



Access to the NHS by foreign nationals – Government response to the consultation

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Document Purpose	For Information
Gateway Reference	15683
Title	Access to the NHS by Foreign Nationals - Government Response to the Consultation
Author	Financial Planning & Allocations Directorate, Department of Health
Publication Date	18 Mar 2011
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Special HA CEs, Directors of Finance, GPs
Circulation List	
Description	This is the Government's response to the consultation Review of Access to the NHS by Foreign Nationals, outlining minor changes to Charging Regulations and opportunities for collecting debts to the NHS by refusing visas to NHS debtors. The document also announces a wide-ranging review of free access to the NHS.
Cross Ref	Review of Access to the NHS by Foreign Nationals
Superseded Docs	n/a
Action Required	n/a
Timing	n/a
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Access to the NHS by foreign nationals – Government response to the consultation

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March 2011

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Introduction

The National Health Service (NHS) is built on the principle that it provides a comprehensive service, based on clinical need, not the ability to pay.¹ But the NHS is not free of charge to all comers. Only those who are 'ordinarily resident'² in the UK are automatically entitled to free NHS hospital treatment. Those patients who are not ordinarily resident in the UK, eg holidaymakers, those visiting family, former residents now living overseas or those persons living here without permission, are deemed 'overseas visitors' and are subject to charging regulations.³ These place a duty on NHS bodies to make and recover charges for hospital treatment from those overseas visitors to whom no exemption from charge, as listed within the charging regulations, applies. Different rules apply in primary care where a GP has the discretion to register a non-resident; registration with a GP does not necessarily imply that a non-resident person is entitled to free NHS hospital treatment. There are extensive reciprocal arrangements with EEA countries/Switzerland under EU regulations and EEA/Swiss nationals also have residency rights in other member states under defined criteria.

In February 2010, the Department of Health launched a consultation on a limited number of proposals to extend exemptions from charges for NHS secondary healthcare to certain groups of overseas visitor and also sought feedback on the clarity and effect of a consolidation of the existing charging regulations as well as redrafted accompanying guidance. It also consulted on the sharing of data to assist debt recovery by enabling the UK Border Agency to refuse requests for visa stays or extensions to those who have outstanding debts for previous NHS treatment (in respect of a parallel consultation run by the Home Office⁴). Finally, it sought views on some early thinking around the possible introduction of a health insurance requirement for some overseas visitors.

This document outlines the government's response to the consultation. In the main we intend to implement the proposals, with some modifications reflecting what we have heard. However, while the NHS must remain essentially a humanitarian organisation, current rules and practices around charging non-residents are complex and difficult to apply, and so may not provide the right balance between fairness and affordability. We are therefore beginning a more wide-ranging review of rules and practice, which will lead to further consultation where appropriate. This new review is outlined in the last chapter of this Response.

¹ NHS Constitution 2010,

[/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613)

² 'Ordinary Residence' is not defined in the enabling legislation. It takes its meaning from *Shah v Barnet London Borough Council* [1983] 2 AC 309, [1983] 1 All ER 226 as applying to someone living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here that has a sufficient degree of continuity to be properly described as "settled".

³ National Health Service (Charges to Overseas Visitors) Regulations 1989, as amended

⁴ The UKBA consultation can be found at:

<http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/consultations/nhs-debtors/>

Consultation Process

On February 26 2010, the Department of Health and the Home Office launched parallel consultations on a package of proposals relating to charges to overseas visitors accessing NHS hospital care. The consultation proposed limited amendments to the charging regulations relating to secondary care (hospital) treatment, in particular extending the exemption from charges to:

- those failed asylum seekers who are receiving support from the UKBA whilst there are recognised barriers to them leaving the UK or because they have families; and
- children who are found to be unaccompanied in the UK by a parent or guardian.

It also proposed to:

- extend the time a person is allowed to be outside the UK each year before charges become a possibility.

In addition, the consultation took the opportunity, in line with good parliamentary practice, to consult on a consolidation of the charging regulations, which stem from 1989 but have since been amended or added to on numerous occasions. This is intended not to materially change the intent of the regulations. Revised guidance was also included with the consultation for comment.

UKBA launched its consultation at the same time on proposals to change the immigration rules to allow a person to be refused entry, an extended stay in the UK if they have an outstanding debt to the NHS. The DH consultation set out proposals on sharing appropriate information to facilitate this wider government objective in order to assist debt recovery.

In contrast to some other countries there is no current requirement to possess health insurance when visiting the UK. The consultation sought early views on whether, in principle, it would be a good idea to introduce this requirement. It asked for problems that might arise to be identified and suggestions on how these might be overcome. The early consultation on this question was to inform possible further evaluation of such a policy.

The consultation was live for an extended period to ensure sufficient time for response over the 'campaign period' following the dissolution of Parliament and so closed on 30 June 2010. All NHS organisations were informed of the consultation's launch and we directly alerted many interested parties and organisations through both DH and Home Office communication channels. The launch also received widespread coverage in national media.

Executive Summary

Following the consultation we intend to lay the proposed consolidated regulations on charging visitors for secondary care (hospital) treatment as soon as possible. However, in response to feedback received we will make modifications to the consultation draft. In particular:

- we will not make any immediate changes to the definitions of chargeable NHS services (eg, to include NHS walk-in centres) but will look again at how this may need to be reviewed in line with the full range of providers of NHS services envisaged in the recent White Paper *Equity and Excellence*⁵; and
- we will correct the 'easement clause' (whereby existing courses of free treatment will be continued) to ensure this is applicable to all persons whose exemption status changes.

We will also take this opportunity to include two further modifications not included in the consultation:

- the trigger definition for exempting charges for Pandemic Flu treatment will be that human-to-human contact spread is evident; and
- including a specific exemption for accredited participants and officials of the London Olympic & Paralympic Games in line with commitments made during the bid process.

New guidance to support the revised regulations will be published when the consolidated regulations come into force. Minor changes to the consultation draft have been made in response to comments received, in particular relating to the provision of urgent treatment.

