



National Audit Office

Report

by the Comptroller
and Auditor General

Department of Health

Recovering the cost of NHS treatment for overseas visitors

Key facts

£97m

charged for treating overseas visitors in 2013-14

£289m

charged for treating overseas visitors in 2015-16, including a new immigration health surcharge for students and temporary migrants

**up to
£500m**

target annual amount to be recovered for treating overseas visitors by 2017-18

£164 million generated by a new immigration health surcharge for students and temporary migrants from outside the European Economic Area in 2015-16

15,500 cases that hospital trusts reported under the European Health Insurance Card scheme in 2015-16

50% additional amount above NHS tariff prices charged to overseas visitors from outside the European Economic Area from 2015-16 onwards

Around half proportion of debts we estimate, using 2013-14 and 2014-15 data, that trusts in England recover from patients outside the European Economic Area

65% of trust chairs and board members who are aware of the cost recovery programme consider that the programme's benefits will outweigh the costs to the NHS

58% of hospital doctors are aware that some people are chargeable for the NHS healthcare they receive

Summary

1 The NHS in England provides immediately necessary and urgent treatment to any patient who needs it. People who are ordinarily resident in the UK are entitled to free NHS hospital treatment. However, patients who are not ordinarily resident, such as people visiting from abroad, former residents who live overseas and short-term migrants, may have to pay for the hospital treatment they receive.

2 Statutory regulations set out which patients may have to pay for their treatment, and which treatments they have to pay for. Some treatments, including GP appointments and accident and emergency care, are currently free to all patients; and some patients, such as refugees and those applying for asylum, are exempt from charges. In other cases, the statutory regulations require hospital trusts to recover the cost of treatment from overseas visitors.

3 There are different rules for recovering the cost of treating chargeable visitors from European Economic Area countries and Switzerland (EEA), and those from outside the EEA. Visitors from the EEA are usually covered by agreements under which their sponsoring EEA state pays for their treatment. The EEA schemes include the European Health Insurance Card (EHIC) which covers people whose need for healthcare arises during their visit. Chargeable visitors from outside the EEA are usually invoiced directly. Since April 2015, temporary migrants and students from outside the EEA who come to the UK for six months or more pay an immigration health surcharge (the surcharge).

4 A minority of visitors from the EEA are not covered by the EEA schemes, and are personally liable to pay for chargeable treatment. The Department of Health (the Department) considers that the amounts invoiced directly to these patients are likely to be small, but relevant data that would be needed to separate them from other directly invoiced patients are not collated nationally. The category we describe, for simplicity, as 'visitors from outside the EEA' includes all directly invoiced patients.

5 The Department is responsible for the system in England for charging patients from outside the EEA, and the system across the UK for charging patients from within the EEA. The arrangements for recovering the cost of treating overseas visitors also involve the Department for Work & Pensions, the Home Office and a large number of healthcare commissioners and providers.

Focus of our report

6 This report focuses on the Department's work to help the NHS increase the amount charged and recovered for treating overseas visitors. It examines progress in this regard (Part Two) and the factors that affect successful cost recovery (Part Three). We set out our audit approach in Appendix One and our evidence base in Appendix Two.

7 It is difficult to know how much money the NHS should be charging and recovering for treating overseas visitors and migrants. Data are incomplete and unreliable, but the best available estimates suggest that the NHS is recovering significantly less than it could. There is substantial uncertainty about the figures, but research for the Department in 2013 indicated that the NHS charged less than a fifth of the amounts it could have charged.

8 The health system bears the cost of treating chargeable patients who are not identified or do not pay. While the amounts are small in the context of the health budget as a whole, failing to recover these costs means that trusts are not complying with the statutory regulations. It also reduces the amount of money that the NHS has available for other people who need it. In light of concern that the NHS was "overly generous" to overseas visitors, in 2014 the Department launched an overseas visitor and migrant cost recovery programme (the cost recovery programme).¹ The programme aimed to increase the amount of money recovered for treating overseas patients by extending the scope of charging and implementing the existing regulations more effectively.

