identifying them, results in a financial burden to the NHS. However, any relaxation of the rules relating to ex pats' entitlement to free NHS care would be contrary to the fundamental residency basis of the NHS. The counter argument is that the current rules are unfair in the case of ex pat retirees who may be net contributors to the NHS.

## Undocumented migrants

### Introduction

115. Failed asylum seekers' entitlement to free NHS treatment was one of the main issues explored as part of the previous DH / Home Office limited review of overseas visitor charging policy. The agreement reached at the time was that only State-supported failed asylum seekers would be given access to free NHS secondary care. That review did not consider other categories of undocumented migrants, or any broader issues relating to this group.

116. This comprehensive review of the overseas visitor charging system therefore needs to consider the specific challenges posed by the undocumented (or irregular) migrant population, who are present in the country in significant numbers.

### Undocumented migrant populations

117. Undocumented migrants are broadly defined as anyone who is present in the country without residency rights or lawful residency status. This does not include asylum seekers or registered refugees, who have lawful right to remain (and are covered by an exemption under the Charging Regulations) while their applications to remain and any appeals are live. It does however include:

- Failed asylum seekers whose full appeal process has concluded unsuccessfully. A small number – those covered by Section 4 or Section 95 of the Immigration and Asylum Act 1999 – may retain lawful status (and qualify for exemption from charge under the Charging Regulations);
- Trafficking victims forcibly brought to this country, mainly for either sexual exploitation, slavery, servitude or forced labour. A small number may attain lawful status – and be covered by an exemption from charge under the Charging Regulations – through a decision by UKBA or the UK Human Trafficking Centre;
- Economic migrants who have entered the country illegally or who have overstayed their visa, and who maintain independent economic status through work;
- Other vulnerable groups, including those with debts arising from their transit to the country, who are often destitute or below poverty and subsistence levels due to their living circumstances.

118. In the main these are not formal categories and there can be overlap between them. For obvious reasons, there is no reliable formal data on the size of the undocumented migrant population in total or by sub-group. Several studies have however calculated estimates in recent years. These vary considerably – between 270,000 and 670,000 present in the UK in the studies we considered for this review (for details see section on

analysis of the overseas visitor charging system). Based on this, we take around 500,000 to be a good estimate of the number of undocumented migrants present in England at any one time.

**Undocumented migrants' entitlement to NHS care**

119. *YA v Secretary of State for Health* in 2009 considered whether asylum seekers and failed asylum seekers could be considered ordinarily resident in the UK. The Court of Appeal found that they were not. As case law has determined that undocumented migrants cannot be considered ordinarily resident, they should be charged for most NHS hospital treatment unless they are otherwise covered by an exemption under the Charging Regulations.

120. The Charging Regulations were amended in 2008 to exempt victims or suspected victims of human trafficking whose status has been confirmed. However this exemption may pose a high bar and some trafficking victims will therefore remain chargeable – see Box 10.

***Box 10: Specific issues relating to human trafficking victims***

The crime of human trafficking is associated with significant health risks, including in some cases extreme physical, psychological and sexual violence. Evidence suggests that most trafficking survivors emerge from a trafficking experience with a range of health care needs, many of which are acute and require immediate treatment.[30]

Only those identified as victims or suspected victims (whilst investigations are continuing) by the UKBA or UK Human Trafficking Centre (UKHTC) – the competent authorities for the purposes of the Convention on Action Against Trafficking in Human Beings[31] – are exempt from hospital charges under the Charging Regulations.

Although a proportion of trafficked people may opt to make themselves known to law enforcement staff, there are concerns that a significant number choose not to present themselves and are not willing or able to be in contact with UKBA or the UKHTC.

121. The Regulations were amended again in 2011 to exempt from charge failed asylum seekers who are receiving support from the UKBA (under Section 4 or Section 95 of the Immigration and Asylum Act 1999[32]) whilst

[30] Zimmerman, C., et al., The health risks and consequences of trafficking in women and adolescents. Findings from a European study. 2003, London School of Hygiene & Tropical Medicine and the Daphne Programme of the European Commission: London.
[31] http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=197&CM=1&CL=ENG
[32] http://www.legislation.gov.uk/ukpga/1999/33/pdfs/ukpga_19990033_en.pdf, Section 4 support is available for those who are taking all reasonable efforts to leave the UK and where there is a genuine recognised barrier to leaving, such as being unable to obtain a passport. Section 95 support is available for those asylum seekers who would otherwise be destitute,

there are recognised barriers to them leaving the UK or because they have families.

122. Even after taking these exemptions into account, undocumented migrants are the largest category of chargeable 'visitor' and account for around half of those who are chargeable under current rules. NHS hospitals identifying this group have no option but to make and recover charges from them.

123. As described earlier in this report, there are no separate rules of entitlement for overseas visitors in primary care so GPs are able to register any person for primary medical services, irrespective of their immigration status. They also have the discretion to refuse registration but only on reasonable, non-discriminatory grounds[33]. There are no charges for primary medical services other than in respect of prescriptions.

