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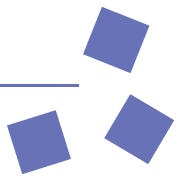
Qualitative Assessment of Visitor and Migrant use of the NHS in England

Observations from the Front Line - Summary



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Observations from the Front Line - Summary

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Department of Health

The views expressed in this report are those of the authors and the respondents taking part in the research, and not necessarily those of the Department of Health (nor do they reflect Government policy).

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The members of the research team would like to express our thanks to everyone who gave up their time to talk to us and share their views, to gather data and to help organise our schedules, often within very tight timescales. We hope that we have represented your views accurately and fairly. It has been a pleasure for us to work on this project and witness at first hand the dedication of everyone we have met.

1 Key Findings

- The complexity of the **current rules** around eligibility undermines the efficiency with which Trusts can identify patients who are ineligible for free NHS care and therefore chargeable.
- There is also some confusion and disagreement across Primary Care Practices both in terms of who they can and cannot register and whether or not overseas visitors can be charged for non-emergency treatment; some are charging while others are not.
- Although the **different categories of migrants and overseas visitors** are recognised and are being seen in all Trusts and Primary Care Practices involved in the research, data is not being collected in any systematic way and therefore evidence about the numbers presenting and the impact they are having is based on estimate and cases that are recalled. There was a high degree of consensus on many of the issues both within and between Trusts and Primary Care Practices, which suggests the data are reliable.
  - **EEA temporary residents and their families** are often felt to be having a significant impact in both primary and secondary care because of their numbers. For example, most Trusts involved in the research report that workers, students, those who are unemployed and/or their families are accessing a range of services including maternity
  - A similar picture is painted by respondents for **non-EEA temporary residents and their families**; in addition, there are frequent reports of family members coming to the UK to access treatment, sometimes on a regular basis
  - Although they may not be the largest patient group, for some Trusts taking part in the research, **irregular migrants** represent their greatest challenge both because of the amount of time it can take to establish their circumstances and, once established, because such patients often cannot or will not pay for their treatment

- **Ex-pats** present problems, partly due to the difficulty of identifying those who are visiting (as opposed to returning to reside in) the UK and partly because of the expectation on the part of many ex-pats that they are entitled to free NHS care
- Although there is widespread recognition of **people who 'fly in'** with the purpose of accessing NHS services **and then 'fly out' again**, respondents in both primary and secondary care report the difficulty in proving intent.

- The pressures upon already stretched **resources** by often increasing numbers of migrants and overseas visitors are widely felt in both primary and secondary care. These impacts are not only financial but also include concerns about the level of professional care staff are able to give, the knock-on effect on other patients`, and staff morale. It should be noted that such impacts may also be associated with treating the wider patient population. There is a call for these impacts to be recognised and addressed.
- Each Trust consulted during the course of the research is approaching the issue of **identifying and charging visitors** and migrants who are ineligible for free NHS care in a different way. The current systems used in many of these Trusts are not sufficiently effective and robust to identify all chargeable patients. There is plenty of opportunity for patients not to be identified as potentially chargeable.
- Respondents acknowledge that they are not identifying all of the chargeable patients being treated by their Trust. This is true not just in those Trusts who are currently doing the least to identify such patients; even the most proactive Trusts acknowledge this is the case. There is clearly **scope for Trusts to identify significantly higher numbers of chargeable patients and to improve recovery rates**.
- Respondents working within the NHS in both primary and secondary care **broadly support** the proposals put forward by the Department of Health although they raise **questions and concerns** about how they would work in practice.

2 Introduction

2.1 Background and Objectives

While the NHS provides a comprehensive service based on clinical need rather than ability to pay and is free to those who are 'ordinarily resident' in the UK, it also has a statutory duty to make and recover charges for treatment in NHS hospitals from non-residents and from those who are not exempt from charging under a large range of exemption categories.

The Department of Health (DH) is aware that the current system for charging is complex and difficult to implement and is seeking to address these weaknesses through a review of both the rules underpinning the system and their application. This research was commissioned as one of the strands contributing to this review.

The overall aim of the research was to provide DH with a better understanding of how key NHS stakeholders perceive the issue of migrant and overseas visitor use of the NHS in England, by engaging with a wide range of clinicians in primary and secondary care as well as managers and admin staff across England. Its purpose was to build a detailed picture of current practices and procedures and reactions to the proposed changes, whilst also looking into the scope of the issues and providing a basis from which DH can estimate the use of the NHS in England by different key groups. The findings, alongside findings from a quantitative modelling study, will feed into the consultation process and form a key component of the DH impact assessment to support policy changes.

Legislation permitting persons who are not 'ordinarily resident' in the UK to be charged for NHS services dates back to 1977, and subsequent regulations, first introduced in 1982, impose a charging regime in respect of hospital treatment for overseas visitors[1]. 'Ordinarily resident' is not defined but is a common law concept, which was the subject of a judgment in the House of Lords in 1982 in the context of the Education Acts, where it was defined as:

> *living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, whether they have an identifiable purpose for their residence here and whether that purpose has a*

[1] Source: www.parliament.uk/briefing-papers/SN03051.pdf

sufficient degree of continuity to be properly described as "settled". (Source: see footnote 2)

The situation is complex when it comes to deciding in practice who is and who is not eligible for free NHS hospital treatment. A summary of the situation for a number of different categories of people who may be living in the UK at any one time and who may or may not be eligible for free NHS hospital treatment other than emergency care provided within A&E is set out in Box 1 below. In practise, these distinctions can be very difficult to make on the ground.

The focus of this research is on categories 3, and 5 to 9; as a group, they are referred to throughout the report as 'migrants and overseas visitors'.

The term 'migrant' is used throughout the report to refer only to 'temporary residents' and not migrants and/or their descendents who have applied for, and been granted British citizenship (category 1), migrants who have ILR (category 2) or EEA permanent residents (category 4). However, it should be noted that NHS staff are unlikely to be able to differentiate between permanent and temporary EEA residents (categories 3 and 4).

