Review of access to the NHS by foreign nationals

Consultation on proposals

February 2010

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Department of Health

Review of access to the NHS by foreign nationals

Consultation on proposals

Prepared by Resource Allocation,
Efficiency & Income Generation Division

February 2010

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Foreword by Ann Keen, Parliamentary Under-Secretary of State for Health

The National Health Service exists to provide for the country's health and well-being. Free treatment at the point of delivery based on clinical need has been at its heart since it was founded in 1948. Our NHS remains the envy of the world.

There are occasions when people visiting our country will need access to healthcare. The NHS has a duty to any person whose life or long-term health is at immediate risk, and medical treatment must not be denied to them. Wider public health must also be protected by ensuring that infectious diseases are identified, treated and contained wherever they occur in the population.

However, we cannot afford to become an 'international health service', providing free treatment for all. This would also risk encouraging people to enter, or remain, in the country solely to access treatment. Successive governments have therefore maintained a policy of charging non-residents for most hospital treatment.

Maintaining a policy that balances cost, public health, migration and humanitarian principles is challenging. We set up the Review of Access to ensure that our policies continue to reflect these competing needs. The review was undertaken jointly with the Home Office (UK Border Agency), with input from frontline NHS professionals. It also took into account the views of a range of key interest groups. Ministers have considered the findings of this review and concluded that the current policy balance remains substantially sound, but has proposed limited changes to protect the rights of the most vulnerable groups, which are the subject of this consultation.

In particular, we want to ensure that the health of vulnerable children is not compromised by the status or actions of a parent or guardian. We are also proposing that failed asylum seekers who are supported formally by the UK Border Agency while there are recognised barriers to them leaving the country should retain their entitlement to free healthcare during this period. This exemption would be consistent with the support that the Border Agency already provides to those who are co-operating with their eventual removal. We do not, however, believe that other failed asylum seekers, who make no commitment to leave, should be afforded this benefit.

Free NHS hospital treatment is provided as of right only to current lawful residents of the UK, but increasingly some of these residents want and need to travel abroad for extended periods, whilst still substantively living in this country. We want to ensure that this does not compromise their NHS entitlement and are therefore proposing an extension in the period of time that they may be absent before this may occur.

Unpaid debts from visitors who have been charged for their treatment are small in relation to total NHS spending but it is important that we maximise recovery, not least to discourage deliberate abuse by a small minority of visitors. The Home Office are consulting separately on a proposal to refuse requests for entry visas and permission to stay to those who have outstanding debts for previous NHS treatment. We support this initiative as an important measure to recover debt and reduce further misuse of the NHS, and propose to share the data and information necessary to enable this.

Many other countries expect or require visitors to meet their health costs through personal insurance. In this country, we exempt a range of visitors from NHS charges including many workers and students. For those who are charged we rely on recovering costs directly from the individuals themselves with the collection difficulties that often poses.

However, it is right that we look again at the scope of exemptions for visitors, particularly where these are not reciprocated for UK residents by other countries. Insurance-based approaches create many practical difficulties, and raise questions about how they could be enforced effectively and equitably. Nevertheless, such an approach would enable us to simplify our rules and better manage access to NHS resources and we are determined to address any challenges to deliver this goal.

We will now commence a more comprehensive study leading to development of firm proposals and are seeking early input to inform this work. This consultation provides you with the opportunity to comment on the proposed changes to the charging regime for hospital treatment and the recovery of these charges, and also on our initial thinking around the possible introduction of a health insurance requirement for some visitors, and I look forward to receiving comments.

Chapter 1: Introduction

Background to NHS access and charging rules

The National Health Service (NHS) Act 1946 created the NHS to provide health services free at the point of need. This founding principle was restated in subsequent NHS Acts including the NHS Act 2006 and in the NHS Constitution[1]. Entitlement to free NHS secondary care services is based on ordinary residence in the United Kingdom. People who are not ordinarily resident may still receive treatment but will usually be charged for it. The NHS Act 1977 introduced powers to charge those who are not 'ordinarily resident' and regulations to enable charging for secondary care (hospital treatment) first came into force in 1982.

This basic position is modified by two considerations:

- Public health: Preventing the spread of infectious diseases requires early identification and treatment. In particular, the treatment of certain infectious diseases, such as tuberculosis and pandemic flu, is free to all.
- Emergency treatment: Access to emergency healthcare should not be denied to any person. Treatment in an Accident and Emergency department is always free and immediately necessary or urgent treatment given elsewhere is not refused or delayed due to the patient's immigration status or ability to pay, although they will be charged.

The widespread availability of high quality healthcare that is free at the point of access creates a risk that some visitors to the UK deliberately access healthcare without paying, known as 'health tourism'. For others who attempt to enter and/or remain in breach of the country's immigration laws NHS services may be one attraction among many. As part of the Government's immigration strategy, both to discourage illegal entrants and to dissuade those already present from overstaying, access to public services and benefits is restricted; people who are not residing lawfully are entitled to healthcare only on a chargeable basis.

So, the regulations and guidance on NHS access and charging have to support the provision of healthcare that meets residents' entitlements, public health and humanitarian obligations, while also protecting finite NHS resources, and supporting wider government strategy on migration. Administrative processes to

1 www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

manage access and implement charging also have to be practical, proportionate and cost effective, and professional clinical staff, whilst having a responsibility to help ensure that the charging regime is upheld, should not be held accountable for administering immigration rules. Charges should be applied to non-UK residents in a rational, non-discriminatory, consistent and defensible way.

Background to the Consultation

In March 2007 the Department of Health agreed to a joint review with the Home Office of the rules governing NHS access for foreign nationals[2]. The review considered whether our policy on access for overseas visitors is consistent with the aims and principles described above. The review team included Department of Health and Home Office officials, as well as NHS and UK Borders Agency (UKBA) representatives. The review's recommendations were considered by ministers in both departments. The terms of reference for the review (see Annex 2) focused on specific issues relating to migration and healthcare. However, the broader principles of charging for hospital treatment and the current charging exemptions were also considered as they arose.

This led to a package of proposals, which were announced in a written ministerial statement on 20 July 2009 (see Annex 1):

- failed asylum seekers who continue to be supported by the UKBA because there is a barrier to their immediate return should be exempt from charges for secondary healthcare;
- other failed asylum seekers should remain subject to charging on the same basis as currently;
- all unaccompanied children should be exempt from charging;
- the period of time that UK residents can spend abroad without being potentially liable for charges for treatment should increase from three to six months;
- overseas visitors with significant debts to the NHS may be denied the right to enter the UK; and
- we will explore ways to make health insurance compulsory for visitors who do not qualify for reciprocal healthcare.

Ministers concluded that there should be no change in current access rules for primary care (see Annex 4), and that secondary care charges for maternity services should remain (although maternity care should not be delayed pending payment).

2 http://www.ukba.homeoffice.gov.uk/sitecontent/documents/managingourborders/enforcementstrategy/

A new study has been commissioned to review the evidence base underpinning the policy on charging for HIV treatment.

This consultation seeks responses on:

- the proposed changes to the Charging Regulations;
- the guidance that supports application of these Regulations;
- the outcome of an exercise to consolidate existing Regulations on NHS charging (whilst maintaining current policies and rules); and
- initial considerations on the option of compulsory health insurance for some visitors (to inform further policy development work).

The Home Office is running a separate consultation on the review proposal to amend immigration powers to withhold access to the UK where a visitor has an outstanding material debt for NHS treatment[3].

The provision of healthcare is a devolved responsibility and so the proposals described here are applicable to the NHS in England only. Immigration and border control powers, however, are UK-wide and the Department of Health and the Home Office are working with the devolved administrations to identify where there are opportunities to co-operate to meet the challenge of health tourism.