**Access to healthcare**

124. Despite all being entitled to register with a GP and receive free primary medical services regardless of immigration status, evidence suggests that access among migrant communities is low. Two separate surveys, each of around 700 migrants, found that around half had registered with a GP[34]. In reality undocumented migrants may face barriers such as discriminatory decisions by GP practices (see earlier section on primary care), the migrants themselves wrongly assuming that they are not entitled to access primary care, or not approaching practices for fear of disclosure to the authorities. This is in addition to the obstacles affecting the migrant population as a whole, such as a lack of awareness of the role of primary medical services, and language and cultural barriers.

125. As discussed above, undocumented migrants are required to pay for the majority of NHS hospital services. This in itself is likely to create some level of deterrent effect as evidence suggests that undocumented migrants face poor living and working conditions[35] and have few resources to pay.

126. Undocumented migrants may also be deterred from accessing secondary healthcare for fear of disclosure to the authorities. In fact, when NHS bodies become aware that a patient may not have proper authorisation to be in the country they may face a decision as to whether they should report the suspected immigration status without the patient's permission. The NHS should not share patient information with third

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and for families with children under 18, this support usually continues if the asylum application and appeals have been refused.

[33] They cannot turn down an applicant on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

[34] As reported in the December 2011 National Institute of Economic and Social Research study commissioned by the Migration Advisory Committee http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/workingwithus/mac/27-analysis-migration/02-research-projects/impact-of-migration?view=Binary

[35] International evidence as reported in Hargreaves et al (2006), "The identification and charging of Overseas Visitors at NHS services in Newham: A Consultation. Final Report"

parties without the patient's consent except where they are required to do so by law or there is an overriding public interest to do so, e.g. where the police are investigating a serious crime. DH guidance advises that an immigration offence is not, in itself, usually considered a serious crime in this context. In addition, the public interest argument for reporting the patient's immigration status needs to be weighed against the competing interests of protecting patient confidentiality and wider public health considerations.

127. All hospital maternity and obstetric services including delivery are chargeable. DH guidance makes clear that all maternity services, including routine antenatal treatment, must be treated as being immediately necessary which means no woman should ever be denied, or have delayed, maternity services due to charging issues. However, there is some limited anecdotal evidence of NHS Trusts delaying suspected undocumented migrant women's access to maternity services. There is some evidence of late presentation of pregnancy among migrants who have not registered with a GP[36].

128. A common concern raised by migrant support groups is that undocumented migrants have no alternative to the NHS for their healthcare needs. Partly in response to this issue Médecins du Monde UK established Project: London[37]. Through the project volunteer doctors and nurses provide free basic healthcare to vulnerable people in London (including migrants, whatever their status) who have difficulty accessing mainstream NHS healthcare services.

**Individual and public health issues**

129. Evidence is mixed around the health needs of undocumented migrants. Some studies suggest that undocumented migrants have higher than average health needs due to typically poorer living conditions and limited income. They may arrive from less-developed countries with higher rates of infectious diseases and less-developed healthcare systems. Tuberculosis is of particular concern among these communities (for public health reasons TB is included in the list of exempt treatments under the Charging Regulations). Undocumented migrants may live in cluster communities with poor living standards, which can increase the spread of communicable diseases. The practical issues relating to undocumented migrants' access to GP services mean that immunisation programmes can be compromised. And as shown above, there are particular health problems associated with trafficking victims.

130. However Médecins du Monde UK found that the health conditions seen in migrants accessing Project: London services broadly reflected those seen among the general population in GP clinics, with patients requiring primary care or antenatal services rather than expensive specialist

[36] Steventon and Bardsley 2011, 'Use of secondary care in England by international immigrants', *Journal of Health Services Research and Policy,* Vol. 16.
[37] http://www.doctorsoftheworld.org.uk/projectlondon/

treatment[38]. Illegal economic migrants with regular work and income will predominantly be a younger and healthier cohort than the average UK resident. A National Institute of Economic and Social Research (NIESR) study[39] looked at migrants' demands on education, health and social care services, and concluded that non-European economic and student migrants impose costs on these public services that are small both relative to the total cost of these services and to the share of these groups in the population as a whole.

131. One study[40] researched hospital admissions of international migrants and found that recent migrants were more likely than others to have had a hospital admission, but the research does not distinguish between groups of migrants. The study's overall conclusion was that the assumption that international immigrants use more secondary care than the members of the indigenous population appears to be unfounded.

132. Nevertheless, the overall health needs of undocumented migrants are higher than for short-term visitors by virtue of them being here indefinitely.

**Implications for the NHS**

133. The requirements to provide urgent and immediately necessary treatment regardless of a patient's ability to pay, but to then hold and account for the resulting debts from unpaid charges, is resulting in a burden to the NHS and affecting Trusts' bottom lines. Many of these issues arise from the treatment of undocumented migrants. Hospitals also incur additional administration charges through the usually futile process of screening, charging and attempting to recover debts from undocumented migrants.

134. Migrant support groups and others such as the BMA argue that the barriers relating to undocumented migrants' access to timely healthcare can result in these groups being treated once symptomatic in A&E departments and them receiving only treatment to stabilise rather than cure their condition. They argue this could facilitate the evolution of drug resistant infections and place additional demands on the NHS overall[41].