The term 'overseas visitor' is used to refer to people who are visiting the UK on a temporary basis; this includes British ex-pats (unless they are returning to live in the UK on a permanent basis) as well as those of any other nationality who live overseas (categories 8 and 9).

This research is not concerned with private patients from overseas who are in the UK on medical visas for treatment.

Box 1: Categories of people living in the UK who may or may not be eligible for free NHS hospital treatment
1. **British nationals who have a right of abode and who live in the UK**: this will include immigrants and/or their descendents who have applied for, and been granted British citizenship.
2. **Migrants with 'indefinite leave to remain'** (ILR) who are living in the UK on a permanently settled basis.
3. **European Economic Area (EEA)[2] temporary residents:** EEA nationals (and their family members) who are resident in the UK but have not yet acquired permanent residence in the UK. An EEA national has an initial right to reside in the UK for three months. They have an extended right beyond that if exercising 'EU treaty rights' as a worker, a self-employed person, a job-seeker, a student, or a self-sufficient person. Until an EEA national acquires 'ordinarily resident' status, they would be chargeable for their hospital treatment unless covered by an exemption under the charging regulations, e.g. they have an EHIC card or are students. In practice this means that most EEA nationals are entitled to free treatment.
4. **EEA permanent residents:** EEA nationals who have been residing in accordance with the above conditions for five continuous years, at which point they acquire a right of permanent residence in the UK, which means they no longer need to exercise treaty rights in order to have a right of residence here.
5. **Non-EEA temporary residents:** people from outside the EEA (and their family members) who have been granted a right of residence for a limited period (usually between six months and five years). They may or may not go on to acquire ILR.
The above groups are all likely to pass the current 'ordinary residence' test and therefore be entitled to free NHS hospital treatment.
6. **Asylum seekers:** anyone who has made a formal application with the Home Office to be granted temporary protection, asylum or humanitarian protection which has not yet been determined. Formal applications are those made under the 1951 UN Convention and its 1967 Protocol and also some claims made on protection from serious harm grounds under Article 3 of the European Convention on Human Rights. A person whose application for asylum (or humanitarian/temporary protection) is accepted becomes a refugee.
7. **Irregular migrants:** any non-EEA national who does not have immigration permission to be in the UK.
8. **British ex-pats:** British nationals (or other person not subject to immigration control in the UK) who is a former resident of the UK but who now lives overseas.
9. **Visitors:** those, of any nationality, who live overseas but are visiting the UK.
The above groups (with the possible exception of refugees) will not pass the current OR test, so are chargeable except where exemptions from charge in the Charging Regulations apply.

[2] The European Economic Area (EEA) comprises the member states of the European Union (EU) plus Iceland, Liechtenstein and Norway. Switzerland has not joined the EEA, but has a similar agreement with the EU and as far as NHS services are concerned, Swiss nationals enjoy the same rights as nationals from EEA countries.

The research is qualitative in nature. This means that it is based on the opinions of a relatively small number of people (circa 150) but that these have been explored in considerable depth. Some numerical data is reported based on information provided by Trusts and Primary Care Practices but this research is not about measures of how many people thought one way or another but instead, about the range of different views and where the balance of opinion lies. **The findings should be read as indicative of the broader picture in terms of the range and diversity of practices being adopted across Trusts and Primary Care Practices in England. Nevertheless, great care is needed when trying to generalise to the wider population of Trusts and Primary Care Practices.**

2.2 Research Method

The research was made up of four main components as follows:

- **expert briefings:** two briefing sessions with members of the Overseas Visitor Advisory group (OsVAG)[3] to begin to develop an understanding of the issues
- **scoping study:** to gain a broader and more in-depth picture from individual Trusts selected to reflect the characteristics of all 161 Trusts in England; supplemented with views from officers on the front line at airports
  - 29 telephone interviews with 36 respondents from a cross-section of Trusts. In each Trust, this involved one or more OVOs or others taking on this role, and, in one or two cases with a more senior manager
  - interviews with nine members of Border Force and Immigration Enforcement based at five major airports in England
- **case studies**: to build greater understanding of the impact of migrants and overseas visitors in both primary and secondary care and how practices and Trusts are coping with them
  - seven Trusts involved in the scoping study were selected, in part, on the basis of a qualitative segmentation of the Trusts taking part. Four loose

[3] The Overseas Visitors Advisory Group (OsVAG) is a group formed and run by Overseas Visitor Officers, Overseas Visitor Managers and other NHS staff working in the area of identifying and charging non-UK residents who are not entitled to hospital treatment. OVOs are members of staff who have the responsibility for implementing the overseas visitor hospital charging regulations. Some individuals fulfilling this role were 'managers' (OVMs) while others were 'officers' (OVOs) on lower pay bands. For consistency, throughout the report, the term OVO has been used.

groupings were identified that reflected differences in attitude and approach to the issue of identifying and charging patients ineligible for free NHS care (see section 4.1 for further details). A total of 69 members of staff were interviewed face-to-face within the case study Trusts; these included OVOs, Finance managers, clinicians, nurses, reception and back office staff

- in each of the seven Trust areas, two Primary Care Practices were visited and interviews conducted with a similar cross-section of clinical, managerial, administrative and reception staff (14 practices and 62 people in total); a representative of the CCG[4] was also invited to take part (three were interviewed)

- **diary exercise:** to collect data about migrants and overseas visitors in a more consistent way; a 'diary' was distributed to all OsVAG members inviting them to keep a record of all patients brought to their attention over a two week period.[5]

[4] Clinical Commissioning Groups are groups of GPs that are responsible for planning and designing health services in their area to meet local needs.

[5] At the time of writing, the diary exercise was still on-going and the findings will be incorporated into a supplementary report.

