Understanding changes to NHS charging regulations for patients from overseas

The NHS, often described as the UK's 'crown jewel', has received much recent negative press. That it is in desperate need of more money to provide high quality care is not a point of contention; however, whether underfunding or overspending is the source of its shortfall is hotly disputed. One area persistently purported as a root cause of its financial stress is the cost of overseas visitors to the NHS. Media headlines, such as 'Health tourism is much worse than anyone admits and it costs us BILLIONS' (Meirion Thomas, 2017), serve to fuel the idea that 'health tourism' is a major driver of the NHS financial crisis.

Since the NHS was established in 1948, overseas visitors using the NHS have always theoretically been billed for secondary care. However, it was not until the introduction of the Immigration Act 2014 when the emphasis started to be placed on the recuperation of costs. The then home secretary Theresa May introduced the idea of a 'hostile environment' as one of the government's key tactics to reduce immigration through negative incentives. This included the creation of the overseas visitors manager, a non-clinical staff member whose role within the hospital is to identify chargeable patients.

With several media outlets fuelling public dissatisfaction with immigration, and with this hostile environment in mind, updates to the 2015 Department of Health Implementing charges for overseas visitors were brought in on 23 October 2017. These changed the regulations on charging migrants and non-UK nationals for NHS England care. For the first time 'non-ordinary residents' would receive an estimated treatment bill of 150% of the normal NHS tariff, that must be paid in full before receipt of care, except if that care was 'urgent or immediately necessary' (Department of Health, 2017). An example of this cost is £6500 for maternity care for an uncomplicated pregnancy and delivery (Doctors of the World, 2016). What exactly constitutes urgent or immediately necessary is not black and white, and the definitions in the legislation are shown in *Table 1*. Despite assurances that changes would not burden clinicians with additional work, the decision about the urgency of care ultimately falls on the shoulders of the attending clinician.

As well as identifying what care is chargeable upfront (i.e. needs to be paid for in full before it is received), there are also a number of exemptions for certain services and patient groups. Who is chargeable, when and for what can be difficult to navigate for health professionals, let alone for patients who may be unfamiliar with the structure of the NHS and may not speak English. This article informs hospital clinicians of the potential impact of these new regulations on their practice and on outcomes for their patients. Clinicians have a responsibility to patients to know and understand the legislation, to provide them with the care they need and to act as their advocate where necessary.

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Table 1. What is urgent and immediately necessary care?

Urgent	Treatment that cannot wait until they leave the UK. This should take into account pain, disability and the risk of the delay exacerbating their condition
Immediately necessary	Life-saving treatment that will prevent a condition becoming life threatening or will prevent permanent serious damage

Exemptions to charging

Services that are free for everyone include primary care, accident and emergency, walk-in centres, minor injuries units, contraception services (excluding termination of pregnancy), specific communicable diseases (e.g. tuberculosis), palliative care, school nurses, district nurses and NHS 111 services. Other specific treatments that are always free include treatments for consequences of sexual or domestic violence, female genital mutilation and torture. However, most victims of domestic violence, female genital mutilation and torture do not necessarily reveal this information until trust and rapport has been established with a clinician, by which point they may have already been denied care for non-urgent treatment because of their inability to pay. As of 2015, services that are not free extend beyond secondary care and include all community-based treatments that are NHS funded, including services provided through third sector organizations (i.e. those provided by charities such as Marie Stokes).

Outwith these services anyone who is not an ordinary resident in the UK is chargeable upfront for all treatment that is not urgent or immediately necessary. An 'ordinary resident, means, broadly, living in the UK on a lawful, voluntary and properly settled basis for the time being' (Department of Health, 2017). This, for example, excludes British expatriates who have moved abroad.

Other groups of patients that are exempt from all charges are anyone from within the EEA, those from without the EEA who have paid the health surcharge, those with a valid student visa, refugees (those for whom asylum has been granted; *Table 2*), asylum seekers (those with pending applications), survivors of trafficking going through the national referral mechanism, people detained under the Mental Health Act 1983, those detained in immigration facilities, and unaccompanied minors under the care of the state.

The health surcharge was introduced in 2017 and is a fixed sum payable before a visa

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Table 2. Definitions

Refugee	A person whose asylum application has been successful, according to Article 1 of The 1951 Convention Relating to the Status of Refugees
Asylum seeker	A person who has left their country of origin and formally applied for asylum in another country on the basis of the Refugee Convention or Article 3 of the European Convention on Human Rights but whose application has not yet been concluded
Undocumented migrant	Someone whose entry into or presence in a country contravenes immigration laws. This may include people who have overstayed their visas, entered the country without declaring themselves, or been trafficked

may be granted (this only applies to visas for over 6 months' stay, i.e. it will not apply to tourist visas and tourists are always chargeable, unless they fit into one of the exceptions above). For children who are not under the care of the state, their eligibility for care depends upon their guardian's status, meaning children can be denied non-urgent care based on their parent's immigration status. A reciprocal agreement with EEA countries sees the country of origin being billed for the specific treatment their citizens receive, as opposed to the NHS absorbing these costs. Similar arrangements are in place for select non-EEA countries, with different ceilings of care covered dependent on the patient's country of origin (NHS England, 2016).

