Institute for Public Policy Research

TOWARDS TRUE UNIVERSAL CARE

REFORMING THE NHS CHARGING SYSTEM

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ABOUT THIS REPORT

This report meets IPPR's educational objective by detailing new research on the impacts of the government's NHS charging system. It also supports our objective to advance physical and mental health by exploring options for reforming the current charging system to improve healthcare access in England.

ABOUT THE AUTHORS

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SUMMARY

The system of charging migrants for healthcare in England has become increasingly stringent in recent years. The government's Overseas Visitor and Migrant NHS Cost Recovery Programme (the 'Cost Recovery Programme') and charging regulations have sought to increase charges and accelerate efforts to recover costs. Under the current rules, anyone not 'ordinarily resident' in the UK is charged 150 per cent of the NHS national tariff for any secondary healthcare they receive (although some exemptions apply). 'Ordinary residence' is generally understood as residing in the UK legally and voluntarily for a 'settled purpose'. Anyone subject to immigration control must also have indefinite leave to remain to be considered 'ordinarily resident' – unless they are a citizen of the EU or European Economic Area (EEA) or family member with pre-settled status. The main groups affected by these rules are non-EU short-term visitors and people living in England without immigration status.

Since the introduction of the new rules, there is a growing body of evidence highlighting their adverse impacts. Research has indicated that the charging regulations have led to significant delays in treatment and prolonged indebtedness. One study found that there had been an increase in delays in treating tuberculosis in non-UK patients following the introduction of the Cost Recovery Programme. There is also emerging evidence that people without immigration status have been put off from coming forward to seek treatment for Covid-19 as a result of NHS charging rules, thereby hampering our collective response to the pandemic.

Through interviews with people with direct experience of NHS charging, healthcare workers and policy professionals, we found further evidence of systemic problems with the current charging system. Our interviewees were in broad agreement about the weaknesses of the system: they highlighted that the current charging rules deter people from seeking treatment, incentivise NHS staff to discriminate when identifying potentially chargeable patients, and lead to inefficiencies in the delivery of clinical care. One interviewee, who had previously worked as an overseas visitor officer for an NHS trust, said that they had discriminated between patients based on their name when trying to identify which patients were chargeable.

Other countries in Europe operate fairer systems to provide healthcare for residents without immigration status. For instance, in Spain, residents without immigration status are eligible for free healthcare provided they have a health card and can show that they are not insured for healthcare in another country. In France, there is a special system – Aide médicale de l'État (AME) – for accessing healthcare for people without immigration status on a low income. And in Sweden, people without immigration status can access acute care and care 'that cannot be deferred' (including maternity care) that is subsidised by the state.

Drawing on these examples from other countries, we tested out alternatives to the current system with our expert interviewees. We heard a range of different views. The idea of exempting charging for patients based on whether or not they are long-term residents or on a low income received mixed responses: while some saw the benefits of widening access, others raised problems for how individual patients would be able to prove they were eligible. The idea of expanding exemptions for vulnerable groups met with a cautious response, given that current exemptions are often underused and ineffective. And while abolishing NHS charging altogether was popular with many, there was also a recognition that this would be politically unrealistic in the short to medium term.

Based on our interviews, we drew up a shortlist of five alternatives to the current charging system:

- **Option 1: Means testing for free NHS care.** All people not ordinarily resident could be guaranteed free healthcare at the point of delivery provided they earn below a specified income threshold or they can otherwise demonstrate they do not have the financial means to pay for care.
- **Option 2: Exempting 'medically necessary' treatment from NHS charges.** Treatment defined as 'medically necessary' could be exempt from charging.
- **Option 3: Basing entitlement to healthcare on residency.** All patients who are UK residents could be exempt from charging at the point of delivery in England, regardless of their immigration status, provided they meet the other conditions of 'ordinary residence'.
- **Option 4: Giving providers greater autonomy over charging.** Trusts and other providers could be given greater flexibility over the extent to which they identify and pursue chargeable patients. This would involve rolling back the incentives and sanctions imposed as part of the Cost Recovery Programme.
- **Option 5: Replacing the charging rules with a health surcharge for short-term overseas visitors.** The current system of charging at the point of delivery could be abolished and instead healthcare costs could be recouped through a new health surcharge for short-term overseas visitors.

We assessed each of these options according to:

- inclusivity and ease of access
- the feasibility of implementation
- the implications for public health.

Our analysis is summarised in table S1.

TABLE S1:

Our summary assessment of each of the five alternative charging system policy options

Option	Inclusivity and ease of access	Feasibility of implementation	Implications for public health
1: Means testing for free NHS care	Expands access to healthcare for those without the means to pay.	Difficult to implement as people without immigration status may have difficulty providing proof of their financial situation.	Reduces the 'deterrent effect' of the current system, but continued charging of some patients would mean risk is not completely eliminated.
2: Exempting 'medically necessary' treatment from NHS charges	Expands access for treatment defined as 'medically necessary'; level of inclusivity depends on the definition of 'medically necessary'.	Reduction in administrative burden given that more treatments would be exempt; unless the definition of 'medically necessary' is clear, it could lead to inconsistent practice.	Helps to clarify rules on entitlement to services, including treatment for infectious diseases, but low understanding of the rules could continue to pose risks.
3: Basing entitlement to healthcare on residency	Expands access to all residents, regardless of immigration status.	Successful implementation is highly dependent on allowing residence to be demonstrated in a range of ways.	Reduces the 'deterrent effect' of the current system, but continued charging of some patients would mean risk is not eliminated completely.
4: Giving providers greater autonomy over charging	Overall impact probably positive, but there are likely to be inconsistent practices across providers.	Relatively straightforward to implement as a reversion to the pre-2015 system.	Research suggests delays in treatment could be reduced overall, although health risks are unlikely to be eliminated.
5: Replacing the charging rules with a health surcharge for short-term overseas visitors	Significantly improves ease of access by removing charging at the point of delivery.	Relatively straightforward to implement through the visa system, but may be critiqued for recouping costs from all visa nationals rather than only those accessing healthcare.	Removal of charging at the point of delivery would minimise public health risks.

Source: IPPR analysis

Based on our analysis, replacing the current definition of 'ordinary residence' with one which includes all residents regardless of immigration status is the most effective alternative to the current system. This change would help to ensure that no resident is refused care in England because of their immigration status. It would allow for a relatively light-touch approach to proving eligibility, as all that would be required would be proof of residency – which could be demonstrated through statements from community figures or organisations (such as charities, general practitioners [GPs], social workers, schools, landlords or neighbours). Finally, it would simplify the administration of the system and reduce the costs involved in pursuing patients who cannot afford to pay healthcare charges. While there would no doubt be challenges in implementing such a system, our analysis suggests that this change would reduce delays in treatment, improve medical outcomes and ultimately help achieve the UK's commitment to health coverage for all.

1. INTRODUCTION

In recent years, the UK government has introduced an increasingly stringent set of NHS rules and practices to restrict overseas visitors and migrants in England from accessing free healthcare. These rules affect short-term visitors making use of the NHS during their stay in England, as well as longer-term residents, including refused asylum seekers and other people without immigration status.

While charging overseas visitors has been a feature of the NHS for decades, in the past few years the government has introduced new measures to expand charging and explicitly target people without immigration status. This has coincided with broader efforts by the Home Office to introduce a 'hostile environment' for people without permission to be in the UK. When introducing the immigration bill to parliament in 2013, the then home secretary, Theresa May, announced how the government wanted "to ensure that only legal migrants have access to … health services" (Home Office 2013a).

Since then, the government has increased the number of people who can be charged for accessing NHS services and accelerated efforts to target and recover costs. The Cost Recovery Programme, rolled out in 2014, and the charging regulations, introduced in 2015, increased healthcare charges for overseas visitors to 150 per cent of the NHS national tariff and put in place tighter systems for NHS providers to identify and recover costs from patients. In 2017, new laws were brought in to implement upfront charging where this would not prevent or delay urgent or immediately necessary treatment. The rules have become increasingly complex, with the official guidance for providers now extending to more than 130 pages.

Since the introduction of the Cost Recovery Programme, there has been a growing body of evidence highlighting the adverse impacts of the current system on the experiences of healthcare of people living in England. The charging regulations have resulted in extensive delays in treatment for people subject to NHS charges, including those with serious and life-threatening conditions (DOTW 2020a). Charges are often imposed on those who cannot afford to pay, forcing people into prolonged indebtedness (ibid). A recent survey of 200 child healthcare professionals found that around a third reported cases where the charges had impacted on patient care, including instances of delays, refusals of treatment and worsening health outcomes (Murphy et al 2020).

Moreover, experts have warned that the charging system presents a risk to public health in England. Evidence shows that people subject to charging, including those without immigration status, are reluctant to come forward to use NHS services, for fear of incurring large fees that they cannot pay back or having their data shared with the Home Office (DOTW 2017). This can even affect treatment for certain conditions that are exempt from charging because they are communicable. A study of the impact of charging found that there has been an increase in delays in treating tuberculosis in non-UK patients following the introduction of the Cost Recovery Programme (Potter et al 2020). Similarly, there is evidence that charging has deterred people with HIV from accessing healthcare and led to delayed diagnoses (NAT 2021).

Recent research has highlighted how this 'deterrent effect' has seriously undermined the government's Covid-19 pandemic response. Many people with insecure or no immigration status have feared accessing the NHS during the pandemic and have been unaware that Covid-19 treatment is exempt from charging (DOTW 2020b; Kanlungan 2020; Patients not Passports 2020; JCWI 2021). Fears over being charged for a vaccination and being reported to the Home Office have been identified as reasons for lower vaccine uptake among people without an immigration status (Deal et al 2021).

There are also concerns that the current policy of NHS charging in England does not meet our international commitments. In 2015, the UK adopted the United Nations' 2030 Agenda for Sustainable Development. As part of the agenda, the UK signed up to Sustainable Development Goal 3 on health and wellbeing, which included achieving "universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (UN no date). The current charging system does not live up to this ambition, excluding people living in England without a regular immigration status.

Finally, it is unclear whether the recent reforms to healthcare charging have ultimately proved to be cost effective, given the costs of delayed treatment and of administering the system. The NHS consolidated provider accounts suggest that NHS providers received only £35 million in cash payments in the financial year 2018/19, despite issuing invoices totalling £91 million (Waites 2019).[1] In London, providers wrote off more in unpaid fees than they collected in cash payments through the charging system (ibid). The Department of Health and Social Care has itself struggled to estimate the net gain of the Cost Recovery Programme for the NHS (NAO 2016).

Given the wide-ranging critiques of the NHS charging system and the recent evidence that the policy has hindered the national Covid-19 response, there is growing momentum for an alternative to the existing system. In this report, drawing on interviews with people with lived experience of facing healthcare charges, NHS professionals and policy analysts, we discuss the different considerations for reforming the rules and analyse the alternative policy options for replacing the current system.

We then assess the different options for reform according to a number of important criteria: inclusivity and ease of access; the feasibility of implementation; and the implications for public health.

Finally, drawing the analysis together, we make recommendations for an alternative approach to healthcare entitlements, which expands access to the NHS, allows for effective implementation and promotes public health.

Further details on our methodology can be found in appendix 1 and additional fiscal analysis can be found in appendix 2.

1 The respective figures for 2019/20 are £39 million and £93 million (NHS Trust Development Authority 2021).

2. POLICY CONTEXT

Migrants in England currently face a highly complex and obstructive system for accessing healthcare services. According to the current regulations, people who are not considered 'ordinarily resident' are charged for receiving secondary healthcare. These rules are targeted at migrants who have lived in England for long periods as well as at short-term visitors. In this chapter, we explain how the current system of NHS charging works in England and how it compares to the approach taken in other nations of the UK and in selected European countries.

THE HISTORY OF NHS CHARGING

The system of charging for NHS care in England dates back to the National Health Service (Amendment) Act 1949, which made provisions to allow for legislation charging people not 'ordinarily resident' in Great Britain. For many years, these powers were never used, and while guidance on charging short-term visitors was issued in 1963, it was not regularly enforced (House of Commons 1982; McHale and Speakman 2020).

The first regulations imposing NHS charging for overseas visitors were introduced in 1982 (House of Commons Library 2020; McHale and Speakman 2020). These regulations required health authorities to charge overseas visitors – that is, people not ordinarily resident in the UK – for certain types of secondary healthcare. Further reforms were made to these charging regulations in 1989 and 2011.

In 2015, the government introduced a series of major reforms to the charging regulations in England, significantly tightening the rules for overseas visitors. These rules introduced a new charge of 150 per cent of the NHS national tariff for secondary care (unless exemptions applied). They also introduced new incentives and sanctions to encourage NHS providers to identify chargeable patients (House of Commons Library 2020).

These measures came alongside new provisions in the Immigration Act 2014, which introduced a health surcharge for temporary non-EEA migrants. The Act redefined ordinary residence to exclude people with limited leave to enter or remain and instead allowed the government to impose a health surcharge on those applying for limited leave in order to freely access the NHS (ibid).

In 2017, the government amended the 2015 regulations to introduce upfront charging for people not ordinarily resident, provided that doing so would not prevent or delay the provision of urgent or immediately necessary healthcare. The 2017 regulations also extended charging to apply to relevant community care services not directly provided by NHS bodies (ibid).