Following this consultation we will work to develop processes to support the sharing of data about outstanding debts for NHS treatment as soon as is practical after new immigration rules are introduced by Home Office. These will allow UKBA to refuse persons with outstanding debts further or extended entry to the UK, or citizenship. The comments we received in response to consultation stressed the importance of ensuring that any data shared does not include clinical information and is shared solely for these purposes. We will ensure that any process for data sharing respects these concerns and is both secure and fully compliant with data protection legislation.

Responses to the questions on the feasibility of introducing a requirement for health insurance for categories of chargeable visitor have been documented and will inform further analysis and evaluation of this future policy option.

The previous review failed to address fundamental issues in the current charging regime. Current rules and practices around charging non-residents are complex and difficult to apply, and do not provide the right balance between fairness and affordability. We will therefore carry out a further review that will include:

- qualifying residency criteria (including ordinary residence);
- the full range of other current criteria that exempt particular services or persons from charges for their treatment;

⁵ *Equity and Excellence: Liberating the NHS* was published in July 2010 and can be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

- whether GP services and other NHS services outside of hospitals should be charged for;
- establishing more effective and efficient processes across the NHS to screen for eligibility and to make and recover charges; and
- whether to introduce a requirement for health insurance tied to visas.

The review will be thorough and consultative, and will take full account of NHS values, public health needs and humanitarian obligations. We expect that developed proposals will be ready for further consultation during 2012.

What the Consultation told us and our responses

Level and range of responses

There were 166⁶ responses to the consultation. Of these, 83 were from members of the public or healthcare professionals, including a significant number of NHS staff, and individuals who may be affected by one or more of the proposals. The other 83 were from organisations, including professional bodies such as the British Medical Association (BMA), as well as several migrant welfare organisations (see Annex A).

The consolidated charging regulations and accompanying guidance (Questions 1 - 4)

Q1 – Do you agree that the draft new consolidated Regulations provide a clearer, accurate and more succinct reflection of the existing Regulations?

What we heard:

One hundred and thirty-five respondents answered this question, with 44% agreeing and 56% disagreeing. However, many of those who disagreed did so because they believed the consolidated regulations had introduced material changes in policy, which is covered in Q2. These issues are discussed below at Q2.

Others who answered 'no' were unhappy that the consolidated regulations did not include new provisions they would have liked to see, in particular a system of entitlement to primary medical services, but, as the consultation made clear, the aim here was to produce clear consolidated regulations, not to introduce any new or changed provisions. There was also some confusion between what should appear in regulations and what should appear in guidance explaining how to apply those regulations.

Some did feel that the consolidated regulations were more complex than existing charging regulations because they sought to reflect the increasing range of providers offering NHS services by introducing a duty for 'NHS contractors' to notify the contracting NHS body if they believe they are treating an overseas visitor. For instance the BMA said that:

the draft new consolidated Regulations appear to be an accurate reflection of the existing Regulations [but] it may not be clear who has legal responsibility for assessing eligibility and where the responsibilities for recovering charges lie.

Others also felt that the consolidated regulations provided greater clarity. The Black Health Agency said

We welcome particularly the clarification that primary care services ... are not included in the list of potentially chargeable "relevant services". We also particularly welcome the confirmation that anyone who has a pending application for humanitarian protection will be exempt from charges.

⁶ A further 10 emails were received, but these did not fully engage with the consultation questions or proposals or their comments were out of scope.

Q2 – Do you agree that the consolidated Regulations do not imply any material change in policy?

What we heard:

One hundred and thirty-two respondents answered this question, with 35% agreeing and 65% disagreeing.

The consultation had proposed changes in the consolidated regulations that were intended to allow the charging regime to work as was originally intended but in today's NHS. However, a number of responses in response to Q1 or Q2 highlighted that some proposed changes are material and potentially problematic, in particular:

- Requiring the commissioning NHS body to operate the charging regime whenever an NHS contractor provides services to an overseas visitor will result in confusion and untrained people making decisions as the commissioning NHS body is unlikely to have the necessary expertise;
- Moving from charging only for services provided at a hospital or by hospital staff to charging for all non-primary medical services, including those provided in the community, will also lead to confusion as it will be unclear which services are chargeable;
- NHS contractors could include GPs providing secondary care type services. This could harm engagement with primary care and risk public health if such GPs had a duty to refer onwards for an assessment of charges;
- Community mental health services provided by NHS bodies/NHS contractors would become chargeable if not classed as primary medical services. This could deter engagement with mental health services and jeopardise public health.

Several respondents, particularly those organisations that deal directly with issues relating to HIV/AIDS, expressed concern that the so-called "easement clause" within the regulations (regulation 4(3) in the current regulations)⁷ has been described differently in the draft guidance to how it is commonly understood. Recent legal advice is that this easement clause only relates to regulation 4(1)(b) (i.e. the one year's lawful residence exemption). Therefore, only a person who had begun a course of treatment free of charge under that particular exemption can, if their exempt status changes, continue to be treated for free until that course completes. Respondents pointed out that asylum applications are increasingly dealt with before a year passes, so that many failed asylum seekers will not be able to benefit from the easement clause and will begin to be charged part way through a course of treatment. They also highlighted the significant risk of drug resistant HIV strains developing because of people interrupting their HIV treatment.

Another response noted that Regulation 24 makes a material change by changing the wording from exempting the spouse/civil partner and child who 'lives on a permanent basis with the overseas visitor in the United Kingdom' to one who is 'lawfully present with the exempt person whilst they are in the UK'. The change would unintentionally allow spouses (etc) who are temporarily visiting the exempt overseas visitor to benefit from the exemption in a way they cannot at present.

⁷ <http://www.legislation.gov.uk/uksi/2004/614/regulation/4/made>

Our response to Q1 and Q2:

The Government intends to lay the consolidated regulations at the earliest opportunity but with the following modifications:

We will not make any changes to the definitions of chargeable NHS services at this time. However, we believe that in the future charges should apply equally across all providers of NHS services. The new review will therefore consider how that can best be achieved.

The 'easement clause' will be amended so that anyone who, after being properly assessed in accordance with the charging regulations, has begun a course of treatment free of charge, will continue with that particular course of treatment free of charge until they leave the country, even if their exempt status changes. This is for sound humanitarian and public health reasons. In practice, this is how the easement clause is already understood to operate by many interested parties, including NHS bodies that apply the charging regime.

