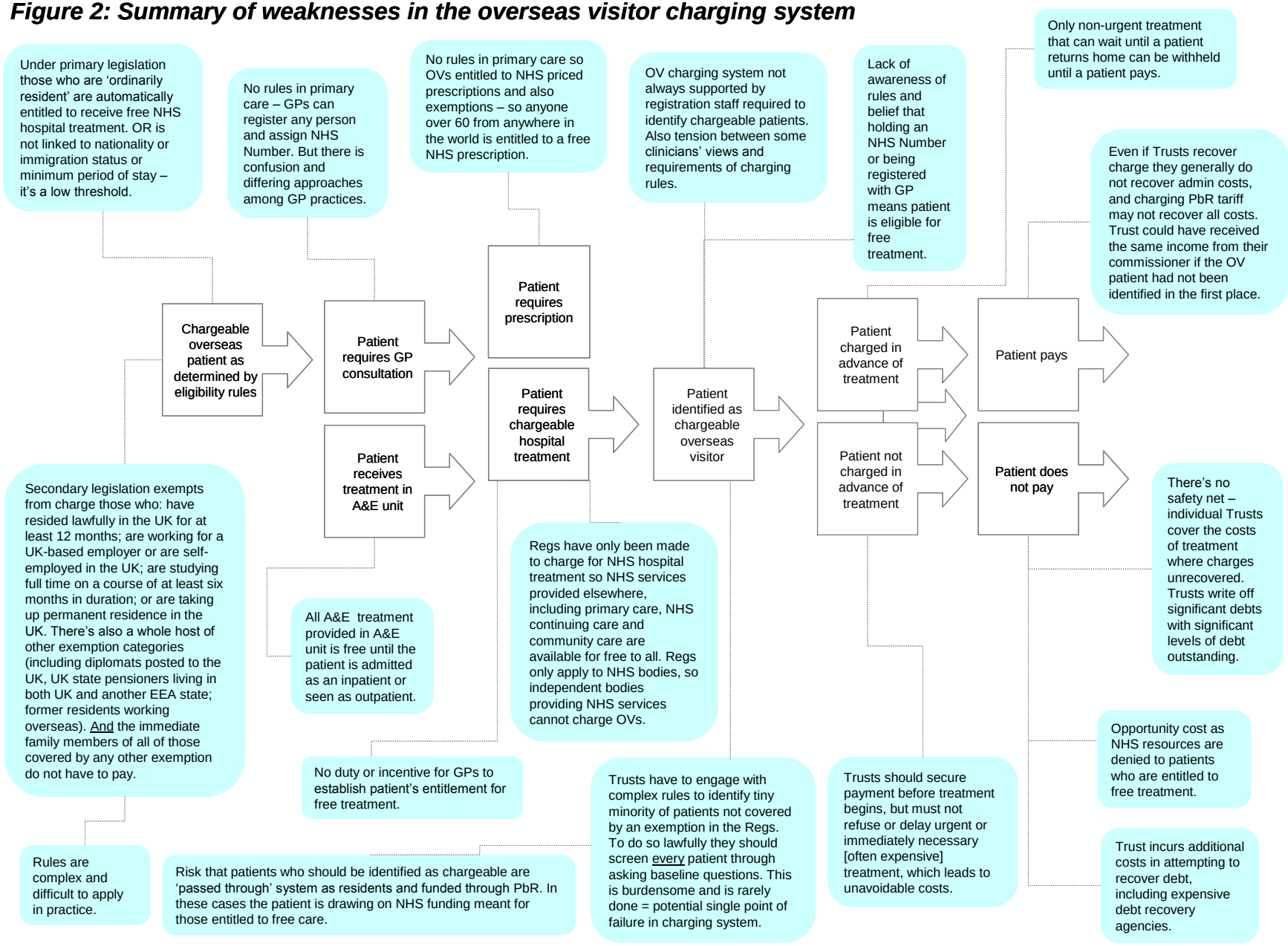
## Conclusion

1. The overseas visitor charging system leaves providers with no choice but to provide treatment for which they do not get paid. When a Trust identifies and treats a chargeable patient and the patient does not pay, the Trust covers these costs from its own reserves. In effect the general NHS funding base is subsidising the treatment of overseas patients. The resulting patient debt also impacts on Trusts' bottom lines and attracts scrutiny. The system is arguably not taking full account of humanitarian obligations, instead leaving individual Trusts to carry the burden. This liability falls disproportionately on London Trusts.

2. Only successful cost recovery from chargeable overseas visitors can reduce the burden currently placed on the NHS. However it is clear that it will be difficult to increase income significantly while Trusts are disincentivised from identifying overseas visitors in the first place and burdened with the visible effect of unrecovered income on their bottom lines.

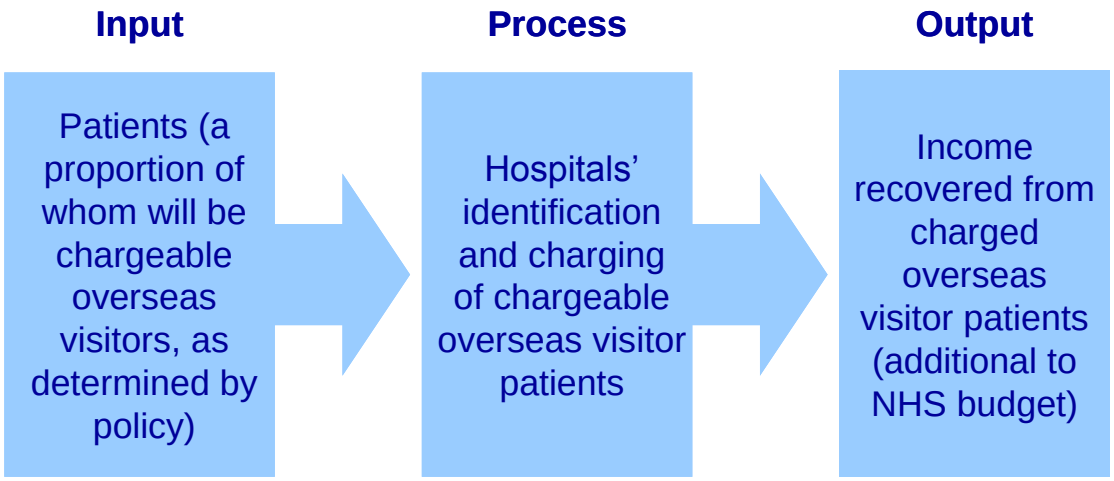
## *Figure 2: Summary of weaknesses in the overseas visitor charging system*



## The overseas visitor charging system: a whole system approach

3. The overseas visitor charging regime can be viewed as a system in its own right[1] – one that is seen as either insignificant (because of the small amount of income generated as a proportion of the NHS budget), tangential (because charging patients does not 'fit' with the usual functioning of the NHS), or as a necessary control on non-residents' access to NHS resources and capacity.

4. At its heart, overseas visitor charging is a simple input > process > output system:




5. The output also helps deliver a major outcome – better outcomes for patients who *are* entitled to free NHS treatment, through a reduced burden on the NHS budget, enabling more of those entitled to free treatment to receive it.

**A whole systems approach**

6. But we cannot consider the design and operation of the overseas visitor charging system without looking at its place within the wider NHS system, and some of *that* system's processes, funding flows, and incentives for individuals and NHS bodies.

7. We therefore conducted a mapping exercise to provide a 'whole systems' view of the overseas visitor charging regime and its place within the NHS. Mapping the system in this way enabled us to picture and describe some of the relationships between key elements of the regime and their interlinkages with wider processes, which will be useful for the process of designing policy interventions.

[1] J. Forrester's Principles of Systems, 1969, defines a system is "a grouping of parts that operate together for a common purpose"

8. This work, including the whole systems map, is in Annex H. It highlights the overseas visitor charging system's links with:

    - the entry of overseas visitors to the country at the border
    - the NHS funding allocations process
    - commissioner payments systems
    - the private patient income cap (for FTs)
    - the GP registrations and referral process
    - administrative and clinical processes within hospitals

## Analysis of the overseas visitor charging system

- The NHS appears to be recovering gross income of £15 - £25m for treatment provided to chargeable overseas visitors.
- We estimate that only 30% - 45% of chargeable income is currently being identified, and 60% of the charges levied are not being recovered.
- The cost of administering the current system in NHS hospitals may be higher than what is recovered – the overseas visitor charging system may not generate a net financial benefit to the NHS.
- Any proposals to increase identification of overseas visitors or extend charging to currently non-chargeable people or treatment settings would need to carefully consider the impact on the costs of operating the charging system, in order to avoid creating more costs than benefits.

**Important caveat**

It is crucial to keep in mind the limitations of the analysis presented as part of this review. There is no comprehensive evidence covering this subject (be it in academic literature, official statistics or easily accessible data from frontline sources such as Hospital Trusts). Therefore, any estimates used in this analysis had to be derived from multiple data sources. These sources include official migration statistics, data from the Office for Higher Education, Trust accounts, the responses to a specifically designed survey of overseas visitors managers (OVM) and others.

All of these data sources come with limitations: they may lack accuracy, sometimes contradict each other and most of the time cannot be easily compared. With the exception of our own survey, they have been compiled for purposes other than the analysis of the overseas charging system, so may not be entirely reliable when applied to our purposes with full reliability. **Therefore, most estimates in this document should be considered as an illustration of likely scope rather than a precise estimate.**

### Introduction

9. This section of the report summarises the analysis supporting the fundamental review of the overseas visitors charging system in the NHS in England.

## Context and background

10. The overseas visitor charging system consists of three major components (for detailed descriptions please see the earlier sections):

    - Eligibility rules – these define who is entitled to free NHS treatment and for what treatments the NHS can levy charges);
    - Frontline implementation – this defines where, whether and how chargeable patients are identified and charged when accessing chargeable services;
    - Cost recovery – this defines how charges to overseas visitors translate into actual recovered income (e.g. whether a charged visitor pays or not).