Alongside these changes, the NHS has increased its cooperation with the Home Office on charging and immigration matters. Since 2011, outstanding NHS debts of at least £1,000 have been grounds for refusal for applications to enter or stay in the UK. In 2016, these rules were tightened further to apply to outstanding debts of £500 (Home Office 2021a: paragraph 9.11.1). NHS providers were also required to notify the Home Office of debts of at least £500 where they had been outstanding for two or more months (for services provided on or after 6 April 2016) (DHSC

2019a). In 2019, it was revealed that Home Office immigration enforcement teams had used information on individuals with outstanding charges shared by NHS trusts to carry out immigration enforcement activities (ICIBI 2019).

Combined, these recent changes to the NHS system of charging have led to a radical transformation in how overseas visitors and migrants are charged for their care.

HOW THE CURRENT SYSTEM OF NHS CHARGING IN ENGLAND WORKS

Under current rules in England, people who are not ordinarily resident are subject to being charged for accessing secondary NHS care, unless they are deemed exempt. This includes secondary NHS care provided in the community. The concept of ordinary residence has been developed through case law and can be understood in the following terms.

A patient is ordinarily resident if all of the following apply (this definition is based on DHSC 2021):

- They are in the UK lawfully.
- They are in the UK voluntarily.
- They are in the UK for 'settled purposes' as part of the regular order of their life for the time being (this could be for a long or short duration).
- Where they are subject to immigration control, they have indefinite leave to enter or remain in the UK (or they are an EU/EEA citizen or family member with pre-settled status).[2]

This definition excludes people residing in the UK without permission, including people who enter the UK through unauthorised routes, overstay their visa or are refused asylum. People without immigration status are therefore subject to charging under the rules, unless an exemption applies. The definition also excludes most people who are in the UK with temporary leave (unless they have pre-settled status) – typically those with time-limited work, student or family visas. Those applying for limited leave to enter the UK for more than six months (and those applying for limited leave to remain) are required to pay an immigration health surcharge of typically £624 a year as part of their visa application, which grants them access to the NHS without having to pay for treatment at the point of delivery.

According to the charging regulations, providers of secondary NHS services must make and recover charges for treatment from people who are not ordinarily resident. Providers are required to make reasonable enquiries in order to determine whether a patient is chargeable, including asking for documentary evidence. Moreover, where it would not prevent or delay urgent or immediately necessary treatment, providers are expected to charge upfront and to withhold treatment if they cannot recover the costs from the patient (DHSC 2021).

Charges are applied at 150 per cent of the NHS national tariff (in effect the list of prices for different NHS services). Commissioners initially pay 75 per cent of the tariff to providers if a charge is identified; once the patient pays the 150 per cent charge, 75 per cent of this is then returned to the commissioner and the remaining 75 per cent is retained by the provider. This arrangement is designed to incentivise providers to identify chargeable patients and recover NHS costs (DH 2014; DHSC 2021).

Some services are exempt from charging – in particular, accident and emergency services, family planning services, the diagnosis and treatment of certain

2 Note that the concept of ordinary residence is UK-wide, even though the focus of this report is the system in England.

infectious diseases (including Covid-19) and sexually transmitted infections, palliative care services and treatment for a condition resulting from torture, female genital mutilation, domestic violence or sexual violence (DHSC 2021). Primary care (including care provided by GPs) is also not included as a relevant service for charging.

There are also important exemptions from charging for certain individuals. This includes exemptions for:

- anyone who has already paid the immigration health surcharge (typically those on temporary work, study or family visas, as explained above)
- anyone whose costs are covered by an EU member state under the Social Security Coordination (SSC) Protocol, provided they show the relevant healthcare document – such as a valid European Health Insurance Card (EHIC)/Provisional Replacement Certificate (PRC) for needs-arising treatment, or an S2 form for planned treatment
- Applicants to the EU settlement scheme who are waiting for the outcome of their application
- Irish citizens
- refugees and asylum seekers, only including those who have had their asylum application refused if they are receiving section 95 or section 4 support from the Home Office or support from their local authority under Part 1 of the Care Act 2014
- children looked after by a local authority
- victims or suspected victims of modern slavery (via the National Referral Mechanism)
- individuals who have been granted leave to enter outside the immigration rules and who have been exempted from charging by the health secretary on a humanitarian basis
- prisoners and people in immigration detention.

The current system of charging is highly complex and, as a result, many NHS trusts employ overseas visitor teams to identify and assess chargeable patients. These teams are made up of overseas visitor managers and overseas visitor officers, who spend their time identifying and assessing chargeable patients. Most recently, overseas visitor teams have been increasingly making use of the MESH (Message Exchange for Social Care and Health) tool, an NHS Digital service that helps the teams to identify potential non-UK residents who may be chargeable for healthcare (NHS Improvement 2021). The processes within overseas visitor teams vary from trust to trust. An example of how these teams identify and assess chargeable patients is presented in box 2.1.

BOX 2.1: CHARGING OVERSEAS VISITORS IN LEWISHAM AND GREENWICH NHS TRUST

Lewisham and Greenwich NHS Trust has one of the highest levels of income invoiced to overseas patients in England. In 2020, KPMG published an internal audit of its processes for charging overseas visitors (KMPG 2020). Drawing on this audit, we summarise below how this trust manages overseas visitors.

Step 1: Identification

The trust both proactively identifies potentially chargeable patients (that is, identifies them before treatment) and reactively identifies such patients (that is, identifies them once they are already in the system – for example they have arrived at accident and emergency or are current inpatients).

For the proactive identification of chargeable patients, the trust takes the following steps:

- Staff in the appointments office may send patient information to the overseas visitor team where the patient is potentially an overseas visitor. Where patients have a new NHS number or have no NHS number at all, or where they are not registered with a GP, this is used as an indicator that a patient may be an overseas visitor.
- Patients in the emergency department may be asked to fill out pre-attendance forms, which are then passed on to the overseas visitor team. Pre-attendance forms contain information on nationality, purpose of stay and relevant visa and immigration documents.
- Patient information may be sent to Experian, a credit checker, which provides a 'residency score' based on the available information. Those with a low residency score (that is, those more likely to be overseas visitors) are then checked against the NHS Spine (the NHS digital platform) via the MESH tool, to identify those who are potentially chargeable.

For reactive identification, the overseas visitor team may be contacted by ward or outpatient clinic staff where they believe there may be a potential overseas visitor.

Step 2: Assessment

Once a patient is identified as a potential overseas visitor, they are then assessed by the overseas visitor team to determine whether they are chargeable. This involves reviewing relevant evidence and in some cases an interview with the patient.

Step 3: Billing

Where a patient is found to be chargeable, then the trust begins the process of billing. If the patient is found to be chargeable before treatment, then the trust charges them upfront (unless treatment is urgent or immediately necessary). If the patient is found to be chargeable after treatment, then they are invoiced for the treatment and, where the patient cannot pay immediately, a payment plan is arranged.

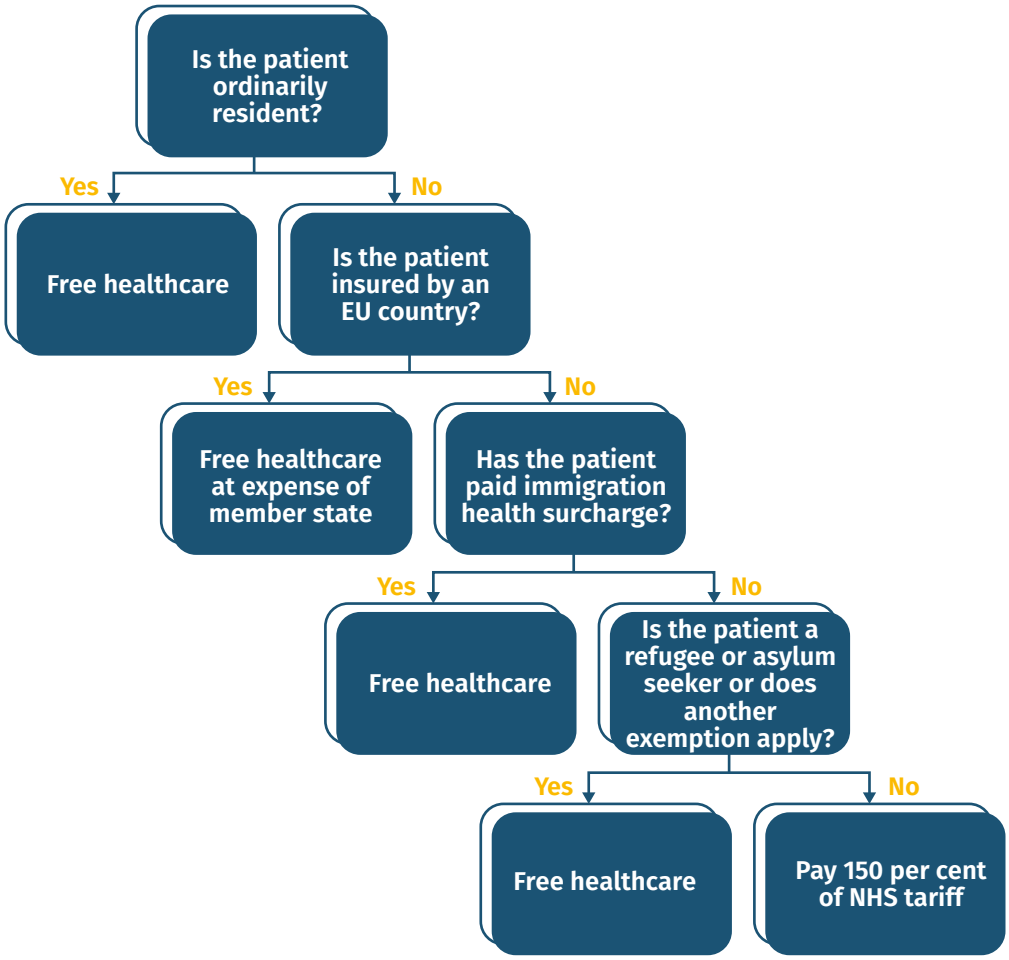
While overseas visitor teams are the main staff responsible for administering the charging system, frontline staff are also involved in charging decisions, because they often play an initial role in referring patients who may be chargeable to overseas visitor teams. Furthermore, clinicians are required to make judgements on whether the service to be provided is urgent or immediately necessary, which is an important step in determining whether payment should be recovered upfront. The recent changes to the charging system have therefore affected the roles of a

wide range of healthcare staff, and they have had a substantial impact on the way the NHS delivers treatment and interacts with its patients.

Figure 2.1 summarises the secondary healthcare entitlements of migrants and overseas visitors.

FIGURE 2.1

Simplified summary of the secondary healthcare entitlements of migrants and overseas visitors



Source: IPPR analysis of Department of Health and Social Care, *Guidance on Implementing the Overseas Visitor Charging Regulations* (DHSC 2021)
Note: This is a simplification of the full details of the secondary healthcare entitlements of migrants and overseas visitors.

HOW OTHER HEALTHCARE SYSTEMS TREAT PEOPLE WITHOUT IMMIGRATION STATUS

As explained in the previous section, England's system of healthcare charging means that people without immigration status are charged 150 per cent of the NHS national tariff for treatment, unless an exemption applies. But how does this compare with other countries? In this section, we explore how other healthcare systems provide treatment for people without immigration status. This analysis will help to inform our charging policy shortlist in later chapters of this report.

Scotland, Wales and Northern Ireland

Healthcare has been a devolved policy area since 1999. The current rules for healthcare charging in Scotland, Wales and Northern Ireland are similar to the English rules, but differ in important respects. In particular, the recent 2015 and 2017 charging regulations were introduced in England only, so many of the new measures implemented in England, such as the 150 per cent charge, do not apply in Scotland, Wales and Northern Ireland.

One of the most notable differences between England and the other three nations of the UK is the treatment of refused asylum seekers. In Scotland, Wales and Northern Ireland, all those who have made a formal asylum application are exempt from charging. This means that all refused asylum seekers, regardless of whether they are receiving Home Office or local authority support, are eligible for free NHS care (NHS Wales 2009; Scottish Government 2010; NI Department of Health 2018).

Spain

Spain, which like the UK operates a tax-based healthcare system, in principle offers free healthcare coverage to residents irrespective of immigration status (PICUM 2007).

In 2012, the Spanish government tightened this system by limiting access to free healthcare to those 'insured' under the social security system and their dependent relatives. Given people without immigration status are excluded from the formal labour market, this restricted their access to healthcare.

However, this approach was reversed in 2018, when the government repealed the 2012 decree and reintroduced the link between healthcare entitlements and residency, rather than insurance. People resident in Spain without immigration status are now, in principle, able to access free healthcare, provided they have a health card and can show that they are not insured for healthcare in another country (Bruquetas-Callejo and Perna 2020).

In practice, though, this policy is implemented in different ways across the country. Health cards are issued by Spain's 17 autonomous communities, which are able to decide the precise administrative process for providing cards to people without immigration status (Bruquetas-Callejo and Perna 2020). The ambiguity of the national rules and the discretion of autonomous communities have led to divergences in approach in issuing health cards. Many autonomous communities require people to be on the electoral register as proof of residency, making health cards extremely difficult to access for people without immigration status. On the other hand, some autonomous communities (such as Navarre and Valencia) accept other forms of proof of residency, such as a statement from a neighbour or a certificate demonstrating that the individual's children attend a local school (REDER 2018).

France

France's healthcare provision is based on a social insurance system, which, in principle, offers universal coverage for all regular residents. This is funded in part through compulsory insurance contributions and in part through general taxation (PICUM 2007).