We will correct the definition in Regulation 24 to require a spouse, civil partner or child to be living permanently with the exempt visitor to benefit from their exemption

Further, we will take this opportunity amend the regulations for two issues that did not form part of the consultation. Firstly, we will change the definition of pandemic influenza in the list of diseases for which no charge can be made, so that the exemption from charge takes effect if a 'Phase 4, 5 or 6' pandemic has been declared by the World Health Organisation. Phase 4 is characterised by sustained human to human transmission of the virus so public health protection is required from that point. Charging for pandemic influenza treatment during a phase 4 or 5 situation, as the regulations require at present, might risk further spread.

We will also take this opportunity to enact a commitment given by the Government as part of the 2005 bid for the 2012 Olympic and Paralympic Games that Games Family⁸ members will receive free medical care. Treatment will be available in a range of locations and London Organising Committee for the Olympic Games (LOCOG) estimates that it will treat 95% of medical incidents in polyclinics in Games' venues. It is envisaged that the NHS will only treat injuries requiring treatment in NHS designated hospitals. This free medical care will be available during the Games Period and will be limited to treatment the need for which arises during the visit to the UK so will not include routine or pre-planned treatment.

Q3 – Does the new draft guidance clearly and comprehensively explain how the consolidated regulations should be interpreted and applied?

What we heard:

We received one hundred and twenty-nine responses to this question. Whilst 71% disagreed, notably both the BMA and the Royal College of Physicians, as well as several NHS staff, at whom the guidance is targeted, answered yes, to this question. The Council of Ethnic Minority Voluntary Sector Organisations said:

⁸ "Games Family" – means an individual who is taking part or involved in the Olympic or Paralympic Games in London 2012, in the UK during the "relevant period" (9 July – 12 September 2012) and who has been given a letter code for the purpose of receiving free treatment the need for which arises during the visit. It includes athletes, technical officials, press, broadcasters and the Olympic and Paralympic family.

the guidance published and regularly updated by the Department of Health includes full explanations of all charging exemptions, the process by which a patient's eligibility should be verified and how charges should be made.

Of those who answered negatively, many said that they felt the draft guidance was an improvement on existing guidance. The comments of several respondents indicate that they have answered no because they do not agree that Chapter 3 is sufficiently clear, which is separately considered at Q4. Those comments are therefore considered there.

The majority of other comments were related to two issues. Some called for greater explanation of the 'ordinary residence' test which governs who is automatically entitled to free NHS hospital treatment. Others called for hospital posters⁹ that advise patients to ask reception for more details on charges to be withdrawn, since receptionists are not sufficiently trained to do so.

Q4 – Does Chapter 3 of the new Guidance document fully and clearly explain the NHS's obligations and requisite processes to ensure the provision of immediately necessary and urgent treatment to chargeable patients who are unable to pay prior to the treatment needing to be provided?

What we heard:

The changes to Chapter 3 of the guidance are particularly important and so we asked a separate question. One hundred and twenty-eight respondents answered, with 37% agreeing and 63% disagreeing. Many felt this chapter was much improved, but still had specific concerns. The main ones were:

- That limiting treatment is in breach of the UK's obligations under international and human rights law, eg Articles 2 and 12 of the International Covenant on Economic, Social and Cultural Rights and Article 2 of the European Convention on Human Rights;
- That clinicians should not have to consider the financial consequences when choosing a course of treatment or limiting treatment to a chargeable person who cannot or will not pay. The BMA point out that doctors have an obligation to consider the costs associated with different treatment options as part of their normal practice;
- That guidance is needed on what to do about diagnosis and investigation, as this is fundamental to an accurate judgement on the urgency of treatment;
- That the form for clinicians to complete on urgency of treatment does not use the same definition for immediately necessary treatment as in the guidance. Also it should not be used as it places clinicians in breach of their ethical obligations and could lead to legal claims against them¹⁰;
- That the use of an estimate of up to six months for how long an undocumented migrant without clear plans on returning home might be in the UK is too short, and if a time scheme is used at all it should be up to one year;
- That debt collection agencies should not be used, at least in relation to failed asylum seekers because they are destitute and without funds;

⁹ The posters are not included in the guidance document but are referred to. They are available on the Department of Health website for NHS bodies to download.

¹⁰ In fact, the current guidance dating from 2004 already recommends using a version of this form.

- That clinicians should not be asked to notify Overseas Visitors Managers when they become aware that a patient may be chargeable. Some Royal College of Physicians (RCP) members were concerned that doing so could harm the patient/doctor relationship and deter patients from disclosing further information necessary for clear diagnosis. However, the RCP said that other members thought:

it might be appropriate for doctors to play their part in enforcing the law, [and that] for patients to receive free treatment to which they were not entitled was not a victimless crime. They also observe that doctors in other countries eg the USA have no difficulty in passing on information if a patient was not insured.

In contrast to those who felt the guidance did not do enough to ensure that those who cannot pay received treatment, others felt that it made the NHS too generous. One member of the public said:

I still feel that compared to other countries Britain is a soft touch when it comes to giving away free treatment to those who really should be paying – even if it was for emergency care. British people going to other countries certainly would not get this same leniency shown to them and would know that we would have to pay or have medical insurance.

Our response to Q3 and Q4:

The guidance will be amended to include more advice on applying the ordinary residence test and to take account of a number of other minor issues raised.

Chapter 3 will also include reference to investigations and diagnosis, and the amendment of the form for clinicians to complete when dealing with a chargeable patient who can not or will not pay. We do not believe that the completion of such a form, which has been in use in hospitals for many years, breaches the clinician's ethical or legal obligations.

We will revise the advice that clinicians should consider the financial consequences when choosing a course of treatment to a chargeable person who cannot or will not pay, as this could lead to discrimination. The BMA commented that clinicians already have a duty to consider the costs of treatment options as part of their normal role.