11. Prior to this review, most of the available evidence relating to overseas visitors in the NHS has been anecdotal. Therefore, much of the analytical work done in support of the review was exploratory in nature – its initial aim being to better understand the scope and nature of the problem. The main questions explored were:

    1) How many overseas visitors (OVs) are there?
    2) How much cost do they impose on the NHS?
    3) How much of this cost is currently recovered through the OV charging system?
    4) What is the cost of administering the OV charging system?

12. It is crucial to keep in mind the caveat at the start of this document regarding the limitations of the analysis presented. Ideally, any further development of policies would be accompanied by a targeted data collection exercise aimed at identifying the true level of demand for NHS services by OVs and the costs of operating the OV charging system, to allow a more detailed assessment of any proposal considered for implementation.

## Description of sources

13. This section briefly sets out the main sources of information used in this analysis.

### *National level migration data*

14. Various sources of migration data have been used to derive illustrative estimates for the number of currently chargeable overseas visitors as well as other groups who are currently entitled to free NHS treatment, but whose entitlement may be subject to review (mainly, ordinary residents who have not yet gained the right of permanent residence in the UK).

- *First,* the Home Office publishes data on border entries into the UK as well as visas granted to non-EEA citizens[2]. This data is used to derive an estimate of the number of chargeable non-EEA visitors on specific visas (such as a students, dependents, workers).

- *Second,* the ONS publishes the International Passenger Survey (IPS)[3], a representative survey of travellers at UK airports and ports as well as derived analyses of Short-Term and Long-Term International Migration. We use this data to estimate the number of migrants and short-term visitors entering and leaving the country, split by purpose of migration (e.g. study, work etc), country of origin and age. The IPS allows us to derive an estimate of migration to England and its regions, rather than the UK as a whole.

- *Third,* UK tourism organisation "visitbritain" has developed an analytical tool based on the IPS[4] that allows us to derive information about the length of stay, age, country of origin and nationality of short-term visitors.

- *Fourth, the Higher Education Statistics Agency*[5] publishes statistics on the number of foreign students in the England.

- *Fifth,* by definition, there are no official statistics on undocumented migrants. Evidence from academic literature is used to estimate the size of this group.[6]

- *Sixth,* we use ONS statistics[7] on the total number of non-UK citizens in England.

***Trust-level data on overseas visitors in the NHS***

15. There is no national data collection on treatment provided to 'overseas visitors' in the NHS. There is partial data (on income and losses) available from Trusts' accounts, but this has been found to be fraught with ambiguities. Therefore, data had to be collected specifically for this review to explore how many overseas visitors are treated in the NHS, what income is generated, at what cost and with what level of compliance with

[2] http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/immigration-asylum-research/immigration-q4-2011/
[3] http://www.ons.gov.uk/ons/rel/migration1/provisional-international-passenger-survey--ips--estimates-of-long-term-international-migration/ips-estimates-of-long-term-international-migration-year-ending-december-2009/index.html
[4] http://www.visitbritain.org/insightsandstatistics/inboundvisitorstatistics/yearlydata/index.aspx
[5] http://www.hesa.ac.uk/; a summary of these statistics is also collated by the UK Council for International Student Affairs (a national advisory body "serving the interests of international students"): http://www.ukcisa.org.uk/about/statistics_he.php
[6] The latest UK government estimate has been produced by Woodbridge, J. (2005) *Sizing* the *unauthorised* (*illegal*) *migrant population* in the United Kingdom in 2001 for the Home Office, a useful summary of academic literature is given by the EU-financed "CLANDESTINO" research project: http://irregular-migration.net/index.php?id=169
[7] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-219289

DH guidance.

16. We carried out a limited data collection exercise by sending out questionnaires to 52 Trusts, i.e. about one in five Trusts in the country (and approximately representative of the geographical distribution of population in England) to get a better picture of the OV charging system.

17. The survey consisted of two components: first, a repetition of a previous survey of overseas visitor managers (OVMs) undertaken by the NHS Counter Fraud and Security Management Service (now NHS Protect) in 2007 asking OVMs to report perceived compliance by frontline staff with DH guidance (e.g. asking patients baseline questions to assess their entitlement to free treatment). In addition, the number of full-time equivalent OVM staff was collected. Second, our survey asked for data about treatments provided to OVs: monetary costs, clinical specialty, exemptions used, nationality of patients, rate of recovery and unrecovered debt.

18. We received answers from **23** Trusts, i.e. **44%** of Trusts in our sample and about **9%** of all Trusts. The Trusts in our sample are, on average, bigger than the mean of all Trusts, so that they represent about **15%** of total expenditure across all Trusts. Responses to our survey appear to be biased towards NHS Trusts in regions with a relatively high inflow of international migrants.[8]

19. The characteristics of our sample suggest that Trusts with more OVs were more likely to respond. Thus, any estimate derived from this sample, without adjustment, may overestimate the scope of the OV inflow into the NHS.

20. Not surprisingly, almost all respondents filled out the parts of our survey that repeated the 2007 survey as OVMs could easily provide answers based on their personal experience. Similarly, almost all Trusts provided us with information about the income charged to OVs. However, response rates were much poorer for the more detailed questions about treatment types (9 respondent Trusts), exemptions used (6 Trusts) and nationality of patients (8 Trusts). Any analysis based on these responses can only be tentative. One Trust has been able to provide much more detailed information than required by our questionnaire. Where appropriate that information has been taken into account.

[8] The difference between the sample average values (share of NHS Trusts, average long-term international migrant population) and the average for England is significant at a 85% confidence level.

**Question 1: How many overseas visitors are there?**

21. In legislation, an "overseas visitor" is anyone who is not ordinarily resident (OR). In practice, this means short-term visitors (such as tourists) only as temporary residents (e.g. students) would be considered OR. For the purpose of this analysis and in light of the data available, we have a wider interest in all of the following groups (mostly non-UK nationals):

    - Short-term visitors: EEA and third country nationals, staying for a period of less than six months and for whom England is not their centre of interest;
    - Undocumented migrants: who are resident in England, but not lawfully so and therefore cannot be considered OR;
    - UK expatriates: who are either visiting from their country of residence (in which case they are chargeable) or returning to live in England (in which case exempt), but have only arrived in the last six months;
    - Non-permanent ordinary residents and exempt visitors: those living in England for a period of up to 5 years, for whom the UK could be considered their centre of interest and who generally would pass an OR test – and those who for some other reason are exempt from charges;
    - Permanent residents: for the purposes of this analysis, this includes everyone who either has gained the right of permanent residence or has lived in the UK for five years or more.

22. The estimates presented in this section are historical estimates and any future trends will depend on many exogenous factors that we have not attempted to predict (such as the relative success of the UK as a tourism destination, the global economic climate, transport prices etc). Furthermore, most migration statistics are collated at the UK level and needs to be adjusted to the England level for our purposes. Unless specific information was available for any particular variable, the adjustment was made by assuming that about 90% of all inbound migrants to the UK settle in England – an estimate derived from ONS/IPS statistics on long-term international migrants.

***Short-term visitors***

23. Home Office data, adjusted for visitors going to other parts of the UK, suggests that about 36m non-UK nationals entered England in 2010. In itself, this is not meaningful for our analysis, because it does not tell us about their length of stay, nor their residency status or entitlement to free treatment.

24. Therefore, we mainly used IPS data to analyse the inflow of visitors to the UK. This allows us to consider short-term visitors and long-term migrants separately, as it includes information about length of stay. However, this

data does not represent official accounts, but *estimates* based on a large-scale survey.

25. Based on the IPS data on the number of visitors coming to England and their length of stay, we estimate that, at any moment in time, there are over 500,000 short-term foreign nationals visiting England (including about 300,000 from EEA countries, excluding those coming as student visitors or dispatched workers from non-EEA countries). IPS data suggests that there are, at any one moment, about **25,000 non-resident workers**[9] and about 40,000 short-term students on temporary stays of less than six months in England.

26. These are *snapshot estimates* based on data for 2010 and as such come with some uncertainty. For instance, the ONS expects the number of **short-term students** to lie with 90% certainty **within a range from 30,000 to 50,000**. It is prudent to assume that our other estimates, which are derived using similar methodology, are subject to similar uncertainty and that the true value might lie within a range of +/- 25% of the indicated value (i.e. **375,000 – 625,000 short-term visitors**).

***Undocumented migrants***

27. Undocumented migrants are full-time residents in England. However their presence is not lawful and as such, they are not considered ordinarily resident and are not entitled to free treatment under the NHS. Given their unofficial status, there is no reliable data on their numbers and estimates in the literature vary considerably between 270,000 and 670,000 in studies covering 2005-2008.[10] Based on this, we take **about 500,000 undocumented migrants** to be a good mid-point estimate for England.[11]

[9] This is those coming into the country on short-term dispatches from non-EEA countries, for whom – given the length of their stay – the UK could not be considered their centre of interest, even though they are here to work.

[10] The EU funded CLANDESTINO project provides a good overview of estimates proposed since 2000 (which range from roughly 150,000 to 1m for the UK): http://irregular-migration.net/index.php?id=169; all of the estimates need to be adjusted to reflect England only.
Düvell, Franck 2007, in: Triandafyllidou, Anna and Ruby Gropas (eds.) (2006): European Migration: A Sourcebook, Aldershot: Ashgate – best estimate: 240,000.
Gordon, Ian et al 2009: Economic impact on the London and UK economy of an earned regularisation of irregular migrants to the UK, London, London School of Economics – best estimate: 618,000;
Migration Watch UK (2005): The illegal Migrant Population in the UK, Briefing Paper, London: Migration Watch UK – best estimate: 670,000.