The French system includes a number of allowances for people on a low income and in irregular situations. For people with no immigration status who are in financial difficulties, there is the State Medical Assistance (Aide médicale de l'État or AME). There are three elements to the AME: statutory AME, which is the primary scheme available for people without status; the 'emergency treatment' scheme, which provides emergency care for some people not supported by statutory AME; and 'humanitarian' AME, which is a derogation allowing non-residents access to hospital care at the discretion of the health minister (Wittwer et al 2019).

Statutory AME covers all treatment relating to illness or childbirth within the limits of social security rates (with a small number of exemptions, including fertility treatment). There are, however, a number of eligibility criteria. Most importantly, applicants must have been resident in France for a minimum of three months and must earn less than a specified income annually (currently 9,041 euros for a single person) to access the scheme (André and Azzedine 2016).

Recent changes in 2021 have tightened the rules on eligibility for AME. Applicants must now have lived in France for at least three months from the expiry of their visa or residence permit in order to be eligible. In addition, new AME recipients must now typically wait at least nine months before they can access certain non-emergency treatments (Ameli 2021).

There is evidence that the administrative requirements involved in applying for the benefit are a barrier to receiving healthcare (André and Azzedine 2016). Inconsistencies between different health insurance local branches can create challenges for access. This is particularly problematic for the implementation of the three-month residency requirement: some local branches accept documentation from private individuals supporting claims to residency, while others do not (Wittwer et al 2019).

The Netherlands

The Netherlands has an insurance-based healthcare system, whereby all regular residents are required by law to be insured. The system is delivered by private health insurance companies, which are obligated to offer insurance to applicants. Insurance payments are made through contributions from individuals and employers; where individuals cannot make payments, they can apply for an allowance financed by the state through general taxation (PICUM 2007).

People without immigration status cannot purchase health insurance due to the Linkage Law, which links certain entitlements of an individual to their right to reside. However, under the Aliens Act 2000, there is an exception for medically necessary care and care required to protect public health. Under certain circumstances, healthcare providers that lose income due to providing medically necessary care to people without status can be compensated by the 'CAK' (Central Administrative Office, a public service provider tasked by the Dutch government to implement these rules) (Derckx 2021).

In practice, however, there is limited knowledge of these provisions among both migrants and medical professionals and confusion over what constitutes 'medically necessary care', although there have been efforts to clarify its meaning. The nature of the policy means that the provision of care is effectively at the discretion of the provider (IISS 2020; Derckx 2021).

Sweden

Sweden's public health system is largely funded through taxation and allows for access for all regular residents (PICUM 2007).

Before 2013, people without immigration status were excluded from the public health system, other than in the case of emergency treatment (which was unsubsidised). However, after public pressure and criticism from the United Nations' Special Rapporteur on the Right to Health, new legislation was introduced in 2013 (Button et al 2020). Under the new law, people without immigration status are able to access acute care and care 'that cannot be deferred' (including maternity care and dental care), normally provided they make a small payment. In addition, children without immigration status are granted the same access to healthcare as regular residents. There is also scope under the legislation for regions to offer more generous levels of provision; as of 2017, a total of six had done so (PICUM 2017).

The change in the law led to a 56 per cent increase in the number of undocumented migrants receiving healthcare between 2014 and 2015 (Statskontoret 2016). However, there are still barriers in accessing these new provisions for people without immigration status. In particular, there is uncertainty over the meaning of care 'that cannot be deferred' (PICUM 2017; SMER 2020). There is also limited awareness and understanding of the law among some healthcare professionals (Statskontoret 2016).

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This brief review of the different approaches to healthcare entitlements for people without immigration status in other nations of the UK and in selected European countries highlights that, while there is no one example of a perfect system, there are multiple healthcare systems that grant more extensive access to treatment compared with England. The healthcare systems we have studied use a number of policy mechanisms for expanding access to healthcare to a wider range of people. These include:

- **using residency-based measures** – for instance, in Spain, granting access to a health card and free treatment based on proof of residency
- **using income-based measures (that is, means testing)** – for instance, in France, providing access to statutory AME for people without immigration status who are on a low income (alongside other conditions)
- **using measures of vulnerability** – for instance, Scotland, Wales and Northern Ireland granting access to free secondary healthcare to all people who have applied for asylum, regardless of the result of the application
- **providing exemptions for medically necessary treatment** – for instance, in the Netherlands, exempting medically necessary treatment, or in Sweden, ensuring that people without immigration status can access acute care and care 'that cannot be deferred'.

While these policy measures have their limitations – they can create ambiguity and confusion over definitions, leading to inconsistencies between different regions and healthcare practitioners – they all allow for ways for healthcare entitlements to be expanded to residents in need of treatment. In the next chapter, we draw on these international examples to explore different policy options for reforming the system in England. Our findings are based on a range of interviews on NHS charging with people with direct experience of the charging system, healthcare workers, members of overseas visitor teams and policy professionals.

3. FINDINGS FROM OUR STAKEHOLDER INTERVIEWS

In this chapter we outline the findings from interviews with 24 people who have knowledge of the NHS charging system, including people with lived experience of being charged for healthcare, healthcare workers, members of overseas visitor teams and policy professionals from a range of advocacy and membership organisations.

We asked participants about their views and experiences of the charging system in general. We also discussed their views on a range of policy ideas to identify opportunities and challenges for reforming the current system.

The policy ideas were developed through our analysis of the UK's devolved nations' and international healthcare systems, as discussed in the previous chapter, and a list of potential options was shared with participants to inform the discussion. The list included the following options:

- **abolishing the current charging system** – so that all people in England can freely access secondary healthcare
- **expanding the definition of ordinary residence** – so that people who are resident, regardless of their immigration status, can access free healthcare while short-term visitors are charged (drawing on the eligibility system in Spain, discussed in the previous chapter)
- **changing assessments of vulnerability** – so that there are greater exemptions from NHS charging for people in vulnerable circumstances and there are simpler ways of assessing when patients fall into this category (drawing on the exemptions used in Scotland, Wales and Northern Ireland)
- **means testing** – so that people earning below a certain threshold or who otherwise cannot afford to pay are exempt from charging (drawing on AME in France)
- **giving healthcare workers more discretion** – so that they have greater flexibility in applying the charging rules (drawing on practices in the Netherlands).

A number of participants put forward additional policy suggestions, which they considered would alleviate some of the challenges with the existing system. These are also considered below.

We first discuss five key themes that emerged from the analysis of the interviews, focusing on the challenges with the current system: deterrence, discrimination, lack of clarity, inefficient and ineffective treatment and care, and the public health impact. We then go on to outline how participants evaluated our proposed policy alternatives.

DETERRENCE

A key concern for a majority of participants was that the current charging system deters people with irregular or insecure immigration status from accessing healthcare, whether or not they are in fact eligible for free treatment. Participants with lived experience spoke about their reluctance to access healthcare as a result of their previous interactions with the NHS. One woman seeking asylum told us:

> ***"There was a time I [was sick]. I couldn't move ... Someone else asked me, 'Are you okay?' I said, 'No.' They said, 'Why don't you go and see your GP?' I said, 'I don't want to go, I'm scared because they might call Immigration for me because I'm not entitled to any care stuff like that.'"***
>
> Participant with lived experience

Patients were deterred due to both concerns over charging and fears that personal information could be shared with the Home Office. A policy professional explained that this was a common theme in their own organisation's research on experiences of the charging system:

> ***"We call it the two fears ... There's the fear of debt, straight up the fear of debt ... And then the other fear is the fear of Immigration Enforcement and exposure to Immigration Enforcement, which again even if they can't deport you, the kind of flagging up in the system and then being kind of hounded and harassed."***
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> Policy professional 10

Some participants described how this could lead to some people only accessing health care when there was an emergency or a crisis. As one policy professional said, "they just won't turn up unless they're really sick", ultimately leading to more costly interventions.

Some were concerned that people were being deterred even when they were technically eligible for free healthcare:

> ***"If they're currently seeking asylum, they'll just be deterred from care because if they see that hostile environment in the NHS, they become worried, even though they are perfectly entitled to it. They become worried that ... if they rack up a bill, it's going to look bad against their [immigration] application, things like that."***
>
> Policy professional 3

A health worker agreed that deterrence was a big issue, meaning many people without immigration status are unable to even get through "the front door" of healthcare services:

> ***"Undocumented migrants ... are already afraid how much it might cost them to access healthcare here ... So there's already kind of a threat hanging over them ... there are things in the news which tell you your data is not secure, that people are being deported all the time, and you are asked to fill in documents saying whether or not you were born in the UK ... Someone will come along and say, 'By the way, you might be charged for this care.' At which point you walk out, and you haven't got your diagnosis ..."***
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> Health worker 2

Indeed, an overseas visitor manager we spoke to told us that the number of chargeable patients deterred from seeking care was recorded by NHS England and NHS Improvement as a positive achievement, and used to rank trusts.

DISCRIMINATION

Discrimination and the profiling of patients were seen by many who we interviewed to be inherent to the design of the charging system. Some noted that, because the NHS had not been designed to charge patients, there was no feasible way of implementing the rules without some form of discrimination to identify those who were chargeable.

Participants spoke of a number of cases where they believed that ethnicity, name, country of origin and accent were used as markers to differentiate between and discriminate against patients. One woman seeking asylum felt asylum seekers were routinely discriminated against:

> ***"Sometimes I go to the hospital. The doctor will know you are a migrant. The doctor will know you are an asylum seeker, the way they will look at you, the type of treatment they give all the other people."***
>
> Participant with lived experience

As one policy researcher told us, healthcare workers sometimes used nationality as a proxy for determining chargeability, in contravention of the current rules:

> ***"We had one case in our research where there was a young boy, a recently recognised refugee on the refugee resettlement scheme – so was literally pre-screened [for disease] in a camp in North Africa and brought over to the UK and had been here several months, went to a clinic appointment that had been arranged and the [administrative] staff at the clinic … told them they were going to have to pay because they stated their nationality and this family then freaked out and thought, 'We can't pay for this' and they left … It was known before he even entered the country as a refugee that he had this condition, but the admin staff had just gone, 'Oh, you're from X country, you're going to have to pay.'"***
>
> Policy professional 3

A participant with experience of working as an overseas visitor officer spoke of how discriminatory judgements formed a fundamental aspect of determining who might be chargeable:

> ***"You can't go through every NHS number that doesn't correspond with the person's age. So … if you've got a, I don't know, Mohammed Khan and a Fred Cooper, you're obviously going to go for [investigating] the Mohammed Khan … Even for someone who's, you know, well I'd like to think hopefully open minded, like myself, you're just trying to save yourself time because there's not enough hours in the day."***
>
> Overseas visitor officer 1

A health worker also reflected on their experiences, reporting that discrimination on the basis of ethnicity was used to determine who might be chargeable:

> ***"It's a system that is designed to benefit [white] people like me, not people you know like … the patient on intensive care who is black and British and was unconscious and sent a bill. So why did someone think that he was not eligible for care? Given he was unconscious most of the admission, significantly unwell. Probably not his accent, more likely his skin colour maybe."***
>
> Health worker 2

LACK OF CLARITY

Participants spoke about the complexity and ambiguity of the charging system, reporting a lack of clarity in the rules and guidance. This resulted in a limited understanding among NHS trusts and healthcare workers, as well as among patients themselves.

Participants with lived experience of the charging system spoke of how they did not know about particular exemptions to which they may have been entitled. One participant raised the fact that there was little upfront information about fees, describing a disconnect between the clinical care they received and the charging system:

> ***"The specialist really opened my eye, he come down to my level for me to understand what is wrong, and he told me the way to correct it … I was very, very glad. But he never told me that it was going to involve money or anything … Initially I was happy because the day I met with the doctor and he told me that they are going to correct it and how it was to be done. But the day I received the letter [regarding charges], and I don't know the way forward now. I'm not happy."***
>
> Participant with lived experience

A lack of clarity was thought by many to stem from the length of the guidance on the charging system, with a number of participants citing the fact that, put together, the guidance documents run to "over a hundred pages". Some participants described how the guidance could be interpreted in different ways. For instance, a decision made by a doctor could be "pushed back on very strongly by overseas visitor managers".

Some participants observed that the lack of clarity came from the top down, as they felt that the overall aims of the charging system were opaque.

> ***"The system is very complex. The rules governing charging are extraordinarily complex, which leads to confusion, mainly misunderstandings within the NHS trusts and certainly amongst vulnerable women in the community."***
>
> Policy professional 9

Participants with experience in overseas visitor teams noted that practice often varies across providers and between individual overseas visitor managers and overseas visitor officers. One former overseas visitor officer noted the lack of consistent training and highlighted the consequences for patient care:

> ***"I fell into the job through agency work that I was doing … it's all made up on the job, the training. There's no courses … that I'm aware of. I could be wrong and yet you're going into a healthcare setting and sometimes things like [intensive care] and it felt quite inappropriate at times … I would always speak to the nurse looking after the patient and say, 'Well how is this patient? What's their emotional and psychological state like?' Whereas I know my colleagues didn't … and certainly on most cases when I went to the wards with them, they would just go and interview patients directly."***
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> Overseas visitor officer 1

While several participants called for clearer guidance, some cautioned that this would not necessarily lead to a fairer system:

> ***"It's not that it's difficult to apply them accurately, it's that even [if] you apply them accurately they will harm people."***
>
> Health worker 2

INEFFICIENT AND INEFFECTIVE TREATMENT AND CARE

Participants described how the charging system led to inefficiencies in the delivery of treatment and clinical care, which they suggested had led to worse health outcomes for those subject to charges.