3 Extent of the Use of NHS Services by Migrants and Overseas Visitors

3.1 Categories of Migrants and Overseas Visitors using the NHS

DH is interested in understanding the extent of use of the NHS by various categories of migrants and overseas visitor; these are summarised in Box 2. The categories were discussed in the expert briefing sessions with OsVAG members and refined based on their experience of working in Trust hospitals.

Box 2: Categories of migrants and overseas visitors		
European Economic Area (EEA) temporary residents		
students	workers	self employed
job seekers	economically inactive who do not have a right of residence as a family member	economically inactive who are state pensioners in another country
Non-EEA temporary residents		
students	workers	self employed
resident on another basis e.g. staying with family		
Asylum seekers		
Irregular migrants		
illegal immigrants	failed asylum seekers	overstayers
absconders	those applying for leave to remain	
British ex-pats		
visiting the UK	returning to live in the UK	
Visitors who fall ill unexpectedly while temporarily in the UK		
EEA nationals (with and without an EHIC)	Non-EEA nationals	
Visitors who 'fly in and fly out' (sometimes referred to as 'health tourists')		

In most cases, Trusts and Primary Care Practices taking part in the research are not systematically capturing information about the types of migrant and overseas visitor patients they are seeing; nevertheless, all of the categories were recognised and Trusts and Primary Care Practices reported seeing patients in all or most of the main categories. They occur in varying proportions depending on a range of local factors such as the level of tourism, the opportunities for casual employment, and the demographics of the local population, including the numbers of minority ethnic residents.

Given the lack of data on the numbers of patients falling into each category, what follows is largely based on estimate and experience, although in the case study Trusts, the views of the OVOs were largely backed up by the experiences of colleagues and in primary care, there was also consensus within practices.

3.1.1 EEA temporary residents and their families

For many Trusts involved in the research, it was reported that patients who are EEA temporary residents and their families[6] represent a key and growing challenge, in particular, the influx of patients from Eastern European countries. Typically, these patients are younger and of working age, are having families in the UK and in some cases, having parents to stay/live with them. Patients from EEA countries are, in most circumstances, not chargeable however some of the Trusts consulted are struggling to cope with the increasing numbers and see this category as presenting the biggest challenge. When trying to establish if someone is 'ordinarily resident' (OR) and therefore exempt from charging, Trusts face a particular difficulty with patients who have no documentary proof of employment or residence i.e. they are working for 'cash in hand' or staying with friends. So-called 'economically inactive' migrants who do not have a right of residence as a family member are potentially chargeable as they are required to be 'self-sufficient'. Some Trusts involved in the study are endeavouring to identify such cases but most have difficulty understanding who these people might be and are therefore not looking out for them.

3.1.2 Non-EEA temporary residents and their families

Non-EEA temporary residents and their families are evident in many Trusts involved in the research but especially those with diverse local ethnic populations. Some of the Trusts report seeing large numbers of students from local schools, colleges and universities accessing a range of services and there are reports of family members coming to the UK to access treatment, sometimes on an annual basis for check-ups and regular treatment. Often, these are elderly family members with increasing and chronic

[6] Since the acquiring of permanent residence happens automatically and is not dependent on the EEA national applying for it or receiving any associated documentation, the NHS is unlikely to differentiate between EEA nationals who are 'temporary residents' and those who are 'permanent residents' and some of the feedback relating to 'temporary residents' may, in fact, relate to both 'temporary' and 'permanent' residents from EEA countries.

health conditions. It can be particularly difficult to identify those who are not eligible for free treatment because they will claim to be residing permanently at the address of a family member and will typically have registered with a GP.

The Primary Care Practices involved in the research tend not to differentiate between patients from EEA and non-EEA countries. Nevertheless, they report broadly similar issues and, like their colleagues in secondary care, often feel these two categories present them with the greatest challenge due to the numbers of patients they are dealing with.

3.1.3 Asylum seekers

It was noticeable that the term 'asylum seeker' was often used when, in fact, respondents were talking either about 'failed asylum seekers' or 'refugees'; the former group falls into the 'irregular migrants' category.

Asylum seekers are not reported in large numbers and those who have been given indefinite leave to remain are viewed by respondents as comparatively easy to deal with because they readily present their documentation.

The difficulty with this category is during the period when their claim is being considered because they should not be working and the documents they provide can be of poor quality; for example, a photocopied A4 sheet provided by UKBA[7] with hand written details. Moreover, while an ARC (Application Registration Card) records the date the application was made, there is nothing to show when it is valid until and the cards are not taken away when the application is unsuccessful. Some OVOs report that failed asylum seekers use their ARC as a means of trying to access free healthcare.

3.1.4 Irregular migrants

Although they may not represent the largest patient group, for a number of Trusts involved in the research, irregular migrants represent the greatest challenge in terms of the amount of time it can take trying to establish if they are chargeable (this may involve liaising with immigration officers) and, once this has been established, recovering the

[7] On 1 April 2013 the UK Border Agency was split into two separate units within the Home Office: a visa and immigration service and an immigration law enforcement division. However, most respondents continued to refer to it as the UKBA and this is reflected in the report.

cost of treatment (it was reported that such patients are rarely in a position to pay for their treatment).

A number of respondents from primary care commented that in many situations they would not know whether or not a patient is an irregular migrant as they do not screen beyond asking for some form of ID and proof of address. Some practices are willing to accept patients of no fixed abode (NFA) and may not insist on patients providing any form of ID. One practice spoke about accepting referrals from asylum seeker and refugee support groups. Another spoke about pressure being brought to bear to register such patients by local inclusion groups.