We will qualify the advice on an estimated return home date of six months for those without clear ability to return, to note that a longer estimate of return may be appropriate in some cases. If clinicians think that treatment cannot safely wait a particular length of time, it should be provided regardless of advance payment and to the usual clinical standards and timings.

We do not accept that there is a breach of the UK's obligations under international and human rights law by advising the NHS to withhold or limit treatment that can safely wait until a chargeable patient who does not pay in advance can return home. Indeed, this has been the position for some time. Further, we believe that clinicians have a role to play in meeting the legal obligations of the NHS body where they work. NHS bodies have a legal obligation to recover the cost of providing treatment and it is right that they consider the use of debt collection agencies as part of their efforts to recover debt, unless it would clearly not be cost effective to do so, eg when patients are genuinely without funds.

We do not accept that posters highlighting that charges might apply should be removed from circulation. The NHS body will of course need to ensure that more information is available, either in printed form or by referring the enquirer to an experienced member of staff.

Proposals for change to the Charging Regulations (Questions 5 – 7)

The consultation also considered three specific proposals to amend current charging regulations in respect of particular categories of visitor:

Q5 – Do you agree with the proposal to exempt Section 4 and Section 95¹¹ failed asylum seekers from charges for NHS hospital treatment?

What we heard:

We received one hundred and fifty-one responses to this question with 85% agreeing and 15% disagreeing. Some members of the public did not agree with this proposal, mainly based on concerns about the costs or that the NHS should not be responsible for non-residents.

Several organisations, such as Refugee Action, the British Red Cross and the UK Faculty of Public Health called upon the Government to exempt from charge all failed asylum seekers on efficiency, human rights and public health grounds, as well as to simplify the charging process and to be consistent with the situation in Wales and Scotland. Some thought it unfair to charge this group when the main driver for the charging regime is to prevent health tourism and to ensure that general tourists to the UK are charged for any treatment given. Still others considered it a breach of the UK's human rights obligations to charge failed asylum seekers for NHS hospital treatment.

A particular issue raised is the changeable nature of UKBA support for failed asylum seekers. It is claimed that failed asylum seekers often move on and off support regularly, that some are wrongly denied support due to delays or difficulties with the UKBA applications process. Also, many failed asylum seekers do not know they can receive the support in the first place. There are concerns that it will not be easy for the NHS to establish eligibility and that it will introduce more complexity into rules that are already frequently misapplied.

One respondent commented that other groups of failed asylum seekers who are receiving social services support (for example under the National Assistance Act or the Children Act) should be exempt from charge.

Our response to Q5:

We welcome the high level of support for this proposal and will amend the charging regulations to bring it into force. However, we do not accept that it is a breach of the UK's human rights obligations to apply a charge to the hospital treatment of failed asylum seekers, since they are never to be denied treatment that is immediately necessary or urgent, regardless of advance payment, whilst debts can be, and often are, written off, if they are clearly unable subsequently to pay for it.

NHS staff will, with the patient's informed consent, be able to establish with the UKBA whether a person is supported at a given time. In the main, families with children will remain on s95 support throughout their stay in the UK. Those seeking s4 support are subject to review if their circumstances in respect of barriers to return home change, but any particular course of

¹¹ 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, and for families with children under 18, this support usually continues if the asylum application and appeals have been refused.

treatment that they receive while being supported will remain free of charge even if they no longer receive that support.

New applications for s4 support are processed in a matter of days and are made in writing through electronic means. There are a number of organisations that assist those seeking s4 support with administration and advice on UKBA support is available online and through organisations who represent or provide advice and support to failed asylum seekers.

Introducing a wider range of other support related exemptions would be a further scope change may also be difficult to administer. It would not be appropriate to do this without further evaluation.

Q6 – Do you agree with the proposal that any unaccompanied non-resident Children should be exempted from NHS treatment charges?

What we heard:

We received one hundred and forty-nine responses to this question, with 94% in agreement. The few people who did not agree with this proposal based their concerns on costs or that the NHS should not be responsible for non-residents.

Many who supported this proposal called for all 'resident' children to be exempt from charges and some called for all children to be exempt (even if accompanied by a parent or guardian). The UK's obligations under the UN Convention of the Child and the Children Act 2004 are cited as reasons why all children should receive free NHS hospital treatment.

Some pointed out that the children of failed asylum seekers who are not supported by the UKBA will not become exempt from charges by these proposals, and will therefore be penalised by the actions of their parents. The Royal College of Paediatrics and Child Health said

the ministerial forward stresses that they do not want to punish children with parents who have been refused asylum and refused to leave. The proposal is then to do exactly that and penalise this group.

Other respondents pointed out that this could encourage the abandonment of children by parents keen to have their sick children treated for free by the NHS. The Royal Pharmaceutical Society said that they

would be concerned that more children may be sent to the UK unaccompanied if this were to be implemented.

Several respondents called for guidance on what to do when the age of a child is disputed, or when a child becomes an adult part way through a course of treatment. Others, including the BMA, raised concerns over using a different definition of a child to that within the UN Convention on the Rights of the Child.

Our response to Q6:

Children found to be unaccompanied in the UK are taken into the care of the Local Authority, at which point they would likely be considered ordinarily resident in the UK and so entitled to free treatment. However, we have decided to create an exemption category for such children to put this beyond doubt. A child who becomes an adult during treatment or who leaves the care of the Local Authority will continue to benefit from the easement clause for a particular course of

treatment. Failed asylum seekers with children are likely to be on s95 support for which we propose to permit free treatment.

Framing the exemption around those children in the care of the Local Authority avoids the situation of NHS staff having to assess the age of unaccompanied children when that age is disputed. It also prevents a child becoming exempt from charges simply when in the UK with a person who is not their parent or guardian, such as an extended family member (possibly to attempt to receive treatment). We will advise the NHS to use their discretion to write off debts if they treat a child who shortly afterwards is taken into the care of the Local Authority, having been found to be unaccompanied in the UK.