Subject to this consultation, the proposals, which are described more fully in Chapter 3 will require changes to the existing Regulations. The new Regulations will also reflect a consolidation of previous Regulations (details of which are in Chapter 2). The Operating Guidance will also be reviewed and take effect when the new Regulations come into force. The proposals contained in Chapter 4 will require implementation by a variety of means, including secondary legislation. The proposals set out in Chapter 5 are only at a very early stage of consideration.

3 Home Office/UKBA Consultation on Refusing Entry or Stay to NHS debtors. A Public Consultation around Proposed Changes to the Immigration Rules. This document can be found on the Home Office web site www.homeoffice.gov.uk

Chapter 2: The Charging Regulations and Guidance

The legislative context

The NHS Act of 1946 requires that health services are provided free at the point of need for the 'people of England and Wales'. The NHS Act 1977 provided the Secretary of State with powers to make charges for the provision of healthcare to persons who are not 'ordinarily resident' in the UK[4].

Patients who are not ordinarily resident in the UK are charged (at NHS tariff rates) for their hospital treatment unless benefiting from exemptions. `Ordinary residence' was considered by the House of Lords[5] and applies to a person living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, with an identifiable purpose for their residence here which has a sufficient degree of continuity to be properly described as 'settled'.

So, free entitlement is based on current lawful residence, not nationality, past residence or past or current payment of taxes or national insurance.

Exemptions from charging are set out in Regulations, including:

- treatment for certain infectious diseases, such as pandemic flu;
- treatment in an Accident and Emergency department;
- an entitlement for visiting students and some former UK residents working abroad; and
- an entitlement for treatment on a 'needs arising' basis for nationals or residents of countries with which the UK has a bilateral healthcare agreement.

The Regulations place a legal obligation on NHS bodies to:

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

4 These powers were subsequently consolidated into the NHS Act 2006.
5 R v Barnet LBC EX p Shah (Nilish) 1983 2 AC 309 HL

- charge those liable to pay; and
- recover the charge from those liable to pay.

Consolidating the current Regulations

The current Regulations were made in 1989 and have since been amended to take account of changes in the NHS structure and organisation, the implications and requirements of devolution, and EU and international law or treaty commitments, as well as a number of policy changes. Frontline NHS managers and patients have told us that some of the Regulations and definitions are unclear or potentially ambiguous.

In response, we have prepared a consolidated set of Regulations. Although these have been restructured and simplified, they do not change the intent of the existing Regulations, but clarify them to ensure that they can be applied properly and consistently within the current NHS structure. To support comparisons of the current and new draft Regulations, a list and explanation of the main amendments (other than simple changes like reordering) is provided at Annex 3. A full copy of both the current Regulations and the draft new Regulations have been provided in the papers supporting this consultation document. These draft new Regulations may be subject to further modification for legal or technical reasons.

Substantive policy changes, if confirmed by this consultation, will be incorporated into this new consolidated draft before it comes into force, expected to be during 2010.

Question

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

Question

2. **Do you agree that the consolidated Regulations do not imply any material change in policy?**

Guidance on implementing the charging Regulations

To support the application of the Regulations, the Department of Health has published and regularly updated Guidance[6]. This includes full explanations of all charging exemptions, the process by which a patient's eligibility should be verified, and how charges should be made. It is aimed primarily at NHS staff who administer the Regulations, but patients have also found it useful.

An updated version of the Guidance will be published when new Regulations come into effect. A draft of new Guidance to support the consolidated Regulations has been published alongside this consultation document[7]. This draft does not reflect the proposals we are describing in Chapters 3 and 4.

Question

3. **Does the new draft Guidance clearly and comprehensively explain how the consolidated Regulations should be interpreted and applied?**

Safeguards for the provision of urgent treatment

In line with obligations under the Human Rights Act, current guidance makes clear that immediately necessary treatment (to prevent a condition from becoming immediately life threatening or is needed to prevent permanent serious damage to their health) must not be denied, irrespective of whether a patient is liable to charges or their ability to pay such charges.

Furthermore, urgent treatment (not immediately necessary but, in the opinion of a clinician, cannot wait until a person is reasonably able to return home), should not be delayed if payment cannot be secured ahead of treatment.

Treatment should be limited to what is required to prevent significant or life threatening deterioration in health before the patient may leave the country.

In April 2009, the Court of Appeal ruled[8] that the then current guidance on these obligations was not sufficiently clear. The Department issued interim guidance, in a letter to the NHS[9], immediately following the judgment, and committed to a more comprehensive review before reissuing the full guidance document.

6 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4080313
7 Document can be found at: http://www.dh.gov.uk/en/Consultations/index.htm
8 R on the application of YA v Secretary of State for Health, [2009] EWCA Civ 225
9 www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_097384

Working with key stakeholders, this section has now been redrafted and is included as Chapter 3 of the proposed new Guidance.

Question

4 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?

Chapter 3: Proposals for change to the Charging Regulations

Introduction

The current entitlements to healthcare for overseas visitors are designed to balance protecting the taxpayer, ensuring people's human rights, protecting public health, and potential impacts on migration. We are proposing further changes to ensure these considerations remain properly balanced in the following cases:

- failed asylum seekers who are supported by UKBA because there is a recognised barrier to their immediate return;
- unaccompanied children; and
- UK residents who are absent abroad for up to six months.

The proposals relate to secondary care (hospital treatment) that is covered by the Charging Regulations described in Chapter 2.

Asylum seekers and failed asylum seekers

Currently people seeking refuge or asylum are exempt from NHS charges while their claim is still outstanding, and any appeal is ongoing.

Those whose claims have been refused (failed asylum seekers) are chargeable for most treatment that begins after they have been directed to leave the country and their full appeals process has been exhausted[10]. Immediately necessary or urgent treatment may still be provided in advance of payment (see 'Safeguards for the provision of urgent treatment' in on page 8) although a charge must be levied. Charges may be written off after reasonable efforts have been made to seek recovery, taking into account the person's ability to pay.

10 Failed asylum seekers who have been in the UK for one year or more prior to treatment can continue, without charge, with a course of treatment already underway when their application is ultimately refused. This course of treatment will remain free of charge until a clinician considers it to be completed, or until they leave the country. As with any other overseas visitor, failed asylum seekers receive compulsory psychiatric treatment, family planning services and treatment for certain infectious diseases free of charge, whilst treatment within an Accident and Emergency department is also free.

We are not proposing any change to these arrangements for the vast majority of failed asylum seekers. We recognise that many failed asylum seekers have limited resources, meaning that debts to the NHS are often written off and the cost of administering charges is likely to outweigh the income recovered, and that some untreated non-urgent conditions may lead to subsequent more costly, urgent provision for which costs would be unlikely to be recoverable. However, automatic entitlement to full, free secondary care, including both urgent and non-urgent treatment, would not be consistent with the denial of leave to remain and may act both as a deterrent to leaving the UK on a voluntary basis and an incentive to others to travel here illegally.

Similarly, we are proposing no change to the current position for other people, such as illegal entrants and over-stayers, who have no lawful basis of stay in the UK and so are subject to charges.

We are proposing a specific exception for those Failed Asylum Seekers who are co-operating with UKBA and are supported under sections 4 or 95 of the Immigration and Asylum Act 1999:

- Section 4 support is available to those adults 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). Support is provided in the form of accommodation and food vouchers/payment cards;
- Section 95 support is provided for all asylum seekers where they would otherwise be rendered destitute. This support is retained until their asylum application and appeals have been determined. In the case of families with children under 18 support is normally maintained until the family has departed voluntarily or been removed. Support is provided in the form of accommodation and/or subsistence only in the form of cash.

Section 4 and section 95 support does not currently include free healthcare. The extension of free healthcare to these groups therefore is wholly consistent with this element of the Government's migration and asylum policy.

Around 9,600 applicants are currently supported under section 4 and 7,600 failed asylum seekers supported under section 95 in England. In practice, many of these people will already be receiving emergency or urgent treatment, for which the costs are never recovered. We estimate that recurrent additional costs to the NHS budget would be £9 million per year.