3.1.5 British ex-pats

British 'ex-pats' includes those who are visiting the UK (and currently chargeable) and those who are returning to live in the UK (for whom NHS care is free). They are seen by most Trusts and Primary Care Practices taking part in the research with some coming to the UK to access healthcare for chronic conditions and/or costly treatments and younger ones coming to access maternity services. It is often difficult to identify those living overseas because they have retained a UK address, GP and NHS number. They may also be unaware that they are chargeable and resentful of the fact if brought to their attention.

3.1.6 Visitors who fall ill unexpectedly while temporarily in the UK

Visitors who fall ill unexpectedly may be from any part of the world and may present with or without an EHIC (if from the EEA) or other form of insurance. A number of issues around EHICs were described by respondents including the lack of awareness of them on the part of visitors from some EEA countries, the fact that some patients may not qualify for one and the ease of accessing a UK EHIC which may be used by the citizens of EEA countries when accessing treatment elsewhere in Europe.

Depending on their location and/or the local demographics, some Primary Care Practices in the research sample are seeing large numbers of tourists and/or people coming from abroad to visit families.

3.1.7 Visitors who 'fly in and fly out'

Although widely recognised, visitors who 'fly in and fly out' is not a discrete category but instead describes patients who fall into other categories who are coming to the UK with the express purpose of accessing healthcare and it was suggested by numerous respondents, potentially other benefits too. It may include the relatives of EEA and non-EEA temporary residents, self-sufficient EEA temporary residents, ex-pats, students and people travelling on visitor visas. In many cases where OVOs and primary care staff have suspicions, it is difficult for them to prove the patient's intent. Respondents in both primary and secondary care reported cases where patients have arrived in the country and very quickly enquire about registering with a practice and/or present in A&E with a pre-existing condition. Such patients are often felt to be very knowledgeable about accessing both the healthcare and benefits systems.

3.1.8 Clinical areas being accessed by migrants and overseas visitors

Most Trusts consulted as part of the research are able to provide an indication of the clinical areas more frequently accessed by visitors and migrants. Of the wide range identified, three stand out, namely Maternity, A&E and Trauma and Orthopaedics. For all but the specialist Trusts consulted in the research, Maternity is one of the departments most frequently accessed by migrants and overseas visitors and is felt to contribute to the pressures that such services are under.

Other clinical areas mentioned include the following but this is by no means an exhaustive list:

Cardiology	Oncology	Stroke
General Medicine	Ophthalmology	Termination of pregnancy
Gynaecology	Renal	Transplant

While for some procedures, the cost of treatment may be small (a few hundred pounds), for others such as dialysis or organ transplant, just one chargeable patient who is unable to pay will have a significant impact on resources and create tens if not hundreds of thousands of pounds worth of debt for a Trust.

3.2 Impacts of Migrants and Overseas Visitors

The main impact of migrants and overseas visitors is financial. As illustrated in the next section, Trusts involved with the research are currently failing to identify many chargeable patients and, where such patients are identified and charged, a significant proportion of the charges is not being recovered.

Although primary care is not chargeable, migrants and overseas visitors are perceived to be having a significant impact on most Practices taking part in the research through the combination of additional costs (for example, longer surgery hours and additional staff) and lost income (for example, through their inability to meet QOF[8] targets, such as childhood immunisation). The perception is that the method by which practices are reimbursed fails to take into account the additional demands placed on practices by migrants and overseas visitors especially where they have little, if any, English.

Those working in both primary and secondary care report other ways in which visitors and migrants make an impact on already over-stretched resources. These include impacts on other patients through bed blocking (for example, where a patient cannot be discharged because there is nowhere suitable for them to go), increased waiting lists and the ability to give less time to other patients because of additional time spent with patients who cannot speak English. It should be noted, however, that communication challenges may also apply when treating 'ordinarily resident' patients and indeed, UK citizens.

Clinicians sometimes also express concerns about the level of professional care they are able to give and their own vulnerability, particularly where there are communication challenges and it is difficult to ensure the patient is giving informed consent. Some of the more vulnerable patients (particularly irregular migrants) have complex health issues, arrive without health records and, combined with the language difficulties, take a great deal of resource to treat and manage, both clinically and with respect to social care.

[8] The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement.

Some respondents spoke of the impact on morale of treating some patients who, possibly as a result of cultural differences or variations in medical services or the way different conditions are treated in their home country, may turn up late (and sometimes not at all) for appointments, appear very assertive about the way they expect to be treated and intolerant of the waiting times and processes that UK residents accept as standard.

3.3 Conclusions

- The research has confirmed that the complexity of the current rules does undermine the efficiency with which the Trusts taking part in the research can identify patients who are ineligible for free NHS care and therefore chargeable. Understanding of who is eligible for free treatment and who is not is variable; even some OVOs lack a full understanding.

- There is also some confusion and disagreement across Primary Care Practices involved in the study both in terms of who they can and cannot register and whether or not overseas visitors can be charged for non-emergency treatment; some are charging while others are not.

- Although the different categories of migrants and overseas visitors are recognised and are being seen in all Trusts and Primary Care Practices involved in the research, data is not being collected in any systematic way. However, there is a high level of agreement and consensus both within and between Trusts and Primary Care Practices about their experience of these categories and the impacts they are having.

- EEA and non-EEA temporary residents and their families (see footnote 6, p9) are often felt by respondents to be having a significant impact in both primary and secondary care because of their numbers.

- In contrast, although they may not be the largest patient group, for some Trusts taking part in the research irregular migrants represent their greatest challenge both because of the amount of time it can take to establish their circumstances and, once established, because such patients often cannot or will not pay for their treatment.

- Ex-pats present problems, partly due to the difficulty of identifying those who are visiting (as opposed to returning to reside in) the UK and partly because of the expectation on the part of many ex-pats that they are entitled to free NHS care.
- Although there is widespread recognition of people who 'fly in' to access NHS services and then 'fly out' again, respondents in both primary and secondary care report the difficulty in proving intent.