**Migration policy**

135. The government has a clear objective to tighten up the immigration system, stop abuse and support only the most economically beneficial migrants. As a result it expects that net migration will reduce to the tens of

[38] Project London: Report and Recommendations 2007, http://www.doctorsoftheworld.org.uk/lib/docs/104524-report2007light.pdf
[39] The study, 'Analysis of the Impacts of Migration' was conducted for the Migration Advisory Committee, an NDPB sponsored by UKBA, which advises the government on migration issues. http://cream-migration.org/files/MAC_report_jan2012.pdf
[40] Steventon and Bardsley 2011, 'Use of secondary care in England by international immigrants', *Journal of Health Services Research and Policy,* Vol. 16.
[41] See for example http://www.migrantsrights.org.uk/files/Access-to-Health-Care.pdf

thousands in the near future. The need to control and reduce inward migration to the UK means that the Home Office wishes to discourage many categories of migrants from coming to the UK or remaining here. This is particularly the case for those in the country illegally, and the UKBA is working for the removal and voluntary return of such groups[42].

136. The Home Office is concerned that the provision of high standards of healthcare may attract new migrants to enter the country unlawfully, or discourage them from leaving when their right to stay has expired.

137. There are no legal requirements for EU Member States regarding the provision of healthcare to undocumented migrants[43], so as a result there is nothing preventing Member States from using healthcare as an instrument to serve migration control purposes[44].

138. The issue of undocumented migrants accessing public benefits including healthcare is also the subject of deeply held concerns by large sections of the public, and can undermine public perceptions of the effectiveness of migration control policy.

139. Most if not all European and North American countries face similar dilemmas and have adopted differing approaches – see Annex I for the paper on international healthcare systems, which gives an overview of these.

**Conclusion**

140. There is a fluid but, in effect, permanently resident group of around half a million people in England who have in practice limited access to primary care, are not entitled to free NHS hospital care and who are unable to pay incurred charges. The circumstances and health needs of this group are distinctly different from other chargeable visitors. They are in the main not able to insure or otherwise provide for healthcare costs, and in the main have no alternative to the NHS for essential healthcare needs. This results in a burden on the NHS and some risks to individual and public health.

141. There are directly competing issues and concerns. On the one hand, proactive and managed provision could have a positive impact on public health and limit NHS costs overall. But on the other there are strong public and political concerns about providing taxpayer-funded healthcare to people who have no right to be in the country, and who may be incentivised to stay as a result.

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[42] See for example UKBA business plan: http://www.ukba.homeoffice.gov.uk/sitecontent/documents/aboutus/uk-border-agency-business-plan/business-plan/ukba-business-plan?view=Binary

[43] The International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families, which protects the rights of all migrants irrespective of administrative status, has not been ratified by any member of the EU.

[44] As noted in the 2009 study by the HUMA (Health for Undocumented Migrants and Asylum Seekers) Network, 'Access to healthcare for undocumented migrants and asylum seekers in 10 EU countries', http://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf

## Frontline implementation

- The Charging Regulations place a legal obligation on hospitals to identify patients who are not ordinarily resident, charge those liable to pay, and recover those charges.
- The process of screening all patients at the point of admission to determine their eligibility status has significant weaknesses, and imposes comes with significant costs and bureaucracy for Trusts.
- The most significant problem is the fundamental financial disincentive to identify and charge visitors. In effect Trusts are expected to turn down the guaranteed commissioner funding source, incur administration costs in identifying overseas visitors, and rely on full recovery from the patient to cover their costs.
- We estimate that Trusts identify on average between 30% and 45% of chargeable overseas visitor income, and estimate that the total cost of Trusts' frontline implementation of the overseas visitor charging system may be more than £18m.

### Introduction

142. The rules governing the overseas visitors charging system (discussed in the previous section) are a key determinant of the number of chargeable overseas visitors that might enter the NHS. But it is the application of those rules by Trusts and their identification of chargeable overseas visitors that is the biggest determinant of the number of visitor patients actually charged for treatment.

143. This section of the review therefore focuses on NHS bodies' steps under the current charging rules to identify and charge overseas visitors, and looks at some of the issues and barriers faced. Further analysis relating to frontline implementation of the overseas visitor charging system can be found later in this review, including the cost of administering the system and detail of our estimates of the number of overseas visitors not identified by frontline processes.

### NHS bodies' obligations

144. The Charging Regulations place a legal obligation on relevant NHS bodies in England to:

- ensure that patients who are not ordinarily resident in the UK are identified;
- assess liability for charges in accordance with the Charging Regulations;

- charge those liable to pay in accordance with the Regulations; and
- recover the charge from those liable to pay.

145. This is not optional, and NHS bodies have no authority to waive charges once they have been found to apply. NHS bodies can seek help and advice from DH, but the ultimate decision on whether a patient is liable for charges is theirs alone.

146. Most NHS Trusts employ at least one Overseas Visitor Manager (OVM) to oversee the implementation of the charging regime across all Hospital departments – something strongly encouraged by DH guidance.

147. The Department of Health has produced comprehensive guidance[45] to assist NHS bodies in their implementation of the Charging Regulations, yet the Overseas Visitors helpdesk receives a significant number of calls and emails from hospitals experiencing confusion or difficulties.