We do not accept that it is a breach of the UK's obligations under the UN Convention of the Child and the Children Act 2004 not to provide free NHS treatment to all children. All people, children and adults, will be provided with immediately necessary treatment without delay for charging matters, whilst other urgent treatment that cannot wait until the person returns home will also be provided, even if they (or, in the case of children, their parent/guardian) are unable to pay in advance. Charging issues will then be sorted afterwards. The children of failed asylum seekers who are not being supported by the UKBA will not be exempt from charges but the above principles on the provision of urgent treatment will equally apply to them. Debts can be written off when the liable person is genuinely without funds.

Q7 – Do you agree that UK residents may be absent from the UK for up to six months in a year before potentially being liable for charges for NHS treatment under the Charging Regulations?

What we heard:

We received ninety-eight responses to this question, with 77% in agreement.

Among the comments from those who disagreed were that temporary absence should instead be managed through a better understanding and application of the ordinary residence test, that there should be no limit on time spent living out of the country, or that extending the absence period would encourage further inappropriate use of the NHS from those who do not really live here. There was a wish from some for this to be easier to assess in practice, whether three months or six months absence is allowed each year.

Some pointed out the fact that this might not tie in with GP registrations (whereby a person is supposed to deregister after an absence of three months). The Royal Pharmaceutical Society expressed concern that this could lead to a consequential change in the advice on prescribing for periods of absence from up to three months, to up to six months. This could lead to shortages of medicines or could risk patient safety since it would be impossible to monitor them when necessary or call the patient back for a review of their medication.

Our response to Q7:

We welcome the broad agreement with this proposal and will amend the charging regulations to bring it into force. We accept that many people who spend between 3 and 6 months each year outside the UK, or even longer in some cases, may still be 'ordinarily resident' in the UK and we will amend the guidance to provide more advice on that. However, it can be difficult for some patients to demonstrate that they meet the ordinarily resident criteria, and amending the regulations in this way puts the entitlement to free NHS hospital treatment for those who spend the majority of the year lawfully living in the UK beyond doubt.

We are not persuaded that free NHS hospital treatment should be guaranteed for those spending 6 months or more each year living outside the UK beyond the ordinarily resident criteria and exemptions already in place. This would be a material change with significant cost implications. Guidance on GP registrations and prescribing periods will not change.

Impact Assessments (Question 8)

The consultation documentation included impact assessments and equality screening for the two changes to current regulations that may have a material cost implication – failed asylum seekers and UK residents absent for 3-6 months. The proposed exemption for unaccompanied children will not result in any material cost as such cases (of which there are only a few per year anyway) would typically be judged as ordinarily resident already. The data sharing proposal was in support of a policy change by Home Office for which their own consultation provided an impact assessment (which included DH costs) and equality impact assessment. The consultation was only seeking early views on health insurance to inform further analysis that will include impact and equality impact assessments if definitive proposals are put forward at a later date.

Question 8 asked if, in respect of the proposals for regulation changes referred to in Questions 5-7, respondents were able to provide any additional data that might inform the calculations of costs and benefits. Some provided comments and information but none informed any material change to the calculations used in the impact assessments.

A small error within the impact assessment for the proposal at Q5 (failed asylum seekers) was identified whereby a social benefit was wrongly attributed as being a social cost. We have also sought more recent data on the numbers of failed asylum seekers on Section 4 or Section 95 support. These have reduced from 17,200 to 10,300, reducing the cost of the change to a recurrent cost from Year 3 of £6m. We have amended and republished this impact assessment to reflect these two changes.

The change to the definition of pandemic influenza is necessary on public health grounds and it will only impact on the NHS. Prompt detection and treatment of early cases will help to contain further spread and the resulting cost of treating new cases. The amendment in relation to the Olympic and Paralympic Games is necessary as the UK has committed to ensuring that certain Games Family members will not be charged for NHS hospital treatment during Games Period. In any event, the numbers accessing NHS hospital treatment are expected to be small: LOCOG has estimated that 95% of medical incidents will be treated in local polyclinics, for which LOCOG are responsible, whilst many will use their own medical teams. Further, many Games Family members would have been exempt under another category anyway, eg those visiting from a country with which the UK has a bilateral healthcare agreement.

The completed impact assessments included an equality screening that identified that the respective proposals had limited positive impacts on some equality strands. Respondents to the consultation did not challenge or raise further issues of inequality within the current charging regulations and guidance or the proposed regulation changes. A full Equality Impact Assessment will be done on the charging regime as a whole, and any specific future proposed changes as part of the future work programme that is discussed in the final chapter of this response. We will also publish an equality analysis on the current regulations and guidance, together with final impact assessments in respect of supported failed asylum seekers and the residents absence period when those consolidated regulations come into force.

Tackling NHS debt and misuse (Questions 9 – 13)

Q9 – Do you agree with the proposal to require an overseas visitor receiving chargeable NHS treatment to provide personal information to aid subsequent recovery of charges?

What we heard:

One hundred and twenty-two respondents answered this question and the opinion was evenly divided.

Most of those who gave a negative answer were concerned that it would harm the doctor/patient relationship or that it would discourage migrants from seeking urgent healthcare if there is seen to be a link to the immigration service. Some of them asked that failed asylum seekers in particular be exempt from having to provide this information, as it is futile to chase them for debts any way. Some commented that it would encourage migrants to use false details, others asked what would happen if the patient refused to provide this information.

Many of those who answered positively felt that obtaining these data and sharing it with the appropriate authorities would be a vital and proportionate tool in maximising the recovery of NHS debt and preventing future misuse of NHS resources.

Q10 – Do you agree with the proposal that NHS organisations must provide information relating to outstanding debt for NHS treatment to the Department of Health or to an appointed agency?

What we heard:

One hundred and twenty-nine respondents answered this question, with 43 % agreeing and 57% disagreeing.

Similar issues were raised as in the previous question around protecting vulnerable migrants such as failed asylum seekers. Many of those who disagreed thought that this would be a breach of patient confidentiality and some were concerned that debt collection agencies would be given the information. Some claimed that the measure would increase people smuggling and make the recovery of debts more difficult since the person will not be allowed back into the UK where it will be easier to obtain payment from them. Some respondents commented that the healthcare needs of a person who is dependant on the person refused entry have not been considered, for example in circumstances where the refused person has a child resident in the UK. Monitor replied that requiring information related to outstanding debt to be provided to the Department of Health by foundation trusts undermines the principles of foundation trust autonomy but that they would have no objection to the Department of Health approaching foundation trusts to participate on a voluntary basis.