Question

5. **Do you agree with the proposal to exempt section 4 and section 95 failed asylum seekers from charges for NHS hospital treatment?**

Charges in respect of the treatment of children

Article 24 of the UN Convention on the Rights of the Child provides that States' parties shall strive to ensure that no child is deprived of his or her right of access to healthcare facilities. A child is defined in the Charging Regulations as being under the age of 16, or under the age of 19 and in full-time education, and in respect of whom Child Benefit would be payable.

Unaccompanied children are those present in the UK without their parent or legal guardian. As soon as they are identified as unaccompanied, they are taken into the care of the local authority, at which point they are deemed to be ordinarily resident and so automatically entitled to free treatment. Unaccompanied children who have claimed asylum are also exempt. However, if they are treated before being taken into care or having claimed asylum, that treatment may currently be chargeable. We propose making all non-resident unaccompanied children exempt from charges to remove this anomaly and ensure compliance with human rights obligations regarding children. We will also clarify the Regulations to confirm that the accompanying parent or guardian of a child is responsible for a chargeable child's treatment cost.

Reliable data are not available on either the number of unaccompanied children or the secondary care treatment they receive. However, NHS Overseas Visitors Managers have indicated that the number of chargeable unaccompanied children is very small, fewer than 20 per year, and any charges currently made in these circumstances are unlikely to be recovered, so additional costs from this change will be minimal. A full impact assessment has therefore not been completed for this proposal.

Question

6. **Do you agree with the proposal that any unaccompanied non-resident child should be exempted from NHS treatment charges?**

Temporary absence exemption for UK residents

People living in the UK for part of the year, while also spending significant periods of time abroad, risk being considered as not ordinarily resident and so not entitled to free NHS treatment, although some exemptions do protect this group:

- Any UK state pensioner[11] living abroad, who has previously lived in the UK for at least ten years, receives free treatment for immediate needs arising during any temporary visit to the UK, but not for existing conditions or elective needs;
- UK state pensioners, living for no more than six months per year in another EEA country, and the remainder of the year in the UK, retain full eligibility for NHS treatment for the period they reside in the UK, as long as they do not register as resident in the other EEA country;
- EEA nationals (including former UK residents) have the right under European Community Regulations to receive all clinically necessary healthcare when they visit the UK, which is covered by their European Health Insurance Card;
- Those working abroad for up to five years (who have previously resided in the UK for ten years) retain full eligibility during that period;
- Members of the Armed Forces and Crown Servants, together with their dependants, retain full eligibility;
- Those who have previously resided in the UK for ten years and are living in a country with which the UK has a bilateral healthcare agreement will also receive free treatment for needs arising during their visit (and in any case, such other care as is covered by the terms of the agreement);
- People returning from abroad to resume permanent residence are immediately entitled to full free treatment.

If a returning resident is not covered by an exemption, whether or not they are ordinarily resident will usually be assessed by a local Overseas Visitors Manager, on the basis of whether or not they are 'settled' with 'a sufficient degree of continuity' (based on the House of Lords definition[12]). People who may risk being assessed as not ordinarily resident include those on repeat extended holidays or visits to relatives abroad, and retirees living part of the year abroad, particularly those below state pension age and/or living outside the EEA.

11 A person who may have retired early only triggers this exemption when they reach state pension age

12 R v Barnet LBC EX p Shah (Nilish) 1983 2 AC 309 HL

The current regulations include a specific disregard of any period of temporary absence of not more than three months for the purposes of calculating a period of residence – in effect, this allows current UK residents a regular period of absence from the UK of up to three months per year before they risk being chargeable for hospital treatment.

With people having increasingly mobile lifestyles, the time is right to review this regulation. Increasing the permitted period of absence for former residents from three to six months would be consistent with current exemptions for state pensioners. At the same time, six months is a short enough disregard to distinguish between genuine residents who spend the majority (at least half) of the year in the UK, and citizens who now choose to reside in another country for most or all of the year, returning only for short visits, including specifically to access NHS healthcare.

A survey of NHS Overseas Visitors Managers suggests that there are only around 1,500 instances per year across the NHS where repeat absences between three and six months are found and the majority of trusts err in favour of the patient, so only around a third of patients are charged. We estimate that the cost to the NHS of exempting this group from charges will be less than £800,000 per year, while the beneficial impact on some individual British residents will be significant.

Question

7. **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?**

Question

8. **In respect of the proposals referred to in Questions 5-7 are you able to provide any additional data that may inform the calculations of costs and benefits?**

HIV treatment

Regulations currently allow HIV testing and counselling to be provided free of charge for overseas visitors. All subsequent clinical treatment, including the provision of drugs, is chargeable, although immediately necessary or urgent treatment must not be delayed while payment is sought.

Unlike other sexually transmitted diseases (for which treatment is provided free of charge to all on public health grounds), individual treatment for HIV is life-long and does not offer a cure. The risk of infection to others remains and so the case to make HIV treatment exempt from charges on public health grounds is less strong. A charging exemption could attract visitors specifically seeking treatment, increasing NHS costs and demands on available capacity. The need for continuing treatment may also be a disincentive to return for those with no further permission to remain.

However, treatment strategies, based on latest clinical and pharmaceutical advances, and containment strategies, based on clinical research into infectivity and transmission, are constantly developing. It must also be recognised that the long-term denial of treatment may lead to a deterioration in the health of an individual.

The specific exclusion of HIV has now been in place for nearly 20 years and we now believe it is time for a full review of the latest evidence to test if these guidelines need to be updated. This review is now commencing and any resulting proposals will be the subject of separate later consultation.

Maternity treatment

Maternity treatment is unique in that the health and welfare of both the mother and the unborn child or children are affected by treatment decisions. Denial of or delay in treatment can lead to serious, life-threatening complications such as eclampsia or pre-eclampsia. The Department is committed to ensuring that the health of expectant mothers and their unborn children is protected. We have issued very clear guidance that maternity services, including ante-natal care, should always be treated as immediately necessary treatment and provided without delay irrespective of the patient's status or ability to pay. This is being reinforced in the redrafted guidance described in Chapter 2.

UKBA officials report often encountering passengers arriving in an advanced stage of pregnancy seeking entry to visit the UK but who evidently intend to access NHS maternity services. Over 300 such cases were identified at Gatwick between 2006 and 2008, some of whom had used the NHS for previous births and not paid their bill.

We believe that making maternity treatment, including birth as well as ante and post-natal care, free to people who are not otherwise entitled to free NHS treatment would exacerbate the problem of maternity health tourism and so we are not proposing to make any change to the current charging policy.

Access to social care

The review considered how statutory restrictions on the ability of local authorities to provide social assistance to certain categories of migrant might be delaying the discharge from hospital of illegal migrants or other chargeable patients with ongoing social care needs. The review concluded that important exceptions to the restrictions and overriding humanitarian duties under Human Rights, National Assistance and Children Act provisions meant that the problem was not likely to be significant.

Access to primary care

General Practitioners (GPs) are well placed to take account of the healthcare needs of their local communities. GPs also play a pivotal role in the provision of public health services, such as our response to pandemic flu. NHS GPs have the responsibility of determining whether an individual should become a patient of their practice. This applies to all patients and whilst the discretion we give to GPs is limited (for example, decisions must not be discriminatory), we do not believe that any specific changes to access rules are required in respect of foreign nationals. These rules are set out for information as Annex 4.

Chapter 4:
Tackling NHS debt and misuse

Health tourism and NHS debts

`Health tourism' is often used to refer to any foreign national receiving free NHS treatment, even those who are lawfully settled in the UK, or who are charge exempt overseas visitors. Most overseas visitors who seek the help of the NHS do not set out to abuse the NHS as health tourists. Similarly, most unlawfully resident migrants are not health tourists – they come to the UK for other reasons. However, it is still important that these visitors are identified and that they are charged and pay for their treatment where the Charging Regulations require.