Our discussions with people with lived experience of the charging system highlighted that in many cases it is not possible to recoup the costs of care. All of the participants with lived experience told us that they had been unable to pay their bills in full. They had either had support from charitable organisations to 'write off' part of their debt or had arranged monthly payment plans.

One participant who was awaiting her bill explained how she was surviving on food parcels and financial support from the church and charities. She was very worried about how she would pay the charges: "I cannot think straight, I keep imagining even if they ask me to bring £1,000, where will I [get it?] Who would give me? Who would borrow me?"

From the perspective of policy and healthcare professionals, implementing the charging system was described a number of times as a "burden" that distracted clinical staff from their main role:

> ***"I think the thing we've not mentioned, is that I think some NHS staff, certainly from our research, said that they really felt like getting involved in charging wasn't part of their job … They were like, 'I became a doctor to do a good thing' or 'a nurse to do a good thing. I don't want to be worried about patients being charged. I don't want to have to factor that into my decision-making. I just want to look after them.'"***
>
> Policy professional 3

We learnt of a number of cases where disagreements or negotiations between healthcare workers and overseas visitor teams had led to the provision of more limited or substandard care – particularly in relation to conditions that require ongoing management, such as dialysis. One doctor reflected on an experience:

> ***"We were going on the ward round and we decided a patient needed a CT [computerised tomography] scan and then someone said, 'Or, or maybe we should do a chest X-ray instead of the CT scan because it will cost less for the patient.' But the patient definitely needed a CT scan, and we would not have blinked at the idea of that patient needing a CT scan if they had not been paying for that themselves."***
>
> Health worker 2

Another participant spoke about the time and energy spent following up with patients who had been deterred by the charging system:

> ***"Where women are avoiding care, and we know about them, if they've booked into a service at the beginning of their pregnancy and then don't access care from then on, midwives spend a lot of time trying to find them, and when they don't attend appointments, we then need to do some detective work to find out where they are, how they are, whether they've moved and all the rest of it. So, yeah, that's very time consuming."***
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> Policy professional 13

The effect of deterring patients was also recognised to be ineffective from a cost perspective. One participant spoke of how deterred patients can end up being treated for much worse conditions due to the delay to their treatment: "By scaring people off and trying to charge people, for really simple interventions, you then end up having to give them very expensive interventions for free anyway."

A participant with experience of maternity care explained the costs for migrant women subject to, and deterred by, charges:

> ***"In my view, the charging regime costs maternity services a significant amount of money by deterring women from attending care early. These are women who are at high risk of poor health outcomes, they're much more likely to have more complex care needs by commencing care late or missing appointments, and the costs in maternity services are quite significant, both in terms of the care delivered in the maternity service and the lifelong costs of a baby who's born less well, who's born early or born unwell."***
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> Policy professional 9

The majority of participants believed the charging system was not cost effective, and that any recovered costs did not justify the outlay of staff time and resources. This was especially the case when chasing up patients who were destitute or in low-paid work, and so who were most often unable to pay the charges. As one participant summarised:

> ***"So it just seems, when I was there ... we were working for doing something that had a negative impact on people's health and wasn't really helping that much, getting that much money in for the NHS anyway."***
>
> Overseas visitor officer 1

PUBLIC HEALTH IMPACT

As a result of the above issues, a common concern discussed by participants was the impact of the charging system on public health.

One person with lived experience of the system spoke about the tragic consequences of the system for her friends:

> ***"I have a friend that has already died, they are also asylum seekers. They were neglected [by the] NHS here for cancer, you know. It's very difficult for them to access treatment. She has been here ... for 18 years. There was denial of treatment, [she] was just abandoned at the hospital. They took her to [a] care home where she died. It really affected me because she was [a] very good friend to me. They did not help. No one wants to treat her. The doctor had to call the Home Office to confirm her status and they [were] told 'she doesn't have any right to treatment', she [told] me before she died ... [Another friend who] has been 12 years in this country – she's got breast cancer. She was denied treatment and then ... the disease spread to her brain, to every part of her body because they deny her treatment."***
>
> Participant with lived experience

A health worker explained in further detail the consequences of delayed treatment, for both individuals and the wider public:

> ***"I think the really key thing to remember is that when people present late with illness, they are more likely to be more unwell than if they presented early. That damage done from the disease might be longer-lasting and some people will even die as a result. [And] in the case of infectious diseases, delayed presentation means that you are less likely to take measures and precautions that stop the spread of that infection."***
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> Health worker 2

The NHS charging system has posed particular challenges for public health in the context of the Covid-19 pandemic. In general, participants highlighted that the charging exemptions introduced for coronavirus would not necessarily ensure smooth access to treatment. For instance, one woman seeking asylum told us that her family would avoid accessing healthcare as far as possible, regardless of the pandemic:

> ***"I would be scared [to access healthcare] because they already know my status and they abandon me. They help people that pay tax, people that give back to the community, that work. They have a lot of patients with Covid, [so they will ask,] 'Why are we going to accept this one, she doesn't pay tax, she doesn't pay money so why would we respond to her?' ... During Covid that's why we didn't go out at all. We are always indoor 24/7. My children don't go out at all."***
>
> Participant with lived experience

A policy professional similarly highlighted ongoing concerns about approaching the NHS:

> ***"Even where people have known about the existence of the exemption for coronavirus and they have coronavirus symptoms or think they've been exposed, they've still been too scared to go to the NHS and that's even where, you know, a case support worker who knows them well has told them that they can access care for free, they still don't trust health services enough to attend."***
>
> Policy professional 1

More generally, infectious disease exemptions – whereby certain infectious diseases can be treated for free – were seen to be ineffective due to poor take-up. One participant suggested that this was because many patients might be uncertain about the charging outcome. Before receiving a diagnosis, a patient may find it difficult to tell whether they have a (charging-exempt) infectious disease, or a different (chargeable) condition with similar symptoms. A second participant suggested that this is due to poor communication, because "information is not shared very well with migrant communities". Another participant further elaborated:

> ***"I think there's a concern that they'll be reported to the Home Office and also concern that, if they're treated for other things while in hospital, they will be charged for them. So, those are two big reasons why I find exemptions don't work."***
>
> Policy professional 3

DISCUSSION OF ALTERNATIVE POLICY OPTIONS

In this section of the chapter, we summarise how participants evaluated potential policy reform options.

Abolishing the current charging system

The option to abolish the charging system altogether garnered the most support from participants with a policy background and those with lived experience of the charging system. One participant, for instance, saw that the issue of discrimination could not be tackled without abolishing the current system, and argued that "there's not really a workable solution where we're going to actually be recouping costs from people that can afford those costs".

A number of the health workers and overseas visitor managers also expressed a preference for the abolition of the charging system, highlighting that it runs counter to the aims of clinical care, and is ineffective:

> ***"Abolishing the charging system altogether, well that would be my preference. It just seems to create a lot of extra work for people in the health service, who are there to provide care, whereas in fact who [the charging system is] employing are people in finance, who are like, you know, maybe overseas officers, the credit controllers, finance analysts, that's not really what the NHS is designed to do … All of that costs money, when, for instance, in [many cases], they're not going to be able to pay. I mean, we know that from day one. So what's the point?"***
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> Overseas visitor officer 1

While favoured, some participants also recognised that this option was unviable in the current policy context, and therefore that alternatives would need to be considered. One health worker acknowledged that it was a "political hot potato" and that while abolishing the system would "help huge amounts of vulnerable people", it could also "leave the NHS open to being exploited by those from abroad who might have the money to pay". Another participant acknowledged that it was perhaps "idealistic" to think that the system could be abolished, and that some of the other proposed options could still be a "major step forward".

Expanding the definition of ordinary residence

Participants were asked their views on the proposal that all those who are UK residents, regardless of immigration status, should be able to access free healthcare in England, while those who are visitors continue to be charged.

There were mixed perspectives on this option – with views generally dependent on the policy detail and system design. The primary concern with this option related to the practical challenge of distinguishing residents from visitors. Initial conversations highlighted how Home Office data would be inadequate for determining residency. One policy professional identified that historically there had been a lack of effective "tracking" of overseas visitors and migrants:

> ***"Well, if they are a short-term visitor then they should have a visa, which basically gives them a right to remain for a period of time. The problem was, [there was] an awful lot of inefficiency … the Home Office had no strategy for dealing with people who overstayed their visa when they came to the UK. They didn't know where they were, where they were staying, or how many of them there were …"***
>
> Policy professional 4

While this participant suggested that there needed to be improved data within the Home Office and greater sharing of data between the Home Office and the NHS, a number of others were concerned that this would conflict with calls for a 'firewall' preventing data sharing between the Home Office and other government departments, and that there could be unintended consequences that would worsen the effects of the hostile environment and impact on civil liberties (see Qureshi et al 2020).

Others highlighted problems with establishing residency through the use of credit-check companies – an approach that has been taken to verify requests for Covid home-testing kits – and which would likely disadvantage a number of groups, including many migrants. One participant reflected on how credit checks have already been implemented in the charging system:

> *"Some trusts were using credit-check companies ... to double check if the person was a regular resident in the UK ... Which obviously is extremely discriminatory. It's not a perfect way of assessing whether a person lives in the UK or not."*
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> Policy professional 7

In response to these criticisms of pre-existing methods of checking residency, we discussed the idea of a 'vouching' system, in which acceptable evidence could be provided by professionals and organisations with standing in the community to certify that a patient has been in the UK for a certain period of time. Some participants agreed that using this type of information would be beneficial:

> *"I think more emphasis should be placed on evidence provided by voluntary organisations and GPs and social workers who've worked with someone. So rather than actually seeking a new round of paperwork, simply to accept the statement from someone who's provided support or care to someone in the past or their lawyer that they are aware that the person's been in the country for a certain period of time."*
>
> Policy professional 9

Our conversations with participants with lived experience of the charging system highlighted how a flexible approach to residency might work in practice. Participants with lived experience suggested a number of pathways through which they could prove how long they had been in the UK, including: providing letters from schools, faith groups, charities and GPs; showing passports with date of entry and entry visas; and using their asylum registration card.

Some participants, however, raised concerns about the logistics of implementing this system and the additional administrative burden on staff. One person suggested that there may be uneven geographic effects, as "there are so many parts of the UK where there aren't charitable or voluntary sector organisations that will take on that role [of vouching for patients]".

Changing assessments of vulnerability

For this policy option, we proposed greater charging exemptions on the basis of vulnerability and suggested adapting the way in which assessments of patient vulnerability are determined.

On the whole, participants were cautious about this suggestion. They raised concerns over increasing the complexity of the rules in an already hard-to-navigate system. They also said that there were already challenges related to determining vulnerability, noting that practitioners applied the current exemptions in subjective and inconsistent ways. One participant drew on an example:

> *"There is, in theory, an exemption for domestic violence. It doesn't work. We're currently dealing with overseas visitor managers who are making their own assessment as to whether or not a woman's experienced domestic violence according to Home Office definitions. They do not have the skills to do that. They're making bad decisions."*
>
> Policy professional 9

Conversations with people with lived experience of the charging system revealed that they had a range of experiences that put them in vulnerable circumstances and could, in principle, grant them exemptions under the current charging regulations. However, none of the participants were aware of any such exemptions, and neither had any exemptions been applied to their cases.

Reinforcing this point, some participants noted that exemptions do not address the issue of deterrence. They spoke of how low trust among patients often inhibits the disclosure of their circumstances:

> ***"People don't walk around with a sign on their neck saying, 'I've been trafficked' or 'I'm a victim of torture' or 'I have tuberculosis'. Those labels require confidence between an individual and the health service and that confidence comes from a long history of confidentiality being the cornerstone and the foundation of the relationship between healthcare workers and the healthcare system and the patients they serve. By bringing in surveillance mechanisms and duties of reporting [for] patients who are deemed ineligible for free NHS care, we start to erode that confidence, that trust, between patients and healthcare professionals."***
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> Health worker 2

However, we found support from participants for exempting people for maternity care, as well as allowing free treatment for children and young people. Three of the five female participants with lived experience had accessed maternity care in the NHS, and all felt that this care should be free. One professional from a maternity care background told us:

> ***"It is extraordinary that we would charge anybody for pregnancy care, I think. And I don't think people are aware that we charge. In general, the population does not know that some people are charged for pregnancy care. So, I think if we're going to focus on improvements on the current policy, I think that's definitely the first thing that we should focus on."***
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> Policy professional 7

Means testing for free NHS care

This option involved expanding eligibility for free healthcare to individuals on a low income or who otherwise could not afford to pay. There was mixed support for this option – with some participants considerably more in favour of it than others. One person saw it as a pragmatic step:

> ***"It should be at the very, very least, it should be means tested, because there is just no point in chasing after, spending hours and hours and hours and millions of pounds of people's salaries, chasing after women who don't have any money, and probably will not in the foreseeable future. So, that's just a waste of everybody's time and it's just manufacturing huge amounts of misery in addition to that."***
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> Policy professional 12

However, some raised the issue that it would be difficult in many cases to provide proof of finances and felt that means testing would not address the 'deterrent effect' of NHS charging:

> ***"There's some argument that [means testing] could have a potentially positive impact for people who have got far enough to actually access care. What's not very clear yet, but what I think is probably happening now actually, is that that's really only the tip of the iceberg, and what we're not seeing is all the people who are not going at all to the hospital, people who are generally scared of public authority, of public institutions, anyway because of their precarious status."***
>
> Policy professional 1

Giving healthcare workers more discretion over applying the charging rules

There was overwhelming consensus that individual health workers should not be burdened with greater personal discretion over healthcare charging, as it was argued that individuals are fallible to their own political and ideological views. Participants suggested that different views and practices would be likely to lead to greater potential for discrimination, as well as a lack of parity in NHS care.