**Weaknesses in identifying potentially chargeable overseas visitors**

148. Trusts have an incentive to resolve swiftly the question of whether a patient is ordinarily resident, because if they are classed as such then the Charging Regulations are in no way applicable. But as discussed earlier, the vagueness of the definition means that there is often no quick way to determine ordinary residence. In order to eliminate the vast majority of patients definitely not liable for charges DH guidance advises the use of two baseline questions framed around an exemption in the Charging Regulations, for persons who have resided lawfully for 12 months immediately prior to treatment:

> "Are you a UK/EEA/Swiss national or do you have a valid visa or leave to enter/remain in the UK?"
>
> and
>
> "Which country or countries have you lived in during the last 12 months?"

149. The overseas visitor charging system requires Trusts to identify a small minority of patients who are not ordinarily resident and, of those, the tiny minority who are not covered by an exemption in the Regulations. But to do this lawfully Trusts must act in a non-discriminatory way. DH guidance advises that it is not discriminatory to ask someone if they have lived lawfully in the UK for the last 12 months as long as Trusts can show that all patients – regardless of their address, appearance or accent – are asked the same question when beginning a course of treatment.

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45 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127393

150. The multiple points at which a patient can be brought into contact with a hospital – during pre-admission assessment or screening, attendance as an outpatient, admittance as a day patient or an inpatient, or on presenting at A&E[46] – are all occasions to ask the baseline questions. And because patients' status can change, the questions should be asked every time a patient begins a new course of treatment.

151. Registration staff should request supporting evidence of residency (such as housing contracts, tenancy agreements, utility bills, and bank statements) and evidence of lawful residence (proof that they are a UK/EEA/Swiss citizen, have valid leave to enter/remain, valid visa). The guidance strongly recommends that Trusts include a pre-attendance form with appointment letters to inform patients that they will be asked to provide certain pieces of evidence, and the reasons for this. Any patient unable to provide evidence should be referred to the OVM for further investigation. Information from baseline questioning should be entered onto the Trust's records – usually the hospital's Patient Administration System (PAS), which underpins the patient journey.

152. A 2007 survey of OVMs highlights cause for concern about registration practices (see Box 11 for more from the survey). 72% of respondent OVMs reported that their Trust's PAS did not have mandatory fields for entering responses to baseline questions. The survey also asked OVMs whether, based on their knowledge and experience, their Trust's admissions staff asked patients the two baseline questions[47]. 40% of respondent OVMs said admissions staff asked the first baseline question 'not very often' or 'not at all', with 67% of respondents claiming the second baseline question was asked 'not very often' or 'not at all'. And if a patient stated that they had lived in the UK for the last 12 months, almost 58% of respondents said admissions staff never asked for evidence to support this claim.

153. We asked the same questions again in our recent survey conducted for this review. Compliance appears similar or worse than in the 2007 survey – 65% responded that the baseline questions are never or not very often asked and 50% said that frontline staff never ask for evidence. The fact that compliance is not above 2007 levels confirms that Trusts do not comply fully with the guidance – this may not be surprising given its non-statutory footing.

154. The failure to comply with guidance around baseline questioning suggests that Trusts are not identifying many overseas visitors. Our best estimate is that Trusts identify between 30% and 45% of potential overseas visitor income.

[46] Although for many A&E admissions the patient will obviously need treatment ahead of entitlement checks taking place.

[47] The DH guidance recommended slightly different baseline questions at the time of the survey: 'Where have you lived for the last 12 months?', and 'Can you show that you have the right to live here?'

155. One factor limiting identification of potentially chargeable overseas visitors is that although DH guidance makes clear that being registered with a GP or holding an NHS Number have no bearing on a patient's eligibility for free hospital treatment, we know from OVMs that there is a widespread perception among frontline staff – and some OVMs themselves – that they are linked.

156. Linked to this is the fact that there is little evidence of PCTs holding Trusts to account for their implementation of the overseas visitor charging system. Trusts tell us that commissioners are highly likely to challenge invoices for patients where there is no record of an NHS Number, but PCTs would only realise that a chargeable overseas visitor is being 'passed through' the system as a resident if they see evidence of this – such as an overseas address – in invoicing or PAS documentation. If the chargeable overseas visitor patient is recorded incorrectly, or if identification is not undertaken then the chances of reprisal are practically nil.

157. Asking the baseline questions and evidencing responses is clearly pivotal, so the failure of Trusts to fulfil this aspect of their duties is posing significant risks to the integrity of the charging regime (note however that our survey did not suggest that compliance with baseline questioning is a predictor of the amount of income identified by Trusts). But in a busy acute environment with registration staff under pressure – to register a patient quickly and accurately, ensure they have an NHS Number etc – the temptation may be strong to take a patient's word as evidence enough.

**Bringing potentially chargeable overseas visitor patients to the OVM's attention**

158. In all cases where baseline questioning suggests a patient may not have lived in the UK lawfully for 12 months, registration staff should refer the patient for an interview with the OVM – wherever possible before treatment begins. Again, the 2007 survey of OVMs indicates risks. Only 37% of respondent OVMs said that patients who stated that they had <u>not</u> lived in the UK for the last 12 months were referred to the overseas visitors staff 'every time'. Our recent survey conducted for this review suggests that 45% are referred to the OVM (see section on Analysis of the overseas visitor charging system for further detail).