Similarly, those who answered positively generally raised similar issues from the previous question. Many pointed out that NHS providers have a duty to recover debts, so this would assist them in that legal obligation as well as helping to prevent a further debt if the person returns to the UK to seek healthcare.

Q11 – What safeguards on the protection of personal information are needed beyond those described?

What we heard:

Some respondents provided suggestions of safeguards needed, although some of these had already been described in the consultation document. Many organisations advocating for those with HIV felt that the sharing of data would risk a person's HIV status being deduced due to the organisation where treatment was provided being known to be a provider of HIV treatment. Some felt that the process should be independently monitored to ensure compliance with safeguards. One commented that if the data are passed outside of the UK then that country's data protection laws might not be comparably robust, meaning that control of that data would be lost.

In general, respondents advocated a transparent and accountable process without the transfer (including inadvertently) of any medical data, with restrictions placed on who can access the information.

Q12 – Do you agree that the NHS Counter Fraud Service should transfer the data from the Department of Health's appointed agency to the UK Border Agency to support recovery and implement any agreed immigration sanctions under rules approved by parliament?

What we heard:

We received one hundred and twenty-four responses to this question, with 39% agreeing and 61% disagreeing. The respondents' comments in support and against the proposal raised similar issues as those in earlier questions. Specifically, the issue of protecting vulnerable migrants by not discouraging them from accessing important healthcare services was voiced again, with many saying that this transfer of information should not take place. Some did not think the NHS Counter Fraud Service should be involved because it introduced another agency in the chain of those passing on information, which increased the margin for error and involved unnecessary costs than if the information was transferred directly to the UKBA.

Q13 – Do you agree that the Secretary of State Directions to the NHS Business Services Authority should be amended to enable the NHS Counter Fraud Service to lawfully carry out the data transfer process?

What we heard:

One hundred and twenty-one responses were received, with 40% agreeing and 60% disagreeing.

The comments received highlighted similar issues to those to earlier questions.

The BMA did not provide answers to Q9 – Q13, but, whilst they had some concerns, they did comment:

The BMA in general supports the introduction of appropriate measures to aid the recovery of debt and to minimise fraud and abuse of NHS resources. The proposal to pass on information to the Department of Health or appointed agencies, in certain cases where debts are outstanding, seems consistent with this duty.

Our response to Q9 to Q13:

The Government believes that it is reasonable to require anyone receiving chargeable treatment, for which they have not yet paid, to provide personal and contact details in order for the provider of that treatment, or their appointed agents, to recover the cost. While it recognises the need to protect vulnerable individuals, it has a duty to the public purse to take all reasonable steps to recover such debts.

We are content that the Data Protection Act permits the sharing of necessary information both to recover debts and to enable another government department to carry out functions that it has enacted (in this case the proposed immigration rules)¹². The National Health Service Act 2006 provides for 'power to make such incidental, supplementary, consequential, saving or transitional provision ...as the person or body exercising the power considers to be expedient'¹³. We believe that this would permit the reasonable use of new regulations, directions and guidance to support the existing legal duty on the NHS to levy and recover charges for NHS treatment.

In confirming our intention to make these provisions, we will take necessary account of the concerns raised by respondents to the consultation regarding data privacy that the Data Protection Act also requires:

- Chargeable patients already provide personal and contact details as part of the pre-entry screening process and subsequent written undertakings to pay charges. We will look to standardise this information set, and make clear to the visitor how it may be used if the debt is not settled. We recognise that refusal or inability to provide information could not result in urgent treatment being refused. We will also take account of the NHS's concerns around the provision of information.
- It would not be reasonable to exclude any particular group from this requirement, but NHS bodies have the option to write off the debts of individuals who are genuinely without the resources to pay, in which case they would not fall within the intended data sharing process. In practice, therefore the measures will be targeted primarily at regular visitors who fail to pay for treatment before leaving the country.
- As already set out in the consultation, we will ensure that this data will only be used for the purpose of actual debt recovery and for immigration purposes limited to the Home Office proposals to refuse a person entry to the UK or extension of their stay here if they have an unpaid debt above the threshold.
- We will ensure that all parties involved in the collection, collation, transfer or use of data comply fully with their obligations relating to data security and medical confidentiality. Information provided to the UKBA will remain within its own secure systems and will not be shared further with any further third parties inside or outside the UK. NHS Counter Fraud have a legitimate interest in debt recovery trends and are a necessary conduit to ensure secure transmission to the UKBA.

We will therefore develop regulations, directions and guidance as necessary to meet these needs. This will include a Privacy Impact Assessment that will be published alongside those regulations.

¹² Data protection Act 1988 Schedule 2 at: www.legislation.gov.uk/ukpga/1998/29/schedule/2

¹³ National Health Service Act 2006 Section 272(8)

Health insurance for overseas visitors (Questions 14 – 17)

Q14 – Do you support the principle that a requirement for chargeable overseas visitors to have health insurance should be introduced to cover the costs of any NHS treatment they may require during their stay?

Q15 – What issues may arise from a system of either strongly recommended or mandatory health insurance for chargeable overseas visitors? How might these be overcome?

What we heard:

We received one hundred and twenty-three responses to question 14. 56% of respondents did not support this principle. Question 15 gave respondents the opportunity to expand on their concerns and offer solutions.

Most of the reasons given for not supporting this principle were already identified as difficulties within the consultation document, but some others were given.

Many of the organisations advocating for those with HIV claimed that compulsory health insurance would in effect re-instate HIV testing at borders and restrict travel, be discriminatory under the Equality Act 2010 and force individuals to disclose their HIV status in their country of origin when arranging insurance, which might put their welfare at risk. One pointed out that if insurance premiums were reasonably priced and covered pre-existing conditions it could actually encourage people to come to the UK for treatment rather than face the full costs of treatment in their country of residence. Newham LINKs stated that it was forbidden or “harem” (sic) for Muslims to acquire health insurance.

