



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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## **Department of Health**

# Recovering the cost of NHS treatment for overseas visitors

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Department of Health

# Recovering the cost of NHS treatment for overseas visitors

Report by the Comptroller and Auditor General

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to be printed on 26 October 2016

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National Audit Act 1983 for presentation to the House of  
Commons in accordance with Section 9 of the Act

Sir Amyas Morse KCB  
Comptroller and Auditor General  
National Audit Office

24 October 2016

This report focuses on the work of the Department of Health to help the NHS to increase the amount charged and recovered for treating overseas visitors not entitled to free NHS treatment.

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## Key facts

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**£97m**

charged for treating overseas visitors in 2013-14

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**£289m**

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

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**up to  
£500m**

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

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**£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).<sup>1</sup> 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.

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

**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.

# Part One

## What the health system does to recover the cost of treating overseas patients

**1.1** This part of the report sets out information on the legal framework for recovering the cost of treating overseas patients, responsibilities, the extent of under-recovery in the past, and the response of the Department of Health (the Department).

### Legal framework

**1.2** The NHS will always provide immediately necessary or urgent medical care to any patient who needs it. However, only people who are ‘ordinarily resident’ in the UK are automatically entitled to free NHS hospital treatment.<sup>3</sup> Overseas visitors – patients who are not ordinarily resident, such as people visiting from abroad, former residents who live overseas or short-term migrants – may have to pay for their treatment.

**1.3** Statutory regulations set out which patients may have to pay for their treatment, and which treatments they have to pay for (**Figure 2**). 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, hospital trusts have a legal obligation to charge and recover the cost of treatment from overseas visitors.

<sup>3</sup> ‘Ordinarily resident’ is not defined in statute. The Department’s *Guidance on implementing the overseas visitor charging regulations 2015* explains that, when assessing a person’s status, an NHS body will need to consider whether they are “living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being”. Nationals of countries outside the EEA must also have indefinite leave to remain in the UK in order to be ordinarily resident. The Department has developed an online tool for NHS staff to help them establish whether a person is ordinarily resident.

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**Figure 2**

## A simplified overview of the overseas charging regulations

**Whether patients are liable to pay for treatment depends on whether they are resident in the UK, and on the sort of treatment they receive****Patients who are entitled to free treatment**

People who are 'ordinarily resident' in the UK (who have settled in the UK and have indefinite leave to remain).

Temporary migrants and students who have paid the immigration health surcharge as part of their visa application.

Vulnerable patients such as refugees, asylum seekers and children in local authority care.

Prisoners, immigration detainees, and people detained under the Mental Health Act.

People covered by reciprocal healthcare agreements or other international obligations.

**Patients who are potentially chargeable**

Holidaymakers.

People visiting family in the UK.

Former residents who are now living overseas (expatriate citizens).

People living in the UK illegally.

Short-term migrants, who are staying in the UK for less than six months.

**Treatments that are not chargeable**

Primary care, including GP appointments.

Accident and emergency care, up to the point a patient is admitted to hospital or referred for an outpatient appointment.

Treatment for infectious diseases that could present a threat to public health, such as HIV.

Family planning services (excluding termination of pregnancy).

Most services such as community healthcare provided outside a hospital.

**Treatments that are potentially chargeable**

All other care, including:

- acute care after admission to hospital;
- most elective hospital treatments;
- emergency care for hospital inpatients;
- maternity care; and
- outpatient appointments provided by a hospital trust.

Source: National Audit Office summary of the main elements of the National Health Service (Charges to Overseas Visitors) Regulations 2015 and the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2015

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**1.4** There are different rules for charging visitors from European Economic Area countries and Switzerland (EEA), and charging those from outside the EEA.<sup>4</sup> Three schemes apply to EEA patients: the European Health Insurance Card (EHIC), which covers people whose need for healthcare arises during their visit; the S1 scheme which is typically used for state pensioners living abroad; and the S2 scheme for pre-planned treatments agreed in advance of a person's visit. Patients treated under these schemes are not charged personally because their sponsoring EEA state covers the cost of treatment.<sup>5</sup> 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. Hospital trusts invoice directly other patients from outside the EEA.

## **Responsibilities**

**1.5** The arrangements for recovering the cost of treating overseas visitors involve national and local bodies, including several government departments and a large number of local healthcare commissioners and providers (**Figure 3**).

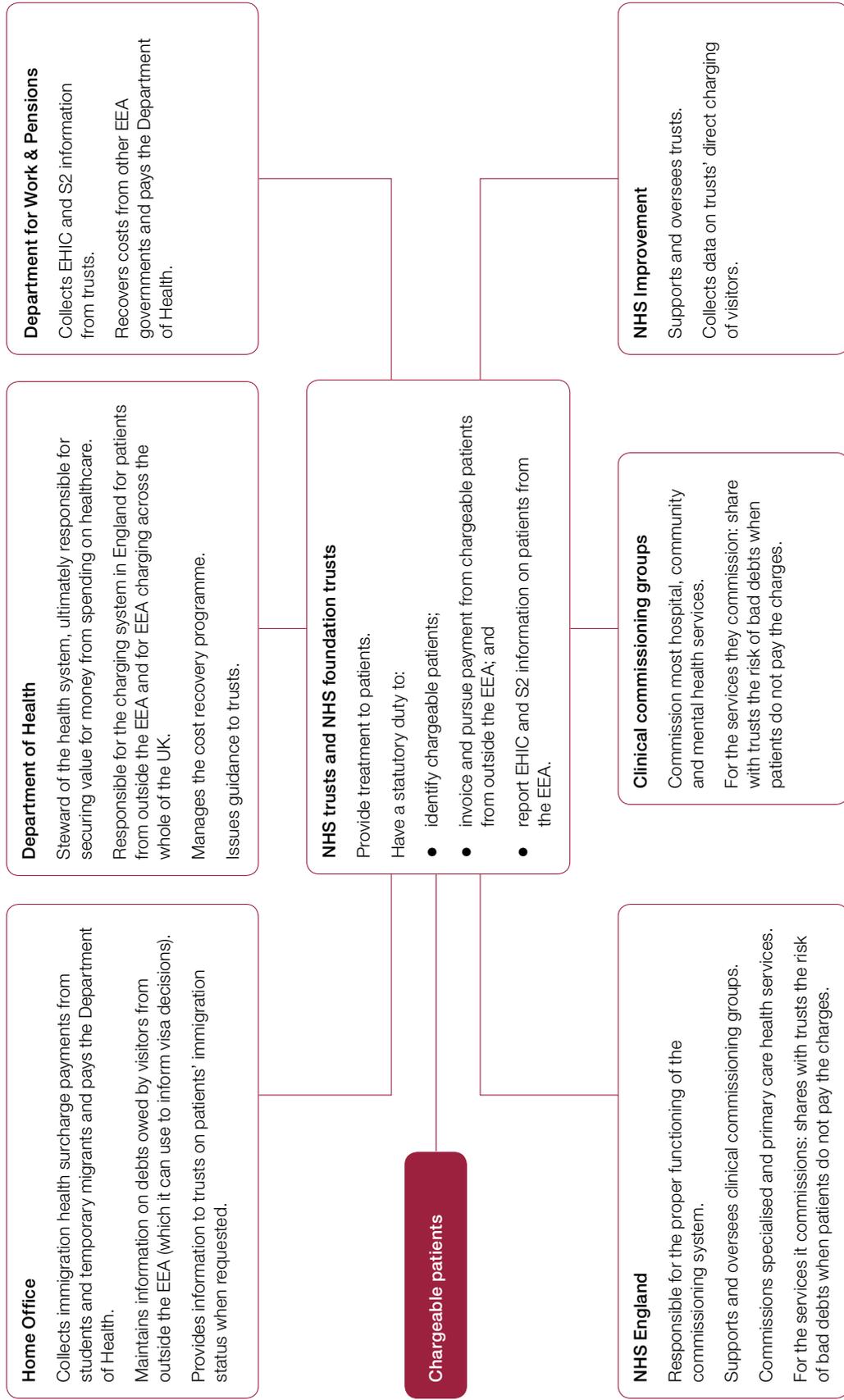
**1.6** The Department is responsible for the system for charging visitors and migrants from outside the EEA for their use of the NHS in England. As health is a devolved matter, separate legislation covers non-EEA charging in Scotland, Wales and Northern Ireland. Central government departments act on behalf of the UK as a whole to reclaim costs from other EEA member states under the EHIC, S1 and S2 schemes.

**1.7** NHS trusts and NHS foundation trusts have a statutory responsibility to identify chargeable overseas visitors, recover payment from those who are directly chargeable, and report details of amounts to be recovered from other EEA member states. However, commissioners (NHS England or local clinical commissioning groups) often have to cover the costs if trusts fail to do so. This means that, to protect public funds, commissioners have a responsibility to assure themselves that trusts have adequate policies and procedures for recovering costs.

4 The EEA comprises the 28 European Union countries and Iceland, Liechtenstein and Norway. While not a member of the EEA, Switzerland has also signed up to EU legislation on the internal market and free movement of people. In this report, where EEA is referred to, we are including Switzerland as well as the member states.

5 The exemptions in the charging regulations (set out in Figure 2) do not apply to the EHIC, S1 and S2 schemes. This means that the UK can recover the cost of all NHS treatment provided to EEA patients covered by these schemes. If an EEA patient cannot show an EHIC card, or an S1 or S2 form, they are personally liable for payment, charged at 100% of normal NHS tariff prices. In this situation, the exemptions that apply to non-EEA patients would also apply to them.

**Figure 3**  
Organisations involved in recovering costs



Source: National Audit Office

## The extent of under-recovery in the past

**1.8** It is difficult to know how much money the NHS should be charging and recovering under the regulations because data are incomplete and unreliable. Any estimate relies on assumptions, for instance, about the number of overseas visitors receiving NHS care, the cost of their treatment, and the effect of various exemptions in the regulations.

**1.9** However, the best available estimates suggest that trusts collectively could have charged significantly more than they did (**Figure 4**). A review for the Department in 2013 estimated how much was potentially chargeable.<sup>6</sup> There is substantial uncertainty about the estimates but, comparing them with the amounts actually charged, indicates that, in 2012-13, the NHS charged:

- an estimated 65% of the amounts it could have charged visitors from outside the EEA (£40 million actually charged out of an estimated potential £62 million); and
- an estimated 16% of the amounts it could have charged for treating EEA visitors (£49 million actually charged out of an estimated potential £305 million) – most of the potentially chargeable amount (£219 million) related to the EHIC scheme.

**1.10** The research also estimated that ‘health tourism’ could plausibly cost the NHS between £70 million and £300 million each year. However, figures on health tourism are particularly uncertain. Health tourists include people who come to the UK specifically to obtain free care to which they are not entitled, and frequent visitors who are registered with GPs and take advantage of the system by accessing routine care and elective treatment. Because of the extent of uncertainty, the research excluded these figures from the estimated potentially recoverable amount.

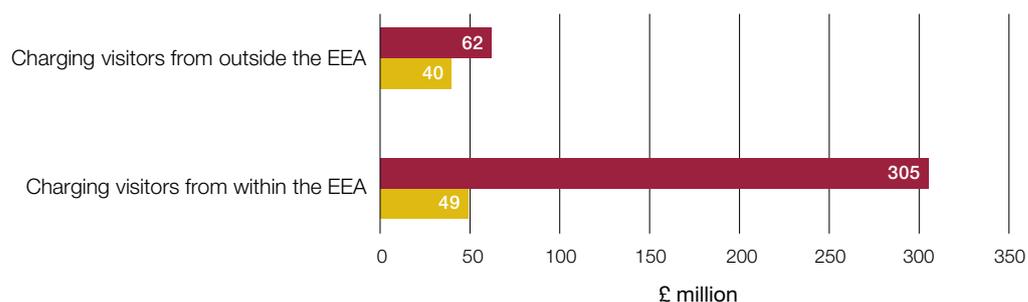
**1.11** Importantly, as well as significant under-charging, difficulties in collecting payment mean that trusts do not recover all of the amounts they invoice to directly chargeable patients, most of whom are visitors from outside the EEA. We estimate that around half of the charges made to these patients result in payments to the NHS. This means that the amounts recovered are considerably lower than the amounts charged (paragraph 2.5). Amounts charged through the EEA schemes and through the surcharge are paid in full.