159. There is much anecdotal evidence however that Trusts are employing additional techniques to get around the weaknesses in admissions processes and ensure they identify chargeable overseas visitors. Many OVMs personally check the PAS for patients with overseas addresses, and run reports of patient admissions to weed out and investigate patients who have registered with a GP in the last year. Some OVMs tell us that in the absence of rigorous admissions processes they rely on ward staff involving them when they suspect a patient may be liable to charges. This is problematic as such practices are inherently discriminatory – they do not apply to all patients, and mean a chargeable white British expatriate is

more likely to evade detection than someone whose appearance suggests they may be an overseas visitor.

160. Having said that, the success of the charging regime does rely on staff being aware and supportive of the role of the OVM. There are many examples of good practice where OVMs have taken steps to educate others. But there are other examples of OVMs struggling to get others on board, as explained by two respondents to the 2007 OVM survey: "there is an attitude of "I'm far too busy to do this as well as my own job""; and "clinical staff belief that patient care should not be compromised (patients may discharge themselves if they have to pay)".

***Box 11: OVMs' perspective***

In 2007 the NHS Counter Fraud and Security Management Service (now NHS Protect) conducted a survey of OVMs. The survey was issued to all Trusts providing secondary care services with the aim of obtaining a national picture of the fraud risk of chargeable overseas visitors. 42% of acute Trusts and acute Foundation Trusts in England responded.

As part of the survey OVMs were asked about some of the barriers and difficulties they face in implementing the overseas visitor charging rules:

- "It is […] difficult to ensure that all departments in the hospital follow the Regulations as it does not directly affect them and they are concentrating on other issues that have targets attached to them. There are also barriers from clinical staff who are not interested in money or the requirement to charge overseas visitors and just want to provide the care patients need."

- "There are [so] many loopholes and exemptions that it is very difficult to identify if a patient should be chargeable. Many of the overseas visitors are more aware of the system and the rules than NHS staff are and how to find a loophole."

- "Some patients know exactly the right answers to give to slip through the system and be treated as a free NHS patient. Others use the addresses and GP details of their relatives or sponsors."

- "Regulations are complex and many cases need extensive investigation to ensure the information is correctly interpreted. There is a lack of timely support from external agencies to help trusts".

**Investigating potentially chargeable overseas visitor patients**

161. When OVMs interview potentially chargeable visitors they must establish whether the patient is in fact ordinarily resident, despite not living in the UK for 12 months. Trusts need to make their own judgement about whether a patient is ordinarily resident – but this is not a simple matter. A person who has the right of abode or who has been given leave to remain

and has an identifiable purpose for being in the UK may not meet the "settled" criterion if they are only here for a few weeks. Alternatively, someone may be here legally, for several months, but with no identifiable purpose.

162. If the interviewer decides the patient is not ordinarily resident, the patient is classed as an overseas visitor and it must be established if one of the multiple exemptions listed in the Charging Regulations applies. This process can be onerous as rather than making a positive decision that a patient is chargeable, OVMs should consider and rule out each exemption. The process is highly bureaucratic and time-consuming as OVMs must seek and retain evidence supporting their decision either way (classification as chargeable or as charge-exempt[48]).

163. OVMs tell us that they struggle daily with how to apply the exemption categories when they do not harmonise with an easily demonstrable piece of information such as a particular visa (or indeed the payment of taxes or National Insurance contributions). For several exemption categories, it is difficult for OVMs to determine or prove that a person is indeed exempt in the way that they claim, often due to insufficient evidence from the patient or their circumstances being less usual than the draftsperson of the Charging Regulations might have envisaged.

164. And too often, whether a person is exempt is subjective – is a student who is irregularly attending their course due to pregnancy or health needs really in the UK for the purpose of studying? Is a person claiming to be here to take up permanent residence in the UK really doing so if they apparently had no property or goods to sell overseas and are now staying with family in the UK?

165. The identification of chargeable overseas visitors relies on the patient providing accurate information, but there is little incentive for chargeable visitors to volunteer their full circumstances. Many OVM respondents to the 2007 survey reported patients' non-co-operation as a key barrier.

166. Similarly, it may be important for an OVM to establish the immigration status of a person. Hospitals can use a UKBA secure email service, but only after obtaining the patient's informed consent (which again they may be unwilling to provide). And OVMs state that the UKBA's aim to respond in 10 days is not timely enough for their needs.

167. Trusts are only allowed to share [non-medical] information with third parties without the patient's consent when it is for the purpose of collecting debts owed to the NHS. And if a Trust becomes aware that a patient has overstayed their visa or is otherwise here illegally, their obligations around patient confidentiality mean they are highly unlikely to report the patient's suspected immigration status without the patient's permission.

[48] Charge-exempt overseas visitors (CEOVs) must be recorded separately as data on CEOVs is reported to PCTs and on to DH in order to inform the following year's PCT allocation exercise – see system map in Annex H.

168. In cases where a patient refuses to give their permission to contact UKBA and has not provided valid evidence to support a claim to be living lawfully in the UK, Trusts should levy a charge. However the incentives may be stronger not to do so (see below)

**Resourcing the administration of the overseas visitor charging regime**

169. Resourcing the administration of the charging regime appears to be spread thinly, and there is strong variation across Trusts. In our recent survey of NHS Trusts, the average Trust employs about 1.8 full time equivalent (FTE) OVMs. We estimate there to be around 350 FTE members of OVM staff in the NHS.