A small proportion of visitors, however, do travel specifically to obtain NHS treatment that they are not entitled to receive free of charge including those who:

- conceal a prior intention to use the NHS when seeking to enter the UK as short-term visitors;
- know they should pay but who hope that they will not be identified as chargeable;
- seek treatment in the belief that the NHS is free to all and subsequently are unwilling or unable to pay when charged;
- hope that clinicians will consider their need for treatment sufficiently urgent to be given it ahead of paying, and then refuse to pay; and
- claim to be entitled when they are not.

Evidence of health tourism and debt

The NHS does not collect detailed data on the overseas visitors it treats or charges so the precise scale of health tourism is difficult to quantify. However, NHS frontline staff regularly report examples of people who have apparently travelled to the UK to seek treatment, sometimes even arriving with their medical notes to show to clinicians. UKBA also informs us of regular cases where visitors arrive at ports and airports with evidence of hospital appointments and medical records in their luggage.

Travelling from abroad for maternity treatment is a particular problem. When heavily pregnant women arrive, even though there may be grounds to refuse entry (where the purpose of the visit is to seek health treatment), airlines may refuse to carry them home. As discussed above, our policy is that, to protect the unborn child, maternity treatment is not denied or delayed while payment is secured. As a result, some mothers may subsequently return home without paying.

Over the last three years an average of £5 million per year of overseas charges have been written off by NHS Trusts, accounting for around 25 per cent of the income due. Based on a sample of Trusts, we estimate that, where payment has not been secured in advance of treatment (that is when urgent treatment has had to be provided), 50 per cent of outstanding debt is overdue for more than one year and around 5 per cent of chargeable patients had three or more unpaid invoices. Although some multiple invoices relate to a single episode of treatment, some visitors have clearly received, but not paid for, treatment on a number of occasions. One patient had 18 unpaid invoices representing at least five episodes of care over three years.

Difficulties in detecting and preventing NHS misuse

The NHS devotes considerable resources to assessing eligibility for free treatment, and then pursuing outstanding debts for those who have not paid in advance of treatment. UKBA already take steps to identify and refuse entry to clear cases of health tourism. A number of factors limit these efforts:

- identifying all chargeable visitors when they present for treatment;
- only limited personal information on chargeable patients is captured, and this varies between hospital Trusts, making it more difficult to trace those with unpaid debts;
- returning visitors may obtain subsequent treatment at different Trusts so the existence of a previous debt may not be identified;
- where the debtor has returned to an overseas address, contact details are even less reliable. Whilst debt recovery agencies may still be employed by the Trust to which the money is owed, their effectiveness is reduced in these circumstances; and
- the sharing of information between government agencies is limited in the case of healthcare provision on the grounds of patient confidentiality.

The NHS Counter Fraud Service[13] is responsible for preventing, detecting and investigating fraud and other unlawful activity against the NHS. Where there is a suspicion or allegation of fraud, they will investigate and prosecute when appropriate.

Trusts are responsible for their own debt recovery and may engage a professional debt recovery agency. However, many chargeable patients will not have a permanent UK address and may quickly return to their home country, making recovery more difficult, and resulting in significant sums remaining outstanding or being written off.

Action to tackle NHS debtors

A person travelling to the UK to get medical treatment can be denied entry, unless they hold a private medical visa. However, having an outstanding debt to the NHS is not, in itself, currently a reason to deny entry in the absence of other grounds for doubting the person will comply with the immigration rules. Working with the Home Office, we are developing proposals that any foreign national (other than those with European Community rights) may be refused a new or extended period

13 Part of the NHS Counter Fraud and Security Management Service, a division of the NHS Business Services Authority

of stay in the UK if they have a significant outstanding debt to the NHS (England). This would both support debt recovery and be a deterrent to deliberate abuse of NHS services.

This will require changes to immigration rules and the Home Office is therefore leading a separate UK-wide consultation[14] on this proposal.

Information sharing to support debt recovery and tackle NHS misuse

Collecting and sharing information about patients with debts is key to reducing current levels of unrecovered costs. Organisations who may need access to information include UKBA, NHS Counter Fraud Service and other agencies to which the Department or the NHS contracts services (such as debt recovery).

Data security and protection, especially for confidential personal information, must be our first priority. However, recovering debt and identifying and pursuing misuse of NHS services is sufficient reason under the Data Protection Act to share data. Data collected and shared for these purposes would:

- not include any clinical information;
- be provided in the knowledge that patient information may be shared with the UKBA if they fail to pay for their treatment, and that this may lead to them being refused entry to the UK in the future; and
- be held and transmitted securely in line with Cabinet Office guidelines on information privacy and security[15].

Subject to these limitations and controls, we are proposing the following new measures to facilitate debt recovery and fraud investigation, and related approved sanctions (including immigration controls). These relate only to the NHS in England. Devolved administrations may decide whether to consult on similar measures:

- any person receiving chargeable NHS secondary care treatment in England must provide personal and contact details including their name, date of birth, nationality, current passport number, UK contact address and permanent home country address. (Most of this information is already collected in many Trusts

14 Home Office/UKBA Consultation on Refusing Entry or Stay to NHS Debtors. A Public Consultation around Proposed Changes to the Immigration Rules. This document can be found on the Home Office web site www.homeoffice.gov.uk

15 The 2008 report and resulting government-wide procedures can be found at: www.cabinetoffice.gov.uk/ogcio/isa/publications/data_handling.aspx

but a consistent full dataset is crucial for improved recovery. NHS organisations would also need to keep up-to-date records to ensure that visitors who had cleared their debt were not unfairly denied entry to the UK;

- NHS organisations providing secondary care treatment must provide information relating to outstanding debts for chargeable NHS treatment to the Department of Health (or its appointed agency);
- the NHS Counter Fraud Service would receive data about outstanding debt from the Department of Health's appointed agencies, and transfer this securely to UKBA. The NHS Counter Fraud Service will also retain a copy of these data, in compliance with the Data Protection Act, to identify potential fraud; and
- the Department, or its appointed agency, will share this information with the NHS Counter Fraud Service who will pass it securely to the UKBA (to support recovery and implement any agreed immigration sanctions under immigration rules approved by Parliament).

Estimated NHS costs for additional data handling of £150,000 initial set up and £100,000 annually have been included in the Impact Assessment undertaken by the Home Office. These costs equate to around 1 per cent of the outstanding debt that could be recovered.

Question

9. 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?

Question

10. 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?

Question

11. What safeguards on the protection of personal information are needed beyond those described?

Question

12. Do you agree that the NHS Counter Fraud Service should transfer the data from the Department of Health's appointed agency to the UKBA to support recovery and implement any agreed immigration sanctions under rules approved by Parliament?

NHS Counter Fraud Service Directions

Secretary of State Directions have been given to the NHS Business Services Authority[16]. However, as the data to be transferred to the UKBA concerns debt and not fraud, the Secretary of State Directions to the NHS Business Services Authority, will need to be amended to enable this additional function to be carried out lawfully by the NHS Counter Fraud Service.

To meet UKBA requirements on receiving data from external, non-public bodies, it is proposed that the NHS Counter Fraud Service receives data concerning outstanding debt from the Department of Health's appointed agency, and transfers this securely to the UKBA. The NHS Counter Fraud Service will also retain a copy of this data, in compliance with the Data Protection Act, to identify trends and anomalies that may be indicative of fraud.

Question

13. 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?

16 Directions can be found at: http://www.nhsbsa.nhs.uk/ The Counter Fraud Agency is in Schedule 1

Chapter 5: Health insurance for overseas visitors

Context

This chapter sets out our early thinking on the possible introduction of health insurance for visitors that may enable the current scope of exemptions from charging for NHS hospital treatment to be simplified and reduced.

It summarises current rules in England and describes the approaches taken by some other countries. A range of options for insurance-based healthcare provision for visitors are set out. Feedback is requested on the principles of these approaches and any challenges that would need to be addressed. Next steps in the development of proposals are set out.