6 Prederi, *Quantitative assessment of visitor and migrant use of the NHS: Exploring the data*, October 2013.

**Figure 4**

Amounts charged in 2012-13 for treating overseas visitors, compared with the estimated potentially chargeable amount

Research for the Department suggested that in 2012-13 the NHS charged only a small proportion of the amount estimated to be potentially chargeable for treating overseas visitors



- Potentially chargeable amount estimated by research in 2013
- Reported amount charged in 2012-13

**Notes**

- 1 There is substantial uncertainty about the amounts that are potentially chargeable.
- 2 Amounts noted as potentially chargeable exclude illegal or irregular migrants. Prederi estimated that the gross cost to the NHS of treating irregular migrants was £330 million, but this figure is very uncertain. Prederi assumed that most irregular migrants would have no means to pay and that it would be misleading to show this as potentially recoverable.
- 3 Amounts noted as potentially chargeable also exclude health tourists. Prederi estimated that health tourism could plausibly cost between £70 million and £300 million. However, it did not estimate how much might be potentially chargeable.
- 4 The Prederi estimate of the EEA chargeable amount did not consider formula or waiver agreements that the UK has with a number of EEA member states. Where these agreements apply, the UK does not charge through the EHIC scheme for individual patients treated, but agrees with other countries a block payment and may benefit from reduced or nil charges from other EEA states. The above chart may therefore overstate under-recovery through the EEA schemes.
- 5 Students and temporary migrants from outside the EEA were not chargeable under previous 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.
- 6 The amount recovered as cash is lower than the amount charged. The Prederi research estimated that £73 million was recovered in 2012-13.

Source: National Audit Office analysis of Prederi, *Quantitative assessment of visitor and migrant use of the NHS in England: exploring the data*, 2013, and information on 2012-13 charging provided by the Department of Health

## The Department's response

**1.12** The Department recognised that it needed to take action to increase the amount recovered for treating overseas patients. In July 2014, it published plans to implement an overseas visitor and migrant cost recovery programme (the cost recovery programme).<sup>7</sup> The programme's current ambition is for the NHS to recover up to £500 million of income relating to overseas visitors per year by 2017-18. This represents a very substantial increase (of nearly 600%) on the estimated £73 million recovered in 2012-13. By identifying more chargeable patients and increasing the amounts recovered, the Department also aimed to deter 'health tourists' from coming to the UK.

**1.13** The Department has put in place programme management and governance arrangements to oversee implementation of the cost recovery programme. It has set up an NHS reference group, which helps to advise the programme on risks, and an operational programme board that includes representatives from NHS England and NHS Improvement.<sup>8</sup> The board routinely reviews risks to achieving the programme's objectives and considers how likely it is that further intervention will reduce those risks.

**1.14** External to the Department, the Infrastructure and Projects Authority has carried out four reviews over the course of the programme.<sup>9</sup> These have considered policy, approach, risks and governance arrangements. The Department also commissioned Ipsos MORI to evaluate the programme between 2014 and 2016. The aims of the evaluation included determining how far the programme had led to changes in culture and behaviour among NHS staff and learning lessons about what works in improving cost recovery.

### Implementation plan

**1.15** The Department's implementation plan for the cost recovery programme set out what it would do over the first two years. The plan set out four phases:

- **Phase 1. Improving existing systems in trusts**

The Department found, from a public consultation in 2013, that there was confusion and inconsistent practices across the NHS.<sup>10</sup> Phase 1 of the programme aims to make it easier for front-line staff to integrate overseas charging within their 'day job'. It includes work to produce guidance, share best practice and introduce financial incentives to encourage trusts to identify chargeable patients and recover costs.

<sup>7</sup> Department of Health, *Visitor & migrant NHS cost recovery programme: implementation plan 2014–16*, July 2014.

<sup>8</sup> The NHS reference group is chaired by Sir Keith Pearson, who is also chair of Health Education England. Members include representatives from NHS England, NHS Digital, Public Health England, professional bodies and healthcare providers. The chair is also a member of the programme board.

<sup>9</sup> The Infrastructure and Projects Authority is hosted by the Cabinet Office and incorporates the former Major Projects Authority.

<sup>10</sup> Department of Health, *Sustaining services, ensuring fairness: government response to the consultation on migrant access and financial contribution to NHS provision in England*, December 2013.

- **Phase 2. Aiding better identification of chargeable patients**

Research for the Department in 2013 found that NHS staff faced a particular challenge in determining whether patients were chargeable.<sup>11</sup> Phase 2 of the programme involves changes to processes and systems to help share information across the NHS and make it easier for staff to identify who should be charged.

- **Phase 3. Implementing an immigration health surcharge in partnership with the Home Office**

Home Office legislation introduced an immigration health surcharge (the surcharge) in April 2015.<sup>12</sup> Temporary migrants from outside the EEA, subject to limited exceptions, pay a surcharge of £200 per person per year. Students and applicants to live and work in the UK under the youth mobility scheme from outside the EEA pay a lower rate of £150 per person per year. The payment is made up front at the time of the visa application. Having made this contribution, they are entitled to the same free NHS treatment as people who are ordinarily resident in the UK. Before this change, most would have been entitled to free NHS treatment. The surcharge therefore provides a new stream of income for the health system.

- **Phase 4. Extending charging to other NHS services**

Phase 4 of the programme looks at amending the charging regulations, for instance extending charging to accident and emergency and some primary care services. In May 2016, following a consultation, the government announced it would bring forward legislation to change the charging regime.<sup>13,14</sup> Policy work was ongoing at the time of our work, and we did not examine this part of the programme.

11 Creative Research, *Qualitative assessment of visitor and migrant use of the NHS in England: observations from the front line*, October 2013.

12 The Immigration Act 2014 created a power for the Secretary of State to impose a charge on persons who apply for permission to enter or remain in the UK for a limited period. The Immigration (Health Charge) Order 2015 introduced the surcharge from April 2015.

13 Department of Health, *Making a fair contribution: consultation on the extension of charging overseas visitors and migrants using the NHS in England*, December 2015.

14 The Queen's Speech 2016, May 2016.

## The Department's ambition

**1.16** The Department did not set a trajectory for how it would achieve the ambition in its 2014 implementation plan to recover £500 million by 2017-18. However, it set a trajectory, for internal use, on the amounts it expected would be charged each year. Because not all charges result in payments to the NHS, the amount of cash recovered will be less than the figures in the trajectory. Forecasts in the trajectory are based on current trends and data, and assume no changes in the charging rules. At October 2016, the Department forecast that £346 million a year would be charged by 2017-18. **Figure 5** shows that most of the difference between the ambition in the implementation plan and the estimate in the trajectory relates to forecast income through the EEA schemes. This is mainly because income through the EHIC scheme has not increased as fast as the Department expected.

**1.17** Increasing overseas visitor income is one of several measures intended to reduce the deficit that trusts reported, which reached £2.45 billion in 2015-16. Despite revising the trajectory, the Department restated, in its 2016 shared delivery plan published in February 2016, its ambition to recover up to £500 million by 2017-18.<sup>15</sup> Without further changes to the charging regime, the Department's forecast trajectory indicates that the amounts charged will be at least £150 million below £500 million.

**1.18** The ambition to recover up to £500 million a year is a gross amount – it does not take account of any additional implementation costs so the expected net gain for the NHS is not clear. The Department carried out an impact assessment in 2014 which concluded that the benefits of the cost recovery programme would significantly outweigh the costs.<sup>16</sup> However, the Department does not have a good understanding of the costs that trusts incur in seeking to recover the cost of treating overseas visitors, for example, in employing dedicated overseas visitor managers, training staff and pursuing debts. For trusts with a small number of overseas visitors, it is possible that the costs of implementing the regulations (for example if they needed to employ an overseas visitor manager) might outweigh the extra income generated.

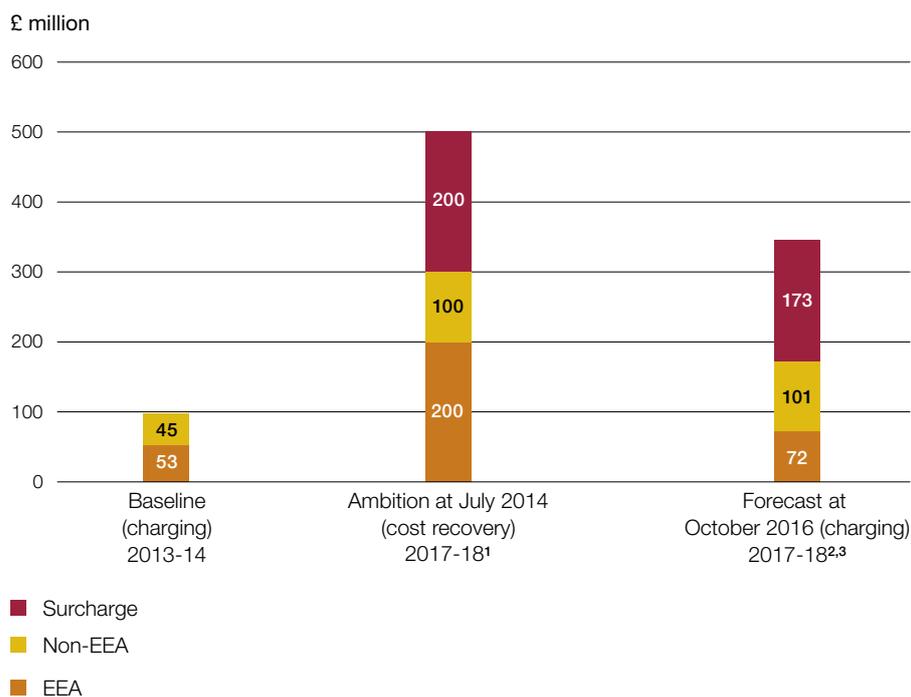
<sup>15</sup> Department of Health, *Shared delivery plan: 2015 to 2020*, February 2016.

<sup>16</sup> Department of Health, *The visitor and migrant cost recovery programme: impact assessment*, July 2014.

**Figure 5**

The Department's ambition for cost recovery and internal forecast for amounts charged

The Department has reduced the amount it expects to be charged through the schemes for treating patients from the EEA

**Notes**

- 1 This breakdown is included in the Department's implementation plan, published in July 2014, and is based on cost recovery.
- 2 This forecast, used for internal programme management, is based on amounts charged. Not all amounts charged to overseas visitors are recovered.
- 3 The forecast excludes amounts that could be generated from future changes to the regulations or pricing.

Sources: Department of Health, *The visitor and migrant NHS cost recovery programme: implementation plan*, July 2014; and information provided by the Department of Health and the Home Office

## Part Two

### Progress in increasing the amounts charged and recovered

**2.1** This part of the report looks at the amounts being charged and recovered, how national performance has changed and the extent of variation between trusts.

#### National performance

**2.2** Since the start of the cost recovery programme, the total amount charged has risen from £97 million to £289 million, an increase of 198%. Of the 50 trusts that responded to our consultation, however, only 11 expected income from overseas patients to increase significantly in future.