170. It is common for OVMs to be responsible for other duties (e.g. private patient administration). As OVMs work standard office hours they are not available to conduct interviews on many occasions when registration staff or clinicians identify potentially chargeable patients. The overseas visitor charging regime relies on the OVM undertaking a face to face interview, which means they have to travel between different hospital sites (74% of respondents to the 2007 OVM survey said their Trust had more than one site). OVMs tell us they can experience unproductive downtime waiting at wards for a patient to be well enough or willing to be interviewed.

171. There is anecdotal evidence from Trusts that increasing investment in OVM capacity results in greater identification of chargeable overseas visitors. However, as this is accompanied by an increase in unrecovered costs and liability on Trusts' bottom lines, it is clear to see that the incentive is strong for Trusts not to invest heavily in OVM staff.

**Costs of implementing the overseas visitor charging system**

172. Trusts incur costs in their frontline implementation of the overseas visitor charging system. In addition to the employment of OVMs there is the frontline staff time spent on screening patients to identify overseas visitors, and additional admin costs linked to charging (sending invoices and follow-up letters etc). We estimate that the total cost of employing OVMs in the NHS may be up to £17m and that the value of staff time lost in screening patients may be more than £1m. This reflects the current less than universal commitment to providing necessary resource to fulfil statutory duties in respect of charging in hospitals only.

173. In order to identify a small number of people who are chargeable, the overseas visitor charging system overlays a bureaucratic system which should involve the questioning of every single person presenting at a hospital. This is different from other countries where the nature of the national healthcare system involves an element of automatic entitlement checks for all patients or may involve the presentation of a medical card or the processing of co-payments, where infrastructure and economies of scale already exist.

174. It is not clear whether the OV charging system is generating a net benefit to the NHS or whether the costs of operating it outweigh the income generated.

***Box 12: Link between overseas visitor charging system and EEA revenue***

As described earlier the UK has a statutory duty to refund other EEA Member States for healthcare that those countries have provided to UK citizens, and vice versa. Since 2002/03, total UK payments to other EEA Member States for reimbursement of healthcare costs have risen significantly, from £250m to more than £830m in 2009/10.

Income from UK claims is significantly lower than expenditure, which is mostly due to the very large difference between the numbers of UK pensioners choosing to spend their retirement abroad, compared with the numbers of other countries' pensioners choosing to spend their retirement in the UK.

But inconsistent levels of identification of EEA patients by NHS Trusts are a factor too. The UK is unable to make claims from patients presenting valid EHICs/S2s/E112s without Trusts reporting these details via the Overseas Visitor Treatment portal. The personnel involved in identifying and processing EEA patients / EHICs in NHS Trusts are the same as those dealing with chargeable overseas visitor patients.

There is no incentive for Trusts to do this as there is no benefit to them in reporting, and no disbenefit of failing to report. However unlike the overseas visitor charging system, Trusts still receive the commissioner payment for treating such patients, so the disincentive is not as strong.

DH's European Health Income Programme is the umbrella for a number of initiatives designed to contain UK liabilities in this area and maximise access to entitled revenue streams. One initiative is a pathfinder project at University College London Hospitals NHS Foundation Trust (UCLH), focused on driving up identification of patients from the EEA and recovery of costs from the patients' home healthcare systems.

The project has explored whether structured investment in key areas such as training, guidance and targeted staff resources can generate increased EEA data reporting and hence income. Initial findings from the project suggest that increased investment does indeed lead to increased income (however some of this is in relation to processing a backlog of S2s/E112s for pre-planned treatment). And unsurprisingly given that the same personnel are involved in both processes, initial findings are that the investment targeted at EEA income has had a knock-on effect on increasing the identification of chargeable overseas visitors.

## Fundamentally misaligned incentives

175. It appears that fundamentally misaligned incentives are the key root cause of some Trusts' failure to fully implement the charging rules. There is no incentive for NHS Trusts to identify chargeable overseas visitors because failure to do so has no impact on the Trust's income – they still receive payment from NHS commissioners who have no way of knowing that the patient was not entitled to free treatment. By requiring Trusts to identify chargeable overseas visitors we are in effect expecting them to remove such patients from the guaranteed NHS commissioner payment system and expend time, effort and costs in pursuing an inherently unstable funding stream of full recovery from the patient.

176. There is not only no reward or incentive for Trusts to fulfil their obligations under the Regulations, they are actively penalised for doing so because by identifying greater numbers of overseas visitors they are exposing themselves to greater levels of unrecovered income (as is clear from the following section on cost recovery), draining their own resources. The Director of Finance at a Hospital Trust explained this to us as "the better my OVM does their job, the worse off financially the hospital is."

177. Given the weight of the financial disincentive for Trusts, it could be seen as surprising that any fulfil their duties under the legislation. The incentive value of altruistic protection of wider NHS resources and the desire to comply with a statutory duty appear to be strong.

## Conclusion

178. The process of screening all patients at the point of admission to determine their eligibility status has significant inherent weaknesses. However the most significant weakness in frontline implementation of the charging rules is the fundamental financial disincentive to identify and charge visitors.