Background

Few visitors receive NHS treatment through an individual or corporate health insurance scheme that would reimburse the hospital directly. Adopting an insurance requirement for some visitors would make payment more likely and act as a deterrent for 'health tourists' entering the country to obtain treatment. In the longer term a requirement or expectation of personal health insurance may be considered for some groups of visitor that are currently exempted from charges for secondary healthcare, particularly where such provisions are more generous than those afforded to UK citizens travelling abroad in equivalent situations.

Although our initial proposals relate only to the NHS in England, they may be more effective if applied on a UK-wide basis. The devolved administrations have therefore been engaged and further proposals may be developed in partnership with them. They may also choose to undertake their own consultations. The Home Office would consult on any specific proposals relating to Immigration Controls on a UK-wide basis.

Current situation

As has been set out in Chapter 2 of this document, the basis of entitlement to free NHS secondary care is by virtue of a person currently being 'ordinarily resident' in the UK. There is no defined minimum period of stay that will trigger this. It is not linked to nationality or immigration status, so a foreign national who has leave to remain for a limited time period, for example as a worker or student, may in some cases be treated as ordinarily resident.

Some temporary visitors are entitled to free treatment for needs arising during their visit under reciprocal agreements whereby UK nationals are also entitled to equivalent free health treatment in the visitor's country. The countries with which the UK has reciprocal agreements are set out in Schedule 2 of the Charging Regulations. There are also separate European reciprocal arrangements covering the EEA and Switzerland[17].

The EC Residence Directive[18] provides that those who choose to settle and reside in another EU country who are not economically active, and students, should have comprehensive sickness insurance as a pre-condition of the right of residence in another state. However, in the UK, once a person who is not economically active becomes ordinarily resident they become automatically entitled to free treatment and so their insurance provision is not relied upon for payment.

Some visitors may also qualify for free secondary care treatment under specific exemptions that are set out in the Charging Regulations. These include any students on a recognised course of study and any people employed by UK-based or UK-registered companies. A further exemption covers any person who has resided lawfully in the UK for at least one year. This residence qualification may be attained through temporary leave to remain.

Although England, Scotland, Wales and Northern Ireland each maintain their own Charging Regulations, the requirement of ordinary residence is met by a visitor's presence in any part of Great Britain. Reciprocal Agreements and European Union obligations apply to the UK as a whole.

A number of foreign nationals present in the UK, as either short-term visitors or with longer-term but time limited leave to remain, may therefore qualify for free NHS secondary care treatment under one or more of the above categories. Other visitors must be charged for their secondary care treatment. It is not currently possible to identify the number or cost of exemptions for non-residents. Rules governing access to primary care services in England are different and are set out in Annex 4.

Any non-EEA visitor to the UK, regardless of whether or not they require a visa in advance of entry, must satisfy the requirements of the Immigration Rules[19]. For example, they must show they intend to leave the UK at the end of the visit;

17 The most important provision is Regulation (EC) 1408/71, shortly to be replaced by Regulation (EC) 883/2004

18 2004/38/EC, as implemented in the UK by the Immigration (European Economic Area) Regulations 2006 (SI 2006/1003)

19 The rules can be found at www.ukba.homeoffice.gov.uk/policyandlaw/immigrationlaw/immigrationrules/

that they can meet the cost of the return or onward journey; and that they can maintain and accommodate themselves without recourse to public funds. `Public funds' refers to a variety of means-tested benefits but does not include NHS treatment.

Identifying those visitors who are eligible for charging when they present is difficult due to the complexity of entitlements and practical difficulties of screening individuals and ascertaining relevant information. As they are currently personally liable for the charge if identified there is little incentive for such a visitor to volunteer their full circumstances.

UKBA[20] guidance advises visitors that NHS treatment is not free and that they should have enough travel insurance to cover their stay. However, there is no requirement for them to take out health insurance as a condition of entry.

Current Situation in Other Countries

Other countries that require some visitors to have health insurance include:

- the Schengen countries[21], which have no internal border checkpoints and controls, require non-EEA visitors to have health insurance worth at least €30,000 before granting a visa, although there is anecdotal evidence that this is not enforced rigorously;
- Australia, subject to the application of bilateral agreements, where only permanent residents are eligible for their universal healthcare scheme. Visiting students and some categories of workers are required to have health insurance cover, while those entering on temporary visas are strongly advised to take out health insurance as they would not typically be entitled to free healthcare; and
- New Zealand, where free healthcare is earned after two years of temporary residence. Other temporary residents or visitors must pay, unless covered by reciprocal country agreements, and are strongly recommended to take out insurance. Students and some categories of worker are required to have insurance as a visa condition.

20 The guidance can be found at: www.ukba.homeoffice.gov.uk/visitingtheuk/rightsandresponsibilities/

21 The Schengen countries comprise: Austria, Belgium, Czech Republic, Denmark, Estonia, France, Finland, Germany, Greece, Hungary, Iceland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland,Portugal, Slovakia, Solvenia, Spain, Sweden and Switzerland

Outline options for consideration

Options for introducing health insurance requirements include:

(i) Compulsory health insurance

Requiring visitors to take out health insurance as a condition of entry to the UK would require changes to the Immigration Rules as well as to NHS primary and secondary legislation. The requirement could apply to:

- all persons subject to immigration control entering the UK, whether or not they require a visa;
- all persons subject to immigration control requiring visas, of whatever type (a Schengen-style requirement); and
- persons subject to immigration control who require a visitor visa only.

Checks on visitors could be made either as part of entry clearance at a British Mission abroad (for visa applicants) or at the port of entry (for all visitors). Asking every applicant for evidence of health insurance would be time-consuming, but there could be spot checks at ports of entry.

A mandatory scheme could, however, create some difficulties:

- the insurance market is not well-developed in some countries, although it may encourage the development of new insurance products;
- insurers would wish to make individual checks on pre-existing disease and may base premiums on personalised risks, effectively preventing travel by those with a poor health record, including elderly family visitors;
- it could act as a deterrent to people coming here to visit, work or study with potential economic impacts. It may have a disproportionate impact on certain groups, raising equality and discrimination issues;
- difficulties in assessing the validity and/or adequacy of insurance documents and the associated risk of forgeries;
- increased delays as consulate and UKBA officers assess the adequacy of each health insurance policy;
- potential difficulties of verifying insurance and applying charges for the NHS; and
- non-visa visitors would have to be assessed at entry ports, leading to delays, but exempting non-visa visitors may be unfair and discriminatory.

(ii) Recommended insurance

A lighter touch option would be to increase the profile and incentives for visitors to have health insurance on a voluntary basis, based on a continuing message targeted at visitors who are not covered by reciprocal entitlement or other exemptions, making clear that NHS treatment is not free and that they should ensure that they have adequate means of payment.

It may also be possible to review the exclusion of NHS services from 'public funds' although this would be complicated by the need to reflect exemptions relating to reciprocal agreements, infectious diseases and identified categories of visitor, and to safeguard the provision of urgent treatment.

A clearer statement on the limits of access to NHS services would, however, allow Entry Clearance or Immigration Officers to check for evidence that an individual had the means to look after him or herself if they became ill whilst in the UK. Such evidence could include health insurance although the requirement might be satisfied simply by evidence of satisfactory funds.

A non-mandatory approach would not require health insurance as a condition of entry and so would reduce the extent of issues around deterring visitors and of potential equality issues. It would reinforce the message that NHS hospital care is not free for overseas visitors, whilst allowing Entry Clearance Officers to apply a more discretionary and (non-discriminatory) light touch approach. However, in doing so it would not offer the same level of guarantee that overseas visitors would discharge any NHS debts making recovery by the NHS more difficult and raising less income.