- In the first year of the programme (2014-15), the amounts charged were £97 million, the same as in 2013-14.
- In the second year of the programme (2015-16), charges rose to £289 million: an increase of £192 million. Most of this increase was due to the introduction of the immigration health surcharge (the surcharge) for students and temporary migrants from outside the European Economic Area (EEA), which generated £164 million (paragraph 2.12). Trusts were also able to charge higher prices to visitors from outside the EEA, which may have accounted for up to £24 million.<sup>17</sup>

#### Charging visitors from outside the EEA

**2.3** The amount that trusts charged visitors from outside the EEA rose significantly in 2015-16. Charging increased from £44.5 million in 2013-14 and £46.8 million in 2014-15 to £69.2 million in 2015-16, a rise of 48% from 2014-15 to 2015-16 (**Figure 6**).

<sup>17</sup> We assessed the potential impact of the higher prices as 50% of the £46.8 million charged in 2014-15.

**Figure 6**

## Charging visitors from outside the EEA, 2013-14 to 2017-18

The increase in the amounts charged in 2015-16 appears to be due to changes in the regulations which meant that trusts increased prices by 50%

**Notes**

- 1 The charging regulations changed in April 2015, allowing trusts to increase their prices by 50%.
- 2 The trajectory is the Department's forecast at October 2016.
- 3 There are timing differences between amounts charged and cash received. The amount charged relates to that financial year, whereas the cash received relates to both that financial year and previous financial years.

Source: National Audit Office analysis of NHS trust and NHS foundation trust accounts data

**2.4** The rise followed changes to the statutory regulations which meant that trusts increased their prices by 50% in April 2015. Trusts now charge patients from outside the EEA 150% of the 'tariff' price for treatment. There are no nationally collated data on how many patients from outside the EEA the NHS treats each year. However, stripping out the likely effect of the change in the charging rules means that the increase in the amount charged in 2015-16 is likely to be due to the rule change rather than trusts identifying more chargeable patients. Because the rule change was a one-off adjustment, the increase attributable to this cannot be expected to be repeated in future years. On this basis, our view is that the Department is unlikely to meet its trajectory of charging £101 million to visitors from outside the EEA by 2017-18.

**2.5** It is difficult to tell whether trusts are getting better at converting amounts charged into amounts recovered, but it is clear that a significant proportion of charges do not result in money being paid to the NHS. It is not possible to calculate a precise debt recovery rate by comparing amounts charged and recovered in the same year, because some payments are made over a longer period of time. Cash recovered in any year will include amounts in respect of charges made in previous years, and amounts charged in any year may be paid in future years. However, the longer a debt remains unpaid, the lower the likelihood of recovering it in full. To give an indication of the debt recovery rate, we compared the amount recovered with the amount charged, using data for 2013-14 and 2014-15. We also took account of provisions for bad debts included in trusts' financial statements. On this basis, we estimated that trusts collect only around half of the debts owed by visitors from outside the EEA.

**2.6** When charges increase, as they did in 2015-16, a direct comparison of payments with charges will underestimate the debt collection rate. This is because the timing difference between charges and payments means they may be accounted for in different years. In total, £29 million of payments were collected in 2015-16, against the £69 million charged. However, some of the amount collected will relate to the lower charges made in previous years. Further amounts relating to the higher charges made in 2015-16 are likely to be collected in 2016-17 and beyond.

### Charging for visitors from the EEA

**2.7** Overall, the amount the UK charged across the three EEA schemes (paragraph 1.4) changed little over the first two years of the cost recovery programme (**Figure 7**).

**2.8** Charging for visitors from the EEA has not increased as quickly as the Department forecast. During 2015-16, it aimed to charge £88 million in 2015-16 and £163 million in 2017-18. However, after £56 million was charged in 2015-16, the Department has reduced its forecast for 2017-18 to £72 million. The Department's initial trajectory was based mainly on significant increases in the amounts charged through the EHIC scheme, rather than the S1 scheme, S2 scheme or formula agreements.

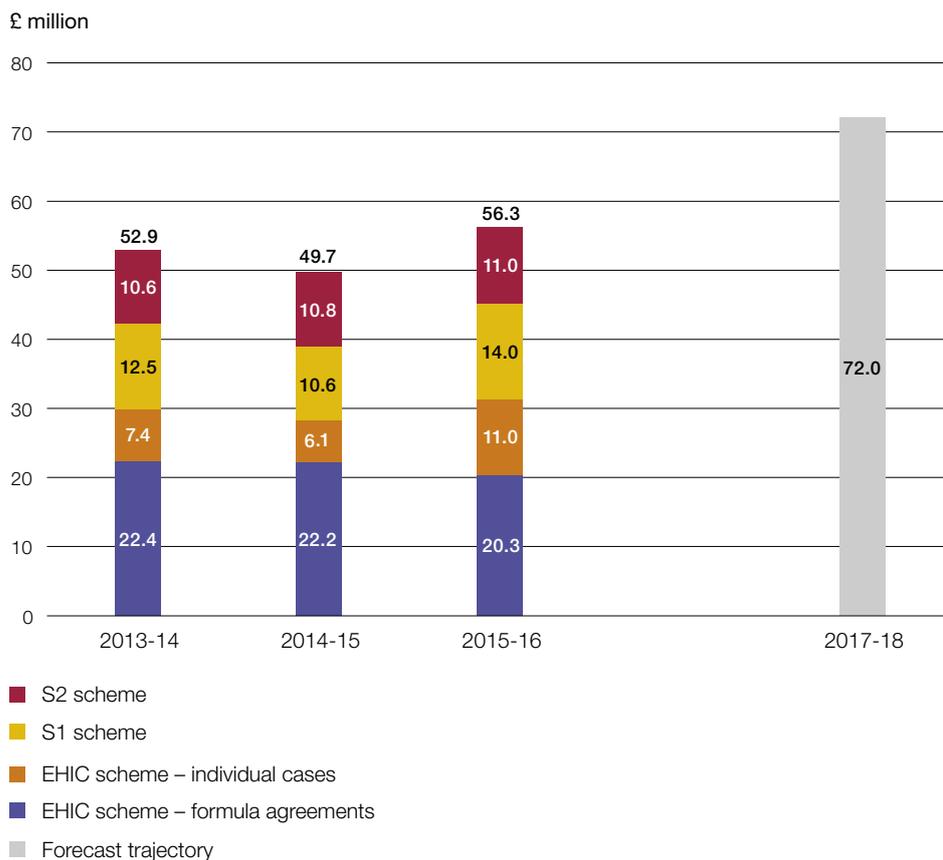
### **EHIC scheme**

**2.9** The amount the UK charged other EEA governments for individual cases under the European Health Insurance Card (EHIC) scheme increased over the first two years of the cost recovery programme, from £7.4 million in 2013-14 to £11.0 million in 2015-16. The increase was largely due to trusts reporting more episodes of care, rather than a change in the average value of cases. The number of episodes of care that trusts identified under the EHIC scheme increased from 5,000 in 2013-14 to 15,500 in 2015-16.

**Figure 7**

Charging for visitors from the EEA, 2013-14 to 2017-18

**EHIC charging has increased, but overall EEA charging has not changed significantly since the start of the cost recovery programme and remains well short of the Department's trajectory**



**Notes**

- 1 Figures shown are estimates of income related to healthcare activity in each year.
- 2 References to income linked to the EHIC scheme will also include some income related to the S1 scheme. Figures for the S2 scheme include amounts under formula agreements. Of the S2 total, £1.3 million was from formula agreements each year.
- 3 The trajectory is the Department's forecast at October 2016.

Source: National Audit Office analysis of information from the Department of Health

### Other EEA schemes

**2.10** The Department forecast that income under the S1 scheme (which typically covers EEA state pensioners who live in the UK) would gradually increase between 2013-14 and 2017-18, as GPs reported more cases. Income has not changed significantly to date, with an estimated £12.5 million charged in 2013-14, £10.6 million in 2014-15 and £14.0 million in 2015-16. Income relating to pre-planned elective treatment (S2 scheme) is not expected to increase.

**2.11** The UK also has agreements with some EEA countries that payments for healthcare are set in advance, and not based on individual cases. There are two types of agreement: formula agreements, whereby two countries agree to pay a set figure based on their estimates of how much they would otherwise expect to pay under the EHIC or S2 scheme, or both; and waiver agreements, where the two countries agree not to charge each other at all. The UK recovers slightly more than £20 million each year from EHIC formula agreements. There have been no significant changes to either the formula or waiver agreements since the start of the cost recovery programme.

### Charging through the surcharge

**2.12** The surcharge, levied on students and temporary migrants from outside the EEA who come to the UK for six months or more, generated £164 million of new income for the health system in 2015-16. The amount of income depends on the level of immigration from outside the EEA and the cost of the surcharge. Unless these factors change, income is unlikely to increase significantly.

**2.13** The Home Office expects income will rise by around £9 million a year as a result of two changes.<sup>18</sup> First, in April 2016, the surcharge was extended to visa applicants from Australia and New Zealand, who were previously exempt while discussions were ongoing about the scope of existing reciprocal healthcare agreements.<sup>19</sup> The Home Office expects this change to increase income by around £11 million a year. Second, the annual rate applicable to the youth mobility scheme was reduced from £200 to £150. This is expected to reduce income by around £2 million a year.

### International comparisons

**2.14** Making meaningful international comparisons is difficult because the UK's health system is different to that in most other countries, and because limited data are available. The UK is unusual in having a residency-based system rather than a charging-based system, where people tend to take out insurance to cover the cost of healthcare. In addition, unlike some other countries, the UK does not have a standard document, such as an identity card, that can prove a patient's residency and entitlement. Outside the EEA schemes, little data are available on how much other countries recover for treating overseas visitors.

<sup>18</sup> Home Office, *Removing the Immigration Health Surcharge exemption of nationals from Australia and New Zealand and reducing the annual rate applicable to the Youth Mobility Scheme from £200 to £150: impact assessment*, January 2016. The figures quoted are at 2016-17 prices.

<sup>19</sup> Under reciprocal healthcare agreements, residents from other countries are largely treated as if they are UK residents when in the UK, and vice versa.

**2.15** We reported in 2014 that the UK claimed less from other EEA countries for the cost of healthcare than the other countries charged to the UK.<sup>20</sup> In 2014-15, the UK claimed £49.7 million from other EEA countries and these countries claimed £674.4 million from the UK. These figures are not directly comparable. In particular, the Department's assessment is that more British pensioners retire to other EEA countries than vice versa. Some 80% of the UK's EEA healthcare bill relates to state pensioners and their dependents. The Department recognises, however, that the UK does not recover as much as it could.

### Variation between trusts

**2.16** It is difficult to say how much money any trust should charge for treating overseas visitors. The number of patients treated depends on the location and size of the trust, and on fluctuations in the number of visitors. The cost for each patient varies according to the nature and complexity of treatment provided. A few high-value cases can have a significant impact on how much money a trust charges.