[11] We have given double weighting to the Gordon 2009 study both because it is more recent and because it is deemed to be of higher quality. In addition, we have assumed – as for other groups of migrants in this section – that about 90% of all undocumented migrants live in England. This results in an estimate of 480,000.

***UK expatriates***

28. A UK citizen living abroad is not ordinarily resident in the UK and therefore not automatically entitled to receive free NHS hospital treatment. Based on IPS data, we estimate that, at any moment in time, there are **up to 100,000 UK expatriates** visiting England (again, we might want to consider an indicative range of +/-25%). This includes **about 15,000 UK state pensioners**. In addition, each year **about 75,000 UK citizens return** to take up residence in England (in these circumstances they would be exempt from charge).

***Non-permanent and permanent ordinary residents***

29. According to ONS statistics on the total number of non-UK citizens in England, **about 4m international long-term migrants are ordinarily resident** in England. However, from IPS long-term migration figures, we estimate that a majority of these, **about 2.6m are or could be permanent residents** (they have resided in England for more than 5 years). We derive separate estimates for the most important groups of non-permanent ordinary residents. In the main, these are non-chargeable either due to being ordinary residents or because they are covered by specific exemptions from charging.

30. **Students:** estimates for the number of non-UK students may be derived in different ways – with a surprisingly wide range of results:

    - Figures from the Higher Education Statistics Agency suggest some 330,000 foreign students in England in 2010/11;
    - IPS based long-term international migration data suggests a *net* inflow of more than 600,000 students in 2006 – 2010;
    - However, taking into account that some foreign students will have stayed in England, but ceased being a student (e.g. because they have got a post-study visa), it is more likely that there are less than 400,000 foreign students in England, at any one moment in time;
    - UKBA grants 300,000 study visas per year to non-EEA students. Considering that the Higher Education Statistics Agency counts more than 125,000 EEA students (who do not need any visa), this suggests that there would be, at least, more than 425,000 foreign students in England, in any year;
    - As the average length of stay on study visa is longer than a year, the best annual estimate would be closer to 530,000.

31. Thus, estimates of the number of foreign students in England range from 330,000 to 600,000. The estimate of 530,000 (from HO data) may be an over-estimate if the actual length of stay was shorter than imputed by the length of granted visas. At the same time, the low estimates derived from the Higher Education Statistics Agency figures appear implausible given the number of student visas granted. It may reflect a narrow interpretation

of who is a "student" (e.g. not counting certain types of courses). We deem it prudent to rely on the definition used in UK visa law. Therefore, as an indicative best estimate, we consider there to **be about 500,000 foreign students in England** in any one year (likely range: 400,000 – 530,000).

32. **EEA citizens:** from IPS long-term international migration data, we estimate that about 770,000 long-term EEA migrants came to England in 2006-2010, while about 400,000 EEA long-term migrants left the country. This suggests that there are, at the very least about 370,000 EEA citizens who are non-permanent, but ordinary residents in England – and at most 770,000.

33. The true number will depend on how many of the 400,000 leavers had arrived in England prior to 2006 and by now would have acquired the right of permanent residence had they not left. As an indication, we estimate there to be **about 450,000** EEA citizens who are non-permanent, ordinary residents in England. [12]

34. **Third country citizens on work visas:** In 2010, UKBA granted about 200,000 work-related visas to third country (non-EEA) citizens. Using the same adjustment as above, this suggests there are at least 180,000 non-EEA workers in England who are ordinarily, but not permanently, resident. Of these about 70,000 are applying for a two year extensions of a previously granted visa. If all visa holders were to stay in England for the whole duration of their visa, this would suggest an upper bound of 410,000 workers.

35. For a more realistic estimate, we consider that, every year, about 20,000 grants of settlement are given to applicants who have held a work-related visa for 5 years or more. Once settled, they become permanent residents. Thus, realistically, there are **fewer than 300,000** non-EEA nationals who are non-permanent residents and hold a work-related visa (broad range: 180,000 – 410,000).[13] However, it should be noted that this figure includes an unknown number of visitors from countries with whom the UK has reciprocal agreements (so who would not be chargeable in any case). Note also that for the purpose of this analysis we treat anyone who has

[12] Some 300,000 EEA students will have started a degree over the five years in question – about half of them will have started a one year course. Of those beginning a three year degree, some 2/5 ought to have finished their degree by now. In total, this suggests that up to 210,000 students who came to England in 2006-2010 have finished their degree and may have left the country (but some will have stayed). This leaves upwards of 190,000 unexplained leavers in 2006-2010. We assume that the probability of leaving diminishes over time as people settle. Thus, we expect that no more than half of the unexplained leavers (fewer than 95,000) have arrived prior to 2006. From this follows a net stock of EEA citizens who are non-permanent, but ordinary residents of less than 465,000 (=370,000 + 95,000).

[13] Given the length of work-related visas, visa holders cannot gain the right of permanent residence with one single visa. Thus, almost everybody who has been granted settlement in 2008-2010 will have applied for an extension of visa in 2006-2010. We need those visa extensions from our estimate as their holders will have become permanent residents. Given an average of about 24,000 grants of settlement per year, this suggests that there will be less than 340,000 non-permanent, non-EEA nationals working in England. Realistically, the figure will be lower as not all visa holders will stay until the end of their visa period.

been in England for more than 5 years on a work-related visa as permanent resident. Even if they have not formally achieved this status, they would be likely to apply if entitlement to free NHS treatment were dependent on it.

36. **Third country national dependents:** Dependents of UK visa holders may join them for the duration of their visa stay. From Home Office data, we derive that, in 2010, 25,000 dependents of non-EEA students and about 33,000 dependents of non-EEA workers in England were granted right to enter the UK. Reflecting average duration of stay, we estimate that there are **about 50,000** non-EEA student dependents (likely range: 40,000 – 60,000) and **about 95,000** non-EEA worker dependents (55,000 – 130,000).

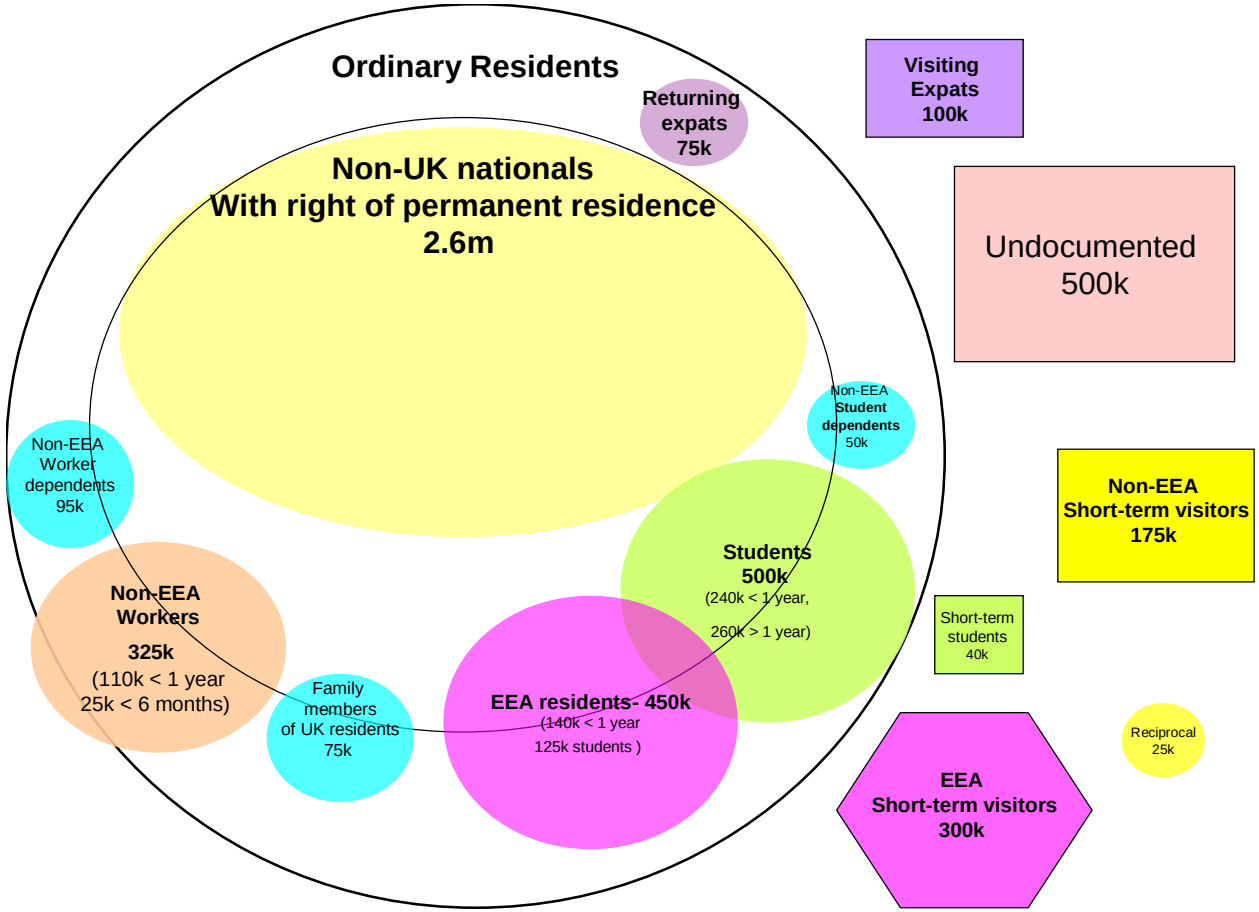
37. **Family members of permanent UK residents:** finally, non-UK national family members of UK permanent residents do not gain permanent residence automatically, but after two years. Home Office data suggests that this affects **about 75,000 persons** at any one time.