(iii) Replacing current exemptions with specific insurance-based provision

If a requirement to hold health insurance could be enforced for all visitors, it may be possible to amend our approach for some groups of longer-term visitors who are currently exempt from charges and where UK citizens do not receive a reciprocal benefit. This could include:

- visiting students – there are over 350,000 overseas students in the UK at any time;
- employees of UK-based or UK-registered companies and self-employed;
- non-residents including short-term visitors/tourists requiring hospital Accident and Emergency treatment; and

- temporary residents (who are currently automatically exempt after one year) or new migrants until they have obtained full residential status.

The issues and challenges will differ in nature and extent for each of these options. These challenges include possible economic impact (for example if significant numbers of students or workers were deterred from coming to England), costs and effectiveness of overseeing compliance. Particular attention will need to be paid to equality risks.

For students and workers, it may be possible to make take up of health insurance a condition of course or employment registration through the employer or educational institution, and/or their associated visa application, although we would need to understand and minimise any impact on institutions or employers.

If adopted, these would each be significant changes, at least some of which would be likely to require primary legislation. In particular, the current 'ordinary residence' basis of NHS entitlement (through which a number of categories of visitor may also qualify currently) is embedded in primary legislation.

The streamlining of visitor exemptions would not be dependent totally on a requirement for health insurance. Instead, the individual may be billed directly for the charge as happens currently for many non-exempt visitors. There is currently no charge for treatment in an Accident and Emergency department but, if set or capped at a standard rate it would not be significant for the individual and the cost recovered at the point of treatment, as happens in many other countries. However, this could be less effective for wider healthcare needs, where it is often difficult to recover the high cost of unexpected acute or critical care needs without recourse to insurance cover.

Conclusion and next steps

These proposals are at an early stage, but introducing an expectation of at least some overseas visitors paying for their healthcare through insurance is an attractive proposition. It would increase the likelihood of recovering costs from those visitors who are already charged for their NHS treatment. It may also be an appropriate alternative to the current policy of exempting some visitors where the cost to the NHS is high and is not reciprocated by other countries. However, we recognise that we will need to overcome some significant operational and policy challenges.

We are determined to realise the maximum potential of such an approach but recognise that we will need to overcome some significant operational and wider policy challenges.

We are therefore planning a more comprehensive comparative study of other countries that require some visitors and migrants to have health insurance. This will include understanding their rules, how these are applied in practice, and how operational and policy challenges have been addressed. It will also compare policies on the provision of healthcare to new migrants during their application period. We will also undertake work to estimate the extent and cost of current entitlements.

This further research, together with responses to this consultation, will inform analysis of the options outlined here, together with other approaches identified following this consultation. Analysis will include financial, regulatory and equality impact assessments. Irrespective of whether the devolved administrations consult on similar proposals, the research conducted by England will be shared with them. We will then come forward with detailed and specific proposals to be put to further public consultation.

Question

14. 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?

Question

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

Question

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

Question

17. 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?

Summary of questions

Question

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

Question

2. **Do you agree that the consolidated Regulations do not imply any material change in policy?**

Question

3. **Does the new draft Guidance clearly and comprehensively explain how the consolidated Regulations should be interpreted and applied?**

Question

4. **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?**

Question

5. **Do you agree with the proposal to exempt section 4 and section 95 failed asylum seekers from charges for NHS hospital treatment?**

Question

6. **Do you agree with the proposal that any unaccompanied non-resident children should be exempted from NHS treatment charges?**

Question

7. **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?**

Question

8. **In respect of the proposals referred to in Questions 5-7 are you able to provide any additional data that may inform the calculations of costs and benefits?**

Question

9. **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?**

Question

10. **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?**

Question

11. **What safeguards on the protection of personal information are needed beyond those described?**

Question

12. **Do you agree that the NHS Counter Fraud Service should transfer the data from the Department of Health's appointed agency to the UKBA to support recovery and implement any agreed immigration sanctions under rules approved by Parliament?**

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Consultation process

How to respond

We would like to hear your views on this Review of Access. Please complete the response template that accompanies this consultation. If you are referring to specific sections or to a specific annex of the regulations, please set this out clearly. If you are responding on behalf of an organisation, please include some details of the organisation, including the people that it represents.

The consultation is accompanied by an Impact Assessment, which includes Equalities Screening. If your comments address aspects of either the Impact Assessment or the Equalities Screening, please make this clear in your response.

Send your comments to overseasvisitorsconsultation@dh.gsi.gov.uk by **Wednesday 30th June 2010**

Please note that parts of your response may be published in a summary report of the consultation (names of individuals would not be included). If you would prefer your response not to be included in a report, please state this clearly.

We would prefer your comments to be sent electronically to the email address above. However, if you would prefer to respond in writing, please send your response to:

NHS Overseas Visitors Policy Team
Department of Health
Room 4W04 Quarry House
Quarry Hill
Leeds LS2 7UE

Criteria for consultation

This consultation follows the 'Government Code of Practice', in particular we aim to:

- consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;

- ensure the consultation documents are clear about the consultation process, what is being proposed, the scope to influence, and the expected costs and benefits of the proposals;
- ensure the consultation exercise is accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum so that consultees' 'buy-in' is obtained;
- carefully analyse responses carefully and give clear feedback to participants following the consultation; and
- provide guidance to officials in how to run an effective consultation and share what they have learned from the experience.

The full text of the code of practice is on the Better Regulation website at:
Link to Government Code of Practice on Consultations

Comments on the consultation process itself

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

Consultations Co-ordinator
Department of Health
Room 3E48
Quarry House
Quarry Hill
Leeds
LS2 7UE

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

Please do not send consultation responses to this address.

Confidentiality of information

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

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

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

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

Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at:
http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Annex 1: Written Ministerial Statement

Review of access to the NHS by foreign nationals

Since the publication of the cross-government immigration enforcement strategy "Enforcing the rules: a strategy to ensure and enforce compliance with our immigration laws" the Department of Health and the Home Office have been working together to review the rules on charging non-UK residents for access to National Health Service (NHS) services in England.

The House will wish to know that the joint review has concluded and the Government is today able to outline its conclusions.

The National Health Service was founded over sixty years ago. Sixty years on this Government remains committed to its founding principles; a national health service for the benefit of the people of the United Kingdom, free at the point of delivery and funded by general taxation.

However, it is neither feasible to operate the NHS without proper controls over access, nor fair, in an age of mass global travel and movement, to ask the taxpayer to fund unrestricted access to non-UK/EEA nationals. It is the Government's responsibility to protect NHS resources from exploitation or inappropriate use.

That is why, in concluding the review, the Government is today announcing measures to support a clearer and fairer system of access to NHS services – a transparent system that will maintain the confidence of the public by preventing inappropriate access.

The Government has decided to maintain the current system of charging non-residents for most secondary care (hospital) services. Treatment in an Accident & Emergency department, and treatment for specified infectious diseases that could create a public health risk, will remain free to all. The Government also proposes limited extensions to the current range of exemptions from charges for hospital treatment for certain non-residents.

Persons seeking refuge or asylum are already exempted from charges for the duration of their application including the full appeal process. The Government has not been persuaded that this full exemption should be extended to all of those whose application has failed but have not yet left the country. It has however

recognised the case for those whose claim has been refused but who are being supported by the UK Border Agency because they would otherwise be destitute, have children and/or because it is impossible to return them home through no fault of their own. It is therefore proposed that an exemption from charges is extended to this group.

The Government also proposes to exempt from charges all unaccompanied minors, including those in local authority care, whilst clarifying the principle that the accompanying parent or guardian of a non-resident minor is responsible for the cost of their NHS treatment. Together with the exemption for victims of human trafficking that was introduced from April this year, these changes reinforce the protection and rights to healthcare of the most vulnerable groups, regardless of their residential status.