**2.17** Very limited data are available to predict how many overseas visitors each trust might expect to treat and how much they might be able to charge. However, looking at absolute amounts alone, there is significant variation in the amounts charged and a relatively small number of trusts are responsible for a large proportion of the charges.<sup>21</sup> In 2015-16:

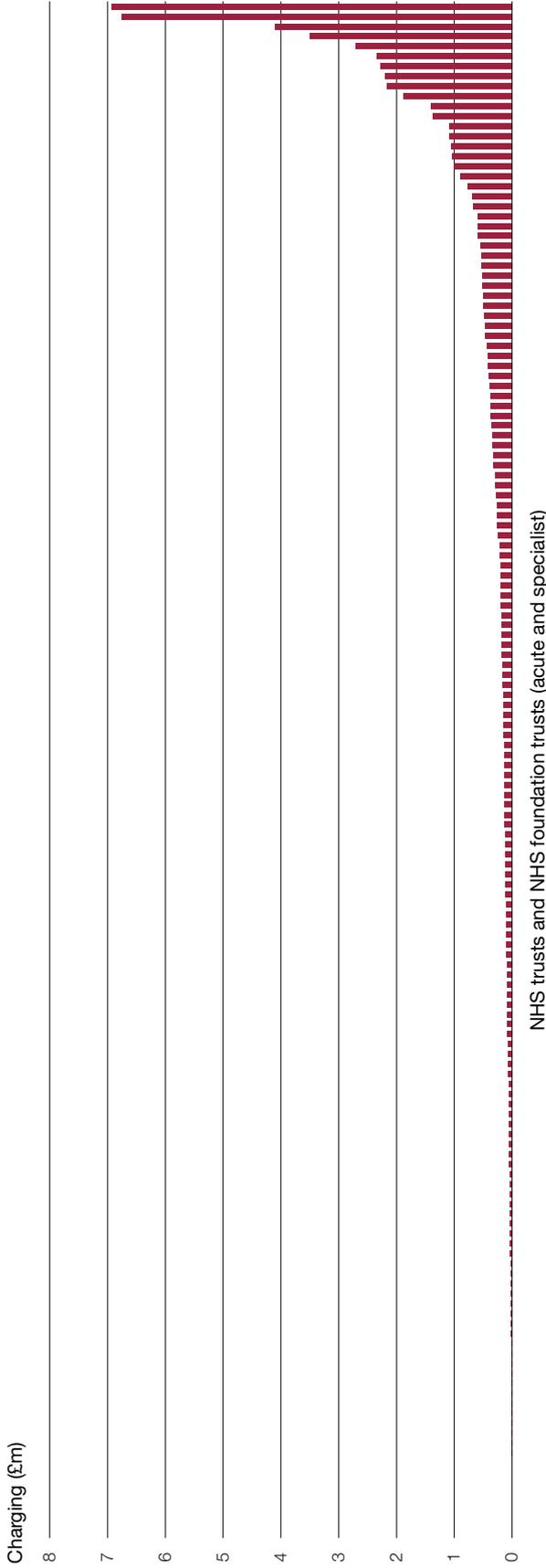
- Just 10 of the 154 acute and specialist trusts accounted for half of the charges made to visitors from outside the EEA (**Figure 8** overleaf). All of these were acute trusts based in London. Eight trusts did not charge any visitors from outside the EEA.
- Ten trusts, from a range of regions, were responsible for more than a quarter of the amounts reported under the EHIC scheme. Twenty-two trusts did not report any cases under the EHIC scheme.

**2.18** Our analysis indicates that some of the variation can be explained simply by factors such as trust size, type and location. For example, larger trusts (those with more patient activity revenue) and trusts in regions with more visitors were likely to charge the largest total amounts. Comparing types of trust, teaching trusts charged the most as a proportion of their total patient income. However, collectively they also had the lowest rates of debt recovery, indicating that they struggle to collect the amounts they charge.

20 Comptroller and Auditor General, *Managing debt owed to central government*, Session 2013-14, HC 967, National Audit Office, February 2014.

21 This analysis of variation covers the amounts that trusts charged to visitors from outside the EEA, and the value of cases reported through the EHIC scheme. We did not incorporate the surcharge as this is dealt with centrally, the S1 scheme as this relies on reporting by GPs rather than trusts, or the S2 scheme as by its nature we would expect a large amount of variation.

**Figure 8**  
 Charging visitors from outside the EEA by trust, 2015-16  
 Ten trusts accounted for half of the charges made to visitors from outside the EEA



**Notes**

- 1 The graph shows teaching, large acute, medium acute, small acute and specialist hospital trusts. Classifications are made by NHS Improvement and presented in each trust's accounts.
- 2 The graph excludes community, ambulance, and mental health and learning disability trusts. Exemptions in the charging regulations mean that much of the care these trusts provide is not chargeable. These trusts charged visitors from outside the EEA £1.7 million in 2015-16.
- 3 The graph excludes Mid Staffordshire NHS Foundation Trust, which did not provide patient services in 2015-16.
- 4 The amount each trust charges is affected by a range of factors, including the size of the trust, which are not adjusted for in the graph above. The graph shows absolute amounts charged only, and does not indicate whether trusts are performing well or poorly.

Source: National Audit Office analysis of NHS trust and NHS foundation trust accounts data

**2.19** A significant amount of variation remains even after adjusting for trust size, type and location. Our analysis suggested that these factors account for around half of the variation between trusts. The remaining ‘unexplained’ variation may be due to factors such as local demographics and the types of treatment offered, which are more difficult to quantify. Alternatively it may indicate that some trusts are performing better than others in identifying chargeable patients, suggesting scope for improvement.

**2.20** Although variation is significant, addressing variation alone would not be sufficient for the Department to achieve its ambition of recovering up to £500 million a year. We estimate that bringing all ‘underperforming’ trusts up to the average for similar trusts would generate an additional £16.8 million of charges to visitors from outside the EEA, and £3.1 million of charges through the EHIC scheme. This compares with the gap of £211 million between current charging and the Department’s ambition for 2017-18.

### Regional variation

**2.21** There is less variation at regional, rather than individual trust, level. We found there is a correlation between the number of people who visit each region from overseas and the amounts charged in each region to visitors from outside the EEA (**Figure 9** overleaf) or reported through the EHIC scheme (**Figure 10** on page 33).<sup>22</sup>

**2.22** However, some regions had less overseas visitor income than might have been expected from their visitor numbers, particularly in respect of the EHIC scheme. For instance, London had 44% of EEA visitors, and reported 35% of the value of EHIC cases. Since there are other factors involved, it is difficult to say with certainty whether any region is underperforming. But this analysis suggests that it may be worth focusing efforts on identifying more chargeable visitors in specific regions.

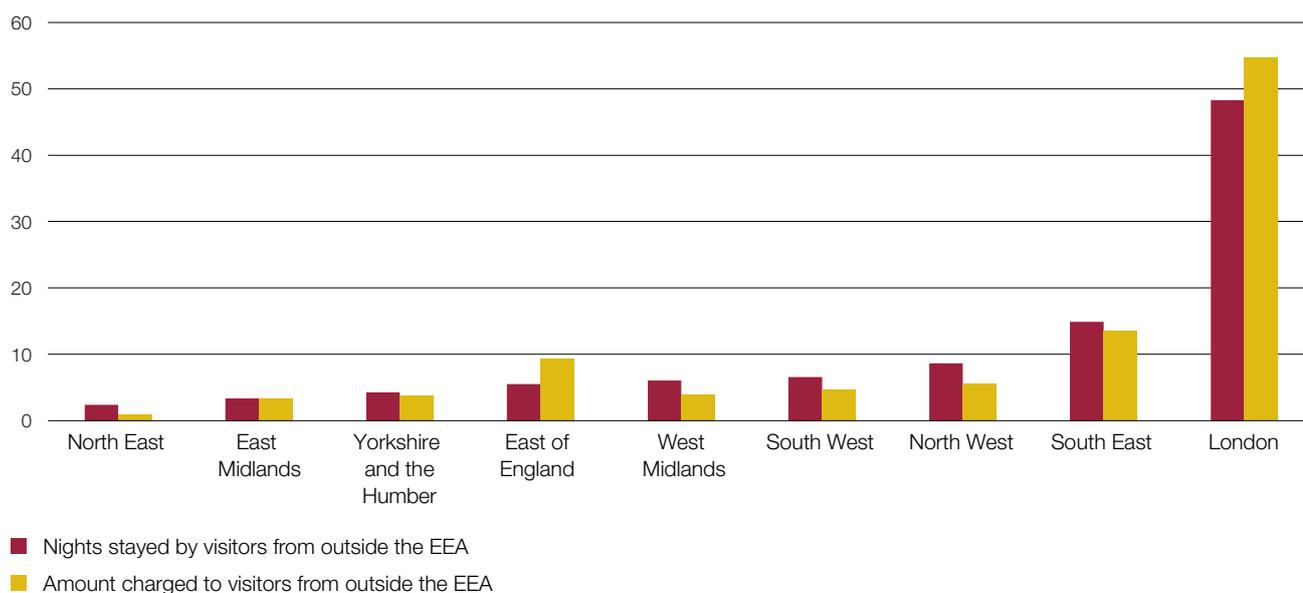
<sup>22</sup> Data on visitor numbers are for nights stayed, as reported in the International Passenger Survey.

**Figure 9**

## Regional variation in charging visitors from outside the EEA, 2015-16

Amounts charged are broadly consistent with visitor numbers in most regions

Share of England total (%)



	Nights stayed by visitors from outside the EEA		Amount charged to visitors from outside the EEA	
	Number (millions)	England total (%)	Amount (£m)	England total (%)
North East	2.5	2.4	0.7	1.0
East Midlands	3.5	3.4	2.3	3.3
Yorkshire and the Humber	4.5	4.3	2.7	3.8
East of England	5.8	5.5	6.5	9.4
West Midlands	6.3	6.0	2.7	4.0
South West	6.9	6.6	3.2	4.7
North West	9.1	8.7	3.8	5.6
South East	15.6	14.9	9.4	13.6
London	50.7	48.3	37.9	54.7
<b>Total</b>	<b>105.0</b>		<b>69.2</b>	

**Notes**

- 1 Visitor figures are indicative only. The International Passenger Survey is only intended to be statistically robust at a national level. Regional comparisons may not be robust.
- 2 Trusts have been allocated to regions based on funding flows within the NHS rather than their geographical location. In most cases the two will match. However, where a trust is close to a regional border, part of their charging has been allocated to one region and part to another. Our assumption is that funding flows better reflect the flow of people.
- 3 Percentages sum to more than 100 due to rounding.

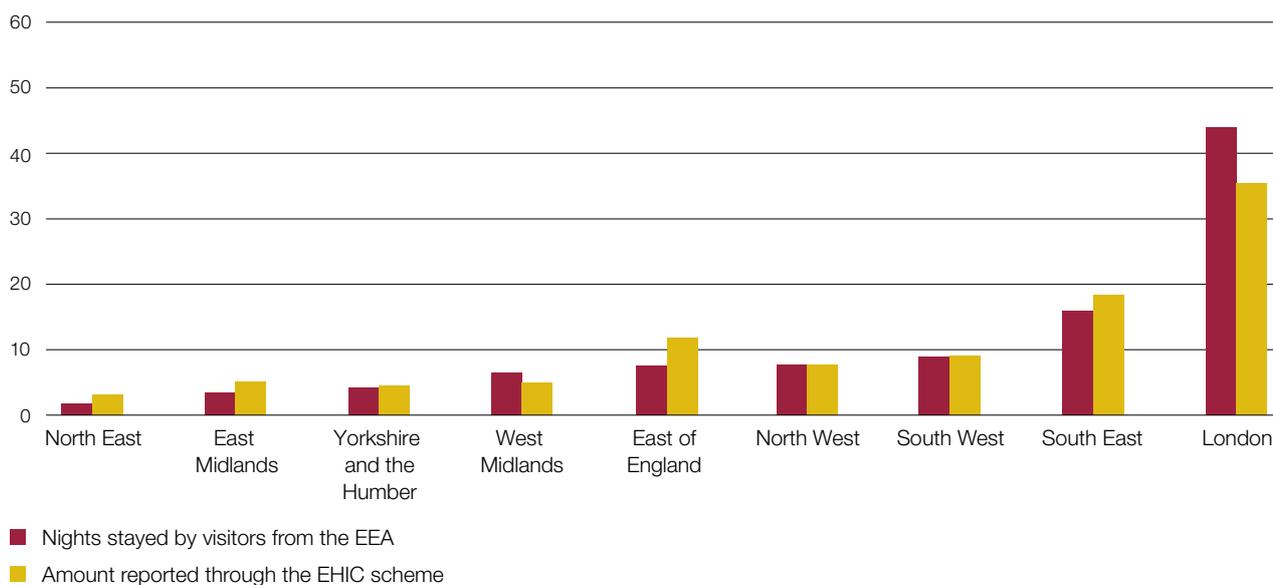
Source: National Audit Office analysis of 2015-16 NHS trust and NHS foundation trust accounts and data from the International Passenger Survey