4 Managing Visitors and Migrants

4.1 Different Approaches, Different Attitudes

Of the thirty Trusts involved in the main part of the research (scoping and case study strands), and those taking part in the briefing sessions, no two approach the challenge of migrants and overseas visitors in the same way, and there is wide variation in the priority they give it, the systems they have in place and the robustness of these systems in identifying and charging overseas visitors. As mentioned in 2.2, the research team concluded, after discussion, that the Trusts could usefully be divided into loose groupings - the less engaged (very small in number), the reactive, those with a clear sense of direction and the proactive (Trusts within the research sample were fairly equally divided between these latter three segments).

The aim of the case study strand of the research was to recruit the seven case study Trusts fairly evenly from across the reactive, clear direction and proactive segments (the less engaged having little to offer in terms of how they were managing overseas visitors and migrants). However, the reluctance of many Trusts in the reactive segment to participate further meant that just one case study Trust came from this segment and the rest were divided equally between the clear direction and proactive segments.

Box 3: A segmentation of Trusts

Segment	Characteristics
Less engaged Trusts	Trusts that either do not recognise the relevance of the issue of charging non-exempt visitors and migrants or have not put in place effective measures to tackle it.
Reactive Trusts	Often at an early stage in developing systems and seem to be waiting for very obvious patients to be flagged by front line staff rather than reaching out to/training staff in the range of patients who are potentially chargeable. May feel they do not have the resources to respond in a timely fashion or follow up patients who do not respond to enquiries about status. However, they are often keen to have a more dedicated role and training themselves, in order to perform better.
Trusts with a clear sense of direction	Aware of their responsibility to follow the guidelines and keen to do this. While systems might not be fully developed, they are often ambitious in what they are trying to do. They are actively training and monitoring what staff are doing on the front line and responding to their alerts promptly. They are also more rigorous in their checking and, on occasion, blocking treatment if patients have not satisfied them that they are eligible for free treatment.
Proactive Trusts	Some of the most experienced OVOs who are continually developing the systems in their Trusts to make them more effective. A few were also reaching out to primary care to improve relationships.

The principal characteristics of the segments are summarised in Box 3; they should be seen as representing a continuum rather than discrete groups as there is some overlap between them.

4.2 The General Process

The identification and charging of a patient who is ineligible for free NHS care is typically carried out in several stages:

4.2.1 Identifying potentially chargeable patients

For the most part, this relies on the eyes and ears of a range of NHS staff but particularly those on reception and in administration. Their task is to identify patients who may be chargeable and refer them to the OVO to investigate further. This may be done by asking questions of the patient and/or looking at other information about him/her.

The central question most Trusts taking part in the research have identified as the one that reception staff should be asking is whether the patient has lived in the UK for the past 12 months; in theory, this should be asked of all patients in order not to discriminate and then followed up if relevant. In reality, the question is not being asked of all patients and varies across Trust departments, individual members of staff and according to the busyness of clinics. Where it is being asked, patients may not provide an honest answer.

Regardless of whether the 12 month residency question is asked, it is clear that staff are using other shortcuts to identify visitors and migrants including language, accent, name and nationality as well as making sometimes incorrect assumptions about who is and is not chargeable.

The other more objective signals of possible chargeability which may be picked up from the patient information system include an overseas address, not having an NHS number or GP, having a recent NHS number, or admitting to having had tests conducted overseas. Some Trusts in the research sample also use a Pre-Attendance Form (PAF) to collect various information from patients, ideally in advance of their appointment.

While clinicians from the sample Trusts are sometimes in a good position to help identify patients who are visitors and migrants, they are generally reluctant to become involved, and prefer to assume that screening is being done elsewhere.

4.2.2 Establishing whether the patient is exempt or chargeable

Once they are informed of a potentially chargeable patient, the OVO makes contact in order to request further information and, in many cases, documentary proof of status; this may be done by phone, email, letter or face to face interview. Patients may be co-operative, obstructive or may simply not respond. Using this information, the OVO then has to check whether the patient might fall into one of the many exemption categories contained in the regulations; this can be extremely time consuming because of the number of exemptions and lack of clarity of the guidelines. Various sources of help may be called upon to support their decision-making. Many OVOs consulted during the research express frustration that only a small proportion of patients they investigate are actually chargeable.

OVOs were asked to provide an estimate of the number of patients being identified as directly chargeable (i.e. excluding those that were exempt or were from the EEA and held an EHIC). The number of chargeable patients being identified in a twelve month period across the sample varied from 0 to 720 per Trust across the 29 Trusts providing an estimate. The total number of such patients across the sample was 3,387 per year. Estimates of the total amount charged to such patients were provided by 26 of the Trusts. The total amount being charged by these Trusts came to just over £4.5m per annum with a range from just under £3,800 to over £900,000 per Trust per annum.

Complete data were provided by 24 of the Trusts and this reveals that the average amount being charged per patient ranged from £250 to over £43,000; the latter was a specialist Trust. In between these two extremes, the average per patient charge was less than £1,000 in the case of seven Trusts, between £1,000 and £2,000 for a further seven trusts, and between £2,001 and £4,658 for the remaining seven Trusts.

4.2.3 Advising and invoicing chargeable patients

The Trusts taking part in the research generally recognise the importance of giving timely advice to patients about the fact that they are not eligible for free NHS treatment and about the amount they might be liable for because of the resentment caused and

resistance to paying if they find out only after treatment has begun. Moreover, many of the OVOs consulted believe this is the fair way to deal with such patients. Some of the Trusts have put in place procedures to enable patients to be invoiced up-front with the understanding that a follow-up invoice will adjust the amount to reflect the cost of the actual treatment provided. However, the inadequacy of current systems/processes often means that there is a delay and patients may be surprised to find they are being charged at all or shocked by the size of the bill.