**Summary of estimates of the number of overseas visitors in England**

38. Figure 2, below, summarises the figures above – focussing, for presentational reasons, on the main estimates. It is important to bear in mind that the true figures are likely to be in a range of at least +/- 25% around these figures, depending on the estimate. In total, our calculations suggest that there are, at any one moment, in England (range indicated, overseas visitors highlighted in bold; all other groups are considered ordinarily resident):

    - **500,000 short-term visitors (375,000 – 625,000);**
    - **75,000 short-term workers and students (56,000 – 94,000);**
    - **500,000 undocumented migrants;**
    - **100,000 visiting expatriates;**
    - 75,000 expatriates taking up residence;
    - 1.4m non-UK national, non-permanent ordinary residents (1m – 1.9m), of which:
        i. 500,000 students (400,000 – 530,000), one in four from the EEA;
        ii. 325,000 EEA citizens, non-student (250,000 – 650,000);
        iii. 300,000 non-EEA workers (180,000 – 410,000);
        iv. 165,000 non-EEA dependents (95,000 – 190,000);
        v. 75,000 family members of permanent UK residents;
    - 2.6m non-UK national permanent residents (3.2m – 4.2m);
    - 47m UK national permanent residents.

***Figure 2: Illustrative estimates of the number of [mostly] non-UK national ordinary residents and overseas visitors present in England at any moment in time (2010)***




**Large circles** –
- outer circle contains the mostly non-UK national groups who are ordinary residents in England;
- middle circle indicates anyone who has been in England for more than a year
- innermost, highlighted, circle represents all non-UK nationals with a right of permanent residence (mostly more than five years of residence)

**Small circles** – specific groups who are currently non-chargeable either because they are considered ordinarily resident (may also be covered by a specific exemption) or because they are from a country covered by a reciprocal agreement

**Hexagons** – currently non-chargeable overseas visitors. Costs are reimbursable from other EEA Member State (via EHIC)

**Boxes** – currently chargeable overseas visitors, including undocumented migrants

**Question 2: What treatment costs do overseas visitors currently impose on the NHS?**

39. Any person present in England – including short-term visitors – may need healthcare and thus generate demand for NHS services. This demand may result in direct costs to the NHS. It is therefore important to understand that OVs' healthcare needs are likely to be different from those of the permanently resident population because:

    - Those travelling and migrating are healthier and younger than the average population;
    - Short-term visitors on average spend less than a week in England and may prefer postponing treatment until after their return.
    - Some visitors, however, may travel specifically to receive treatment (health tourism);

***Health tourism***

40. It is a common concern that OVs may come to England specifically to receive "free" treatment. In particular, anecdotal evidence by some OVMs suggests that there may be an inflow of women from West Africa (notably Nigeria) to receive maternity services. Similar anecdotal evidence of maternity travel has been reported for UK ex pats.

41. Evidence from our survey suggests that maternity services do, indeed, attract a disproportional share of OVs. Among the nine hospitals that have reported a detailed break down of OV treatments by clinical specialty, maternity accounts for over **25%** of the reported chargeable OV income. This compares to a share of 6% of the comparable expenditure among the permanently resident population. However, the small sample size makes it impossible to judge whether this difference indicates health tourism. What would need to be considered is:

    - maternity may be less important in other Trusts – there is no reason to think that the nine respondent Trusts are representative;
    - (non-ex pat) visitors are about 50% more likely to be between 15 - 44, i.e. in the age brackets most likely to need maternity services;
    - given their average length of stay, short-term visitors would need to come to England highly pregnant to still be here at time of giving birth – this may suggest that, at least sometimes, this happens on purpose;
    - more than half of the currently chargeable population is accounted for by undocumented long-term migrants – who, by definition, are residents rather than tourists and may also be more likely to be in the relevant age brackets for maternity;
    - OVs do not appear to be significantly more or less likely to need other types of treatments (when compared to permanent residents) – this suggests that maternity is, indeed, an outlier.

42. Information from eight Trusts on the country of origin of OVs also roughly fits the picture: UK ex pats and visitors from Nigeria are the second and fourth largest group of OV (chargeable and exempt combined) with **18%** and **4%** (EEA **38%**, India **6%**).

43. While the evidence remains indicative at best, the incentives underlying potential maternity tourism would appear to be rational: ex pats may prefer to be closer to friends and family, while Nigerian women, in particular, would have an incentive to avoid giving birth in Nigeria, where maternity services are among the poorest performing in the world. According to data from the World Health Organisation[14], even in the fourth wealth quintile only about **40%** of women use a health facility for delivery and **60%** report financial difficulties in accessing health services. Even more crucially, at **0.84%**, Nigeria has one of the highest maternal death rates in the world.

44. **This analysis cannot draw conclusions on the scale and likelihood of health tourism and any systematic abuse of the NHS.** None of the above is proof of health tourism for maternity services and there is even less proof for any more widespread abuse of the NHS. In fact, we observe no particular concentration of OV inflow into clinical specialties other than maternity. **On the other hand, this is no disproof of health tourism either** and, indeed, it is possible that there are incentives for some visitors to take advantage of the open nature of the NHS. In one Trust which has provided us with a detailed breakdown of OV treatments, about 10% of total chargeable treatment costs have been generated by patients identified as health tourists (from Romania and the US). However, the reliability of this finding depends on the responsible OVM's definition of "heath tourist" and it cannot be tested whether this finding is representative as there is no centrally available data of this detail for other Trusts.

45. Irrespective of the actual scope of health tourism, it is important to consider that health tourists are likely to face strong and urgent health concerns and, potentially questions of life and death. For any policy addressing the issue, this raises problems. Health tourists may require urgent treatment, which cannot be refused until after payment. As receiving treatment is likely to be the single most important consideration for health tourists, it may be difficult to impose policies or sanctions that effectively deter them from coming to England.

[14] http://apps.who.int/ghodata/?vid=240

### *Estimated costs to the NHS of currently chargeable treatments and patients*

46. As noted above, under current rules, it is mainly short-term visitors and undocumented migrants who are chargeable and for certain services only, i.e. secondary care provided in NHS Hospitals outside of A&E. The chargeable groups are likely to be healthier than the resident population (with the potential exception of some undocumented migrants) and may avoid the NHS entirely, either in reflection of their fragile legal status (undocumented migrants) or because they only stay in England for a couple of days.

47. According to **Trust account data, chargeable OV income**[15] in 2009/10 was **£35m**. However, there are ambiguities in the way Trusts report OV income in their accounts. For instance, some Trusts may report their OV income under the private income heading in their accounts. There is also evidence of some reporting commissioner income for charge exempt overseas visitors under the OV income heading. Overall, however, we take the figure reported in the accounts to be a lower bound estimate.

48. In our survey, OVMs from 23 respondent Trusts reported their Trusts' income charged to OV in 2010/11: £9.5m or 0.109% of their total income. However, Trusts in our sample are more likely to be large Trusts, with many OVMs and in London – factors which regression analysis has found to be correlated to a large share of OV income out of total income. Based on this regression analsis, we estimate that **chargeable OV income** accounts for close to 0.096% or **£55m across England**.[16] However, this is an upper bound estimate as this estimate does not correct for inherent sample bias, i.e. Trusts with little OV income and/or no OVMs will have been much less likely to reply to our survey.

49. In addition, it is important to consider that the above range (£35m - £55m) excludes the costs incurred through commissioners funding Trusts for providing treatment to unidentified OVs. Despite a legal duty to identify chargeable OV patients, Trusts are very unlikely to identify them *all*. The reasons for this will be discussed in later sections, but, broadly, the problem results from misaligned incentives and practical difficulties.

50. By definition, we do not know how many chargeable OVs are not identified. To derive a proper estimate, detailed studies would need to be commissioned (e.g. a mystery shopping exercise). For the time being, we attempt to estimate the number of non-identified OVs from information in our sample about Trusts' compliance with DH guidance on identifying OVs by asking a set of baseline questions.

[15] This is the amount charged to OVs, not the actual income that has been recovered.

[16] Note however that the difference between the sample value and the lower estimate for the rest of England is not significant, in statistical terms – which is mainly due to the small sample size. Still, we think it is prudent to use the lower estimate because the logic behind the estimate coefficients is convincing and because we expect our sample to be biased towards Trusts with high OV shares as OVMs from such Trusts would be more likely to respond.

51. In our survey, OVMs could use four categories – each of which was also represented with a percentage range[17] – to describe compliance with guidance at their Trust. From this, we estimate that between 30% and 63% of patients (mid-point estimate: **46%**) are asked the **first baseline question** – which is whether they have a valid visa or leave to enter/remain in the UK. Of those who reply 'no' to this question between 33% and 73% (mid-point estimate: **55%**) **are referred to an OVM**.[18]

52. Taken at face value, this suggests that a perfectly honest patient without visa or leave to remain (e.g. an undocumented migrant) would only be referred to an OVM in about 25% of cases (range: 10% - 45%). There are, however, important limitations which need to be considered:

    - Respondent OVMs are likely to be more engaged than average (this might mean that Trusts in our sample are more compliant than average – but it could also mean that these OVMs have a particularly harsh perspective on compliance in their Trust (and thus under-report compliance);
    - The more OVs that explicitly try to abuse the system, the less will be identified as frontline staff *do not, in most cases, ask for evidence* of claims of residence made by patients;
    - Although guidance requires Trusts to ask the baseline questions to all patients, it is likely that there will be some discriminatory selection by frontline staff – suggesting that the rate at which patients are identified is higher than what is implied by the rate of baseline questioning (with the notable exception of ex pats who may be less likely to be questioned where staff engage in discriminatory questioning);
    - Crucially, OVMs do not only rely on referral by frontline staff, but also identify OVs through other means (such as checking referrals and records of new admissions etc, or relying on tip-offs from ward staff);
    - Finally, it also seems reasonable to suspect that OVs with particularly large bills are more likely to be identified and/or referred to OVMs (e.g. because their cases are more likely to raise suspicion). This suggests that a higher proportion of costs is identified than of patients.