9 At the time of our work, the Department was developing its response to a consultation on extending charging to other parts of the NHS, including some primary care services. We did not examine this policy work as part of our study.

10 During the course of our work, in June 2016, the public voted in a referendum in favour of the UK leaving the European Union. This change will potentially have implications for the nature and scope of future charging arrangements, including any changes to legislation that has operated within a European Union legal framework. At present, the UK's membership of the EEA, by virtue of being part of the European Union, means visitors from the EEA who are insured by their country of residence's state healthcare system are not charged directly for treatment they receive in the UK, and vice versa. How charging for healthcare will work in future is one of the areas that the government will need to agree with the European Union as part of the exit negotiations.

¹ Department of Health, *Visitor & migrant NHS cost recovery programme: implementation plan 2014-16*, July 2014.

Key findings

Progress in increasing the amounts charged and recovered

11 The Department has set an ambitious target to recover up to £500 million a year for treating overseas visitors by 2017-18, and this is intended to help improve the financial position of the NHS. The ambition to recover up to £500 million a year represents a substantial increase on the estimated £73 million recovered in 2012-13. It is part of the Department's shared delivery plan for 2015 to 2020, published in February 2016.² Increasing income from overseas visitors is one of several measures intended to reduce the deficit that trusts reported, which reached £2.45 billion in 2015-16 (paragraphs 1.12 and 1.17).

12 Current trends and data indicate that, within the existing cost recovery rules, the amount recovered will be less than £500 million a year by 2017-18. To monitor progress towards the cost recovery target, the Department has tracked amounts charged since the start of the programme. It has also forecast, for internal use, a trajectory for the amount it expects will be charged each year. The Department has refined the trajectory in light of the amounts that have been charged in practice, and, at October 2016, forecast that £346 million will be charged in 2017-18. There are also two reasons why the net benefit to the health system, in cash terms, will be less than the figures shown in the trajectory. First, because not all amounts invoiced directly to patients are paid, the actual income recovered from this category of patients will be less than the figures in the trajectory. To achieve a cost recovery ambition of £500 million, the trajectory would need to target charging more than £500 million. In addition, the trajectory does not take account of the costs of implementing the cost recovery programme. The Department estimated in its impact assessment that additional costs would be low, but the net gain for the NHS is not clear (paragraphs 1.16, 1.18 and Figure 5).

13 The total amount charged for treating overseas visitors has risen over the past two years, with most of the increase coming from the new immigration health surcharge. The total amount of income identified has almost trebled since the start of the cost recovery programme, from £97 million in 2013-14 to £289 million in 2015-16. Early priorities in the programme were introducing a new immigration health surcharge for students and temporary migrants, work to engage NHS trusts and NHS foundation trusts, and steps to increase reporting of EEA visitors through the EHIC scheme.

Figure 1 on page 9 shows that:

- Most of the increase in income was from the surcharge, which generated £164 million in 2015-16. The surcharge is payable by most temporary migrants from outside the EEA, subject to some exemptions, who make an application to come to the UK for more than six months, or who apply to extend their stay in the UK for any period. Because it extended the scope of the charging regime to people who were previously eligible for free treatment the surcharge is a new source of income for the health system (paragraphs 1.15, 2.12 and 2.13).

- The amount that trusts invoiced to patients directly – mostly visitors from outside the EEA – was 53% higher in 2015-16 than in 2013-14. However, this increase is likely to be due to a change in the charging rules that allowed trusts to charge 150% of the tariff prices for treatment in 2015-16, rather than because trusts were implementing the regulations more effectively. This means there is a risk that the upward trajectory will level off in 2016-17 (paragraphs 2.3, 2.4 and Figure 6).
- Amounts charged for treating patients from within the EEA increased slightly from 2013-14 to 2015-16, but remain well below the ambition for amounts to be recovered by 2017-18. The Department's latest internal forecast is that EEA income charged in 2017-18 is likely to be £72 million, compared with the target in the original 2014 implementation plan to recover £200 million (paragraphs 1.16, 2.7 and 2.8, and Figures 5 and 7).