179. The result is that some Trusts appear to be passing through some overseas visitors as residents. The flaws and gaps evident in frontline implementation of the charging system are threatening the integrity of the policy, to the detriment of those patients who are entitled to receive free NHS care. However, it is clear that Trusts' obligations under the Charging Regulations impose costs and a significant layer of bureaucracy – even with the current less than universal commitment to providing necessary resource to meet statutory duties.

## Cost recovery

- Where Trusts receive no payment from identified chargeable overseas visitors they must cover the costs of providing the treatment from their own reserves – in effect the general NHS funding base is subsidising the treatment of overseas patients.
- There are a number of factors which mean some level of unrecovered costs is inevitable, in particular the duty to provide immediately necessary or urgent treatment in advance of payment and regardless of the patient's ability or willingness to pay.
- We estimate that Trusts only manage to recover around 40% of all invoiced charges.
- Patient debt from unpaid charges affects Trusts' bottom lines and attracts scrutiny.

### Introduction

180. The previous section showed that there are fundamental issues with Trusts' identification of chargeable overseas visitors at the frontline. The majority of chargeable overseas visitor patients are not identified so are in effect being 'passed through' the system as a resident. This sees the Trust reimbursed for the treatment provided, but poses a hidden burden on the NHS. When a Trust identifies and treats a chargeable patient and the patient does not pay, the burden is no longer hidden and falls to the Trust itself, as it forgoes all payment for the treatment. It must cover these costs from its own reserves.

181. We estimate that Trusts currently invoice between £35m and £55m to chargeable overseas visitors, and manage to recover around 40% of this (£15m - £25m). Trusts write off a significant amount of debts relating to overseas visitors each year (£14m in 2010-11[49]), and many hospitals have substantial levels of debt outstanding that they are in the process of recovering.

182. Therefore revising the eligibility rules could increase the potential 'pool' of chargeable overseas visitors, and improving frontline processes and realigning incentives could greatly improve the identification of those patients. But it is only the recovery of income from chargeable patients that can reduce the burden on the NHS.

[49] From NHS Trust Audited Summarisation Schedules, and information from Monitor.

**Some unrecovered costs are inevitable**

183. NHS bodies have a legal duty to make and recover charges from overseas visitors that are not exempt from charge. From a cost recovery perspective, it is obviously preferable for Trusts to demand and receive payment prior to incurring the costs of providing treatment. Trusts have clear guidance from DH that this should be the norm in all cases of non-urgent treatment; this is not the same as refusing to provide treatment – merely requiring payment conditions to be met before treatment is provided.

184. However Trusts have limited room for manoeuvre because out of three categories of treatment, they are unable to demand payment in advance of treatment for two of them – see Box 13 below. NHS bodies have human rights obligations to ensure that treatment which is immediately necessary is provided to any patient, even if they have not paid in advance. The risk, or certainty, of a patient not paying cannot affect Trusts' decision to treat patients. Chargeable treatment does not become free of charge through being provided on an immediately necessary or urgent basis, and charges found to apply cannot be waived.

***Box 13: When can treatment be withheld in advance of payment?***

| **Urgency of treatment (only clinicians can assess this)** | **Assuming both the patient and service are chargeable, <u>when</u> should Trust apply charges?** | **Other considerations** |
|---|---|---|
| **Immediately necessary** (to save a life or prevent a condition becoming immediately life-threatening) | Treatment <u>must not be delayed or withheld</u> to establish a patient's chargeable status or seek payment | Patients should be informed about possible charges but not discouraged from receiving it even if they indicate that they are unable to pay. In many cases a patient may be able to be stabilised, allowing them to be safely discharged and giving them time to return home for further treatment (though not if ceasing or limiting treatment would worsen their condition). |
| **Urgent** (cannot wait until the patient can be reasonably expected to return home) | Trusts should make every effort to secure payment or a deposit before treatment, but if unsuccessful, <u>treatment should not be delayed or withheld</u> | |
| **Non-urgent** (routine elective treatment that could wait until the patient can return home) | Trusts should <u>withhold treatment</u> until the estimated full cost of treatment has been received | If the patient's condition deteriorates or their return home is delayed, the clinician should reassess the urgency of need |

185. In addition, cost recovery is compromised by the fact that undocumented migrants make up the largest group of chargeable overseas visitors, many of whom have few resources to pay charges incurred.

186. Debts are also incurred by short-term visitors who have not ensured they have adequate resources or health insurance to cover their stay, and then need NHS hospital treatment for which they cannot pay. Any visitor to the UK, whether or not they require a visa before entry, must satisfy the requirements of the Immigration Rules, which set out the detailed legal framework governing entry to the UK. Visitors are required to have sufficient funds available to finance their stay, and that of any dependants, which would include provision for their healthcare needs. Many are not doing so, therefore breaking the conditions of the Immigration Rules.

187. It has been said that the overseas visitor charging system "takes full account of humanitarian obligations in the provision of healthcare, in particular ensuring that the emergency medical needs of any person are treated irrespective of their status or ability to pay[50]". However as there is no humanitarian 'safety net' of additional funding built into the charging system it can be argued that the system does not take full account of these obligations – it merely leaves Trusts (disproportionately those in London), with the burden of providing treatment for which they receive no payment.