Where patients are not exempt from charges, they may claim that they cannot afford to pay. In this situation, clinicians may decide to treat regardless of whether it is immediately necessary, or the patient may be stabilised and discharged, or if an elective procedure, treatment may be refused. OVOs may also help patients to arrive at a payment plan to spread the cost but the sums paid each month are sometimes felt to be too small and experience suggests the patient is likely to default on the debt.

4.2.4 Raising and recovering charges

The coding of procedures, raising of invoices and chasing those which are not paid is handled in various ways, with some of the Trusts outsourcing the invoicing and/or recovery elements. The preference is to invoice patients rather than the insurance companies although OVOs will liaise with companies to help patients.

The recovery of charges is a significant problem for most Trusts in the research sample and many are aware that in certain cases payment is unlikely. While many are rigorous in charging wherever justified, others may be more reticent and, in some cases, charge the PCT/CCG if the patient is registered with a GP/has an NHS number. Some OVOs involved in the research readily admit that where they cannot get the information they need about a patient or the patient has no fixed abode (NFA), they may not pursue the matter and put the patient through as exempt.

Threats to report an unpaid bill to UKBA with the consequences for future visa applications are generally seen as helpful in recovering debts from non-EEA patients, especially those with family in the UK who have reason to travel back and forth on a regular basis[9].

[9] If a migrant or overseas visitor owes £1,000 or more to the NHS for treatment from a previous trip to the UK, visa applications can be refused until the debt is repaid.

Estimates of number of patients who are charged but do not pay

OVOs taking part in the research were asked to provide an estimate of the number of patients who are charged by their Trust but who do not pay. Not all were able to do so. Among those that did provide an estimate (n=21), this ranged from 0 to 335 patients per Trust per year, with a total across the 21 Trusts of just over 1,300 patients per year. When this is expressed as a percentage of all the patients charged by each Trust, the range was 0 to 100 per cent of patients; half the sample estimated that less than 50 per cent of the patients who were charged did not pay, while the other half estimated that more than 50 per cent did not pay.

Estimates of the amounts being recovered

23 Trusts provided an estimate of the amounts of money recovered from chargeable patients. The estimated annual amounts ranged from £1,581 to £261,495 per Trust with a total amount across the 23 Trusts of just over £1.2m. When expressed as a proportion of the total amount charged to chargeable patients, the amounts being recovered ranged from less than 1 per cent in one case, to 100 per cent in the case of a Trust that had only charged two patients in 2012/13. 14 of the 23 Trusts reported recovering less than 50 per cent of the amounts that had been charged, while nine reported recovering between 50 and 100 per cent of the sums in question. These figures do not include outstanding invoices where a payment plan has been put in place but, as noted above, it was reported that where there is such an arrangement, the Trust often fails to collect the full amount due.

Levels of debt

For the 22 Trusts providing the information, estimates of current levels of bad debt ranged between £0 and £0.7m pa and, in total, amounted to more than £3m. The estimated level of bad debt per patient charged in a twelve month period ranged from £0 to over £100,000. **NB** the reported levels of bad debt are likely to be an underestimate as they do not include any debt carried over from previous years; they also include outstanding sums where a payment plan is in place but as noted above, these sums may not be recovered.

20 of the Trusts provided data about write-offs; however, the time period that the figures relate to varied from, in one case, 2006 to 2013, to, in five cases, the last twelve months. In some other cases, the time period was not provided. The amounts in

question varied between £0 and £1m, with a total bad debt in excess of £2.25m across the 20 Trusts.

4.3 Examples of Good Practice

Looking in detail at what individual Trusts within the research sample are doing in coping with visitors and migrants, a number of examples of what might be seen as good practice can be identified, predominantly from the proactive Trusts and those with a clear sense of direction. These are summarised in Box 4.

The OVOs involved in the research acknowledge that whatever system their Trust has in place to identify potentially chargeable patients, it is by no means foolproof and that a sizeable number of patients who should be charged are not being identified. This is true across all of the Trusts taking part in the research from those who are currently identifying the largest numbers of such patients to those who are identifying very few. It is not unusual for OVOs and other members of staff to suggest that they may only be identifying 50 per cent of chargeable patients with some admitting that it could be far less. Evidence was also provided of how more resource and/or tightened up procedures has led to large increases in the numbers of chargeable patients identified and charged.

Taking all of the above into account, it is not unreasonable to assume the numbers being identified and the sums being charged could easily double if more systematic procedures were introduced.

A summary of the situations in which patients may not be identified as chargeable or invoiced is set out in Box 5.

Box 4: Examples of good practice

Stage of the process	Ideas for good practice
Identifying potentially chargeable patients	• Ongoing training of staff, ideally including at induction to emphasise the importance of asking all patients the residency question • Making patients aware of the possibility of charging with leaflets and posters in waiting rooms; leaflets sent with requests for information • Supplementing/replacing the 12 month residency question to ascertain pattern of movement, whether a UK national and right to reside in the UK • Using/adapting existing forms used in departments which

	patients have to complete • Using the forms at all stages of the process to ensure patients are not missed including pre-admission appointments for Inpatients • Proactively asking frontline staff for updates on possible migrants and overseas visitors rather than waiting for them to find time to contact the OVO (especially important for A&E and patients who have been referred onwards and therefore become chargeable) • Involving back office staff to screen all referrals, check NHS numbers etc • Where reports are provided of potentially chargeable patients, this is done on at least a daily basis to ensure a fast response • Looking for other indicators e.g. recent NHS numbers that can be followed up using Spine • Automatic referral of all new patients from overseas presenting for the first time late in their pregnancy • Copying/scanning and storing of documents provided as proof of status
Establishing whether the patient is exempt or chargeable	• Requesting patients to send in/bring in to their appointment documents that prove their status so as to screen them before treatment • More rigorous questioning of patients and identification of key documents to be provided as proof of OR status • When patients have failed to prove they are exempt, invoicing in advance of treatment to encourage them to provide the documents and if necessary, blocking treatment (with the agreement of the consultant) • Checks performed with immigration officers and DWP (for ex-pats) with patients' consent
Advising and invoicing chargeable patients	• Advising patients of the estimated cost/invoicing patients in advance of treatment
Raising and recovering charges	• Gaining full or a significant part of the payment in advance • If patients are unwilling to pay, non-urgent appointments may be cancelled • Where patients admitted from A&E are unwilling/unable to pay, their file may contain the statement that they are to be treated until they are stable • Elective Inpatients who are chargeable may be directed to treatment as private patients
Ongoing tracking	• Logging alerts on the Trust database for chargeable patients in case they return/have not paid their invoice • Also logging of relevant details such as visa expiry dates