Revising the rules on urgent and immediately necessary treatment

During our interviews, some participants supported the option of revising the rules on urgent and immediately necessary treatment. Currently, treatment considered urgent or immediately necessary cannot be charged upfront and instead has to be invoiced afterwards. One participant suggested that the definition of these concepts could be widened to include care that, if withheld, is likely to lead to a deterioration in patient health, which would in future require urgent or immediately necessary treatment. Some felt that this was a good option for extending current exemptions.

There were also related discussions about the charging system distinguishing between different types of healthcare. One participant called this the "gritty corners of the system in which very difficult decisions have to be made". A health worker offered the following suggestion:

> ***"I think the system should be based on the kind of illness we're treating. So with cancer, things that are life-saving, that should be free for anyone, but, for example, people with things like hip replacements etcetera, I think that should be tested in some way, certainly at least means tested, because whilst there is a notable increase in quality of life, it's not life-saving in any way."***
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> Health worker 3

Expanding the health surcharge

In our discussions with participants, we heard the suggestion that the current charging system could be replaced with a health surcharge for visitors. This would in effect operate as a type of health insurance policy, extending the current health surcharge for longer-term migrants to people coming to the UK on short stays.

> ***"Why not simply insure people? You know the government is more than capable, as it has … done with longer-term visas where it charges a health surcharge, which is a government-based insurance effectively – health insurance. Why doesn't it just make sure that everyone who gets a visa, you know, especially given that the visa fees are [as] huge as they are, if it wanted to insure everyone on a visa then it would be by far the more sort of effective way in making sure the NHS had enough money … simply put insurance on short-term visit visas for healthcare."***
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> Policy professional 14

However, another participant argued that the current provisions for charging migrants for NHS care on entry are not particularly related to NHS charging per se – rather it is "just about taxing people who come to this country to work, study and join family". They further advised that any policy analysis should "leave that out" as it is "a distinct tax [that is] pretending to be part of this system". Another participant criticised the NHS surcharge for charging "absolutely crazy money".

Relatedly, some highlighted that reciprocal arrangements between countries, or greater use of travel and health insurance, could be prioritised as an alternative means of recovering costs from short-term visitors accessing the NHS. There were some doubts, however, about the political viability of this option, as well as the extent to which patients could be tracked and healthcare costs recouped from their country of origin.

Giving trusts greater autonomy

Although not on our initial policy list, a small number of participants suggested that reversing recent efforts to more rigorously implement cost recovery and returning to the previous system – in which trusts had greater discretion over recovering costs from chargeable patients – was an option worth exploring. This would involve, for instance, removing sanctions on trusts for non-compliance and reducing the 150 per cent charging incentive. Some participants thought this option would have the benefit of giving more scope for trusts and healthcare professionals to decide how they went about recovering costs. One participant argued that the charging regulations from 2015 and 2017 should be repealed:

> ***"I think it needs to go back to a system where it is entirely up to trusts and to doctors to decide whether or not to charge people or to pursue charges, and there's no financial penalty whatsoever if they decide not to. And that would allow NHS trusts that wish to, to charge people who are very clearly health tourists, but it wouldn't create any kind of destructive incentive to charge people who really, it's not worth the time pursuing because they don't have the money … You know, someone who is clearly a wealthy businessman who decides to fly in from Hong Kong to get free treatment on the NHS that they're not entitled to, a trust might decide to pursue charging. They're probably not going to go after a bunch of asylum seekers who have no money in the first place. There's no business case for it."***
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> Policy professional 14

Finally, participants discussed a number of other policy ideas and principles that were broadly viewed as complementary to any of the policy alternatives selected. These can be summarised as follows:

- There was broad support for a **firewall to stop data sharing between the NHS and the Home Office**. This was raised as a necessary addition to any other measures taken, in order to address the 'deterrent effect' of the current system.
- Participants were concerned by the complexity and ambiguity of guidance and a lack of appropriate training on the current system. They argued that **improved guidance and training** would bring greater clarity for professionals and patients. We heard, for instance, about organisations that have sought to clarify the legal obligations of practitioners and the rights and entitlements of patients, as well as groups that have provided training sessions for healthcare workers on how to administer the system in as fair a way as possible.
- Participants highlighted that there is not enough clarity about the intended purpose and aims of the charging system, and therefore the current rules are not rooted in evidence. It is not clear whether the system is intended to recover costs or to deter migrants, or both. There were calls for **an evaluation of the current charging system**, as well as clarity over the metrics used to assess its effectiveness.

In this chapter, we have reviewed the evidence from our interviews with people with direct experience of the charging system, healthcare workers and policy professionals. Building on this evidence, we will now identify our shortlist for policy reform of the system and analyse each policy option in turn.

4. ANALYSIS OF POLICY OPTIONS

In this chapter we set our shortlist of policy options for replacing the current NHS charging system.

Drawing on our analysis of policy approaches in other countries and our discussions with people with lived experience of being charged for care, healthcare workers and policy professionals, we have identified five policy options for reform. These options are not in all cases mutually exclusive, and there is scope for some aspects of them to be combined. Each option, though, represents a different approach to reforming the current system and expanding healthcare access for people living in England. The five options are as follows.

- **Option 1: Means testing for free NHS care.** All people not ordinarily resident could be guaranteed free secondary healthcare at the point of delivery provided they earn below a specified income threshold or they can otherwise demonstrate they do not have the financial means to pay for care.
- **Option 2: Exempting 'medically necessary' treatment from NHS charges.** Treatment defined as 'medically necessary' could be exempt from charging. While the current rules allow 'urgent' and 'immediately necessary' treatment to not be charged upfront, this option would expand these concepts to a wider definition of 'medically necessary' treatment and then exempt this treatment from charging altogether.
- **Option 3: Basing entitlement to healthcare on residency.** All residents, regardless of their immigration status, could be defined as 'ordinarily resident' and so be eligible for free secondary care at the point of delivery. Under the current definition of ordinary residence, it must be legal, voluntary and for a settled purpose. This could be revised to ensure that patients with no immigration status are eligible for free care, provided they otherwise meet the conditions of ordinary residence in the UK.
- **Option 4: Giving providers greater autonomy over charging.** Trusts and other providers could be given greater flexibility over the extent to which they identify and pursue chargeable patients. This would involve rolling back the incentives and sanctions imposed as part of the Cost Recovery Programme, including the 150 per cent incentive charge.
- **Option 5: Replacing the charging rules with a health surcharge for short-term overseas visitors.** The current system of charging at the point of delivery could be abolished and instead healthcare costs could be recouped through a new health surcharge for short-term overseas visitors. This would be a small charge included as part of the fees for applying for a short-term visa (non-visa nationals would be excluded). For some countries, the fee could be exempted on the basis of securing reciprocal arrangements for healthcare costs – similar to the agreement with the EU in the Social Security Coordination (SSC) Protocol.

As noted above, we have identified these options on the basis of our analysis of international policy approaches and our interviews with stakeholders. Two of the options – means testing for free NHS care and basing entitlement to healthcare on residency – are based on the list we originally developed. They received some

positive responses from stakeholders, although some critiques and challenges to these options were also raised. The other options in our original list – for example, greater exemptions on the basis of vulnerability – did not receive sufficient support to make the shortlist for this section.

The other three options in our shortlist – exempting 'medically necessary' treatment from charging, giving providers greater autonomy over charging and replacing the current charging rules with a health surcharge for short-term overseas visitors – emerged through our interviews with stakeholders. We have included them in our discussion because they suggest useful alternative ways forward for reforming the current system, which we analyse further in this section.

We have not included the option of abolishing NHS charging in our shortlist and in the analysis that follows, on the basis that this option is unlikely to be implemented in the short to medium term. While it is clear from our interviews that this option has a number of important merits and could be feasible to implement in the long term, for this report we have assumed that, for the moment, the government will continue to have an interest in recovering at least some costs from overseas visitors.

We assess each of the five options in our policy shortlist against three different criteria:

- **Inclusivity and ease of access.** That is, to what extent does the policy option broaden access to healthcare, with the ultimate aim of ensuring that all people living in England have equitable access?
- **Feasibility of implementation.** That is, to what extent can the policy option be implemented in practice, taking into account the process for documenting eligibility and recovering costs?
- **Implications for public health.** That is, to what extent does the policy option prevent disease, promote health and prolong life among the population as a whole – particularly in relation to infectious diseases such as Covid-19?

We discuss the criteria for each of the five policy options in turn. A summary of our policy analysis is contained in table 4.1. A further piece of fiscal analysis for each of the policy options is included in appendix 2 (due to the methodological limitations of this analysis we have not included it in the main report).

OPTION 1: MEANS TESTING FOR FREE NHS CARE

Under means testing, only migrants who are not ordinarily resident, with an income above a given threshold, would be subject to the charging system. This draws on the approach to healthcare for people without immigration status in France, which provides allowances for people on a low income.

It should be noted that, under the current rules, patients who are destitute can ask their NHS trust to 'write off' their debt. However, this is not equivalent to our means-testing option, for two main reasons. First, writing off debts is done on an ad hoc basis and there is no guarantee that trusts will act uniformly. Second, debt write-offs are currently only for accounting purposes; on paper, the patient still remains in debt to the trust and providers still have the option of recovering the debt if their circumstances change (DHSC 2021).

Inclusivity and ease of access

This policy option would, in principle, expand free access to secondary healthcare for people in England who would otherwise be unable to pay NHS charges. It would therefore aim to remove one of the key barriers to accessing healthcare under the current system. Those still chargeable would be people not ordinarily resident

with sufficient financial resources to pay any charges incurred. In principle, all healthcare services would therefore be accessible.

However, in practice, patients may struggle to demonstrate their eligibility for means-tested healthcare – particularly if they have no immigration status. How inclusive this option is would therefore depend on the way it would be implemented (see the next subsection for further discussion). Moreover, as highlighted in our interviews, this option may deter individuals from coming forward for treatment, due to the concern that they may not be able to prove their level of income and eligibility.

Feasibility of implementation

This option would not be straightforward to implement, given that it would require some way of determining an individual's financial situation, either through self-declaration or additional checks. If individuals are required to prove their eligibility for free care under a means-tested system, they may face challenges demonstrating an absence of income and savings, which is inherently hard to evidence.

Nevertheless, there are ways to make the implementation of this option more feasible. One approach would be to rely entirely on individual self-declaration. Under this proposal, patients would be asked to provide details of any income and, if they receive no income, to explain how they otherwise get by. This option would be easy to administer, although it could be criticised for not being sufficiently robust.

An alternative to self-declaration would be to require independent proof of an individual's situation but allow for a wide range of evidence to be admissible. Providers could check eligibility by, for instance, running credit checks, assessing administrative records or requesting a statement from a community figure or organisation (for example, a charity, GP, social worker, school, landlord or neighbour) confirming that the patient is on a low income or destitute. This would give people without immigration status the option of demonstrating eligibility through informal routes, rather than simply through formal documents such as payslips or bank statements.

One relevant precedent for this policy is the current set of rules for assessing destitution for the purpose of asylum support (Home Office 2019). Destitution is defined here as not having adequate accommodation or any means of obtaining it, or being unable to meet other essential living needs. In this case, the Home Office takes into account income and assets (including cash, savings and investments) to determine whether an individual is destitute. Supporting evidence must be provided as part of the application process. A similar approach is taken for assessing destitution for applications to lift the 'no recourse to public funds' condition, with the latest guidance indicating that decision-makers can apply 'evidential flexibility' – that is, allow for missing evidence where justified (Home Office 2021b).

Another useful precedent is the NHS Low Income Scheme, which helps pay for prescription charges, dental treatment, eye tests, glasses and some other costs for people on a low income (DHSC 2019b). Eligibility is assessed by comparing an individual's income with their living requirements. (Those with savings, investment or property over a particular limit are excluded.) The scheme is available to everyone, regardless of immigration status. To apply, patients must fill out an HC1 application form. This allows applicants to self-declare any savings, income and housing costs. They are only required to provide evidence of payslips if relevant (as well as evidence of financial accounts in the case of the self-employed, and grants, loans, bursaries and awards in the case of students). The form also

allows applicants to declare informal support if they are barred from working or accessing benefits due to their immigration status.

For this means-testing option, the Low Income Scheme could potentially be extended into secondary care to allow patients on a low income to be exempt from charges. This would provide a wider exemption than the Home Office's destitution test because the criteria used to assess eligibility are less narrow. Yet it could also prove difficult to administer in practice, given the current HC1 form can be demanding to complete and requires considerable details on income and living expenses.

Implications for public health

This policy option could help to protect public health by reducing the 'deterrent effect' caused by NHS charging. This would help to improve access to and engagement with all health services that play a role in reducing preventable disease, mortality and disability. In particular, people with infectious diseases may be less likely to avoid seeking treatment, because those who cannot afford to pay would be able to have full access to free NHS treatment.

However, the ultimate effectiveness of this option would depend on how it is implemented, what is decided as to the appropriate threshold for exempting patients from charges, and whether people are aware of the exemption before accessing services. If patients who do not meet the criteria (or who are concerned that they cannot prove they meet the criteria) do not come forward for fear of being charged for treatment, then this charging system would still put public health at risk.