**Figure 10**

## Regional variation in reporting through the EHIC scheme, 2015-16

Amounts reported are broadly consistent with visitor numbers in most regions

Share of England total (%)



	Nights stayed by visitors from the EEA		Amount reported through the EHIC scheme	
	Number (millions)	England total (%)	Amount (£m)	England total (%)
North East	2.5	1.8	0.5	3.2
East Midlands	4.8	3.5	0.8	5.2
Yorkshire and the Humber	5.9	4.3	0.7	4.5
West Midlands	8.9	6.4	0.8	4.9
East of England	10.4	7.5	1.8	11.7
North West	10.6	7.6	1.2	7.7
South West	12.4	8.9	1.4	9.1
South East	22.1	16.0	2.8	18.4
London	61.0	44.0	5.5	35.4
<b>Total</b>	<b>138.7</b>		<b>15.5</b>	

**Notes**

- 1 Visitor figures are indicative only. The International Passenger Survey is only intended to be statistically robust at a national level. Regional comparisons may not be robust.
- 2 Trusts have been allocated to regions based on funding flows within the NHS rather than their geographical location. In most cases the two will match. However, where a trust is close to a regional border, part of its charging has been allocated to one region and part to another. Our assumption is that funding flows better reflect the flow of people.
- 3 The amount reported through the EHIC scheme is different to the amount charged. This is because trusts report details on patients from all EEA states, including those with formula or waiver agreements with the UK which do not pay for individual treatments. An estimated two-thirds of the amounts reported through the EHIC scheme are charged as individual cases to other EEA states.
- 4 Percentages may sum to more than 100 due to rounding.

Source: National Audit Office analysis of data from the Department for Work & Pensions (as reported through the EHIC web portal) and data from the International Passenger Survey

# Part Three

## Factors affecting successful cost recovery

**3.1** This part of the report looks at the processes for charging overseas visitors for NHS treatment, the main challenges that the health system faces in seeking to recover costs, and what the Department of Health (the Department) is doing to help increase the amounts that are recovered.

### Processes for charging overseas visitors

**3.2** The Department has published guidance for trusts about the processes for implementing the charging regulations. A summary is shown in **Figure 11** on pages 36 and 37. It is important that trusts correctly identify whether a patient is chargeable and from the EEA, chargeable and from outside the EEA, or not chargeable. This is because the payment process, and the individual or organisation who bears the cost, is different in each case.

**3.3** The costs of trusts failing to implement the charging regulations fall mainly on other parts of the health system. Specifically, if trusts do not:

- identify and report patients insured under the EEA schemes to the Department for Work & Pensions, the Department of Health bears the cost in the form of lost income, reducing the amount that is available for allocation to the NHS;
- identify and invoice chargeable patients, healthcare commissioners (either NHS England or clinical commissioning groups) bear the cost by paying for the treatment; or
- obtain payment after invoicing chargeable patients, trusts and commissioners share the cost.

**3.4** The evidence suggests that there is substantial variation in the systems that different trusts have set up to implement the charging regulations, and the resources and priority they attach to this area. For example, a consultation we undertook with trusts indicated that around half had a team working specifically on identifying and recovering costs from overseas visitors. Most of the rest had a full-time or part-time member of staff, but four trusts said they had no staff designated to work on this activity. At some trusts, information on charging is reported at a senior level, for example to the board, audit committee or executive management team. At others, it is reported at a more operational level, for instance to managers within the finance department.

## Main challenges

### Determining patients' chargeable status

#### Challenge

**3.5** There is no single document or piece of information that confirms whether or not a person should be charged for NHS treatment. A British passport or NHS number, for example, does not automatically mean that a patient is entitled to free treatment. In addition, because liability to pay is determined primarily by residency (and also, for some, progress through the asylum process), a person's chargeable status can change. This means that trust staff may have to make difficult judgements in determining a patient's status, particularly if patients are unable to provide complete documentation.

**3.6** Research for the Department in 2013 found that trusts were not applying the charging regulations consistently.<sup>23</sup> The complexity of the regulations, and insufficient understanding of them among some overseas visitor managers, had resulted in confusion about which patients were chargeable.

**3.7** Amended charging regulations, which took effect in April 2015, remain complex. There are exemptions for different conditions, treatments and groups of visitors. We heard during our visits to trusts that, although many cases are relatively straightforward, it can take a significant amount of staff time to establish some patients' chargeable status and requires staff to exercise judgement.

#### What the Department has done

##### Guidance and support

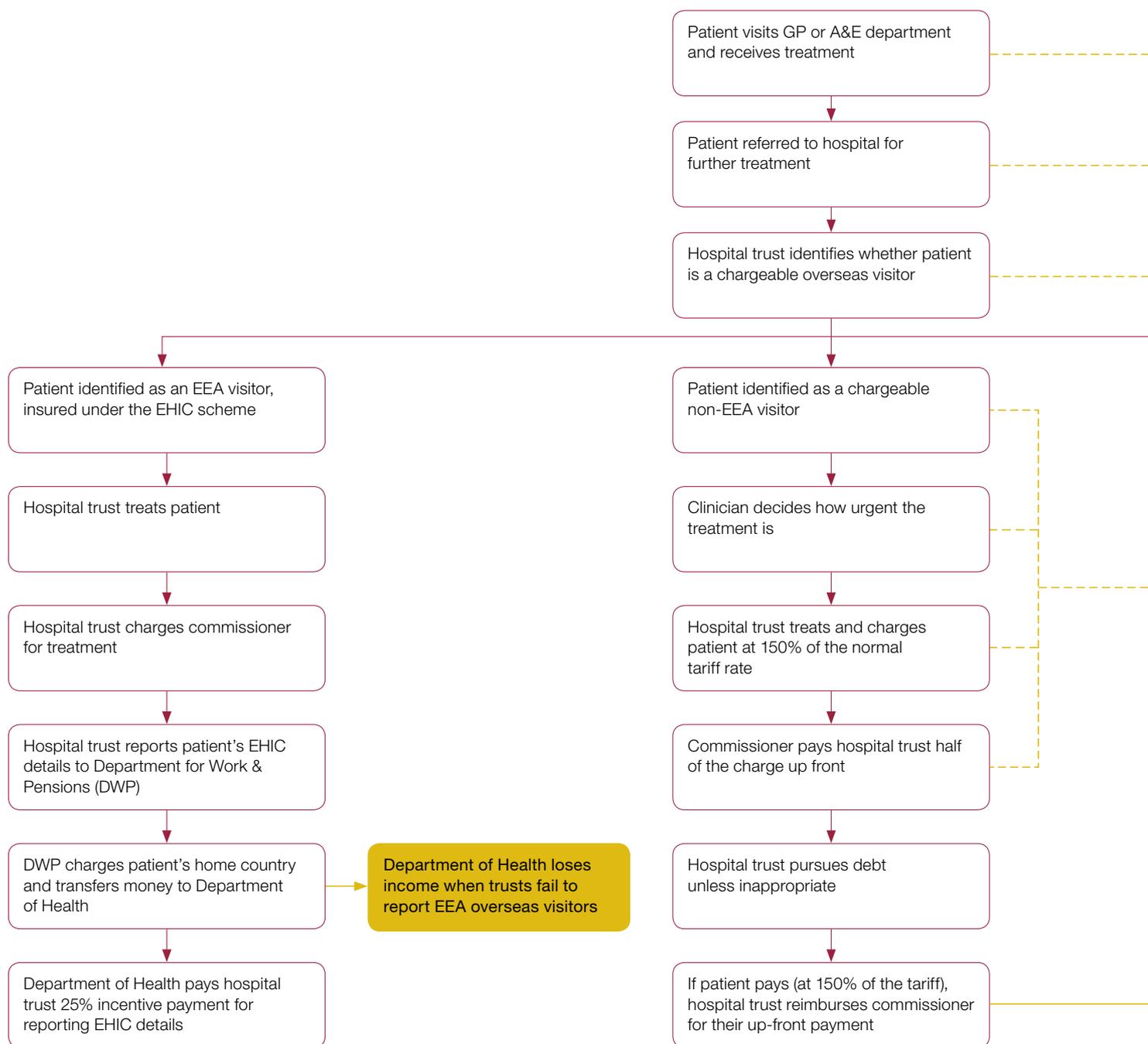
**3.8** The Department has taken action to make it easier for trust staff to learn and apply the charging rules. It has developed new material for overseas visitor managers and other staff to use including:

- detailed new guidance on implementing the charging regulations;<sup>24</sup>
- an online 'toolbox' available to overseas visitor managers – this includes resources such as suggested questions to establish whether a patient is ordinarily resident and guidance on information sharing with the Home Office; and
- an online forum for overseas visitor managers – this helps this important group of staff to share knowledge and discuss issues with their counterparts in other trusts and with the Department.

<sup>23</sup> Creative Research, *Qualitative assessment of visitor and migrant use of the NHS in England: Observations from the front line*, October 2013.

<sup>24</sup> Department of Health, *Guidance on implementing the overseas visitor hospital charging regulations 2015*, February 2016.

**Figure 11**  
Processes for charging overseas visitors



**Notes**

- 1 Overseas visitors most commonly become chargeable after they are referred by a GP or admitted to hospital after attending an accident and emergency department.
- 2 The commissioner may be the local clinical commissioning group or NHS England depending on the treatment.
- 3 Visitors from the EEA who cannot show they are insured by their country of residence should be charged directly for treatment. The process is the same as for chargeable visitors from outside the EEA, but EEA visitors are charged at 100% rather than 150% of the standard NHS tariff price.

Treatment is free. The GP or A&E department cannot charge and has no obligation to identify whether the patient is an overseas visitor.

Treatment is potentially chargeable. The GP or A&E department can (but does not have to) flag the patient as potentially chargeable.

Trust staff (often the booking clerk) should ask all patients a set of baseline questions (set by the Department of Health). If answers raise doubts about a patient's status, the trust 'overseas visitor manager' interviews the patient to establish if they are chargeable.

Decisions on the urgency of treatment should be made by clinicians. These decisions affect when charges and payments are made:

- 'Immediately necessary' treatment (including maternity care) is provided immediately and in advance of payment.
- 'Urgent' treatment is provided regardless of ability to pay, but patients should be asked to pay in advance.
- 'Non-urgent' treatment should be provided only if a patient has paid in advance.