14 There is significant variation in the amount of overseas visitor income that trusts identify, suggesting scope for improvement. The number of patients treated is affected by the location and size of the trust, and the cost for each patient varies depending on the nature and complexity of the treatment provided. It is difficult to say, however, how much money any trust should be charging because very limited data are available to predict how many overseas visitors each trust might expect to treat. In 2015-16, just 10 trusts, all in London, accounted for half of the total amount charged to visitors from outside the EEA. Ten trusts, distributed more widely across the country, accounted for more than a quarter of the total amount reported through the EHIC scheme for EEA patients. In 2015-16, eight of the 154 acute and specialist trusts did not charge any patients from outside the EEA at all, and 22 reported no EEA patients through the EHIC scheme. Our analysis indicates that the variation cannot be fully explained by factors such as trust size, type and region. This suggests that some trusts are better at identifying chargeable patients than others (paragraphs 2.16 to 2.19 and Figure 8).

Overcoming barriers to further progress

15 The Department's management of the cost recovery programme demonstrates many elements of good practice. The Department commissioned research, undertook wide public consultation and carried out an impact assessment before implementing its proposals. It has put in place a clear governance framework, and the Infrastructure and Projects Authority (previously the Major Projects Authority) has undertaken periodic reviews of the programme. The Department has set up a programme board to oversee the cost recovery programme, with representatives from other relevant organisations including NHS England and NHS Improvement. The programme board reviews risks to achieving the programme's objectives and considers how likely it is that further intervention will reduce those risks (paragraphs 1.13 and 1.14).

Figure 1

Key data on recovering the cost of NHS treatment for overseas visitors

Most of the increase in income between 2013-14 and 2015-16 came from the surcharge

| | Visitors from the EEA | Visitors from outside the EEA ¹ | Students and temporary migrants from outside the EEA | Total ⁸ |
|--|--------------------------|---|---|--------------------|
| | (£m) | (£m) | (£m) | (£m) |
| Amounts estimated by 2013 research for the Department: | | | | |
| Estimated potentially chargeable amount in 2012-13 ² | 305 | 62 ³ | Not chargeable ⁴ | 367 |
| Estimated amount recovered in 2012-13 | 50 | 23 | Not chargeable | 73 |
| Amounts the Department recorded as charged: | | | | |
| Reported amount charged in 2012-13 | 49 | 40 | Not chargeable | 89 |
| Reported amount charged in 2013-14 | 53 | 45 | Not chargeable | 97 |
| Reported amount charged in 2014-15 | 50 | 47 | Not chargeable | 97 |
| Reported amount charged in 2015-16 | 56 ⁵ | 69 | 164 ⁶ | 289 |
| Amounts the Department targeted in its 2014 implementation plan: | | | | |
| Ambition for annual amount recovered by 2017-18 ⁷ | 200 | 100 | 200 | 500 |

Notes

- 1 Apart from the potentially chargeable amount, figures in this column are for patients who are invoiced directly for their treatment. Most of these patients are from outside the EEA, but some are EEA visitors who are not covered by the EEA schemes. The Department considers that amounts invoiced directly to EEA patients are likely to be small, but relevant data that would be needed to separate them from other directly invoiced patients are not collated nationally. The potentially chargeable amount is for visitors from outside the EEA only.
- 2 There is significant uncertainty about the amounts that are potentially chargeable.
- 3 A change in the rules meant that, from April 2015, trusts started charging visitors from outside the EEA 150% of the standard NHS tariff prices. This significantly increases the amount that is potentially chargeable. Applying a 50% increase to Prederi's estimate for 2012-13 indicates that £93 million could now be potentially chargeable to this group.
- 4 Students and temporary migrants from outside the EEA were not chargeable under previous charging rules. Prederi estimated that, had students and temporary migrants been charged under the same rules as other groups, the potentially chargeable amount for their treatment would have been £94 million in 2012-13.
- 5 Within the total income from the EEA, amounts recognised under the EHC scheme (excluding amounts under formula agreements) increased from £7.4 million in 2013-14 to £11.0 million in 2015-16.
- 6 An immigration health surcharge was introduced in April 2015 that is charged to students and temporary migrants from outside the EEA as part of their visa applications.
- 7 In its implementation plan, the Department stated that it aimed to recover £500 million a year by 2017-18, from better identification of EEA income and recharging to their home countries, better identification and recovery directly from non-EEA patients, and surcharge income. Amounts due from other EEA states are collected in full, although there can be a time lag of several years between charging and receiving payment. Amounts due for treating visitors from outside the EEA can be recovered over a long period of time, but we estimate that, on average, the cash recovered is around half of the amounts charged. This is because some patients do not, or cannot, pay their invoices, or they do not pay them in full. Figures for the surcharge are actual amounts paid.
- 8 Totals shown in this figure may not sum due to rounding.