OPTION 2: EXEMPTING 'MEDICALLY NECESSARY' TREATMENT FROM NHS CHARGES

Under this approach, all 'medically necessary' treatment would be exempt from charging. Everyone considered not 'ordinarily resident' would remain chargeable for secondary care, but these charges would only apply to a smaller range of services not considered medically necessary. This follows similar approaches taken in the Netherlands and Sweden.

Inclusivity and ease of access

Exempting all 'medically necessary' treatment from charging would help to extend access to free healthcare in a greater number of cases. The scale of the reform and the level of improved access would depend on the definition of 'medically necessary' treatment. For instance, if 'medically necessary' treatment is defined based on whether a clinician judges that delaying treatment could lead to harm, then this would cover a broad range of scenarios. This could help to reduce the risk of serious errors where those in need of care are wrongly denied it.

Yet there is also a risk that, even under this broader set of exemptions, there are grey areas where mistakes are made and treatment is wrongly withheld. Moreover, there will be some forms of treatment that will still be chargeable, even where patients are living in England and cannot afford to pay. This option is therefore inherently limited in terms of achieving full inclusivity.

Feasibility of implementation

There would be some benefits in administering this option, because a wider set of exemptions for 'medically necessary' treatment would reduce the administrative burden for NHS providers.

However, there would be considerable pressure on clinical decisions over what constitutes 'medically necessary' treatment, which could create implementation problems. As discussed in the previous chapter, the current system of NHS

charging is highly complex. In particular, the rules on identifying urgent and immediately necessary care are hard to navigate and often misapplied (DOTW 2020a). There is a risk that this option could face similar challenges.

Drawing on parallels in other countries, there are multiple different ways of defining what constitutes 'medically necessary' care. In Sweden, for instance, people without immigration status are able to access 'care that cannot be deferred'. In the Netherlands, 'medically necessary' care has been defined as all services covered through the basic insurance package and the Long-term Care Act, unless that care can be postponed and it is clear that the patient will be leaving the country shortly (Grit et al 2012). Yet in both countries, there is still confusion over these definitions among healthcare professionals.

This suggests that a new definition of 'medically necessary' treatment could be used in England, but it would need to be accompanied by clear guidance from the NHS. While our interviewees highlighted that some flexibility in the definition would be necessary to allow for professional judgement, they were concerned that too much discretion could lead to inequality in treatment and increase the risk of discrimination. Given England does not have an insurance-based system such as that in the Netherlands, and so cannot use this as a basis of its definition, a definition of 'medically necessary' care would need to include clear guidance on how different treatments should be categorised.

Implications for public health

Expanding exemptions from charging for all care deemed 'medically necessary' could help to improve access to services that prevent disease and promote health. Under this approach, maternity services (currently considered 'immediately necessary'), which play a key role in protecting and promoting the health of pregnant women and children, would become free.

This approach may also improve access to and engagement with infectious disease services (including treatment for Covid-19). Under the current rules, these services are free, but not everyone is aware of these provisions. A new system that clearly exempts a broader range of 'medically necessary' services from charging could help to clarify the rules and communicate them more widely. In practice, however, public understanding of the system is likely to be limited, and people without immigration status may fear coming forward if they are uncertain as to whether their treatment would be classified as 'medically necessary'.

OPTION 3: BASING ENTITLEMENT TO HEALTHCARE ON RESIDENCY

Under this approach, anyone who is a UK resident would be excluded from being charged at the point of delivery in England, regardless of their immigration status. Such a system would be based on the same definition of 'ordinary residence' as used now, but would remove the requirement for residence to be legal (and the requirement for indefinite leave to remain). This follows a similar approach taken in the Spanish healthcare system.

Inclusivity and ease of access

This option would expand the definition of 'ordinary residence' to include all those resident in the UK, provided they were there voluntarily and for a 'settled purpose'. Therefore, people without immigration status would be entitled to free healthcare provided they met the other conditions of ordinary residence. Ordinary residence would not be determined simply by how long a patient was in the UK – they would be considered resident provided they were in the UK voluntarily for a settled purpose, even if they were resident for only a short period. Those identified as visitors would remain chargeable for NHS services received.

In principle, this would allow for a significant expansion of healthcare access for people in England, allowing everyone resident voluntarily for a settled purpose to access free healthcare at the point of delivery and taking a major step towards achieving universal healthcare access. Individuals may still be subject to the immigration health surcharge as part of their visa application, but this would no longer be tied to entitlement to free healthcare in England.

However, in practice, interviewees raised concerns that there may be individuals who would struggle to prove their residency and so fall through the cracks of this new system. People without immigration status are unlikely to have standard documentation such as tenancy agreements in order to prove their status and so could be deemed ineligible for free healthcare. (Credit checking is also unlikely to be effective as a proxy for residency, given that people without immigration status are barred from opening bank accounts.) The extent to which this option would increase access to health services in practice would therefore be highly dependent on the rules for demonstrating residency.

Feasibility of implementation

The feasibility of this option depends on how checks on residency are administered. There are multiple ways of implementing this system.

One option would involve cross-checking a patient's details with Home Office records to identify short-term visitors. However, there are a number of problems with this approach. First, there are practical difficulties in obtaining and using Home Office data (not least that many short-term visitors do not require a visa to come to the UK). Second, using Home Office data would only identify those individuals who are on short-term visas and so are generally not eligible for free treatment, rather than those who are resident and therefore eligible. This is because the Home Office has no reliable record of people without immigration status in the UK. Third, there are widespread concerns over data sharing between the NHS and the Home Office, which this approach could exacerbate.

A second option would involve using NHS numbers to identify short-term residents. Many providers use this approach now, on the basis that those patients with no NHS number or with a very high NHS number (that is, a number recently assigned) are more likely to be overseas visitors. Yet while this may be a useful way of initially identifying patients who could be short-term visitors, it is not a reliable basis for determining eligibility altogether. For instance, someone who has been living in the UK for a number of years but has never registered with a GP may not have an NHS number, but this does not mean they would not be eligible for free healthcare under this proposal. NHS numbers could only therefore be used as an initial screening process, rather than as a means of assessing eligibility.

A third option would be to ask patients to supply official records, such as travel and immigration documents, utility bills and tenancy agreements, to show that they are resident in the UK. However, this information is unlikely to be available for people without immigration status and so will not be flexible enough for the purpose of guaranteeing access to healthcare.

A fourth option would allow a greater range of evidence to be used, including statements from community figures or organisations (for example, charities, GPs, social workers, schools, landlords or neighbours), to demonstrate residency. These statements could either confirm that the patient has been living in the country for a specified minimum period (for example, three months) or, if they have been living in the country for a shorter period, that they are there for a settled purpose (for instance, by illustrating that they send their children to a local school or provide regular care to a person living in the UK). This would give migrants without any formal documentation the option of using alternative forms of evidence to

demonstrate their residency. If this documentation is not available, providers could apply evidential flexibility and rely on the patients self-declaring their residency where appropriate (see above under means testing).

The international case studies discussed in chapter 2 highlight that, where countries do use a residency test to determine eligibility for free healthcare, there can often be inconsistencies in approaches between regions. For instance, in France, due to conflicting messaging from the national government, some healthcare centres accept documents from private individuals as evidence of residency, while others do not. It is therefore vital that this option is combined with clear messaging and guidance on how to implement the policy and the appropriate documents that can be used to determine eligibility.

Finally, there is also a risk of discrimination in the implementation of this policy option, just as there is under the current system of healthcare charging. As highlighted in the previous chapter, if overseas visitor teams are pressed for time, they may make assumptions in the identification process about those whose circumstances need to be scrutinised more carefully. Clear advice would therefore need to be shared with NHS providers to minimise the risk of discrimination in the administration of residency checks. Moreover, in order to allow for a fair system, the government would need to establish a process whereby a patient could challenge the outcome of a residency assessment.

Implications for public health

By expanding free access to healthcare at the point of delivery to all residents, this policy option would offer two key benefits for public health. First, it would enable all residents to be able to receive timely and preventive healthcare, regardless of their immigration status or financial circumstances. Second, by removing all charges at the point of delivery for residents, this system could help to reduce the 'deterrent effect' of healthcare charging and thereby help to address the spread of communicable diseases.

In practice, under this option there may still be some risks to public health, due to barriers for residents who cannot prove their eligibility and due to short-term visitors avoiding the NHS because they would still be subject to charging. These risks could be mitigated by monitoring and proactively addressing barriers and ensuring that the process of demonstrating residency is as smooth and straightforward as possible.

OPTION 4: GIVING PROVIDERS GREATER AUTONOMY OVER CHARGING

This option would give trusts and other providers greater autonomy over how to charge overseas visitors and migrants by repealing the recent rules introduced to incentivise providers to identify chargeable patients and collect payments.

Inclusivity and ease of access

In effect, this policy option aims to return to the old system of NHS charging before the Cost Recovery Programme and the new charging regulations. Providers would have less of an incentive to detect and pursue chargeable patients, because providers would no longer charge patients at 150 per cent of the standard NHS tariff and no longer receive 75 per cent from commissioners at the point of identification; and there would be no sanctions for providers who failed to identify chargeable patients (DH 2014).

It is likely that the overall impact of these changes would be an extension of healthcare access to wider groups, given the removal of financial incentives and sanctions on providers. In particular, this option may benefit those who are in more precarious financial circumstances, given that the change in incentive structures

for providers would make it less in their interest to identify patients without the funds to pay for treatment.

However, it is likely that this extension of access would be piecemeal and not necessarily targeted at the groups most in need. Moreover, there are likely to be inconsistencies across providers. Given providers would have greater discretion over charging, it is expected that some would take a stricter approach to following the rules than others, which could lead to inequitable outcomes across regions and local areas.

Feasibility of implementation

In one sense, this option would be easier to implement than the others, as it would deliberately roll back previous efforts to intensify the enforcement of NHS charging. It would not be difficult to remove recent legislation and to allow for a more flexible approach to charging overseas patients. Yet this option may face criticism for expanding the gap between the charging legislation – which would still mandate providers to identify, and recover costs from, chargeable patients – and its implementation in practice. This option may therefore face accusations of confusion and mixed messaging, particularly if evidence emerged that the level of charging income was falling over time.

Implications for public health

There is evidence to suggest that this policy option could have positive implications for public health. Research on tuberculosis treatment suggests that, following the introduction of the Cost Recovery Programme, the average number of days between the onset of symptoms and the start of treatment for non-UK patients increased from 69 to 89 days – that is, the Cost Recovery Programme has been associated with delays in treatment (Potter et al 2020). This indicates that reversing the measures taken by the Cost Recovery Programme could help to reduce delays in the treatment of contagious diseases such as tuberculosis, thereby helping to promote and protect public health.

However, there are also challenges with simply returning to the previous system. Critically, the experience of the recent reforms to healthcare charging could have permanently changed the culture within many NHS providers and created a longstanding 'deterrent effect' among migrant groups. Simply reversing the recent changes may therefore not be sufficient to change the culture within the NHS and to encourage migrants to feel confident in coming forward to seek treatment.

OPTION 5: REPLACING THE CHARGING RULES WITH A HEALTH SURCHARGE FOR SHORT-TERM OVERSEAS VISITORS

Under this approach, no patient would be charged for healthcare at the point of delivery. Instead, a health surcharge would be applied to short-term overseas visitors as part of their visa application, in order to recoup their healthcare costs. Depending on the precise design of the policy, the charge could also be extended to recover the overall healthcare costs of people without immigration status as well. Non-visa nationals would not be affected.

Inclusivity and ease of access

This option would end the current charging system and allow for free access to secondary care at the point of delivery. Such an approach would significantly improve ease of access for those with healthcare needs.

Yet an initial charge included as part of a visitor visa application could be criticised as punitive for those coming for short-term stays. Arguably, it may also be challenged as inequitable, given certain non-visa nationals (for example, nationals of EU countries or the United States) would not be subject to the surcharge and so

would be exempt from NHS charging altogether, while others would have to pay upfront as part of their visa application.

Feasibility of implementation

Overall, this option would be relatively straightforward to administer, as it would remove the need for checks on 'ordinary residence' and immigration status by providers.

It is possible, though, that there would be complications involved in applying a health surcharge to visitor visas. There is a clear precedent for such a charge – the immigration health surcharge, which currently applies to most visas of more than six months in length and is typically set at £624 a year. It is also not uncommon for visitor visas to include certain health requirements – for instance, the requirement for a travel health insurance certificate for a Schengen visa application. But there could be challenges in setting the right level of the charge in a way that recoups healthcare costs but which does not deter tourism to the UK. (For further details on potential costs, see appendix 2.)

Where possible, it might be beneficial to complement the health surcharge with reciprocal healthcare agreements with specific countries, to facilitate access to healthcare for each other's visitors (as exist now with the EU and some non-EU countries). This would mean that the citizens of some countries would be exempt from the additional healthcare surcharge. Ideally, these arrangements would be made with all countries whose visitors are not required to obtain visas, given that non-visa nationals would not be subject to the health surcharge in any case. However, in a number of countries there are likely to be diplomatic barriers to negotiating such reciprocal agreements. There could also be practical challenges involved in tracking and calculating the costs to be recouped by different partner countries.

Another important practical issue is that this policy option purports to reform healthcare access in England, but the health surcharge would most likely need to apply across the UK, because immigration policy is a UK-wide competence. For this option there would therefore need to be a coordinated approach across the four nations of the UK, ideally based on the principle of removing charging at the point of delivery in all parts of the UK.