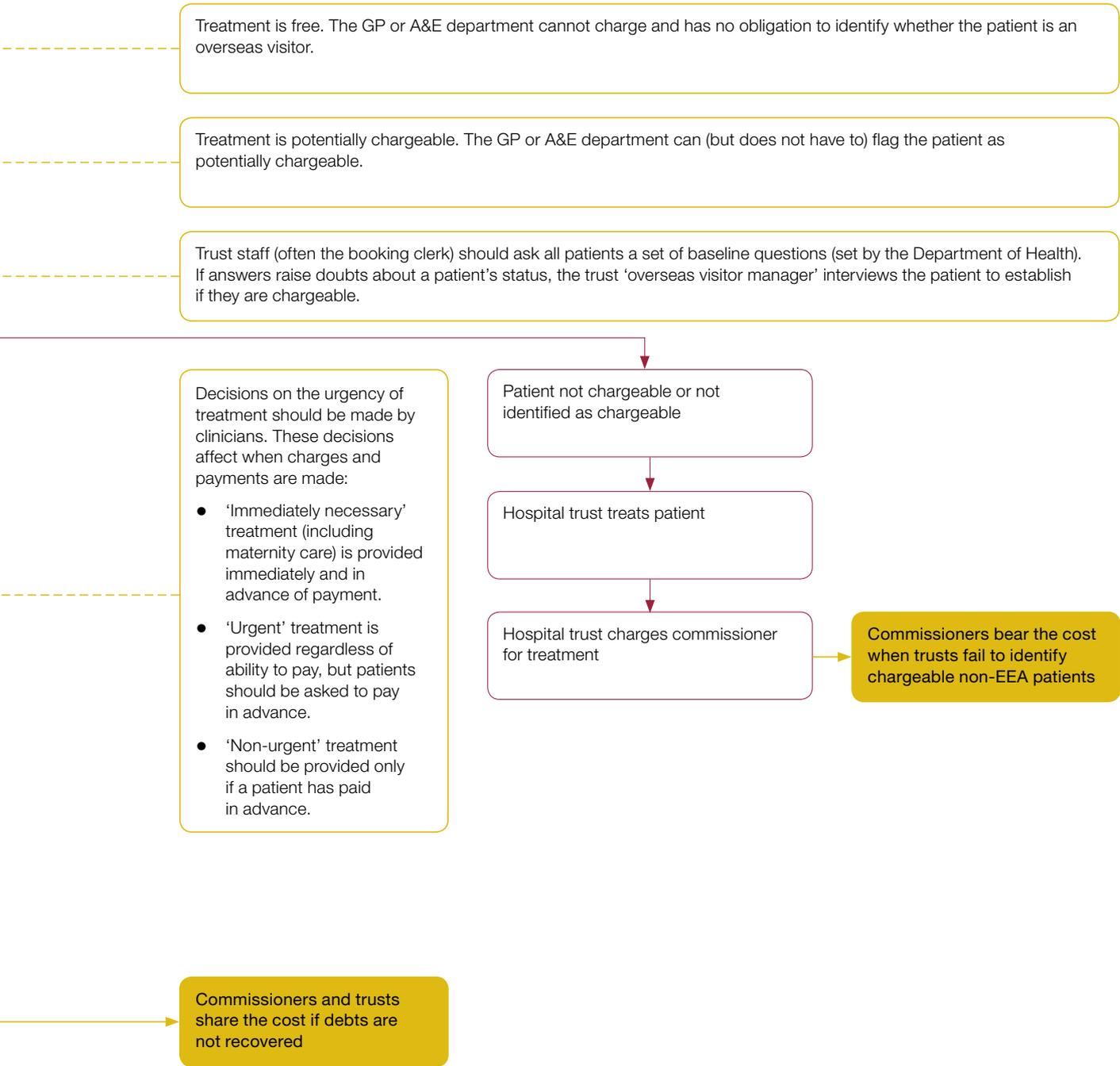
Patient not chargeable or not identified as chargeable

Hospital trust treats patient

Hospital trust charges commissioner for treatment

Commissioners bear the cost when trusts fail to identify chargeable non-EEA patients

Commissioners and trusts share the cost if debts are not recovered



### Data sharing

**3.9** Information from the Home Office, GPs or other trusts can help trusts identify whether a patient is potentially chargeable. Effective data sharing can also mean that patients do not need to produce documentation to prove their status every time they attend hospital.

**3.10** Until April 2015 there was no way of systematically sharing information about patients' chargeable status. Information sharing was ad hoc: trusts could contact the Home Office to confirm a patient's immigration status, and some GPs would provide hospitals with information that indicated that patients might be chargeable. However, the capability for systematic data sharing was not built into NHS IT systems.

**3.11** In April 2015, the Department, working with NHS Digital, added new data fields to patients' personal demographic service records that can be shown as a 'banner' in the Summary Care Record Application available to overseas visitor managers and other NHS staff.<sup>25</sup> The new banner draws on visa information from the Home Office to highlight whether a patient is likely to be chargeable or entitled to free treatment. Specifically, the banner is designed to show trusts whether an individual has paid, or is exempt from paying, the immigration health surcharge (the surcharge).

**3.12** Trusts cannot rely on the banner to indicate the chargeable status of short-term overseas visitors, British expatriates, temporary migrants with visas from before April 2015, and more complex cases such as patients whose application for asylum has been rejected but who are appealing the decision. However, the introduction of the banner should help overseas visitor managers to make judgements and reduce the number of patients that they need to interview.

**3.13** The Department is reviewing proposals for further changes to IT systems to support wider sharing of information about patients' chargeable status. Since August 2016, overseas visitor managers who have completed relevant training are able to update the data underlying the chargeable status banner shown in the Summary Care Record Application. This information is then available to overseas visitor managers at other trusts, helping to reduce duplication and workload. It also mitigates the risk of patients who have been assessed as not eligible for free treatment by one trust approaching another trust in the hope of a different outcome.

**3.14** In addition, the Department aims to link the chargeable status information to trusts' own patient administration systems, helping to embed awareness of charging within day-to-day clinical operations. It is also working with other government departments to identify data sources that could help trusts to identify chargeable patients, including those covered under the EHIC scheme.

<sup>25</sup> NHS Digital is the trading name of the Health and Social Care Information Centre.

## Securing the engagement of NHS staff

### Challenge

**3.15** Staff engagement and cultural change are critical to the success of the cost recovery programme. Trusts' overseas visitor managers often rely on colleagues, particularly ward staff, to help identify potentially chargeable patients. In addition, clinicians must assess whether treatment is immediately or urgently necessary, or whether it can wait until an overseas visitor has returned home.

**3.16** Some NHS staff and stakeholders have highlighted the risk that the cost recovery programme may have unintended consequences, including the risk of unconscious bias in how staff apply the charging regulations. Among the risks and concerns identified were that the programme might make some ethnic groups, homeless people or other vulnerable groups, who may already feel marginalised, disproportionately less likely to seek necessary treatment. In addition, vulnerable groups might be discouraged from seeking healthcare that is in fact exempt from charging, such as treatment for conditions like tuberculosis or HIV. This would have consequent risks for public health. The Department's equality analysis and impact assessment for the cost recovery programme noted that the changes could adversely affect vulnerable groups, and that guidance for NHS staff would be needed to mitigate this risk.<sup>26</sup>

**3.17** Research for the Department in 2013 found that some front-line staff at trusts were reluctant to ask patients questions to establish their chargeable status because they could be perceived as discriminatory, or because it would undermine trust. Many staff, including clinicians, considered that it was not part of their job to support the charging of overseas visitors.<sup>27</sup>

### What the Department has done

#### Staff attitudes

**3.18** The Department has commissioned three independent surveys over the course of the cost recovery programme to measure staff engagement across the health system.<sup>28</sup> The surveys asked questions to assess participants' knowledge of the charging regulations and understanding of roles and responsibilities, and to indicate how far they were aware of the cost recovery programme and agreed with its aims.

<sup>26</sup> Department of Health, *Equality Analysis – Sustaining services, ensuring fairness: Government response to the consultation on migrant access and financial contribution to NHS provision in England*, November 2013; Department of Health, *Visitor and migrants NHS cost recovery programme – impact assessment final version*, July 2014.

<sup>27</sup> Creative Research, *Qualitative assessment of visitor and migrant use of the NHS in England: Observations from the front line*, October 2013.

<sup>28</sup> Ipsos MORI carried out telephone interviews with staff including overseas visitor managers, hospital doctors, nurses and administrative staff, trust board members, clinical commissioning group leads and general practice staff. Three surveys were undertaken: a baseline survey (August to October 2014, involving 2,156 NHS staff); an interim survey (February to March 2015, involving 2,170 NHS staff); and a follow-up survey (January to April 2016, involving 2,165 NHS staff).

**3.19** Analysis of the most recent survey, completed in June 2016, found:

- Survey respondents, across all staff groups, strongly agreed with the principle that it is fair to charge overseas visitors for the healthcare services they receive.
- High awareness of the charging rules among overseas visitor managers, trust chairs and board members. In addition, 65% of the trust chairs and board members surveyed who said they were aware of the cost recovery programme considered that the programme's benefits would outweigh the costs to the NHS.
- Increasing awareness of charging rules among front-line clinical staff, with 58% of hospital doctors and 45% of hospital nurses saying they were aware that some people are chargeable for NHS healthcare.
- Among those staff who knew that some patients are chargeable, 48% of hospital doctors, 27% of hospital nurses and 36% of administrative staff said they did not have a role with regards to chargeable patients.

**3.20** The Department has set up an equalities and vulnerable groups stakeholder group to inform policy and gather evidence. So far, there is insufficient evidence to assess whether, or to what extent, the concerns raised about unintended consequences were justified. The Department is considering further work to assess how the cost recovery programme has affected vulnerable groups in practice.

#### The Department's engagement with NHS staff

**3.21** The Department recognises that it has a well-established relationship with overseas visitor managers, but it has had more difficulty engaging with other trust staff or staff working in GP surgeries and clinical commissioning groups. The Department's programme team has visited around 60 trusts to explain the cost recovery programme to staff and talk through the processes that the trust has in place. The Department told us that one of the most important aspects of these visits has been to encourage senior managers to engage with the work that overseas visitor managers are doing to implement the programme.

**3.22** In addition, the Department has set up a separate cost recovery support team made up of people with recent NHS experience as overseas visitor managers, finance staff or clinicians. This team has visited 23 trusts, at the trusts' own request, to review and help strengthen operational processes for cost recovery.

## Training

**3.23** The Department has developed training materials to support the cost recovery programme by increasing awareness and knowledge among NHS staff. These include: publicly available webinars; an e-learning package, with components designed for overseas visitor managers, clinicians and administrative staff; and a video for use in staff induction. The Department has also chosen 13 'overseas visitor manager training ambassadors' to teach other staff in their trust about charging and to instruct overseas visitor managers in other trusts on how to deliver training.

**3.24** Individual trusts are responsible for training on overseas charging, which is not centrally managed or mandated. In practice, the available data indicate that the NHS has made limited use of the training materials.

## Providing incentives

### Challenge

**3.25** Before the cost recovery programme, the financial benefits of trusts reporting and charging overseas visitors went to the broader health system, and not directly to individual trusts. In some circumstances, trusts were financially worse off when they reported and charged overseas visitors:

- When reporting EEA visitors, trusts incurred administrative costs in recording details of patients' European Health Insurance Cards (EHIC), for which they were not previously reimbursed. The Department received the income relating to these patients.
- When charging visitors from outside the EEA, trusts relied on patients, rather than commissioners, making payments. Difficulty collecting payments meant that trusts collected less than the amount they invoiced.