The Association of British Insurers provided general comments, including that they do not believe that introducing insurance requirements encourages markets to develop. They also felt that there may be administrative problems, such as in cost recovery, if the policy is purchased overseas, and that if purchased in the UK, the underwriting process could be onerous and expensive due to handling medical records from many countries.

Those in support included the Royal College of Radiologists, the Royal Pharmaceutical Society and the Institute of Counter Fraud Specialists. The Royal College of Physicians did not support a mandatory requirement for health insurance but did think that it should be strongly encouraged, at least as a first step. However, most tended to be in favour of a mandatory requirement, at least for some visitors, since a strongly recommended approach will not prevent people who are determined to access the NHS without paying from doing so, as they will choose not to purchase insurance before evading payment.

Many people suggested that there should be a facility to purchase health insurance on entry to the UK, which would mean those from countries without insurance markets could still acquire it. Some felt that insurance should only be available from a limited number of recognised insurers to make the process simpler and to prevent unscrupulous providers of bogus insurance policies from setting up.

As an alternative for health insurance or to complement its introduction, some suggested that sponsors of people to the UK become liable for their NHS debts or pay a guarantee for them, or that a bond be paid by visitors on entry to the UK which could be returned to them at the end of their stay if NHS services have not been used. Others called for the patient’s home country to become liable for any debts.

Q16 – Do you support the principle that some overseas visitors who are currently exempted from charges should instead fund their treatment costs through health insurance?

Q17 – What practical issues may arise if particular categories of overseas visitors or temporary residents were required to cover or insure their own healthcare costs rather than be entitled to free NHS treatment? How might these be overcome?

What we heard:

One hundred and twenty respondents answered question 16 with a marginal majority of 53% not supporting the principle. More detail was provided in response to question 17.

Again, many people pointed out the difficulties already highlighted within the consultation document as reason not to support the principle, such as discouraging students and workers from the UK, with associated economic impacts. Both the UK Council for International Students and National Union of Students felt this, and were concerned that requiring students to have insurance would be an extra financial burden on the individual and administrative burden on the UKBA and educational establishments. They called for evidence of heavy use or misuse by students of NHS services before considering introducing a health insurance requirement for them. Others felt that it was particularly important that students and their dependents cover their healthcare costs whilst in the UK.

Some were concerned that failed asylum seekers and other vulnerable migrants would be required to have health insurance before entering the UK, which was unrealistic.

Our response:

The purpose of these questions in the consultation was to gauge early opinion and to identify issues that would need to be explored in any further development of a proposal to introduce a health insurance requirement for certain groups of overseas visitors. As we continue to consider a requirement for health insurance, as part of the review described below, we will take account of the issues that have been raised.

Other Issues

Some respondents took the opportunity to raise other issues, not specifically covered in the consultation's questions. The main ones are:

Primary Care

Many people stressed the need for clear guidance from DH on entitlement to register with a GP practice for free primary medical services, and called for certain groups to be denied free access. If no checks are made in primary care, and patients are referred to hospital, it makes it very easy for patients who should pay for secondary care to be missed by those assessing for charges in hospitals.

Our response: Primary care was not within the scope of the consultation. However entitlement to free primary care is to be included in the new review, set out in the next section of this response.

Maternity Care

Many organisations and some individuals called for maternity treatment to be free to all overseas visitors. Most felt that the DH guidance to the NHS never to deny access to maternity services was being disregarded, and that applying charges, even after providing treatment, discourages women from seeking essential maternity treatment.

Our response: The Government does not believe maternity treatment should be free to all comers on the NHS. Guidance to the NHS is clear that all maternity treatment, including ante-natal care, must be considered immediately necessary and provided regardless of a woman's chargeable status or ability to pay in advance. This will be reiterated to the NHS as part of the guidance document to be issued imminently.

HIV Treatment

Some respondents called for HIV treatment to be free to all on public health grounds, or at least to be considered always as immediately necessary treatment, and therefore provided to all regardless of whether or not they have been informed of, or agreed to pay, charges.

Our response: This is still under consideration as part of a separate Department of Health review that will report in due course.

Communication

A common feeling across all the questions of the consultation was that the charging regime, including any new rules or the introduction of a health insurance requirement, needs to be clearly communicated to patients, NHS staff and the wider public both in the UK and overseas.

Our response: We will issue revised guidance to the NHS upon new regulations coming into force. We will also update advice to the public on the website.

Summary and Next Steps

Having considered responses to the consultation, and taken account of the issues raised, the government now intends to:

- Lay the consolidated regulations at the earliest opportunity
- Incorporate into these regulations the proposed amendments in respect of failed asylum seekers, unaccompanied children (under local authority care), UK residents abroad for up to six months, the Olympic games and pandemic flu
- Issue revised guidance on the implementation of the hospital charging regulations when the new regulations come into force (likely to be by June)
- Develop and lay the necessary regulations, directions and guidance to support the new immigration rules when they are introduced by Home Office, including necessary safeguards around data privacy
- Take account of the issues raised in response to questions on health insurance in further work to evaluate this policy proposal

Further Review

Context

The underlying principle of the charging legislation has been, and remains, that the NHS is primarily for residents of England, but it also has humanitarian obligations in respect of meeting the immediate medical needs of any person, irrespective of their status. International agreements provide for reciprocal healthcare that benefits visitors from and to participant countries. In particular, residents of the European Union may receive healthcare in any member country on the same basis as their own nationals. Notwithstanding these various obligations, there is also an obligation to the public purse to protect the NHS's finite resources.

The Current Situation

It is increasingly clear that the legislative provisions and their application by NHS providers is not meeting these principles in a balanced way. Overall entitlement to free healthcare is considerably more generous to visitors and short-term residents than is reciprocated for UK citizens seeking treatment in other countries. GPs may choose to register any person as an NHS patient, so many visitors receive free primary care including NHS prescriptions. Exemptions for secondary care treatment are not provided or are more limited in most other countries – this includes accident & emergency treatment and full healthcare exemptions for overseas students and employees.

Applying an ordinary residence criterion can result in some recently arrived and fixed term visitors becoming entitled to free NHS treatment. In contrast, some other countries have a defined initial residence period before being entitled to services.