53. All of this combined suggests that, at the very least, the lower end of the probability range implied by responses to our survey appears unrealistically low. Therefore, as an **indicative range**, it may be reasonable to assume that Trusts identify **between 30% and 45%** of all

[17] The answer options were: Don't know, Never (0% - 10%), Not very often (10% - 50%), Frequently (50%-90%) and always (90% - 100%). These were picked to allow comparison with the older survey from 2007.

[18] Note that the figures would be much the same for questions asked to short-term visitors (who have a visa and/or leave to enter).

chargeable OV income. This suggests that the cost of treating chargeable OVs could be between **£80m and £170m (best estimate: less than £125m)** with between £45m and £115m currently not identified.

54. This is an initial high level estimate based on a number of assumptions. As such, it is important to note that there is **significant uncertainty** around these figures. Compliance with baseline questions has not been found to predict the amount of income identified by Trusts in our survey[19]. While this does not disprove a relation between baseline questioning and identification, it suggests there should be caution in considering the above estimate[20].

55. On the other hand, the above is the best estimate that can be derived without a more in-depth study of what really happens at the frontline level. There is little to suggest that the true value of what should be charged could lie substantially above the upper bound of £170m. For this to be the case, two things would need to happen simultaneously: first, compliance with guidance would need to be close to the lower bound suggested by our survey. For instance, this would imply that as little as one in three patients who identify themselves as not ordinarily resident are actually referred to OVMs. And second, it would suggests that potential discriminatory practice by frontline staff, separate identification work by OVMs and a higher likelihood of identification of OVs with high bills *all* do not substantially raise the rate at which chargeable OV income is identified.

***Costs for treatment of specific groups among the chargeable overseas visitors***

56. We do not have any evidence on how these total costs are split across the various chargeable groups to generate what level of costs. As a first indication, we could estimate the costs for each group based on the above estimated population of each group, in England at any moment in time. This would give a cost split as follows:

    - Undocumented migrants: £75m;
    - Non-EEA short-term visitors (other than from countries with reciprocal agreements): £25m;
    - Visiting ex pats: £15m;
    - Short-term students: £6m;
    - Short-term workers: £4m.

[19] This finding, as such, is not surprising given the considerable amount of uncertainty explained above.

[20] If it was possible to exclude that baseline questioning affects income, it would not be possible to argue that – all other things equal – baseline questions can be used as a predictor of identification. Thus, our estimate for the percentage of chargeable OVs that have been identified would not be meaningful at all. However, given the small sample size, most statistical analysis is inconclusive. With such a small sample, it could easily be that individual identified patients with large bills skew the sample so far that no trend relationship between baseline questioning and income can be identified.

57. However, these are to be taken as **initial assumptions only** as there are good reasons to believe that the relative distribution of costs among the chargeable groups may be very different from the one implied by the population numbers. Most crucially:

    - Ex pats are on average older than the other groups, therefore more likely to need healthcare;
    - Some ex pats may come specifically to receive health care;
    - Undocumented migrants may be both more likely to generate chargeable costs (because they are in England for the whole duration of the year) or less likely (because they strongly avoid chargeable settings).

58. We do not have detailed enough data on what treatments are provided to whom, but data provided to us by one Trust underlines the need to be very cautious about any simple assumptions. In this one Trust, charges to UK nationals amount to less than 1% of total charges and charges to illegal residents amount to less than 7% of total charges (as opposed to the 12% and 60% suggested by our estimates above). Much will depend on how OVs are identified – for instance, anecdotal evidence from some Trusts suggests that they are less likely to attempt to charge UK ex pats (because there may be legal difficulties involved in proving they are not ordinary residents). This is an area where further study and data collection is required.

***Reciprocal healthcare agreements and short-term EEA visitors***

59. In an earlier section, we estimated that there are, at any moment in time, about 300,000 short-term visitors from EEA countries in England and about 25,000 short-term visitors from countries with whom the UK has reciprocal agreements. For simplicity, we assume that the cost generated per person is the same as for other chargeable overseas visitors, resulting in cost estimates of:

    - **£45m** for EEA short-term visitors;
    - **£5m** for visitors from reciprocal countries.

60. These groups are not charged directly for treatment, but the UK is reimbursed by their countries of origin (either per individual case via the EHIC system – which depends on frontline identification and data reporting by Trusts – or in lump sum payments). At first sight, both estimates appear quite low. However, the above estimate is for short-term visitors only, i.e. not for anyone living in England as an ordinary resident.[21]

[21] The estimate for EEA visitors' health needs appears very low at first when compared to DH's estimate of payments of up to £830m to other EEA member states for treatments received by UK residents abroad. However, this mismatch can be explained when considering that most of these UK payments to other EEA member states (about 80%) are for

***Costs of treating non-permanent ordinary residents and/or exempt OV for chargeable secondary care in NHS hospitals***

61. Under current rules, anyone considered an ordinary resident is not chargeable. This includes about 1.4m ordinary residents who do not have the right of permanent residence (or equivalent). A consideration raised in the fundamental review is that it may be preferable only to grant free secondary care to those who are permanent residents. To inform this consideration, this section outlines our estimates for the cost of providing health care to these groups – and conversely, the potential benefit of treating them as overseas visitors instead. Thus, this section only covers the costs of those secondary care treatments that are currently chargeable for overseas visitors.

62. We estimate the healthcare needs for non-permanent ordinary residents based on the average cost per person estimated by the DH Resource Allocations Branch (for the purposes of calculating PCT allocations). However, we take into consideration that different groups of overseas visitors are younger, on average, than the average population[22] and use appropriate average cost estimates. This results in the following estimates:

    - Students: **less than £200m**;
    - EEA ordinary, but not permanent residents (other than students**): less than £140m**;
    - Non-EEA workers: **less than £140m**;
    - Dependents and family members: **less than £90m**;
    - Returning ex pats: **less than £40m**.

63. In total, the costs for secondary care treatment provided in chargeable settings to non-permanent ordinary residents and charge exempt OVs are estimated to amount to no more than £600m. Even so, the above estimates represent an **upper bound**, as long-term migrants will not only be younger than the resident population, but also healthier given their age. Those with expensive long-term conditions and disabilities will be much less likely to travel or indeed move abroad to travel. On the other hand, there will be some individual cases of people moving to England precisely because of their high health care costs.

64. The academic literature on the comparative healthcare costs of long-term

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UK pensioners living abroad. In addition, they might be for treatments which are currently non-chargeable in England and therefore not contained in our estimate, such as primary care, A&E, prescriptions etc. Any remaining difference can be explained by a) more and longer duration outbound travel from England than in-bound travel, b) UK payments to other Member States for treatments received by EEA citizens living in England but receiving treatment abroad (the equivalent of what we label “visiting ex pats” in our overview).

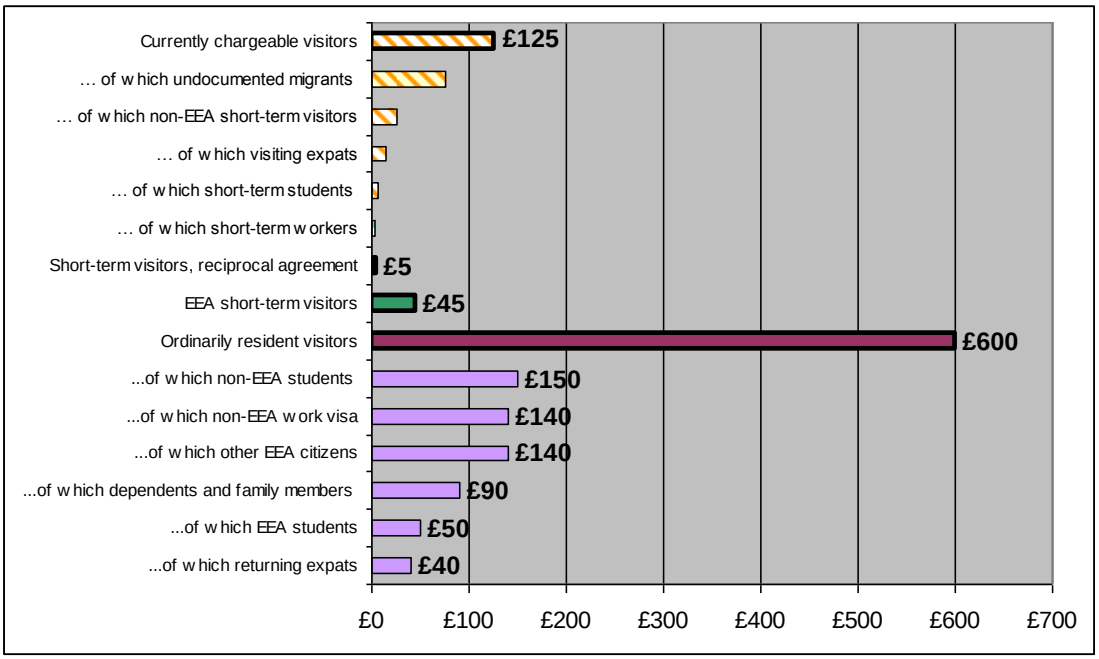
[22] The average age for each group was assumed to be fairly low: age bracket 15-24 for students, 25 – 44 for workers, EEA residents and dependents and 90% of ex pats, 65+ for 10% of ex pats.

migrants is surprisingly scarce. Therefore, to get a reliable and more precise estimate of the treatment costs for ordinarily, but not permanently resident overseas visitors, it would be necessary to collect much more data on the treatments provided to non-chargeable OVs. However, that kind of data is not routinely collected in Trusts. Thus, the above estimates are taken as approximate upper bound estimates.