### What the Department has done

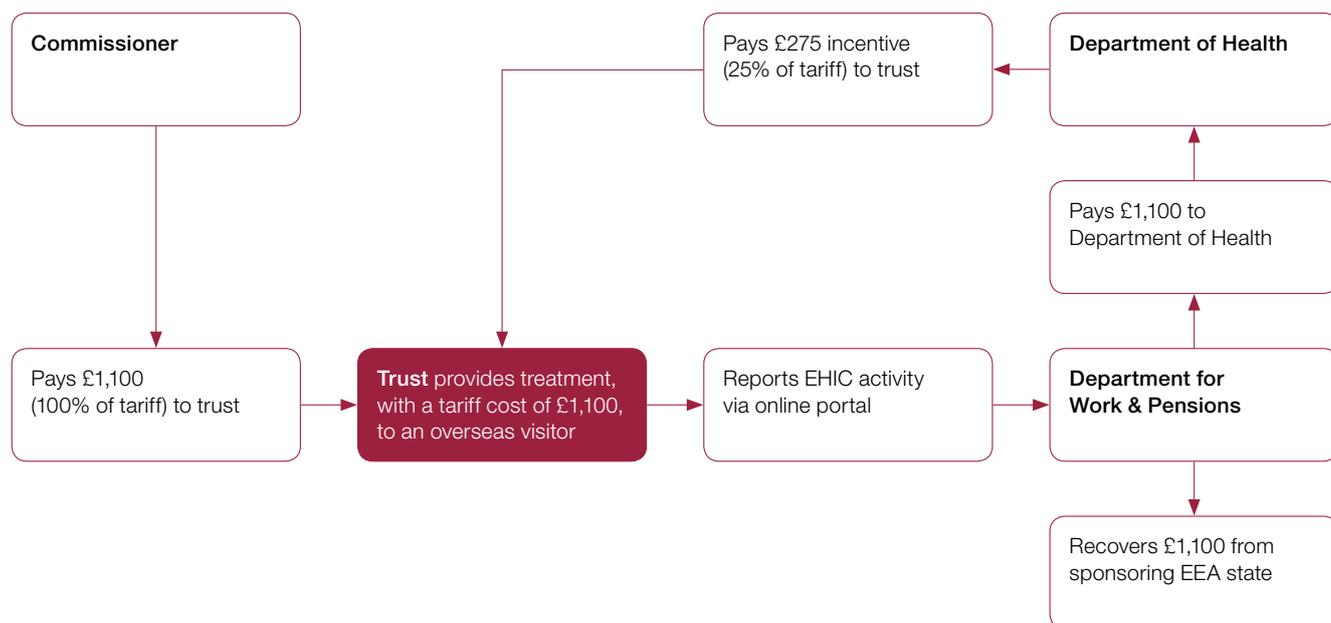
**3.26** The Department has introduced two incentives: one to encourage trusts to identify and report EEA patients whose treatments are covered by the EHIC scheme; and another to encourage trusts to identify and charge patients from outside the EEA.

### EHIC incentive scheme

**3.27** In October 2014, the Department introduced an EHIC incentive scheme. It was initially to run for a period of 12 months and has since been extended. As before, trusts charge commissioners for treatment provided to EEA patients. However, if trusts also record the patient's EHIC details on an online portal, they receive an extra 25% incentive payment from the Department. **Figure 12** shows how this works in practice, illustrated using the £1,100 actual average cost of treating a patient under the EHIC scheme.

**Figure 12**  
How the EHIC incentive scheme works

The Department pays trusts a 25% incentive for reporting EHIC cases, in addition to the payment trusts receive from their commissioner



**Notes**

- 1 The average value per case reported on the EHIC portal in 2015-16 was £1,110. We have rounded this down to £1,100 in the graphic above.
- 2 Around a third of cases reported through the EHIC portal cannot be charged. This happens for instance if the patient was sponsored by an EEA state with which the UK has a formula or waiver agreement. In such circumstances, the Department of Health will still pay a 25% incentive payment to the trust to encourage reporting.

Source: National Audit Office summary of the Department of Health's *Guidance on implementing the overseas visitor hospital charging regulations 2015*, February 2016

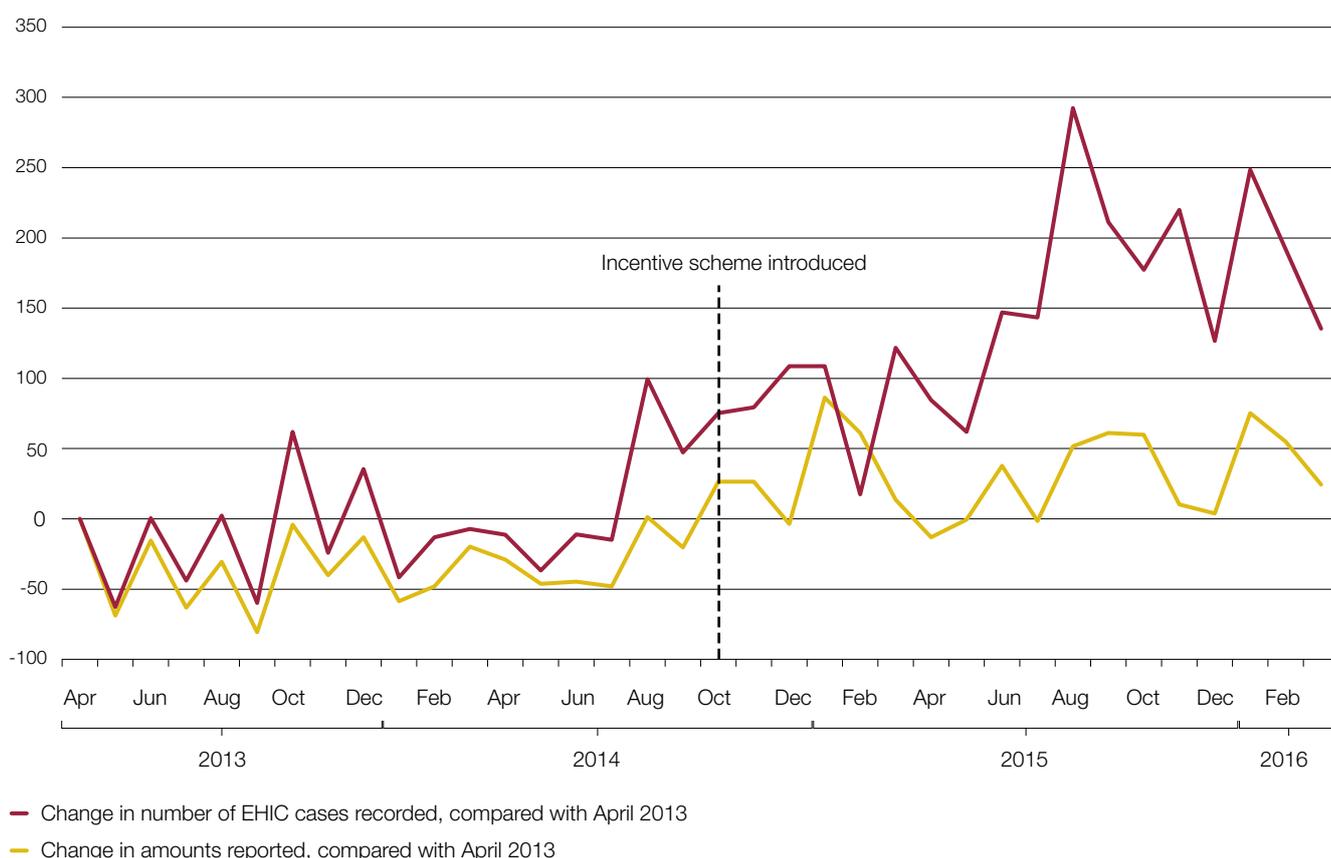
**3.28** The EHIC incentive scheme, which covers the UK as a whole, cost the Department £4.3m in 2015-16. Evidence indicates that this incentive seems to be having a positive effect on trusts' reporting (**Figure 13**). Trusts are reporting details for more patients – the total number of episodes of care reported was 15,500 in 2015-16, compared with 8,500 in 2014-15 and 5,000 in 2013-14. The total amount reported has also increased, from £8.3 million in 2013-14 to £17.2 million in 2015-16.<sup>29</sup> The average value of each case reported has fallen, from £1,663 in 2013-14 to £1,110 in 2015-16, suggesting that trusts are reporting a higher proportion of relatively low-value cases.

**Figure 13**

Changes in EHIC reporting, April 2013 to March 2016

Trusts have reported more patients under the EHIC scheme since the Department introduced incentive payments

Difference from April 2013 (%)



**Note**

1 The EHIC incentive scheme was introduced in October 2014.

Source: National Audit Office analysis of data from the Department for Work & Pensions (as reported through the EHIC web portal)

<sup>29</sup> An estimated two-thirds of the EHIC cases that trusts report result in charges to EEA states. Not all cases can be charged because some EEA states have separate (formula or waiver) agreements with the UK to cover the cost of care, and do not pay for each individual case.

**Non-EEA incentive scheme**

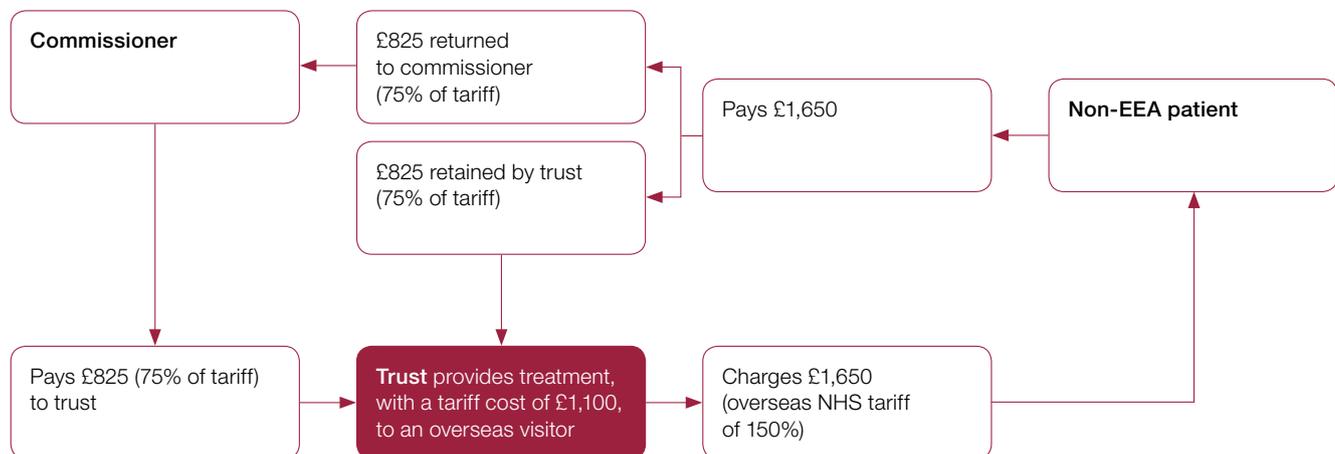
**3.29** In April 2015, the Department introduced a non-EEA incentive scheme (**Figure 14**):

- Trusts now charge visitors from outside the EEA 50% more – at 150% of the standard NHS price (the tariff) for their treatment. Commissioners share the risk of patients not paying by paying trusts half of the invoiced amount (ie 75% of the tariff).
- When patients do pay, trusts share the amounts received with commissioners. If a patient pays in full, the result is that the commissioner is reimbursed and ends up paying nothing, and the trust receives 150% of the normal amount.

**3.30** Any trust that identifies and charges overseas visitors from outside the EEA will be better off under the new incentive scheme than it was under the previous arrangements. However, trusts with low debt recovery rates will still struggle to recoup 100% of tariff (which is what commissioners would pay them if they did not identify patients as chargeable). Trusts need to collect a third of the amounts they invoice to receive 100% of tariff. Given the wide range in debt recovery rates, the effect of the incentive will be different at different trusts.

**Figure 14**  
How the non-EEA incentive scheme works

The non-EEA incentive scheme shares the risk of non-payment between trusts and commissioners



**Notes**

- 1 Data are only available on the value of charges made to visitors from outside the EEA, and not on the number of visitors charged. It is therefore not possible to calculate an actual average price per case. We have used £1,100 for consistency with Figure 12.
- 2 100% of tariff is the standard NHS price that trusts charge to commissioners for treating patients who are ordinarily resident in the UK.
- 3 Visitors from the EEA who cannot show they are insured by their country of residence should be invoiced directly for chargeable treatment. The financial flows are the same as for chargeable visitors from outside the EEA, but EEA visitors are charged at 100% rather than 150% of the standard NHS tariff price.