Secondary care providers have a statutory duty to enforce the regulations, screening all patients for eligibility and applying and recovering charges directly from the patient. Enforcement of these qualifying rules by hospitals appears to vary considerably. This is probably due to a combination of the complexity of the rules, the difficulty in identifying many of those who should be charged, limited local resources and financial disincentives (as the provider is liable for any unrecovered charges, but the local commissioner pays if the patient is never identified as chargeable). Conversely, there is a risk that these financial disincentives may discourage some hospitals from providing essential medical treatment for some chargeable patients.

Collectively these issues reinforce, and indeed exaggerate perceptions of the NHS being widely available free of charge to visitors. The widespread availability of high quality healthcare that is free at the point of access creates a risk that some visitors deliberately access healthcare without paying, known as 'health tourism'. Although only a very small minority of visitors seeking treatment fall into this category, individual cases are identified by both Border Agency and NHS staff on a regular basis, which may result in significant costs.

As a result, overall income from visitors at around £40m per year is lower than we might reasonably expect, even under the current generous rules. At least a further 25% (over £10m) of charges raised are not recovered and are written off each year¹⁴. Low recovery rates for

¹⁴ Figures for overall NHS income and written off debt for chargeable overseas visitors are estimated as the Department does not hold this information for Foundation Trusts

debt incurred where treatment necessarily has to be provided in advance of treatment is a major concern. While the immediate actions to introduce immigration sanctions for debtors seeking to return to the UK will help to reduce levels of unrecovered debt, wider ranging actions are needed.

Planned Action

For these reasons we will carry out a further fundamental review of the current policy, which will include:

- qualifying residency criteria (including ordinary residence);
- the full range of other current criteria that exempt particular services or persons from charges for their treatment;
- the case for extending current charging principles to primary care, and also to enable charges, where applicable, across all providers of NHS treatment in the current and emerging NHS provider landscape;
- financial accountability for providing necessary treatment for those whose subsequent debts cannot reasonably be recovered;
- establishing more effective and efficient processes across the NHS to screen for eligibility and to make and recover charges; and
- additional methods of securing recovery of treatment costs including options for requiring health insurance and improved debt recovery.

The scope of options is deliberately wide ranging and we do not want to rule anything in or out pending further evaluation; indeed our research and consultation may identify other opportunities.

However, the NHS is, and must remain, ultimately a humanitarian organisation. In undertaking the review, we will be mindful of the NHS's core values, in particular its obligations to provide urgent treatment to any person irrespective of their status or ability to pay, to protect the vulnerable and respect our obligations on healthcare provision under international treaties . There is no intention to consider policies that would deny access to any group, only whether an individual should be charged. It will consider the full benefits and costs of introducing new charges including risks of deterred or delayed treatment and any other societal costs. In addition, we will ensure that public health considerations are fully factored into proposed rules and processes (ensuring in particular that access policies do not compromise the identification and control of infectious diseases).

Plans and Timescales

The outlined opportunities will be take forward to more detailed analysis and evaluation. This will be informed by exploring equivalent policies in other health economies. We will also actively seek views and input from NHS managers, other government departments and other interested parties. Evaluation will include full impact and equality analysis.

A comprehensive package of confirmed proposals will be put to full public consultation on completion of the review work, in 2012. We may consult separately at an earlier stage on some options, such as primary care charging, where it would be helpful to seek views to inform development.

ANNEX A List of Respondents

NHS

Beachcroft LLP and Guys and St Thomas' NHS Foundation Trust
Buckinghamshire Hospitals NHS Trust
Health Access Team
Kings College Hospital
Leeds MSLC
Medway NHS Foundation Trust
NHS Bristol
NHS London
Overseas Visitors Advisory Group
Royal Surrey County Foundation Trust
Southampton University NHS Trust
Whittington NHS Trust
Monitor

Professional Bodies

British Medical Association (BMA)
Institute of Counter Fraud Specialists
Royal College of GPs
Royal College of Midwives
Royal College of Paediatrics & Child Health
Royal College of Physicians
Royal College of Radiologists
The Royal Pharmaceutical Society
UK Faculty of Public Health

Third Sector¹⁵

African HIV Policy Network
Asylum Support Appeals Project (ASAP)
Body and Soul
British Red Cross
The Cara Trust
Centre for all Families Positive Health - CAFPH
Churches' Legislation Advisory Service
Doctors for Human Rights
Doctors of the World UK
Dundee University Students' Association
George House Trust
Health Advocacy Project, Manor Gardens Welfare Trust
Immigration Law Practitioners' Association (ILPA)
Leicestershire AIDS support services
Manchester Refugee Support Network
Maternity Action
Medact

¹⁵ The names of two third sector organisations were unclear

Medact Entitlement Working Group
Medical Foundation for the Care of Victims of Torture
Migrants' Rights Network
NAT (National AIDS Trust)
Naz Project London
NCT
Newham LINKs
Positive Action for Refugees & Asylum Seekers
Positive East
Refugee Action
The Refugee Council
RenéCassin
Rights of Women
Still Human Still Here
Suffolk Forum for Refugees, Asylum Seekers and Migrant Workers
Terrence Higgins Trust
Welcome Project
Women's Health and Equality Consortium
Zimbabwe Association
Council of Ethnic Minority Voluntary Sector Organisations
Positively UK
Praxis
Refugee Support SCF

Other

Leeds City Council
NRPF Network
Sijan Kumar Gurung
All Party Parliamentary Group on HIV and AIDS
Association of British Insurers (ABI)
Black Health Agency
British Expats Association Spain
Browne Jacobson Solicitors
Gloucestershire Action for Refugees & Asylum Seekers
Medsin Entitlement Campaign
National Union of Students
North East Strategic Migration Partnership
North West Directors of Public Health and Public Health Networks
North West Regional Strategic Migration Partnership
The Royal British Legion
Sheffield Refugee Forum
West Midlands Strategic Migration Partnership
UK Council for International Students
Yorkshire & Humber Regional Migration Partnership

In addition 83 healthcare professionals or members of the public responded.