Whilst maintaining the principle that other visitors or irregular migrants who are not specifically exempted should be charged for their treatment, and that, in non-urgent circumstances, treatment will be withheld if the costs are not paid, the Government remains firmly committed to the requirement that immediately necessary and other urgent treatment should never be denied or delayed from those that require it. We are currently engaging with key stakeholders to ensure that guidance to the NHS in this respect is clear and comprehensive.

The principles of providing immediately necessary treatment must always be applied to any maternity care, to ensure that the health of the mother or baby is not put at any risk. Maternity treatment therefore must never be delayed or denied. However, the Government has not been persuaded that charges should be abolished in relation to non-exempt patients for maternity treatment. There is clear case evidence that a small number of visitors enter the United Kingdom specifically to use NHS maternity services.

In relation to HIV treatment, the Government recognises that clinical evidence on treatment, including its role in prevention, is developing constantly. Moreover, HIV is a major global problem, the control of which creates significant financial as well as human costs. We will therefore undertake further analysis of the latest medical and public health evidence together with consideration of how the current policy on treatment aligns with the Government's wider international aid strategy for HIV. This analysis will inform a future decision on whether the current treatment policy (that only initial diagnosis and counselling is offered free of charge to non-UK residents or individuals who are not otherwise exempt) should be revised.

The Government also proposes that the period of absence for current residents that can be disregarded for the purpose of determining continued eligibility for free NHS hospital treatment in England is extended from three to up to six months. This proposed change reflects the increasing tendency towards longer periods of travel overseas for some people, and will protect the rights of British citizens who travel abroad whilst still residing substantively in the United Kingdom.

The Government acknowledges that General Practitioners (GPs) are well placed to take account of the healthcare needs of their local communities. GPs also play a pivotal role in the provision of public health services (in which they are currently at the forefront of our response to the threat of pandemic swine flu). Since the inception of the NHS GPs have had the responsibility of determining whether a particular individual should become a patient of their practice. This applies to all patients and whilst the discretion we give to GPs is limited, for example, decisions must not be discriminatory, we do not believe that any specific changes are required in respect of foreign nationals. Where an individual is refused registration, a GP is able to offer routine treatment on a private fee paying basis, but must provide any immediately necessary treatment free of charge.

A small minority of visitors deliberately seek to enter the United Kingdom, legally or illegally, in order to access NHS services without payment, some returning on a number of occasions for additional treatment whilst their previous debt remains unpaid. We therefore believe that there is a strong justification for practical working level co-operation between the NHS and UK Border Agency to apply immigration sanctions to those seeking leave to enter or remain when they have substantial uncleared debts to the NHS. It is only fair that these individuals are prevented from returning to the United Kingdom, or extending their stay here, until they have cleared their debt. The Government therefore proposes to amend the Immigration Rules to provide that non-EEA nationals will normally be refused permission to enter or remain in the United Kingdom if they have significant debts to the NHS.

The Government is also attracted to the principle of visitors (who are not covered by EEA or other reciprocal health agreements), being required to have personal health insurance provision, as is already the case in some other countries. We intend initially to seek views on the merits and feasibility of such a scheme that will inform further work to evaluate possible options.

The proposals apply to England only. The Government will however consult with devolved administrations, particularly with regard to the proposals on health tourism and health insurance where there may be benefits in a United Kingdom wide approach.

The proposed policy changes in this statement will be put to public consultation in the autumn and full supporting information will be provided at that time. Subject to a positive consultation outcome, revised regulations will then be laid as required to enable changes to take effect.

Ann Keen
Parliamentary Under-Secretary of State for Health

20th July 2009

Annex 2: Review of access to NHS services by foreign nationals

Terms of reference

A. Primary medical services

Aim

1. The review is intended to develop new rules, which are:

   - clear;
   - as far as possible, consistent with the rules on charging overseas visitors for NHS hospital care;
   - consistent with the preventative and public health role of NHS primary medical care;
   - consistent with the European Court of Human Rights, other international obligations and humanitarian principles;
   - fair to UK citizens and to foreign nationals;
   - value for money – both administrative and wider service costs or savings; and
   - operable effectively in an environment where services are delivered through 8,000+ different outlets, in the main by independent contractors.

Scope

2. The review is to cover access to services provided by general practices (or by other providers of NHS primary medical services) and NHS Walk-in Centres by the following groups:

   - asylum seekers;
   - failed asylum seekers – co-operating with Her Majesty's Government;
   - other failed asylum seekers;
   - illegal or unregulated migrants (including victims of human trafficking);
   - people from European Economic Area (EEA) countries;
   - people from non-EEA countries with which the UK holds bilateral (or reciprocal) healthcare agreements;
   - overseas students;

- children; and
- people who have lived lawfully for ten continuous years in the UK but who are now working abroad and have not been away for more than five years.

3. The review is to take into account the implications of the new `restricted status' being introduced by the Home Office.

4. The review is also to consider the rules on access to NHS primary medical services by the following groups of UK nationals:
   - diplomats and their dependants;
   - UK citizens who remain overseas during the winter;
   - a missionary whose organisation has a UK principal business place;
   - UK citizens who have gone overseas to undertake charity work; and
   - UK citizens working abroad for a time-limited period; but
   - not members of HM forces (where there are distinct issues).

5. The review will take into account the 2004 consultation, Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services. This can be found at: http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4087618

6. Access to other NHS primary care services (dentistry, pharmaceutical services, ophthalmology) are outside the scope of the review.

B. Hospital services

Aim

7. The aim of the review is to consider a number of specific issues in relation to the overseas visitors charging regime established under the provisions of the National Health Service (Charges to Overseas Visitors) Regulations 1989, as amended (`the Regulations').

8. The review will not be a re-examination of the hospital charging arrangements as a whole. The principle of charging non-UK residents for NHS hospital treatment is well established and not under scrutiny. Rather the review will focus on certain specific areas of concern to ensure that the regime continues both to reflect the most current thinking and to comply with the obligations placed on the NHS by changing international legislation.

Scope

9. The review will cover the following areas of the hospital charging regime:

   - eligibility of failed asylum seekers, both those receiving statutory Home Office/local authority support and others;
   - eligibility implications of the new `restricted status' category being introduced by the Home Office;
   - accuracy of current definition of `refugee' in the Charging Regulations;
   - validity of the interpretation of `ordinarily resident' currently relied on by the NHS;
   - review of Regulation 3 (Services exempted from charges) and Schedule 1 (Diseases for the treatment of which no charge is to be made) of the Regulations;
   - eligibility of overseas visitor children, both accompanied and unaccompanied; and
   - completion of an Equality Impact Assessment to confirm that the Regulations are consistent with the ECHR.

10. In addition, the review will consider the following wider issues:

    - re-examine with UKBA/Foreign and Commonwealth Office the potential for introducing compulsory health insurance for certain categories of overseas visitor;
    - re-examine with UKBA potential for measures in other areas to help combat `health tourism'; and
    - explore with the Home Office the potential for finding better ways of dealing with those foreign nationals who effectively bed-block NHS acute beds because they need social care which the local authority is prohibited, or believes it is prohibited, from providing under Home Office legislation.

11. In pursuing all these issues, consideration will be given to the financial impact of any proposed changes, and to the implications for the role of Primary Care Trusts (PCTs) in assessing the healthcare needs of their local population.

    The review will not cover other non-primary care services, for example, community care, district nursing, community midwifery or other services generally provided by PCTs.