Sources: Prederi, *Quantitative assessment of visitor and migrant use of the NHS: exploring the data*, October 2013; National Audit Office analysis of NHS trust and NHS foundation trust financial accounts, and Department of Health data; Department of Health, *Visitor & migrant cost recovery programme: implementation plan 2014-16*, July 2014

16 The Department has taken action to help trusts identify chargeable patients

more easily. The charging regulations are complex. Trust staff may have to rely on judgement in determining whether a patient is chargeable, sometimes with limited information. Working with NHS Digital, the Department has added new data fields to NHS patients' personal demographic service records, that can be shown as a 'banner' in the Summary Care Record Application available to NHS staff. This draws on visa information from the Home Office to flag whether a patient has paid the surcharge. This information indicates whether a patient is likely to be chargeable or exempt. The Department is taking forward more changes to IT systems to support further data sharing between trusts. It has also issued new guidance and set up an online forum to support overseas visitor managers working in hospitals (paragraphs 3.5 to 3.14).

17 Some NHS staff and other stakeholders have highlighted the risk that the cost recovery programme may have unintended undesirable consequences.

Trust staff, including clinicians, play an important role in assessing whether treatment is immediately necessary and in helping to identify chargeable patients. However, some staff have expressed concerns that the programme may, for example, discourage people from seeking necessary treatment, increase public health risks and undermine trust between clinical staff and patients. There is insufficient evidence to assess whether, or to what extent, these concerns are justified. During the programme the Department has liaised with equalities and vulnerable group stakeholders, and is considering further work to assess how the cost recovery programme has affected vulnerable groups in practice (paragraphs 3.16 and 3.17).

18 The Department is taking action to secure the engagement of NHS

staff. The Department recognised that to implement the cost recovery programme successfully it would need strong engagement from trust staff. Without this, trusts are less likely to identify and charge overseas visitors, or to report information that will allow the UK to recover the cost of treatment from other EEA states. Members of the Department's team have visited around 60 trusts to promote the programme. The Department has also developed training materials designed to increase staff awareness and knowledge of the programme. Surveys show strong agreement, among all staff groups, with the principle that it is fair to charge overseas visitors, and increasing awareness of charging rules among front-line clinical staff. Of those staff who knew that some patients are chargeable, 48% of hospital doctors, 27% of nurses and 36% of administrative staff said they did not have a role with regards to chargeable patients (paragraphs 3.15, and 3.18 to 3.24).

19 The Department's financial incentives appear to have helped increase the amounts being charged. Commissioners pay trusts for treating unidentified overseas patients as if they were ordinarily resident. Before the cost recovery programme, trusts had no financial incentive to report and charge overseas visitors. The Department has now introduced two new incentives – first, to encourage trusts to identify and report EEA patients whose treatments are covered by the EHIC scheme; and second, to encourage trusts to identify and charge patients from outside the EEA. Evidence so far suggests that the EHIC incentive has resulted in trusts reporting more EEA patients. The non-EEA incentive appears to have had a more limited effect but has increased the amounts charged because trusts can now charge 150% of the tariff price (paragraphs 3.25 to 3.32).