Finally, this option could be critiqued on the basis that it would not deter individuals from travelling to England to access the NHS. A small additional charge as part of a visa application could be easily absorbed by visitors who come to England in order to make use of the NHS. Some may also argue that it is unfair that the costs of healthcare are borne by all visa national visitors, rather than only those visitors who make use of the NHS.

Implications for public health

This option would help to minimise the risk to public health, because there would be no charges or checks on any visitors or migrants when accessing NHS services. By charging individuals at the point of a visa application, this would in principle remove the 'deterrent effect' of NHS charging. In practice, this deterrent effect would not be removed fully or instantaneously, and so this option would need to be accompanied by a broader communications campaign to make clear that people without immigration status will not be charged or penalised for seeking medical treatment.

We summarise our assessment of each of the five policy options in table 4.1.

TABLE 4.1

Our summary assessment of each of the five alternative charging system policy options

Option	Inclusivity and ease of access	Feasibility of implementation	Implications for public health
1: Means testing for free NHS care	Expands access to healthcare for those without the means to pay.	Difficult to implement as people without immigration status may have difficulty providing proof of their financial situation.	Reduces the 'deterrent effect' of the current system, but continued charging of some patients would mean risk is not eliminated completely.
2: Exempting 'medically necessary' treatment from charging	Expands access for treatment defined as 'medically necessary'; level of inclusivity depends on the definition of 'medically necessary'.	Reduction in administrative burden given that more treatments would be exempt; unless the definition of 'medically necessary' is clear, it could lead to inconsistent practice.	Helps to clarify rules on entitlement to services, including treatment for infectious diseases, but low understanding of the rules could continue to pose risks.
3: Basing entitlement to healthcare on residency	Expands access to all residents, regardless of immigration status.	Successful implementation is highly dependent on allowing residence to be demonstrated in a range of ways.	Reduces the 'deterrent effect' of the current system, but continued charging of some patients would mean risk is not eliminated completely.
4: Giving providers greater autonomy over charging	Overall impact probably positive, but there are likely to be inconsistent practices across providers.	Relatively straightforward to implement as a reversion to the pre-2015 system.	Research suggests delays in treatment could be reduced overall, although health risks are unlikely to be eliminated.
5: Replacing charging rules with a health surcharge for short-term visitors	Significantly improves ease of access by removing charging at the point of delivery.	Relatively straightforward to implement through the visa system, but may be critiqued for recouping costs from all visa nationals rather than only those accessing healthcare.	Removal of charging at the point of delivery would minimise public health risks.

Source: IPPR analysis

Our policy analysis in this chapter highlights a number of important considerations that need to be taken into account in reforming the current system of NHS charging. In the next chapter, we draw on this analysis to make an assessment of the most effective approaches for reform.

5. CONCLUSION AND RECOMMENDATIONS

The current system of NHS charging is not working. As they stand, the charging rules deter people from accessing healthcare, lead to delays in treatment, distract NHS professionals from their care roles and apply large bills to patients with no prospect of paying them. Throughout the Covid-19 pandemic, the public health implications of the current system have been magnified, given that by inhibiting migrants from coming forward for treatment, the rules risk facilitating the spread of Covid-19. Moreover, even assessed on its own terms, the system is extremely costly and complex to administer. There is therefore an overwhelming case for reform.

Over the course of this report, we identified and analysed a shortlist of five different policy options for reforming the charging regime:

- Option 1: Means testing to provide free NHS care at the point of delivery to all those on a low income or who otherwise cannot afford to pay for it.
- Option 2: Exempting 'medically necessary' treatment from NHS charges.
- Option 3: Basing entitlement to healthcare on residency, so that all residents, regardless of immigration status, can access free care at the point of delivery.
- Option 4: Giving providers greater autonomy over charging.
- Option 5: Replacing the charging rules with a health surcharge for short-term overseas visitors.

Our analysis found merits and challenges with each of the policy options discussed. Drawing the analysis together, however, it is clear that some of the options are more workable than others.

The option of means testing (Option 1) offers clear benefits to those who are unable to afford the NHS charges, but there are significant concerns over how such a system could be practically implemented and the level of proof necessary to demonstrate eligibility.

Similarly, while developing a new definition of 'medically necessary' treatment and exempting all such care from charges (Option 2) could be a step forward, our analysis suggests that it would be difficult to come to a clear definition of what constitutes 'medically necessary' treatment. This risks encouraging inconsistent practices across providers and healthcare professionals. Giving providers greater autonomy over charging (Option 4) could result in similar inconsistencies, whereby some providers operate much more stringent policies than others.

One option that would be relatively simple to implement is the health surcharge for short-term overseas visitors (Option 5). As we found in our analysis presented in appendix 2, in order to match the same level of net revenue as the current system, the additional cost of the surcharge would only need to be around £15. However, it may nevertheless be critiqued as deterring tourism, particularly given the wider challenges involved with international travel as a result of the Covid-19 pandemic. Moreover, some may argue that it would do little to discourage individuals from specifically visiting the UK to make use of the NHS.

This leaves Option 3: basing entitlement to healthcare on residency, so that all residents, regardless of their immigration status, would be eligible for free healthcare at the point of delivery. At the same time, under this option, trusts could continue to take action to recover costs from overseas visitors staying for short periods.

In our assessment, this is the most effective alternative to the current system. It would significantly expand healthcare access, removing legal impediments for people without immigration status. And it would be administratively simpler than the current system, as all that would be required to show eligibility would be proof of residency – which could be demonstrated through statements from community figures or organisations (such as charities, GPs, social workers, schools, landlords or neighbours), with evidential flexibility applied where appropriate.

As with all the proposals discussed, there would also be challenges with this option. Some people without immigration status may struggle to prove residency, even if a wide range of evidence was considered permissible to demonstrate eligibility. There may be inconsistent approaches in implementation between different providers. Moreover, there is a risk that NHS providers could unfairly discriminate (for example, on the basis of ethnicity, name or accent) in the process of determining eligibility.

To address some of these challenges, we therefore outline some additional recommendations to complement our overarching policy proposal, which draw on our interviews with stakeholders and our findings from chapter 3:

- The Department of Health and Social Care should introduce **improved guidance** for NHS professionals to navigate the new system, emphasising simpler and clearer processes, which can be delivered consistently across different providers.
- The NHS should provide **high-quality training** for NHS professionals who administer the charging system, including clinical staff, members of overseas visitor teams and other administrative staff. Training should be provided to ensure fair and consistent approaches to the charging system and to safeguard against discrimination in determining whether patients are chargeable.
- The government should set up an **independent body** to receive complaints about the charging system and review decisions by providers. This would give scope for individuals to challenge decisions where they feel the rules have not been followed or they have been unfairly discriminated against.
- The Department of Health and Social Care should engage in **ongoing analysis and evaluation** of the charging system in order to assess its cost effectiveness, the impact of any potential 'deterrent effect', the risk of discrimination and the implications for patient health outcomes. The system should be regularly reviewed to ensure all residents are able to access the healthcare they need.

With these safeguards in place, Option 3 (basing entitlement to healthcare on residency) is, on balance, our favoured option for policy reform. This option would help to ensure that no resident is refused care in England because of their immigration status. It would allow for a relatively light-touch approach for patients to be able to prove their eligibility. Finally, it would simplify the administration of the system and reduce the costs involved in pursuing patients who cannot afford to pay healthcare charges. While there would no doubt be challenges in implementing such a system, our analysis suggests that this change would reduce delays in treatment, improve medical outcomes and ultimately help achieve the UK's commitment to health coverage for all.

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APPENDIX 1: METHODOLOGY

QUALITATIVE RESEARCH

We interviewed 14 policy experts from 11 organisations; three NHS clinical staff; two current or former overseas visitor service staff; and five migrants with lived experience of the charging system. To help find interview participants with lived experience, we worked with Kanlungan Filipino Consortium and Hackney Migrant Centre.

We conducted hour-long interviews with participants over Zoom, using an interpreter where necessary. We asked participants about their views and experiences of the current charging system and their views on potential policy solutions. We analysed interview transcripts using NVivo software to identify patterns and key findings.

FREEDOM OF INFORMATION REQUESTS

We sent freedom of information requests to 37 NHS trusts. This sample was chosen to be representative across the following criteria:

- region
- size of trust – measured using total operating expenses (NHS Improvement 2019)
- level of charging activity – measured using total charges levied (NHS Improvement 2019).

In addition, trusts with the highest levels of charging activity were oversampled. This was intended to improve the accuracy of our analysis, as these trusts account for a high proportion of total charging activity.

Our freedom of information requests included questions on cost recovery rates by migration status, and the administrative costs of the charging programme, for the financial year 2019/20.

We received five responses with a breakdown of charges levied and revenue received by migration status; and 10 useable non-zero responses concerning overseas visitor service staff costs.[3] No trusts were able to provide information on the wider administrative costs of the charging programme beyond overseas visitor service staff costs.

We then supplemented this data on staff costs with data from previous freedom of information request responses published online. This search yielded 22 further useable non-zero responses. We combined these into a dataset of overseas visitor service staff costs across 32 trusts, which we used in our analysis below.

The rest of the quantitative analysis is detailed in appendix 2.

3 Some trusts reported costs for staff who dealt with both private and overseas patients. It was not possible to determine the split between these two activities, so we have excluded these results from our analysis.

APPENDIX 2: FISCAL ANALYSIS

In this appendix, we estimate the direct financial cost and revenue of the current charging system. We then compare these to the estimated financial cost and revenue of our different policy options.

In addition to their direct financial impacts, these policy options also have significant wider indirect financial and non-financial implications. These are detailed in box A2.1. **This means that our analysis should not be interpreted as a comprehensive estimate of the fiscal or overall impact of these options.**

Moreover, there are inherent difficulties in estimating the different fiscal impacts of these policy options. This is because the data on charging overseas visitors that trusts collect is limited and there is no reliable information on the total population of people who are undocumented in England. This means we have had to make a number of significant assumptions to conduct this analysis. As a result, the analysis in this appendix should be understood as illustrative, rather than as a precise forecast. It is more meaningful to focus on comparing the impacts of the different policy options rather than the absolute numbers.

BOX A2.1: WIDER INDIRECT FINANCIAL AND NON-FINANCIAL FACTORS

In addition to the costs and benefits of the charging system analysed in this appendix, there are other factors that we have not been able to include due to complexity and/or a lack of data. These include:

- the fiscal impacts of delayed treatment, as if migrants are deterred from or unable to access care, this will lead to a reduction in NHS spending in the short term, but in the longer term, there are also costs to the NHS from restricting migrants' access to preventative healthcare – evidence from Germany, Greece and Sweden suggests that restrictions are less cost effective overall than granting regular access to care (Bozorgmehr and Razum 2015, FRA 2015): conditions tend to go untreated until they become emergencies, when treatment is more accessible, but more expensive
- the wider public health impacts from restricting migrants' access to healthcare, for example the potential increase in the risk of infectious diseases among the wider population – the charging system contains exemptions for certain infectious diseases, but (as explained in chapter 3) these do not work well in practice
- the wider programme costs of NHS charging, including non-staff costs (IT equipment, office space) and administrative costs for NHS staff (training staff on how to administer the charging system, time spent by administrative staff collecting information from patients, time spent by finance staff dealing with invoices and time spent by clinical staff making decisions over whether treatment is urgent or immediately necessary)
- the costs borne by migrants themselves from restricted access to healthcare (whether these are included as a factor depends on whether one's cost–benefit analysis looks at the welfare of the migrant population as well as the non-migrant population – the Treasury's guide to cost–benefit analysis recommends that government cost–benefit analysis should take into account the welfare of UK 'residents' but not 'potential residents' or 'visitors'; HMT 2020)
- the impact on the economic outcomes of migrants and on taxes paid
- the impact on overall tourism and migration levels.

THE CURRENT CHARGING SYSTEM

For our analysis of the current charging system, we first estimated the financial costs of the system and then calculated its revenue.

Costs

There are many costs associated with the current charging system, including the staff time spent administering the system, the training of staff and non-staff costs such as IT equipment and office space (for further details, see box A2.1). However, it is difficult to estimate these costs accurately. We therefore focus on the costs of employing overseas visitor service staff in NHS trusts. This is likely to be an underestimate of total costs, particularly as it does not factor in the time spent by clinicians and other administrative staff in interacting with the current system.

In order to estimate the costs of employing overseas visitor service staff, we collated data from freedom of information responses from 32 trusts on the staff costs of their overseas visitor team in 2018/19.[4] We then compared this with data from NHS provider accounts on the gross amount invoiced by each NHS trust and foundation trust in the financial year 2018/19 (NHS Improvement 2019). We found that overseas visitor service staff costs were highly correlated with the amounts invoiced to overseas visitors at the trust level.[5]

Based on this correlation, we were able to use data on the total amount invoiced (NHS Improvement 2019) to estimate the total overseas visitor service staff cost across all 230 NHS trusts and foundation trusts. We found that the total amount invoiced in 2018/19 was £91 million and the total cost of employing overseas visitor service staff was approximately £12 million.[6]

Revenue

To calculate the revenue from the current system, we also used data from NHS provider accounts (NHS Trust Development Authority 2021). These accounts provide information on the amount of actual revenue received from overseas visitors. Trusts do not succeed in collecting all of the amounts levied in charges from patients, which means there is a significant discrepancy between the amounts invoiced by trusts and the cash payments received.