***Box 14 – Accumulating costs of providing immediately necessary treatment***

A patient granted a six month visitor visa in 2009 presented at hospital within a week of arriving in the UK and was immediately transferred to the Intensive Care Unit to receive emergency renal dialysis. The Overseas Visitor Manager interviewed the patient and identified them as chargeable. They explained the charges for regular renal dialysis (around £4,000 per month) and secured an undertaking to pay from the patient's family member. The patient received regular renal dialysis (which cannot be withheld as it is classed as immediately necessary treatment) but refused to pay.

After months of continued non-payment the Trust applied for a County Court Judgement against the patient's sponsor. The court requested that the Trust impose a repayment schedule of £10 per week. Over two years later treatment was still ongoing with costs exceeding £100,000 and rising by around £4,000 per month. Because the Trust is receiving instalments of £10 per week its internal policies prevent it from writing the debt off its balance sheet.

[50] For example the Written Ministerial Statement announcing this review of the overseas visitor charging system: http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110318/wmstext/110318m0001.htm#11031849000007

### Additional costs

188. The Charging Regulations set out Trusts' obligation to make and recover charges from liable overseas visitor patients. The Regulations are silent on the charges themselves but DH guidance advises that Trusts should where possible use the Payment by Results (PbR) tariff relating to non-contract activity. The guidance also advises Trusts recover the full cost of the treatment given (which may include an element to cover reasonable costs of administration).

189. There is evidence of differing practices among Trusts. Very few charge a percentage administration fee; and most charge according to the PbR tariff but some perform bottom-up costing on the patient's individual treatment. There are instances where the tariff, based as it is on averages, may not recover all the Trust's input costs.

190. Furthermore, the overall process of invoicing, and follow up recovery (including individual case handling) is time consuming, and Trusts rarely recover these additional input costs.

### Difficulties in recovering charges

191. When a Trust does identify and charge an overseas patient it is required, according to DH guidance and the NHS Finance Manual, to take all possible steps to recover the payment. Indeed Trusts have strong incentives to do so, to minimise their losses. However this is not straightforward and Trusts face significant difficulties. One overseas visitor manager (OVM) responding to NHS Counter Fraud and Security Management Service's 2007 survey of OVMs stated: "Nothing in the regulations helps us to recover outstanding money owed".

192. There is strong anecdotal evidence from OVMs that significant numbers of patients simply refuse to pay following treatment (in cases where Trusts have been required to provide treatment regardless of a patient's ability or willingness to pay). Once a patient is discharged the process of recovering charges from them is bureaucratic and time consuming and the chances of recovery diminish, particularly where patients leave the country or had given incomplete or false contact details. One of the drivers for the recent introduction of the Immigration Rule on NHS debtors was that the immigration sanction might, in some cases, be the only effective means of seeking to enforce repayment.

193. Analysis conducted for this review (for further detail see following Analysis section) suggests that treatment costs for most overseas visitors are fairly low, but that individual patients may accumulate very high costs. Some of the most expensive treatment that can be provided to overseas visitors is classed as immediately necessary care (including maternity services and renal dialysis) so cannot be withheld in advance of payment. It would appear logical that individuals would have greater difficulty in

paying the biggest amounts (particularly undocumented migrants with least resources to pay), however our survey of Trusts conducted for this review found no evidence supporting particular difficulties in recovering large bills.

194. Trusts do not have expertise in chasing debts. Many at some point use specialist debt recovery companies – a practice recommended by DH guidance – but even these have very limited success, especially if the overseas visitor returns to their home country. One Trust told us that according to their debt recovery agent the usual footprint or profile of debtors is 5% (i.e. they are usually able to establish 5% of debt as traceable), but with overseas visitor debtors this reduces to 0.2%. Even when debt recovery agencies are successful Trusts then lose up to half of recovered income in fees.

195. If a patient is identified as chargeable and then produces evidence of their entitlement to free care much later (outside the commissioner's payment 'freeze window') the Trust normally has no choice but to provide for the treatment from its own reserves.

196. Under the Charging Regulations only the patient is liable for charges incurred (except rarely in relation to ship or aircraft crew, or if the patient is a child). Hospitals can ask a friend or family member to sign an undertaking to pay form, agreeing to pay the charge, but liability does not then legally transfer to that person. Anecdotal evidence suggests that Trusts have varying success at persuading a civil court that the person who signed should honour that agreement. Those who sponsor individuals to come to the UK, agreeing to pay for their costs whilst here so that they do not become a burden on the UK, are not liable for the NHS hospital treatment costs incurred by the visitor they sponsor.

**Impact on Trusts and different accounting decisions**

197. We have seen that the failure of identified overseas visitor patients to pay their incurred charges results in a burden to the provider and an opportunity cost, as Trusts have to cover the costs of providing the treatment from their own reserves. Unrecovered income from overseas visitors can, for some Trusts, mean the difference between surplus and deficit[51]. Our estimates from analysis conducted for this review suggests that in 2010-11 between £20m and £30m was charged to overseas visitors but not recovered in-year.

198. The need to visibly account for this unrecovered income poses additional difficulties. Trusts need to recognise in their accounts when patients do not pay their charges, which they do through making a provision for the bad debt. In effect this leaves the debt sitting on Trusts'

[51] NHS Trusts have a statutory duty to break even (generally interpreted to mean over a rolling three year period). Foundation Trusts have no statutory duty to break even, but must achieve the financial position set out in their financial plan.