65. Figure 3 summarises the costs of treatments, in currently chargeable settings, to currently chargeable OVs and non-chargeable ordinary residents. This presentation is chosen to demonstrate the monetised scope of the total 'visitor' and non-permanent resident workload in currently chargeable settings. In principle, this represents the maximum potential income that could be generated under current rules and/or by changing who is eligible for free treatment in secondary care settings. However, there are several crucial **CAVEATS** to keep in mind:

    - The detailed split of potential income for currently chargeable OVs is just a rough indication based on the size of the groups in question and should not be taken as a true estimate of these costs;
    - For OVs who are ordinarily resident the estimates represent what can be thought of as reasonable upper bound;
    - All estimates represent the total potential gross income – i.e. they **do not take into consideration how much of this income can effectively be raised nor do they consider the costs of doing so** (which will be done in later sections).

***Figure 3: Upper bound estimates of monetised healthcare costs in NHS secondary care (without A&E) for ordinary residents and overseas visitors in England (2010)***




All estimates in millions.
Bars with bold bordering indicate summary categories (with the composite categories appearing beneath).
Bars with striped shading indicate currently chargeable treatments.

### *Treatments in currently non-chargeable settings*

66. In addition to the currently chargeable costs in secondary care, overseas visitors are likely to generate other health care costs, such as in primary care (including prescribing), A&E, community settings and where care is provided by independent providers.

67. As there is no charging in these areas at the moment, there is even less data available than in the chargeable sectors. However, we have good estimates for how costs for these treatments compare to costs for the chargeable treatment categories in the resident population. Assuming that this ratio is about the same for chargeable OVs, we estimate that currently chargeable OVs generate costs of up to **£65m** in non-chargeable settings. However, this is just an indicative estimate. Indeed, OVs may demand more non-chargeable treatments than the resident population (e.g. because visitors are more likely to visit A&E, or as undocumented migrants avoid chargeable settings) or less than the resident population (e.g. undocumented migrants may find it difficult in practice to register with a GP, short-term visitors may not consider doing so given their short stay).

68. Using the same method as above, i.e. adjusting for age, but not for other drivers of demand, we estimate that the cost of treatments in currently non-chargeable settings provided to non-permanent ordinary residents

amounts to **no more than £550m**. As above, this is an **upper bound** estimate.

69. We derive an indicative estimate for total demand by non-permanent ordinary residents and OVs based on the average age weighted cost of NHS treatment per person and the share of that which is allocated to different treatment settings. These shares are taken from 2010/11 PCT allocations and we assume that the relative demand for these treatment settings by OVs and non-permanent residents is the same as for the permanently resident population. From this, we derive an indicative estimate of OV demand across different settings:

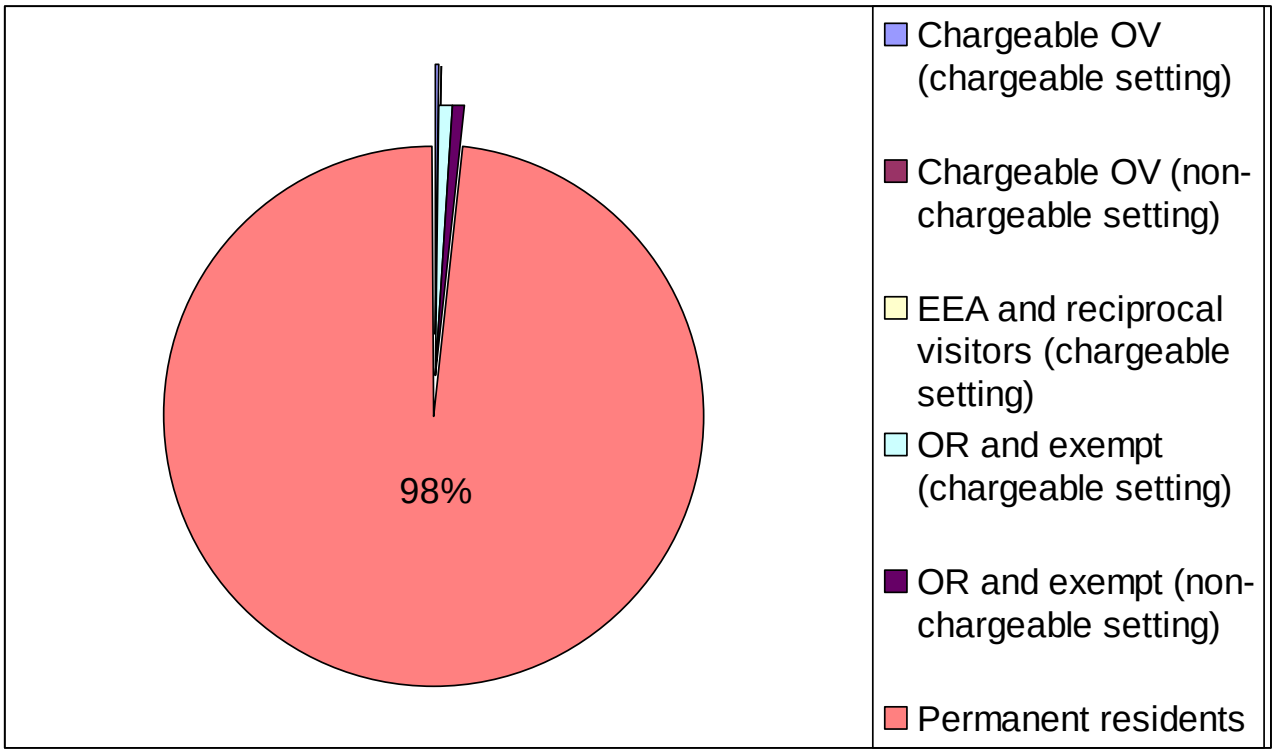
    - A&E: £40m – this is likely to be an underestimate;
    - Prescriptions in primary care: £160m – an upper bound estimate for the total value of prescriptions dispensed which also does not take into account any income that would be generated from prescription charges;
    - Primary care: £165m – upper bound estimate;
    - Community based services: £165m – upper bound estimate;
    - Contractual treatment by independent providers: at least £50m – but likely to continue rising.

70. The same **CAVEATS** as earlier apply. Importantly, trying to raise income in these settings may well be very difficult and costly so that it is not clear, at all, what potential net benefit could be realised from introducing charging.

***Costs relative to the NHS budget***

71. It is important to note that treatment costs for OVs are a small fraction of the overall NHS budget. Figure 4 below demonstrates this by showing the above estimates as a share of the total allocation given to PCTs for all treatments.

***Figure 4: Estimated treatment costs as a share of total NHS allocations for treatments***




72. The figure separates out treatments to currently chargeable OVs, currently exempt OVs or those visitors who are ordinarily resident, and treatments to permanent UK residents (regardless of nationality). It also separates out treatments in settings in which there is charging (about 55% of total OV costs) and settings in which there currently is no charging. Treatments to currently chargeable OVs are highlighted – they represent less than a fifth of the total OV costs.

73. What the figure shows is that all treatments for non-permanent residents account for about 2% of NHS expenditure. The large majority of this is for ordinary residents. It should also be noted that most of the OV cost estimates used are upper bound estimates suggesting that the true share of all treatments to non-permanent residents is **below 2% of NHS treatment expenditure**. Furthermore, *this does not consider how much of this revenue can be realistically raised (e.g. patients may not be able to pay, there may be reciprocal agreements with other countries etc) and at what cost*.

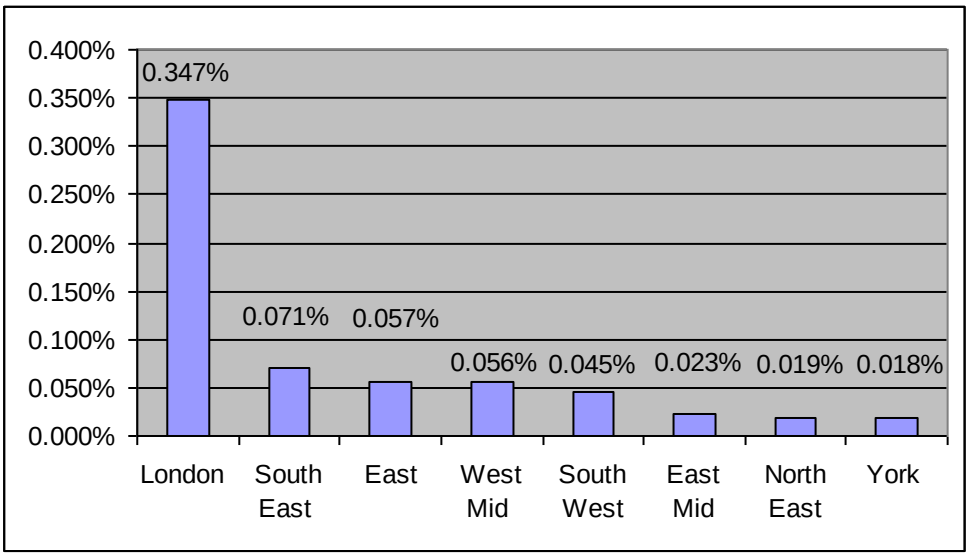
***Distribution of costs***

74. To complete the above overview of costs generated to the NHS, it is important to consider that costs are not equally distributed – neither across regions, nor across hospitals.