Box 5: Reasons why patients may not be identified and charged

- Non-exempt patients who have already accessed NHS services and do not figure as new patients may not be challenged
- It is commonly accepted that having an NHS number means that someone is eligible; all the more so if someone has a GP
- Where GPs or other clinicians have identified a patient as exempt (although they may not be), this may simply be accepted; similarly, referrals via Choose & Book may be subject to less scrutiny
- Use of self check-in points make it easier for patients to give answers that will gain them free treatment without being questioned further
- If patients are asked about their residence as a precursor to finding out whether they are OR, the staff member may accept their answer unless there are any other clues to alert them. Moreover, the patient may not be entirely honest and may provide information that ostensibly suggests they are OR
- If there are clues to suggest someone may not be OR, these may/may not be followed up. Even where Trusts follow up as routine to seek evidence, if the patient is not forthcoming with further information/documentary proof, some Trusts may give up and charge to the CCG
- If patients respond in a confrontational manner, possibly threatening legal action, or refuse to provide answers, a Trust may choose not to pursue the matter
- Given the multitude of exemptions and the lack of clarity surrounding them, a patient could be misidentified as exempt
- Details about a patient's status may be incorrectly entered on the patient information system or may be altered to make him/her exempt
- Having identified a patient as someone who merits further investigation by the OVO, staff may not inform the OVO
- Even though the OVO has been informed, he/she may not have the time to follow up or follow up in an effective way
- A patient may be deemed too difficult to classify or to pursue payment so is not invoiced, for example, if of no fixed abode
- If a patient insists they will not pay or if the Trust believes they do not have funds to pay
- Trusts may not want to risk not being compensated if the patient provides the necessary documentary proof outside the window for charging to the CCG or may not wish to risk double charging (the patient and the CCG)
- If Trusts are invoicing chargeable patients but, as a result of non-recovery of the debt, the amount they are writing off is increasing, they may decide to be more selective about those they pursue.

4.4 Conclusions

- The current systems used in many Trusts are not sufficiently effective and robust to identify all chargeable patients. There is plenty of opportunity for patients not to be identified as potentially chargeable and much disincentive to do this if the

patient's status is unclear or they are unlikely to pay. In such situations, it is easier for the Trust to put the associated costs through to the commissioners.

- Some frontline staff avoid asking basic questions because they feel uncomfortable about asking all patients the central residency question and have fears about being perceived as discriminatory. However, staff are laying themselves open to this charge as they may be using other, more discriminatory indicators and this is neither fair nor effective.
- Even the most proactive Trusts are aware that they are not capturing all chargeable patients, and in some Trusts the numbers who are not being identified could be very large; for example, one of the less engaged Trusts was treating and not charging everyone with a GP and NHS number.
- The starting point of proactive Trusts is much more one of the patient having to prove exemption from charging rather than the frequent assumption of less engaged and reactive Trusts that patients are OR or probably exempt unless there are very strong indicators otherwise.
- Chargeable patients need to be identified and advised that they are chargeable, as well as being informed of the scale of the charges, as early as possible; ideally, this should happen before treatment. An initial invoice should be raised in advance and treatment should not take place unless payment has been received/there is an undertaking to pay as a minimum.
- At the moment, one of the limiting factors in terms of what OVOs can achieve is the number of staff devoted to the task and their ability to respond in a timely manner.
- There is also a need to create awareness of the possibility of charging and the associated tariffs so that patients have an idea of costs; ideally before they arrive in the UK.
- Where Trusts have started to adopt more robust processes, they are identifying and charging more chargeable patients and achieving higher levels of payment; examples include:

- a Trust that has doubled the size of its OV team and developed more effective systems and, as a result, has doubled the number of chargeable patients being identified and increased the level of debt recovered to 87 per cent

- a second Trust reported that the numbers of chargeable patients being identified tripled after it tightened up its procedures

- yet another Trust had started invoicing chargeable patients in advance of treatment wherever possible. As a result, whereas, in the whole of 2012/13, it received £21k in advance payments from chargeable patients, in the first eight weeks of the current financial year, it had already received advance payments totalling £23k.

- Based on their own reports, it is not unreasonable to assume that, at best, only 50 per cent of such patients are being identified. However, this is an unknown and the actual numbers could be considerably higher. There is clearly scope for Trusts to identify significantly higher numbers of chargeable patients.

- Not only are Trusts not identifying all of the chargeable patients they treat, currently they are recovering, in some cases, less than half of the amounts they are charging. There is clearly scope for Trusts to improve recovery rates significantly.

- While the sums of money being charged to non-exempt patients may be very small in the context of the overall expenditure of Trusts, the qualitative effects of these additional patients within both primary and secondary care, with their often particular needs, means that overstretched resources are coming under even greater pressure. The frustration and anxiety caused to staff are very clear and they want the additional demands to be recognised in contracts and the resource to be found to help them cope. They also do not want the service that other patients receive to be less than it should be due to the pressures of meeting the needs of migrants and overseas visitors.

5 Response to Proposals and Other Ideas

DH put a series of proposals for change out to public consultation during the period of the case study interviews. For the most part, those taking part in the research were coming fresh to these and there was not time to discuss them in detail. Other ideas were also invited from respondents that they felt could help improve current systems without, or in advance of, the implementation of the proposals.