Source: National Audit Office summary of the Department of Health’s *Guidance on implementing the overseas visitor hospital charging regulations 2015*, February 2016

**3.31** Part of the purpose of the non-EEA incentive scheme is to engage local commissioners and encourage them to work with trusts to improve the processes trusts have for charging and collecting payments from overseas visitors. A trust we spoke to told us that commissioners were more engaged following the introduction of the incentive scheme, but another said that the risk-sharing arrangement was conceptually difficult and unlikely to engage their commissioners.

**3.32** Evidence indicates that the change in prices has increased the amount that trusts charge to patients from outside the EEA. Charging rose by 48% in 2015-16 compared with the previous year (paragraph 2.3). The Department does not collate data on the number of patients charged. Because non-EEA patients are now charged 150% of the normal tariff price, increased charging cannot be used as evidence that the incentive scheme has so far had a significant impact on the number of patients charged.

## Recovering debts

### Challenge

**3.33** Charging more patients from outside the EEA is of limited value unless it results in more money being recovered. Nationally, we estimate that trusts collected around half of the amounts they charged, using data for 2013-14 and 2014-15 (paragraph 2.5). Of 124 trusts that charged at least £50,000 during this two-year period, estimated debt collection rates varied significantly, from 15% to 100% even after excluding outliers (the top and bottom 10% of trusts). Three-quarters of trusts (37 out of 50) responding to our consultation exercise said that overseas visitor debts were a very or fairly important problem for their trust.

**3.34** Trusts may pursue debts for a number of years but, ultimately, when a trust concludes that it is unable to recover a payment, it will write it off as a bad debt. In 2015-16, trusts wrote off £15.7 million of overseas visitor debts relating to charges made in that year and in previous years. This compares with £16.9 million written off in 2014-15 and £15.2 million in 2013-14.

### What the Department has done

#### Work with trusts

**3.35** The Department has advised trusts that patients are more likely to pay if they are informed of the costs and invoiced at the earliest possible stage. It has strengthened its guidance to advise trusts to provide elective treatment only when a patient has paid in advance and in full. In practice, trusts take different approaches to costing and invoicing. We heard during our visits that some trusts tried wherever possible to calculate likely costs and invoice patients before their treatment, whereas others sent invoices only after the patient had been discharged because they did not want to charge the wrong amount. No analysis has been done to assess which approach is more effective.

**3.36** The Department also recommends that trusts consider using specialist debt collection agencies, although there is little evidence that this is a more effective way for the NHS to pursue its overseas visitor debts.<sup>30</sup> Our consultation with trusts indicated that around two-thirds used a combination of debt collection agencies and pursuing debts in house.<sup>31</sup> We did not find any link between trusts' approach to debt collection and their success in collecting debts.

#### Home Office record of debtors

**3.37** Trust staff we spoke to suggested that an effective way of encouraging overseas patients to pay what they are charged was for the Home Office to refuse visas for re-entry to the UK to people with outstanding debts. Since 2011, the Home Office has maintained a record of people who have debts outstanding with trusts for this purpose. Initially, information was recorded on people with over £1,000 outstanding for at least three months. In April 2016, the Home Office reduced the threshold to £500 outstanding for two months. The Department is seeking to encourage more trusts to submit information on outstanding debts to the Home Office.

**3.38** It is too early to conclude whether the value of debts collected has changed as a result of the cost recovery programme or Home Office work on debtors. A small number of high-value cases can cause significant variation between successive years, meaning that any trends could only be seen over a much longer period.

<sup>30</sup> Department of Health, *Guidance on implementing the overseas visitor hospital charging regulations 2015*. February 2016.

<sup>31</sup> Fifty trusts responded to a question in our consultation asking how they pursue their debts. Thirty-four said they used a combination of a debt collection agency and pursuing debts in house.

# Appendix One

## Our audit approach

**1** This report focuses on the work of the Department of Health (the Department) to help the NHS to increase the amount charged and recovered for treating overseas visitors not entitled to free NHS treatment. The report:

- gives an overview of what the health system does to recover the cost of treating overseas patients;
- analyses progress in increasing the amounts charged and recovered; and
- outlines factors affecting successful cost recovery.

**2** Our work covered the following questions:

- Was the Department's plan to implement the visitor and migrant cost recovery programme well designed?
- Is there evidence that the plan is being successfully implemented?
- Is the Department monitoring and evaluating progress effectively?

**3** We applied an analytical framework with evaluative criteria, which considered what arrangements would be optimal for achieving the Department's aims. By 'optimal' we mean the most desirable possible, while acknowledging expressed or implied constraints.

**4** Our audit approach is summarised in **Figure 15** overleaf. Our evidence base is described in Appendix Two.

**Figure 15**

## Our audit approach

**The Department's objective**

The Department of Health (the Department) is working to increase the amount of money recovered for treating overseas visitors by extending the scope of charging and by implementing the existing regime more effectively. Its current ambition is to recover up to £500 million of income relating to overseas visitors per year by 2017-18.

**How this will be achieved**

The Department is responsible for the system in England for charging patients from outside the European Economic Area (EEA) and the system across the UK for charging patients from within the EEA. In July 2014, the Department published the implementation plan for a visitor and migrant cost recovery programme.

NHS trusts and NHS foundation trusts have a statutory responsibility to identify chargeable overseas visitors, recover payment from those who are directly chargeable, and report details of amounts to be recovered from other EEA member states.

**Our study**

We examined whether the Department of Health is making good progress in increasing the amount charged and recovered for overseas visitors not entitled to free NHS treatment.

**Our study framework**

Was the plan to implement the visitor and migrant cost recovery programme well designed?

Is there evidence that the plan is being successfully implemented?

Is the Department monitoring and evaluating progress effectively?

**Our evidence**  
(see Appendix Two for details)

- Interviews with the Department and arm's-length bodies.
- Review of key documents, including research, impact assessment and implementation plans.
- Consultation with acute trusts.

- Interviews with the Department and arm's-length bodies.
- Analysis of financial data.
- Statistical analyses.
- Illustrative case study visits to hospital trusts.
- Consultation with acute trusts.

- Interviews with the Department and arm's-length bodies.
- Review of key documents, including NHS staff surveys, programme board papers and reviews by the Major Projects Authority and the Infrastructure and Projects Authority.

**Our conclusion**

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.

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.

# Appendix Two

## Our evidence base

**1** We reached our independent conclusion on whether the Department of Health (the Department) is making good progress in increasing the amount charged and recovered for overseas visitors not entitled to free NHS treatment by analysing evidence collected between September 2015 and October 2016. Our audit approach is outlined in Appendix One. The work was not designed to support a conclusion on value for money.

**2 We interviewed staff from the Department.** The people we interviewed were responsible for developing and implementing the cost recovery programme. They included programme and project managers, people who were designing and rolling out training and support for NHS staff, and people who were developing systems to collect more accurate and complete information about the number of overseas visitors using NHS services and the cost of treating them.

**3 We interviewed staff from arm's-length bodies:**

- NHS England – about commissioners' interest in the cost recovery programme, and the impact of the non-EEA incentive scheme that shares the risk of bad debts when patients do not pay the charges between trusts and commissioners.
- NHS Improvement (comprising Monitor and the NHS Trust Development Authority) – about reasons for variation in cost recovery rates between trusts; trusts' capacity to increase amounts recovered; and what opportunities there are for further progress.
- The Major Projects Authority (now part of the Infrastructure and Projects Authority) – about the Department's progress in implementing the cost recovery programme.

**4 We reviewed key documents.** The documents included:

- research that the Department commissioned in 2013 on the extent of unrecovered costs, and the potential to increase the amount charged and recovered;
- the impact assessment that the Department prepared for the overseas visitor and migrant cost recovery programme. We used this to assess the programme design, reasonableness of assumptions used, potential implementation costs, and the benefits the Department expected to achieve from implementing the programme;

- legislation and supporting guidance for trusts' overseas visitor managers. We used these to understand the legislative framework, and how the regulations are expected to be applied in practice;
- the Department's implementation plan and internal programme management plans. This material included trajectories for the amounts the Department forecast would be recovered each year between 2013-14 and 2017-18;
- summary results of three surveys of NHS staff commissioned by the Department: carried out from August to October 2014; February to March 2015; and January to April 2016. We used these to understand what the Department has done to engage staff in the programme, and to assess NHS staff views;
- guidance and training materials the Department has prepared for NHS staff. We used these to understand what the Department has done to explain the cost recovery programme to NHS staff, and how different staff roles contribute to achieving the programme's objectives;
- terms of reference, risk registers, and meeting minutes of the programme board. We used these to assess the arrangements for leadership, governance, accountability, project management and risk management for the programme; and
- gateway reviews undertaken by the Major Projects Authority and the Infrastructure and Projects Authority. We used these to assess project progress, risk management and accountability.

**5 We analysed financial data from trusts and the Department.** We used these data to understand how much income trusts are recognising and recovering, and amounts of debt written off. We also used these data to identify trends in overseas visitor income recognised and recovered, by source, over time and between different trusts. The data included:

- trusts' financial data for 2013-14, 2014-15 and 2015-16, including income recognised in the year, cash payments received, provisions for bad debt and amounts written off, broken down by trust; and
- summary data about recoverable EEA patient income that trusts reported to the Department for Work & Pensions through the European Health Insurance Card (EHIC) portal.

**6 We estimated the most likely debt recovery rate for directly chargeable patients by comparing cash received in 2013-14 and 2014-15 with income recognised over the same period.** This method allows for the fact that some income will be recovered over a longer period of time, as well as the fact that some of the cash recovered relates to amounts charged in previous years. We tested the reasonableness of our estimate in three ways:

- we repeated the calculation using cash and income data for the three years 2013-14 to 2015-16 – this method is slightly less reliable because it includes adjustments to take account of the fact that directly chargeable patients were charged 150% of tariff in 2015-16;
- we reviewed the value of the debts that trusts wrote off as a proportion of their income from directly chargeable patients – this method is likely to be overly optimistic because it takes no account of debts that are unlikely to be paid but have not been written off; and
- we reviewed changes in provisions that trusts made for amounts they did not consider likely to be paid.

**7 We carried out statistical analyses to compare the amounts charged by similar trusts.** We used this analysis to test whether variation between trusts could be explained by trust size, type or location. Using data from the International Passenger Survey, we also tested whether regional variations in the amounts charged could be adequately explained by estimated visitor numbers.

**8 We carried out illustrative case study visits to three hospital trusts in different parts of England.** We carried out face-to-face interviews with senior hospital managers, overseas visitor managers and finance staff. The visits helped us to understand the processes these trusts have in place to identify and recover payment from overseas patients, the impact of the cost recovery programme, the scope to increase cost recovery and the main barriers to doing so.

**9 We conducted an online consultation exercise with 149 acute and specialist trusts.** We received 50 valid responses (a response rate of 34%). Of these, 32 responses were from chief executives or finance directors (or equivalent roles). The remaining responses were from overseas visitor managers (or equivalent roles). The questions we asked covered:

- how well-informed respondents felt about the programme;
- whether respondents expected overseas income in their trust to increase, decrease or stay the same over the next two years;
- if respondents said they expected income to decrease or stay the same, what the reasons for this were;
- what factors respondents thought determined how far their trust identifies and charges or reports all chargeable patients;
- how the trust had decided how much resource to invest in identifying and charging or reporting chargeable patients;
- what management information the respondent's trust generated, to whom the management information was circulated, and how often it was circulated;
- whether the trust had staff designated to work specifically on identifying and recovering costs from overseas visitors, and how much time was spent on this work;
- how trusts pursued outstanding debts from non-EEA patients; and
- whether the trust had identified any risks or unintended consequences, affecting the trust or local population, arising from action to increase amounts recovered from overseas patients.

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