75. Unsurprisingly, OV charging appears to be most of an issue in the Greater

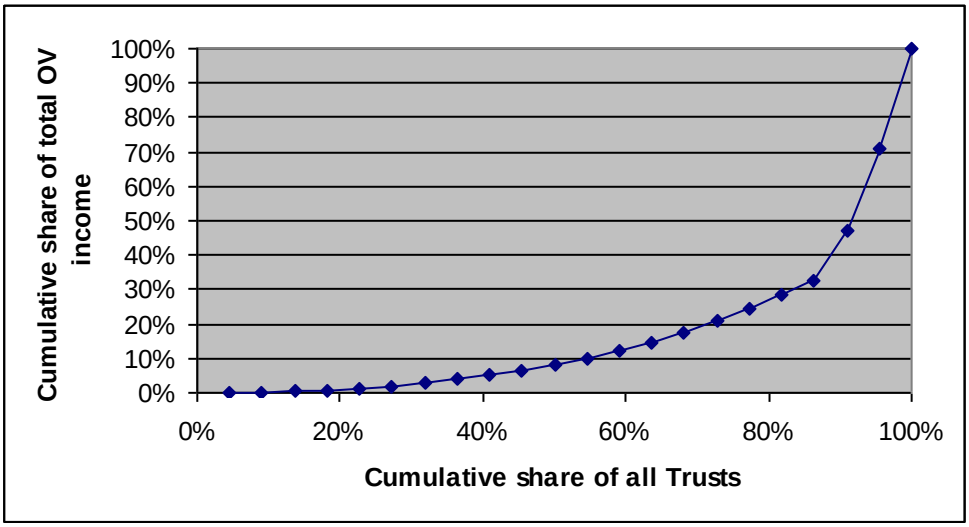
London area – reflecting both London's role as centre of attraction for international visitors and as centre of inbound migration. As a result, in our survey, it is London Trusts which report the highest rate of overseas visitor income as a proportion of total Trust income. Note that the below diagram is a reflection of responses by 23 Trusts only – so that, for instance, there is only one Trust from the East Midlands in the sample. Yet, even with this small sample size, the average value for London is statistically significantly different (at a 95% confidence level) from the average value for the South East.

***Figure 5: Invoiced OV income as a share of total Trust income by region***




76. The strong concentration of OV inflows to London is reflected in the fact that **10%** of the Trusts in our sample combine about **50%** of all charged OV income. Not surprisingly, these are all London Trusts. 20% of Trusts (all London and one from the East) combine over 70% of all charged OV income. Tentative regression analysis suggests that the strong impact of being in London on the charged OV income does not disappear when controlling for the number of OVMs hired. This suggests that the strong concentration of OV income in London Trusts is not an artefact of a potentially more intense OV charging system, but genuinely the result of higher demand in London. Any policy dealing with OV charging must consider that the phenomenon is very different across the country.

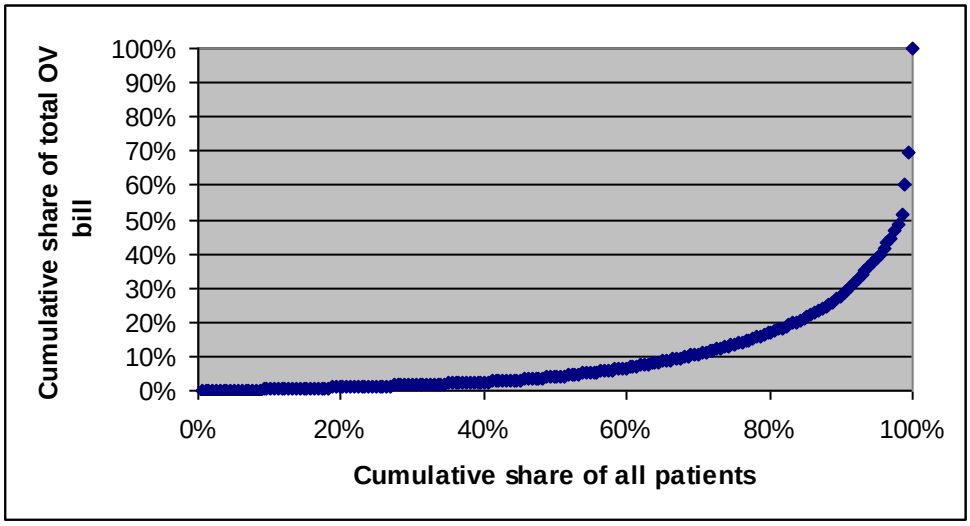
***Figure 6: Concentration of OV income in specific Trusts (Trusts ordered by OV income/ cumulative share of all OV income invoiced)***




77. As noted earlier, potential OV income is also strongly concentrated in a handful of clinical specialties (as is overall NHS activity), but in particular maternity (to a much higher degree than across the NHS).

78. Importantly, detailed analysis of data provided by one Trust suggests that treatment costs for most OVs are fairly low, but that individual patients may accumulate very high costs:

***Figure 7: Distribution of costs across patients (chargeable OV patients in one Trust) ordered by size of bill / cumulative share of total exempt OV costs)***




79. About one fifth of all chargeable OVs account for 75% of all costs charged to OVs in this one Trust. What is more, in that Trust, one single patient accounts for about 30% of total chargeable income.

80. Any measure proposed to raise income from OV needs to reflect this strong concentration of treatment costs in a small number of Trusts and patients and consider whether:

    - Broad-based attempts to identify every single OV are value-for-money considering that it is only a handful of high-cost patients in a small group of Trusts that account for most of the OV bill;
    - It is possible to recover treatment costs from patients whose costs reach hundreds of thousands of pounds (although there is no evidence supporting particular difficulties in recovering large bills);

**Question 3: How much income is currently recovered through the overseas visitors charging system?**

81. Any of the above numbers reflect our best estimates on the costs generated by treatments provided to overseas visitors. We have estimated the value of currently chargeable treatments at less than £125m. However, this revenue only could be realised if a) all chargeable OVs were identified and b) the invoiced costs were paid in full. Both these conditions are unlikely to be met: Trusts do not comply fully with DH guidelines and are unlikely to identify all OV – and even where they do, they do not manage to recover all the invoiced costs.

***Disincentives***

82. It is important to note that the current OV charging system generates a strong **disincentive for Trusts to identify chargeable OVs**, because Trusts give up on a secure payment of £100 by the PCT whenever they identify £100 worth of treatment to OVs. Once an OV is identified, PCTs will not pay the Trust, and the Trust then has to recover the invoiced costs itself. However, as will be explained in the next section, on average they only recover about £40 leaving them with **a net loss of £60 for each £100 invoiced** (before even having considered the costs of running an OV charging system). This problem is even more acute for Foundation Trusts, because they currently have to account each £100 invoiced to OV against their private income cap. Thus, they do not only forgo £100 worth of payment by the PCT, but a further £100 of potential private income leaving them with a net loss of £160 for each £100 invoiced.

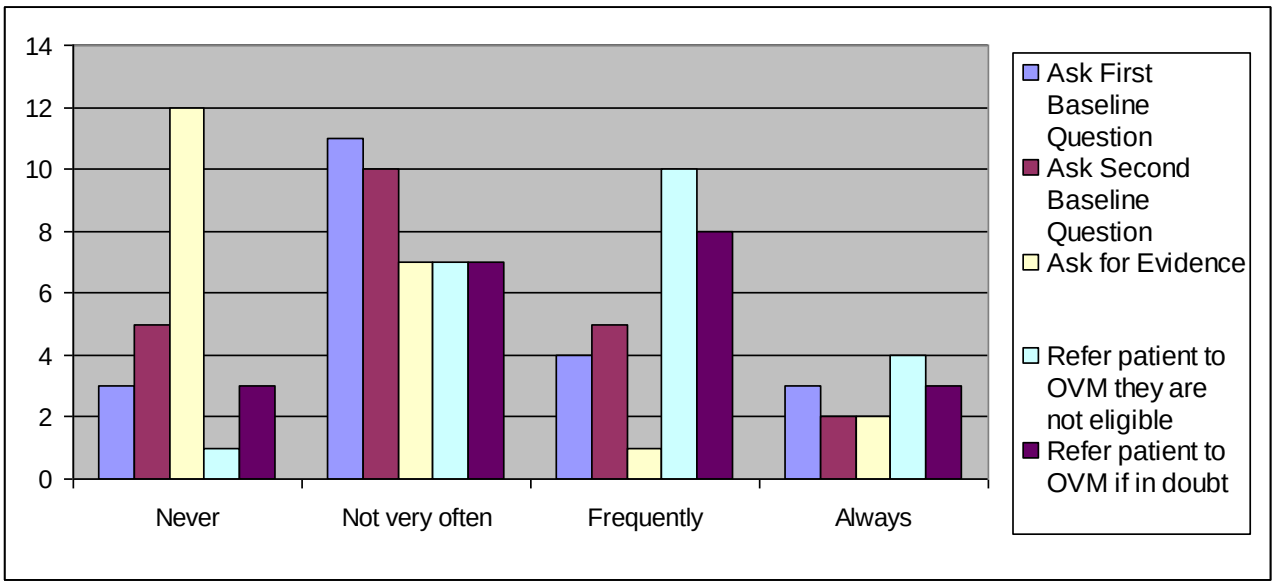
83. To the degree that they comply with their statutory duty, Trusts actually harm their own financial interests. This is important to bear in mind as any measure proposed to raise income from OVs will be difficult to implement unless Trusts are provided with suitable incentives – which, in turn, will be difficult as long as they are burdened with the debt resulting from charging OVs while not recovering the income.

***Non-compliance with DH guidance and non-identification of OVs***

84. From responses to our survey, we know that Trusts do not comply fully with DH guidance to ask each patient baseline questions to gauge their entitlement to receive free treatment. Indeed, most OVMs in our survey report that frontline staff "never" or "not very often" ask the baseline questions proposed by the guidance (over **65%** of Trusts respectively). Even more starkly, **50%** of Trusts report that staff "never" ask for evidence where a patient claims to have lived in the UK for the last 12 months.

85. Overall, the results indicate levels of compliance which are no better than those found in the 2007 survey of all Trusts. This is particularly worrying as there ought to be some self-selection of particularly compliant Trusts being more likely to respond to our survey – so that, possibly, compliance with the guidance may have even decreased.