20 Difficulties in collecting payment mean that significantly less is recovered from patients who are personally liable for the cost of treatment than is charged. Three-quarters of trusts (37 out of 50) responding to our consultation exercise said that overseas visitor debts were a very important or a fairly important problem for their trust. It is not possible to calculate a precise debt recovery rate by comparing the amounts charged and recovered in the same year. However, to give an indication, we used the available data to estimate that trusts recover around half of the amounts they charge directly to patients, mainly visitors from outside the EEA. There is also substantial variation: recovery rates range from 15% to 100% even after excluding outliers (the top and bottom 10% of trusts). The Department does not have a good understanding of why some trusts do better than others. It has advised trusts to invoice patients at the earliest possible point and to consider using specialist debt collection agencies. Our consultation with trusts indicated that most used a combination of a debt collection agency and pursuing debts in-house. We did not find any link between trusts' approach to debt collection and their success in collecting debts. Trust staff we spoke to said that an effective way of enforcing payment was the Home Office record of people with outstanding debts, which could be used to refuse visas for re-entry into the UK (paragraphs 2.5, and 3.33 to 3.38).

Conclusion

21 The Department and the NHS, working with other parts of government, have made progress to recover more of the cost of treating overseas visitors who are not entitled to free hospital treatment. In the past two years, the amounts charged and the amounts actually recovered have increased. Much of the increase is the result of changes to the charging rules, in particular the Home Office's introduction of the new immigration health surcharge. In addition, hospital trusts are identifying more chargeable patients and recovering more money. However, the evidence indicates that trusts remain some way from complying in full with the requirement to charge and recover the cost of treating overseas visitors.

22 If current trends continue and the charging rules remain the same, the Department will not achieve its ambition of recovering up to £500 million of income a year from overseas visitors by 2017-18, and faces a potential shortfall in the region of £150 million. Trusts face a particular challenge in recovering the cost of treating patients, mainly from outside the EEA, who are personally liable for the cost of their treatment. While there is substantial variation between trusts, we estimate that on average they recover only around half of the amounts owed by these patients, weakening the incentive trusts have to pursue patients whose treatment commissioners would otherwise pay for.

Recommendations

- a** **The Department should set an expected trajectory for the net cash it expects charging overseas visitors to generate for the health system, taking into account bad debts.** The Department's current trajectory is for amounts charged rather than amounts recovered. It does not model the impact of debt recovery rates, and does not therefore show the Department's route towards its ambition of recovering up to £500 million a year.
- b** **The Department and NHS Improvement should work with trusts to build up an evidence base of good practice in securing payment from patients from outside the EEA.** The Department recommends that trusts report overseas debtors to the Home Office, use debt collection agencies, and charge patients as early as possible. However, there is currently little evidence on the feasibility, costs and benefits of particular approaches.
- c** **NHS Improvement, supported by the Department, should analyse the available data on charging and cost recovery to identify outliers and engage senior leadership at trusts on this issue.** Outliers can be identified on the basis of trust type, size and location. It is not possible to tell from the data alone whether a trust is performing well or poorly, as very local factors can affect a trust's overseas visitor income. However, the data provide the starting point to understand variation, assess the scope for improvement and identify good practice.

- d **NHS England, supported by the Department, should encourage clinical commissioning groups to challenge trusts to show that they are identifying and charging all the overseas patients they should.** NHS England itself has the same responsibility as the commissioner of primary care and specialised health services provided to overseas patients. Commissioners have an important interest as they cover the cost to some extent when trusts do not identify chargeable patients. In practice, this is likely to involve discussion of trusts' systems and processes for identifying and charging overseas patients, informed by the available data. The NHS standard contract makes clear that, if a provider has not taken reasonable steps to identify chargeable overseas visitors and recover charges in respect of treatment, the commissioner is not liable to pay the cost of that treatment. The standard contract also gives commissioners explicit powers to appoint an auditor to obtain assurance that providers have taken such steps.