Annex 3: Summary of changes included in draft consolidated Regulations

Regulation	Issue	Current policy intent	What change has been made in the drafting to ensure this?	Old Regulations reference
2	NHS bodies to which the Regulations apply	It is intended that charges are made and recovered whenever a non-exempt overseas visitor receives NHS secondary care services. This usually happens in NHS trusts or NHS foundation trusts but may happen elsewhere. "Relevant NHS body" updates the NHS structures and simplifies the drafting by having one term to refer to all aspects.	The individual terms `Authority', `NHS foundation trust', `NHS trust' and `Primary Care Trust' have been replaced by `NHS body', defined as `an NHS foundation trust, an NHS trust, a Primary Care Trust, a Strategic Health Authority or a Special Health Authority'.	1(2)
2	Services to be charged for	It is intended that non-exempt overseas visitors pay for secondary care services, traditionally carried out at a hospital. To simplify, the previous term `services forming part of the health service' has been amended to `relevant services' which are still those in relation to accommodation, services and other facilities provided under section 3(1) of the Act (Secretary of State's duty as to provision of certain services), but not other specified services, including primary care, GP services, dental services, ophthalmic services and pharmaceutical services.	The definition of these relevant services has been updated to refer to the correct legislation.	1(2)

Regulation	Issue	Current policy intent	What change has been made in the drafting to ensure this?	Old Regulations reference
3(2)	NHS contractors	It is intended that charges are made and recovered whenever a non-exempt overseas visitor receives NHS secondary care services. The current regulations only list NHS-bodies. Increasingly, NHS bodies commission services from non-NHS bodies. This Regulation change allows the Charging Regulations to apply when a non-NHS body (an `NHS contractor') provides services to an overseas visitor on behalf of an NHS body.	The Regulation has been amended so that when an NHS contractor provides services to a person it believes to be an overseas visitor it must inform the relevant NHS body, which must then make and recover charges as appropriate. NHS contractor has been defined in Regulation 2(1) as `any person (other than a relevant NHS body), providing services under arrangements made with a relevant NHS body'.	2
6(a)	Accident and emergency services	To exempt from charges Accident and Emergency-type services wherever they occur, until admission to the hospital as an inpatient or provided with an outpatient appointment. This may be provided in settings other than just a hospital Accident and Emergency department or a Walk-in Centre. Minor injuries units have been added and it is sensible to create a general provision on Accident and Emergency services.	The Regulation has been redrafted to say that no charge shall be made for an overseas visitor for `Accident and Emergency services, whether provided at a hospital Accident and Emergency department, a minor injuries unit, a Walk-in Centre or elsewhere, but not including any services provided– (i) after the overseas visitor has been accepted as an inpatient; or (ii) at an outpatient appointment;'.	3(a), 3(aa)

Regulation	Issue	Current policy intent	What change has been made in the drafting to ensure this?	Old Regulations reference
6(d)	Sexually transmitted infections	The intention is that all treatment for sexually transmitted infections (other than HIV) is exempt from charges. The current Regulations confine this to treatment in, or as a referral from, a sexually transmitted diseases clinic. However, diagnosis and treatment may occur elsewhere, and this Regulation change ensures that all treatment for such sexually transmitted diseases will be exempt from charges.	References to sexually transmitted diseases clinics have been removed from the Regulation.	3(d)
6(f)	Treatment requirements imposed by a court	The intention is that if the State requires a person to have treatment (including by way of a court disposal) then that treatment should be exempt from charges. The current regulation only considers the improvement of a patient's mental condition, but there are circumstances when a requirement for treatment imposed by a Court may not be confined to the improvement of mental health. For instance, a Court order can include a medical treatment requirement where the person's medical condition, other than their mental condition, is likely to impose a risk to others.	The regulation has been updated so that treatment which is provided in circumstances where a requirement to submit to the form of treatment concerned is imposed by, or included in, an order of the Court is exempt from charge.	3(f)

Regulation	Issue	Current policy intent	What change has been made in the drafting to ensure this?	Old Regulations reference
6(g)	Community services	The Charging Regulations apply to secondary care services, historically provided in a hospital, but they also apply to community services when they are provided by staff employed to work at, or under direction of, an NHS body/contractor to whom the Regulations apply. This Regulation change makes clear that community services can be charged for when carried out by staff employed at or for an NHS body/contractor, but not when the staff are employed by another body (for example a GP practice).	The Regulation has been redrafted to read that no charge shall be made or recovered in respect of `services provided in the community by a person who is not employed to work for, or on behalf of, any relevant NHS body or NHS contractor'.	3(b)
9	European Union rights	To ensure that the Charging Regulations correctly reflect the provisions of European Union law, providing exemption to those who have a right to free treatment under those Regulations but not those who do not.	Previous Regulations 4(1)(m) and 5(a) have been replaced with one encompassing Regulation setting out the exemption that the visitor is entitled to by virtue of an enforceable European Union right.	4(1)(m), 4(1)(l), 5(a)
11	Refugees	That anyone who makes a formal application to be granted refuge in the UK, irrespective of by which legal route that is submitted, is exempt from charges until that application is finally rejected.	The Regulation has been amended so that those granted `temporary protection' also benefit along with those accepted as refugees and those given humanitarian protection. Those whose applications for asylum or humanitarian protection are still ongoing remain exempt from charges.	4(1)(c)

Regulation	Issue	Current policy intent	What change has been made in the drafting to ensure this?	Old Regulations reference
17	War pensioners	Those in receipt of certain war pensions or other benefits under the relevant legislation are exempt from charges. This Regulation update maintains that intention by extending the exemption to those in receipt of a guaranteed income payment under the Armed Forces Compensation Scheme 2005.	The Regulation has been amended to remove the 1914–1918 War Injuries Scheme, since there are no longer any beneficiaries of this, and to ensure that those in receipt of a payment made under article 14(1)(b) or article 21(1) of the Armed Forces and Reserve Forces (Compensation Scheme) Order 2005 also benefit.	4(1)(e)
23(c)	European Convention on Social and Medical Assistance and European Social Charter	To fulfil the UK's obligations under these international agreements but to confirm that there are limits - those who can benefit under this Regulation must be lawfully present in the UK and free treatment is limited to that for which the need arises during the visit, not pre-planned treatment.	The Regulation forms part of that which relates to free treatment the need for which arises during the visit, and the clause that they must be lawfully present has been inserted to reflect the terms of those agreements.	4(1)(p), 5(d)
23(d)	Persons resident in specified countries	To exempt from charges some treatment that visitors from countries with which the UK has bilateral health arrangements need during their visit. However, two opposing provisions were found to exist in the same Regulation, contradicting one another and necessitating an amendment.	The Regulation to exempt `a person resident in a country, other than Israel, or territory specified in Schedule 2' has been removed (5(e)). Such persons benefit from the proposed Regulation 10 in any event.	5(c), 5(e)

Regulation	Issue	Current policy intent	What change has been made in the drafting to ensure this?	Old Regulations reference
24(4)	Legal guardians of children	Children are rarely exempt from charges in their own right, but instead depend on their parent's circumstances. The intention is that the legal guardian of the child should have parity with the parent of the child within the context of the Regulations, and the change to the Regulation confirms this.	The definition of `member of a family' has been amended to make this explicit, so that it means: a spouse, civil partner or a child in respect of whom the overseas visitor is a parent or guardian. The definition of `authorised child' (Regulation 2(1)) has also been amended.	1(2)
Schedule 1	Diseases for which no charge is to be made for treatment	Treatment for diseases which are infectious is exempt from charges to all on public health grounds. The list of diseases largely reflects Public Health Regulations, and has been updated to reflect Schedule 1 to the [Health Protection (Notification) Regulations 2010 (draft)].	The list of exempt diseases has been amended to reflect the upcoming [Health Protection (Notification) Regulations 2010].	Schedule 1
Schedule 2	Reciprocal Agreement countries	To exempt from charges some treatment that visitors from countries with which the UK has bilateral health arrangements need during their visit. Some arrangements have ended, or are scheduled to have ended by 1 April 2010, or have been superseded by other agreements.	The Schedule has been amended to remove Guernsey and its bailiwick, Iceland, Isle of Man, Israel, Jersey, Sweden.	Schedule 2

Annex 4: Primary care access

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

Primary medical care contractors (GPs) are self-employed and have contracts with the local Primary Care Trust (PCT) to provide services for the National Health Service. Under the terms of those contracts, GPs have a measure of discretion in accepting applications to join their patient lists.

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

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

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

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

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

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

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

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