***Figure 8: Number of Trusts complying with DH guidance on baseline questions and referral to OVM out of sample of 22 Trusts[23]***




86. As noted earlier, there is no direct evidence supporting or disproving that increased compliance with DH guidance actually leads to better identification of chargeable OVs. Our best estimate is that that Trusts identify **between 30% and 45%** of all chargeable OV income. Out of a potential income estimated at between £80m and £170m (best estimate: £125m), they identify between £35 and £55. Thus, we expect that chargeable treatment worth between £45m and £115m is currently not identified.

87. What is more, in our sample, only about **40%** of the income charged to overseas visitors in 2010/11 had been recovered by February 2012. We

[23] 23 out of 52 Trusts responded to our survey. Of these 22 responded to the relevant questions about compliance with DH guidance.

take this to be a reasonable estimate of the recovery rate on income charged to overseas visitors.[24] This suggests that the **income currently generated by the OV charging system lies between £15m and £25m**.

88. The low rate of recovery observed in our sample may not be very surprising, as OVs may be difficult to track down once treated (e.g. they could leave the country) or may not be able to pay (in particular where the costs of treatment are high[25]; or where they are undocumented migrants). Thus, it is doubtful how much could be done to increase recovery. This, in turn, limits the opportunities to increase revenue by identifying more chargeable OVs (or indeed, by removing eligibility for free treatment for those currently exempt). Thus, **if all currently chargeable OVs were identified by Trusts, this would likely increase recovered revenue by £20m - £50m**.

89. However, it is unlikely that any such increase in revenues can be generated as long as Trusts are financially disincentivised to actually identify chargeable OVs (as described above). In addition, for any proposed measure it will be important to consider the costs of actually identifying more revenue.

**Question 4: What is the current cost of running the OV charging system?**

90. The major cost generating components of the OV charging system are:

- overseas visitor managers employed by Trusts;
- frontline staff time spent on screening patients to identify OVs;
- additional admin costs linked to charging (sending invoices, follow-up letters, debt recovery agencies etc) – these have not been quantified for this analysis as they will strongly depend on practices in individual Trusts and also on the identity of OVs.

91. The average Trust in our survey employs about 1.8 full-time equivalent OVMs. Regression analysis suggests Trusts in the rest of England may be likely to employ less OVM staff (about 1.4). From this, we estimate that there are no more than 350 full-time equivalent members of OVM staff in the NHS[26].

92. OVM staff are employed at different grades, thus their salaries vary. From anecdotal evidence, we know that their salary lies within a range of

[24] There is no indication that much more income might be generated after a longer waiting period.
[25] Note however that there is no evidence to prove any link between the likelihood to recover an invoice and its size.
[26] It is important to note that the difference between the estimate for the rest of England and the average sample value does not appear to be statistically significant due to the small sample size. However, we use the lower value suggested by our regression as it appears convincing that our sample (larger Trusts, more likely to be in London) would have a higher number of OVMs per Trust.

£25,000 to £50,000 (although teams of several OVM are likely to employ more junior staff). In addition, there will be on-costs and overhead costs linked with employing a full-time member of staff. Therefore, we take £50,000 to be an appropriate estimate for the average cost of employing one full-time equivalent OVM. Thus, for the NHS as a whole **the costs of employing OVMs may be up to £17m**.

93. It should, however, be noted that there are some spill-off benefits from OVM activity, e.g. on the identification of EHIC holders – which means that not all of the above cost is attributable to the identification of chargeable OVs alone.

94. On top of this, there are costs to the degree that staff screen patients for eligibility – something that, in principle, ought to happen for every patient. Even though the questioning may be fairly straightforward, every once in a while it is likely to require some discussion with the patient. Thus, an average value of 30 seconds of frontline staff per patient subject to screening appears a conservative estimate. Even so, with more than 17m (non-emergency) admissions and day cases throughout the NHS, the time involved in screening every single patient would add up to 140,000 hours a year, which is equivalent to some 77 full-time members of staff across the whole NHS.

95. In monetary terms, it would thus seem that the **cost of screening for OV** adds up to at least £2m a year if all patients were asked the baseline questions.[27] At **current rates of compliance** this figure is likely to be closer to **£1m**. It is, however, important to note that this reflects the monetised value of staff time, not a directly measurable financial cost. Conversely, no direct financial savings would result from saving this, but staff time would be freed up for other activities.

96. Overall the costs of operating the OV charging system may add up to more than **£18m**. Given our estimate of £15m - £25m per year being recovered by the current OV charging system, **it is not clear whether, under current rules, the OV charging system is generating a net benefit to the NHS or a net loss**.

97. Indeed, in some **45%** of Trusts in our sample, **income generated per OVM** is – sometimes substantially – **below £50,000** suggesting that, in those Trusts, more money is spent on the core costs of identifying overseas visitors than is gained through recovery. In about **15%** of Trusts in our sample, **recovered revenue per OVM is even below £25,000**, suggesting that even if they were to identify patients leading to the recovery of an equal amount of EHIC income with no additional recovery costs at all, the country would lose money.

[27] Assuming a total cost of employing one member of frontline staff (including on-costs and overhead costs) of around £25,000.

## Conclusion

98. The overseas visitors charging system is difficult to operate and suffers from difficult incentive structures. Thus any proposal to increase identification of OVs or to extend charging to currently exempt groups will need to address the disincentive currently imposed on Trusts and carefully consider how any proposal will impact on the costs of operating an OV charging system, in order to avoid creating more costs than benefits.

## Conclusions

99. Bearing in mind the degree of uncertainty around the analysis presented in this report, **the NHS appears to be recovering gross income of £15 - £25m for treatment provided to chargeable visitors and non-residents.** This represents less than 20% of estimated chargeable costs. This low recovery is accounted for by only 30% - 45% of chargeable income being identified, and 60% of the charges levied not being recovered. Administering the current system (in NHS hospitals) may be costing over £15m, suggesting that **the overseas visitor charging system may at best be generating a small net gain and possibly none at all.**

100. The process of screening all patients at the point of admission to determine their eligibility status has significant inherent weaknesses. It requires staff with specialist knowledge covering multi-site 24/7 access and the identification processes themselves are burdensome and unreliable. Basic screening questions can easily be evaded by the patient.

101. A significant proportion of the income is recovered from a small number of Trusts. While in part this reflects the skewed geographical spread of migrants and visitors (in particular London and some other major conurbations), it also suggests variable application of the charging regime between Trusts.

102. The most significant weakness is the fundamental financial disincentive to identify and charge visitors. By doing so Trusts forego a guaranteed full commissioner payment for the treatment provided, and replace it with a direct patient payment liability that they can never fully recover. The system actively penalises those Trusts that fulfil their duties, with no consequences for those that do so half-heartedly or not at all.

103. Separate obligations to provide expensive urgent treatment in advance of payment to those who are unlikely to have the means to pay, or pay in full, as well as difficulties in tracking patients after they leave the hospital, mean debt recovery rates will inevitably be low even where local practices are efficient.

104. The amount of income recovered within the current eligibility rules and frontline screening and recovery process is also compromised by the fact that both the largest and third largest chargeable groups of patients are ex pats and undocumented migrants. Ex pats are particularly difficult to screen and identify, and many undocumented migrants have least resources to pay charges incurred.

105. Where Trusts do not correctly identify and apply charges they receive funding from the finite funds of commissioners. Where they do identify and charge patients but they do not pay, the costs are funded from the Trust's general reserves or efficiency gains. Both create an opportunity cost and the foregoing of care for patients who are entitled to free treatment. Some

such treatment stems from the NHS's humanitarian obligations, but it is individual Trusts that are bearing the brunt – there is no separate funding available.

106. Improved practices could increase both identification and recovery from the current very low levels, but the circumstances of the main chargeable groups and inherent process weaknesses limit the potential improvement. Based on our estimates, if all chargeable overseas visitors were identified, we would expect chargeable income to increase by £45m - £115m. However, given the low recovery rate, it is unlikely that this would generate more than £20m - £50m of recovered income. Even this would be dependant on removing the financial disincentives.

107. By contrast, the numbers of visitors and temporary residents who are not chargeable under the current rules are high. More significant revenue could be realised by charging some or all of those currently exempt.

108. The estimated secondary care costs (those for which powers to charge already exist) of currently non-chargeable groups is up to **£600m**, although one third of this relates to EEA nationals. Of the remainder, non-EEA students, workers and various categories of dependants of exempted persons comprise the largest groups. However, workers may be recognised as already contributing to NHS and other public service costs.

109. Moreover, because of the overlap of many exemptions with ordinary residence, just removing some specific exemptions that are the most commonly used would have negligible effect without replacing OR with a more definitive and less generous core residency basis for NHS entitlement.

110. Extending charging to other categories of visitor and/or NHS services carries similar risks to identification or recovery although the characteristics of some may make them slightly less problematic. However, Trusts will still only identify and recover a proportion of the potential extra income.

111. The power to charge those not ordinarily resident has only been enacted for secondary care in NHS hospitals (and not other new providers). No charges can be made for services including primary medical services, community care (given outside of hospital or provided by non-hospital staff) or prescriptions. Together these exempted services comprise around 40% of NHS treatment expenditure. Their estimated cost for all temporary residents and short-term visitors is up to a further **£550m**. Practical operational issues and related administrative costs may limit the scope to extend charges to some of these.

112. We estimate the total healthcare costs of non-permanent residents and visitors to be **up to £1.4bn.** However, we estimate that some £360m of this could relate to EEA nationals.

**113. Although there may be good policy reasons, and potentially significant income opportunities in extending the scope of charging, the NHS is not currently set up structurally, operationally or culturally to identifying a small subset of patients and charging them for their NHS treatment. Only a fundamentally different system and supporting processes would enable significant new revenue to be realised.**