We found that in 2018/19 the cash payments received across all trusts totalled £35 million. In the same year, £39 million of charges was added to provision for impairment of receivables,[7] while a further £30 million was written off altogether. It is important to note that income is sometimes paid over multiple years, so these figures can include income from invoices raised in previous years, as well as in 2018/19. However, for this analysis we have assumed that the figure of £35 million in cash payments received in 2018/19 is equivalent to the total amount of revenue received for all income invoiced in 2018/19.

4 Where necessary, costs have been uprated in line with the NHS pay index (DHSC 2019c) to 2018/19 prices.

5 The R-squared value for the correlation was 0.875.

6 A 22 per cent uplift has been applied to our estimates of wage costs to account for non-wage costs (authors' analysis of ONS 2020b). In some cases it is unclear if the freedom of information request responses included non-wage costs in their figures, so this figure may be a slight overestimate as a result.

7 That is, the trust expects that these charges will not be recovered.

ANALYSIS OF POLICY OPTIONS

We now consider in turn the cost and revenue implications of each of the five policy options in our shortlist.

Option 1: Means testing for free NHS care

Costs

Under a means-testing system, overseas visitor service staff would still be required to identify chargeable patients. However, the workload of following up with chargeable patients and levying charges would be reduced, since there would be a smaller number of chargeable patients.[8]

In order to determine the scale of reduction in costs, we need to estimate how many patients would no longer be chargeable under a means-testing system. Unfortunately, there is no available data on the financial situations of people according to their immigration status, which makes it extremely difficult to develop a reliable estimate of the number of people exempted from charging under this option. For simplicity, we have therefore assumed that all undocumented people would qualify for free healthcare, and that all other patients who are currently chargeable would still be required to pay. We have made this judgement on the basis that undocumented people are unable to work or claim benefits and so are highly likely to be destitute.

This means that we need to estimate the scale of the undocumented population and the documented population currently subject to charging. We define the undocumented population in line with other researchers as all individuals in the UK without immigration status, including those who entered the UK through unauthorised routes, those who overstayed their visa, those born to parents with no immigration status and those who have been refused asylum and have exhausted their appeal rights (GLA 2020).

There are no completely reliable estimates of the scale of the undocumented population in the UK. However, the most recent estimate indicates that the undocumented population (including UK-born children of undocumented people) is approximately 809,000 (GLA 2020). Scaling this to England based on the distribution of the non-UK population, this suggests that the undocumented population in England is around 739,000. Subtracting the number of refused asylum seekers in receipt of Home Office support (who are exempt from charging according to current policy) and adjusting again for the England-only population, this gives an estimate of around 736,000 undocumented people in England. Given there are further exemptions for some vulnerable groups, which are hard to quantify (for example, looked-after children and victims of modern slavery), we subtract 10 per cent from this figure to give a final estimate of 662,000 undocumented people subject to NHS charges.

Alongside this, we estimate the total number of documented people who are subject to charging. Given, in 2018/19, EU citizens were generally not subject to charging (either because they were ordinarily resident or because they were insured by their member state) and non-EU citizens in the UK for more than six months were typically either ordinarily resident or accessed free healthcare by paying the immigration health surcharge, we focus on estimating the number of non-EU citizens in the UK for less than six months. We calculate this estimate by summing the number of nights spent in the UK by non-EU residents visiting the UK for less than six months in 2018/19, using data from the International Passenger Survey (ONS 2020a). We then calculate an annual equivalent figure by dividing

8 In reality, some of the work of levying charges is not done by the overseas visitor service team, but by the wider finance team. However, it was not possible to estimate these costs. Therefore, for simplicity, we have assumed that all of this workload is restricted to the overseas visitor service team.

by 365, accounting for the fact that most visitors spend only short periods in the country. We also adjust for the England-only population. This gives an annualised figure of around 323,000 short-term visitors in England who are currently subject to charging.

Based on the above figures, we then estimate that undocumented people make up approximately two-thirds (67 per cent) of the chargeable population. In the absence of data on the amount of time spent by overseas visitor service staff on different activities, we estimate that between 25 and 75 per cent of their time is spent identifying patients and the rest of their time is spent on engaging with and following up chargeable patients. Given that the number of chargeable patients will be reduced by 67 per cent under the means-testing option, we therefore estimate that overseas visitor service staff costs will fall to approximately £6 million to £10 million.

Revenue

In order to estimate the impact of this option on revenue, we need to make an assumption about the 'recovery rates' for subgroups of the chargeable population (that is, the amount of cash actually received by trusts out of the amounts invoiced). In particular, we need to make an assumption about the recovery rate for the undocumented population.

Our assumption draws on the quantitative analysis for the Department of Health provided in Prederi (2013). This study states that "we have assumed that most irregular migrants will have no means to pay and it is misleading to show this as potentially collectible revenue". We therefore assume a recovery rate of 10 per cent. This is because undocumented people are unable to work legally or access benefits and so they will generally be unable to afford NHS charges. The amount recovered from this population is therefore likely to be very low.

There is further evidence to support this assumption from a survey at a clinic at Doctors of the World (which provides medical care and support for people unable to access NHS services – including refused asylum seekers and others who are undocumented). The survey found that 96 per cent of service users were destitute (n=27) (DOTW 2020a). This suggests that the vast majority would be unable to pay for NHS services. Given this evidence, our assumption of a 10 per cent recovery rate is fairly conservative – in reality, the rate is likely to be lower still.

To calculate the costs for this option, we assume that the distribution of income invoiced for 2018/19 is equivalent to the ratio of the documented and undocumented chargeable population. That is, we assume that around two-thirds of the income invoiced for 2018/19 relates to charges for undocumented people, given that they make up around two-thirds of the chargeable population. Given that the total amount of income invoiced is £91 million, the amount invoiced for undocumented people is then around £61 million. Assuming a recovery rate of 10 per cent (see above), this means that the cash payments received for the undocumented population are around £6 million. This is our estimate of the amount of income that would be lost under this option compared with the status quo.

Given a recovery rate of 10 per cent, our estimated revenue for this option is therefore £29 million (the £35 million received under the current system less the £6 million that we estimate would be lost). Overall, the net revenue for this option is between £19 million and £23 million.

Option 2: Exempting 'medically necessary' treatment from NHS charges

The fiscal impact of this option will depend on what care qualifies as 'medically necessary' and so is exempt from charges. Given that there is no settled definition of 'medically necessary' care, there is no reliable way of estimating the impact of exempting such care. We have therefore not included an estimate for this option.

Option 3: Basing entitlement to healthcare on residency

For this option, anyone who is resident in the UK voluntarily for a settled purpose would be eligible for free healthcare at the point of delivery, regardless of their immigration status. We therefore assume that undocumented people are eligible for free healthcare, while non-EEA visitors of under six months are still chargeable. The analysis for this option is therefore equivalent to the means-testing option discussed above. Our overall estimate of net revenue is the same: between £19 million and £23 million.

Option 4: Giving providers greater autonomy over charging

Costs

This option in effect proposes returning to the pre-2015 system of NHS charging.[9] To estimate the impact of giving providers greater autonomy over charging, we therefore look at the cost from the pre-2015 charging system. The overseas visitor service staff cost of the system was estimated at around £9 million in 2013 (authors' analysis of Home Office 2013b).

Revenue

To estimate the revenue for this option, we look at information on the revenue from the pre-2015 charging system. The actual revenue received from the system was £22 million in 2013/14 (DH 2017).[10] This means that our estimate of net revenue for this option is around £13 million.

Option 5: Replacing the charging rules with a health surcharge for short-term overseas visitors

Costs

Under this option, the current system of charging at the point of delivery would end, and so there would be no need for any NHS costs associated with administering the system, including overseas visitor manager costs.

There may, however, be some set-up and administrative costs for the Home Office in introducing the new health surcharge. The 2013 impact assessment accompanying the initial introduction of the immigration health surcharge for people on longer-term visas estimated the one-off cost from the introduction of the surcharge at £2.0 million, or £2.2 million in 2018/19 prices (Home Office 2013b). We have taken a conservative approach and assumed that the cost will be the same again for extending the existing surcharge to this new group. As this is a one-off cost, we have not included it in our table of results below (table A2.1) – our appraisal is restricted to ongoing costs. However, in line with the impact assessment, we have also estimated that there will be ongoing administrative costs for the Home Office of approximately £1 million a year.

Revenue

The revenue under this option is entirely dependent on the level at which the new surcharge is set. The total number of visitor visas granted in the UK in 2018/19 was 2.3 million (authors' analysis of Home Office 2021c). If the surcharge was designed to cover all of the revenue collected under the current system (£35 million), it would need to be set at approximately £15 per visa. On the other hand, if it was designed to cover all of the amounts invoiced under the current system (£91 million), then it would need to be set at approximately £40 per visa.

9 In reality, trusts may choose to retain some or all elements of the current charging regime. In this case, our analysis will overestimate the fiscal impact of this option.

10 These cost and revenue estimates have been uprated in line with inflation to 2018/19 prices.

RESULTS

Table A2.1 summarises the results from our fiscal analysis. As emphasised at the beginning of this appendix, the best way of interpreting the results is to consider the relative difference in net revenue between the options, rather than the absolute values.

Our analysis indicates that means testing (Option 1) and basing entitlement to healthcare on residency (Option 3) are broadly cost neutral compared with the current system. This is because these options reduce the costs of administering the system while only losing small amounts of revenue, as they exempt individuals who are unlikely to be able to pay in any case (those without immigration status). On the other hand, giving providers greater autonomy over charging (Option 4) would, according to our estimates, reduce net revenue compared with the status quo. Finally, replacing the charging rules with a health surcharge for short-term overseas visitors (Option 5) could bring in additional revenue, but this would depend on the precise level of the new surcharge.

We recognise that this fiscal analysis has limitations and relies on a number of assumptions, such as the size of the undocumented population, the amount of time spent by overseas visitor staff on different activities, and the recovery rate for undocumented patients. Also, we have been unable to include certain factors due to a lack of reliable data. Some of these factors were listed separately in box A2.1, earlier in this appendix; for a more comprehensive understanding of the fiscal implications of the different policies, we recommend reading table A2.1 in conjunction with box A2.1.

TABLE A2.1

Our estimates of the fiscal impacts of reforming the NHS charging system vary depending on the policy option

Cost and revenue for each of the policy options (£ million)

	Cost	Revenue	Net revenue
Current system	12	35	23
Option 1: Means testing for free NHS care	6–10	29	19–23
Option 2: Exempting 'medically necessary' treatment from NHS charges	Depends on definition of 'medically necessary' treatment		
Option 3: Basing entitlement to healthcare on residency	6–10	29	19–23
Option 4: Giving providers greater autonomy over charging	9	22	13
Option 5: Replacing the charging rules with a health surcharge for short-term overseas visitors	1	Depends on level of surcharge	

Source: IPPR analysis

Note: All figures are annual and in 2018/19 prices. Figures may not sum exactly due to rounding.

APPENDIX 3: GLOSSARY

Charging regulations: the National Health Service (Charges to Overseas Visitors) Regulations 2015 and subsequent amendments to these regulations. These regulations reformed the system for charging overseas visitors for NHS care, including increasing the charge for patients to 150 per cent of the standard NHS tariff and introducing upfront charging for where this would not prevent or delay urgent or immediately necessary treatment.

Compliant environment: another term for the 'hostile environment' currently used by the Home Office.

Cost Recovery Programme: a programme started by the Department of Health in 2013 to increase the amount of revenue recovered from overseas visitors and migrants using the NHS.

Hostile environment: a series of government measures that are designed to make it more difficult for those without immigration status to access employment, housing and basic services, including free healthcare. These measures are largely aimed at requiring employers, landlords and frontline public service workers to implement checks and controls in order to charge or bar access for people without immigration status and to share personal data with Immigration Enforcement.

Immediately necessary treatment: treatment promptly needed to save a patient's life, to prevent a condition from becoming immediately life-threatening or to prevent serious damage. Immediately necessary treatment cannot be withheld, regardless of whether the patient is chargeable or able to pay for it.

Immigration health surcharge: a charge that applies as part of some visa and immigration applications to get access to secondary healthcare in a similar way to those who are ordinarily resident. Currently, the standard rate is £624 a year.

NHS tariff: the set of prices and rules that commissioners and providers of NHS services use to deliver treatment.

Ordinary residence: a concept used in NHS charging, which is defined as living lawfully and voluntarily in the UK for a settled purpose. Where individuals are subject to immigration control, they must have indefinite leave to remain to be ordinarily resident (other than EU/EEA citizens and family members with pre-settled status) When someone is ordinarily resident in the UK, they cannot be charged for NHS treatment.

Overseas visitor: someone who is not ordinarily resident in the UK.

Overseas visitor team: the team within an NHS trust responsible for decisions on charging patients for treatment. They are typically made up of overseas visitor managers and overseas visitor officers.

People without immigration status: people staying in the UK without permission. This may include people who have been refused asylum and have exhausted their appeal rights, people who overstay their visa, people who enter the UK through unauthorised routes and people who were born to parents without immigration status.

Primary care: healthcare services that are the first point of contact for a patient (for example, a GP).

Secondary care: healthcare services provided by a specialist via referral from a primary care provider (typically based in a hospital).

Social Security Coordination (SSC) Protocol: part of the agreement reached between the UK and the EU on future trade and cooperation, which provides reciprocal healthcare rights for UK and EU citizens.

Urgent treatment: treatment that is not immediately necessary but which cannot wait until the person can be reasonably expected to return home. Urgent treatment cannot be withheld, regardless of whether the patient is chargeable or able to pay for it.

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