5.1 Response to the Proposals for Change

At the heart of the proposals is the principle that everyone obtaining healthcare from the NHS should make a contribution to the cost of the service. There is broad support across the sample for many of the proposals, at least in principle, although there is some questioning of how they can be implemented and whether they will be the complete answer to the challenges presented by migrants and overseas visitors. A general concern is that the cost of setting up a new complex infrastructure may outweigh any increase in income. More specifically, the feeling was that the changes will not, as they stand, help to identify patients in the system who are chargeable but who are currently hidden because they have an NHS and hospital number and a GP. They will not resolve the issue of irregular migrants who need to access healthcare but who are unable to contribute and who may be deterred from doing so; nor will they tackle the concern of a number of respondents of non-working EEA patients accessing healthcare in the UK that is not available to them in their home country, as well as benefits.

5.2 Health levy/compulsory insurance

Taking each of the specific proposals that were discussed in turn, while the idea of a health levy as a means of contributing to the NHS is understood, the sums of £200 and £500 per person are viewed in terms of individual patients and what they might cost the NHS rather than the creation of a larger fund that will help pay for the treatment of the proportion of such visitors that access NHS services. The fear is that people paying the levy[10] might see it as a cheap means of gaining access to the NHS, or those who might

[10] It should be noted that the levy would not be applicable to short term visitors, who would continue to be charged directly unless covered by a reciprocal agreement. This may not have been apparent to all respondents.

not otherwise access the NHS while in the UK, might now feel they wish to exercise their entitlement to do so. Sometimes seen as a preferable alternative to a levy, the downsides of compulsory insurance are also recognised, not least because Trusts involved in the research are familiar with the problems of dealing with insurance companies. In addition to the fact that disputes can arise with such companies over pre-existing conditions, these downsides include the lack of reliable insurance companies in certain countries and the possibility of people cancelling their insurance once they have used it to obtain a visa.

5.3 Pre-registration

There is support from many respondents for the concept of pre-registration, the idea of screening in advance of accessing healthcare to ascertain a patient's status. While the primary and secondary care providers involved in the research would prefer this process to be carried out before the patient presents and see that it should facilitate identification and charging of those who are ineligible for free NHS care, problems are foreseen with its implementation. The greatest of these is that many patients may fail to pre-register (for whatever reason) and simply turn up in the GP practice or at A&E, possibly seeking emergency care. This eventuality, combined with the numbers of chargeable patients already in the system, means that Trust-based screening will still be needed.

5.4 Extension of charging

The extension of charging for patients ineligible for free NHS care to include A&E and primary care attracted a mixed response across the sample. While such a move reflects the situation encountered by UK citizens travelling to many other countries, it is questioned whether a charge should be levied for genuine emergencies and very importantly, what the effect might be on patients who are unable to pay. Difficulties are also envisaged with the very concept of collecting money at these points including the nature of the fee (flat rate or treatment dependent) and when and where it would be collected. Any charging regime needs to be equal between the two settings unless there is a desire to encourage patients to use one rather than the other.

5.5 Centralised invoicing and recovery/legal gateway

While the idea of centralised invoicing and recovery has some appeal to respondents, greater detail is required to understand how it might work in practice to ensure that it is genuinely more effective at recovering debt. Of all the proposals, that of affirming and developing a legal gateway to assist agencies to share information within certain boundaries is most enthusiastically received by respondents, largely because the perceived need for, and benefits of, such multi-agency working are already recognised by many of the Trusts and Border Force officers taking part in the research, and the idea of making this exchange more straightforward, has appeal.

5.6 Other Ideas Generated by Participants

The various suggestions put forward by participants cluster into five main areas.

5.6.1 Culture change within the NHS

It is felt that there needs to be an acceptance within the NHS that in certain circumstances, patients will be asked to pay for their treatment. Moreover, training is required for clinicians and other staff to understand the rules governing this, their role in ensuring it happens, and how treatment that is non-urgent should not be provided.

5.6.2 Active communication programme

People coming into the UK and patients more generally also need to be made aware of the rules governing eligibility for free treatment, the costs they might face and how the healthcare system in this country works.

5.6.3 Regulatory framework and greater clarity

There is a call for a clear legal framework setting out eligibility for free treatment, consistency between the regulations governing healthcare, social care, immigration and benefits as well as a generic procedure/system to be used by all Trusts. The perception was that the guidelines and support provided by the DH require improvement and strengthening.

5.6.4 Improvements to existing systems

These include the systems for sharing information between agencies, the tariffs that can be charged to ensure costs are fully recovered, patient information systems and the

requirement to renew one's NHS registration every few years to help identify chargeable patients already in the system.

5.6.5 Changes within immigration systems

These are aimed at identifying people who intend to access NHS services and who may wish to avoid paying even though they are chargeable. Most notably, they involve questions being asked about health conditions and the funding that is available to cover the costs of any healthcare that is required.

5.7 Conclusions

- Those working within the NHS in both primary and secondary care and taking part in the research broadly support the proposals put forward by the Department of Health although they raise questions and concerns about how they would work in practice.

- Respondents also put forward a range of suggestions which they feel would help in identifying and charging non-exempt patients either in the absence of the proposed changes or alongside them. These relate firstly to a need for culture change and communication programmes aimed at increasing awareness of, and changing attitudes to, the charging of certain overseas visitors for NHS treatment. Other suggestions address the perceived need to clarify and strengthen the regulations governing charging, and improve the systems and procedures to implement these effectively. These suggestions certainly seem to merit consideration given that they are based on such a wealth of experience on the front line.

- In addition, consideration should be given to whether the role of the OVO should be professionalised in some way in order for the range of skills and competencies it requires to be recognised, appropriate training to be devised and provided, and for the role to be given greater recognition within Trusts.