Outwith these groups, as of 2017, upfront charging of 150% can be applied before treatment is received. Specific services that are exempt from upfront charging (that is they can still be charged retrospectively) are, as outlined above, those urgent or immediately necessary. Maternity care is always classified as urgent and immediately necessary. It is stated in NHS guidance that no women should be denied maternity care as a result of charging issues (Department of Health, 2017).

This is not an exhaustive list of exemptions, but is extensive in and of itself, highlighting the potential for mistakes to be made by patients, overseas visitors managers and clinicians alike when determining a patient's eligibility for care.

What is the true cost to the NHS?

Despite the popular rhetoric about 'illegal' migrants and the lack of funding within the NHS, the actual cost of undocumented and irregular migrants is hard to measure, with estimates inconsistent across sources and often encompassing costs spent on all patients from outside the UK. The government has targets of recovering £500 million in 2017–18, but the amount per annum actually recovered is unpublished, with the anticipated financial saving from upfront charging estimated to be just 0·00016% of the NHS's annual budget (The King's Fund, 2015). This is all based on rudimentary analysis, and does not begin to analyse the cost of delayed access to treatment or public health costs.

This lack of a comprehensive cost analysis extends to the 2017 changes in regulation, in order to ascertain whether they will save more money than they will cost. Their implementation will incur costs with regard to training of health-care professionals, development of internal protocols and the employment of staff involved in recuperation of costs. Additionally, the potential increase in cost to the NHS of denying patients preventative or early stage health care must be considered in a financial analysis.

The idea of health tourism, that is patients travelling to the UK with the express intention of seeking medical care for free, in itself needs to be challenged. The King's Fund (2015) estimates that health tourism costs the UK between £60 million and £80 million per year, or less than 0.1% of the NHS total budget. While not denying that rare individual cases may happen, a Doctors of the World (2016) report has shown that those attending their clinic with problems or fears around accessing NHS services have been in the country an average of 6 years before seeking health care, meaning they can not be called health tourists.

Concerns around upfront charging in the NHS

This change to health-care charges was brought following just 418 responses obtained by the Department of Health from their public consultation, with multiple health bodies and professionals expressing concerns around the true impact of these changes. Owing to the complex nature of the regulations there are multiple examples of patients being charged for care they are exempt from and reports detailing worries around charging deterring patients from seeking medical care, even in cases where they were exempt (Rafighi et al, 2016; Doctors of the World, 2017).

There are also concerns around potential for racial profiling and compounding of health inequalities among black and ethnic minority groups (Hiam and McKee, 2017), as well as the impracticalities of asking every patient to prove his/her eligibility. This has been evidenced in the recent Windrush scandal, which has seen British citizens being incorrectly denied NHS care. Health inequalities are already estimated to cost the UK £5 billion in health-care provision alone, a figure which far outstrips the most ambitious upper limit of the cost of migrants to the NHS (Marmot, 2010).

The impact of these regulations is further exacerbated by increasing communication between NHS Digital and the Home Office. The recently suspended memorandum of understanding between NHS Digital and the Home Office allowed access to non-clinical patient details, such as home address, to facilitate tracing of individuals for immigration enforcement purposes. In 2016 there was a threefold increase in information requests by the Home Office compared to 2014 data, leading to 5854 patients being traced, with only 3% of information requests turned down (NHS Digital, 2018). Additionally, all health-care charges of over £500 outstanding for more than 2 months will still be forwarded to the Home Office, which can then be used as grounds for refusal of an immigration or asylum request.

Such hardline legislation can be a deterrent for migrant and asylum-seeking patients accessing services, potentially compromising the health of these vulnerable groups. For example, Doctors of The World (2017) have observed women declining antenatal appointments because of the fear of their information being shared with the Home Office. There is also a public health risk of creating additional health-care barriers for patients with notifiable infectious diseases. Clinicians should ensure they are familiar with the list of communicable diseases exempt from charging (The National Health Service (Charges to Overseas Visitors) Regulations, 2015), to prevent increased transmission rates and later stage management (*Table 3*).

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KEY POINTS

- Primary and emergency care is always free for everybody.
- Everybody has a right to urgent and immediately necessary care without being charged upfront – this is a human rights obligation of the NHS.
- Whether care is urgent or immediately necessary is a clinical decision – be involved in the overseas visitors manager's management of your patient's case.
- The list of exemptions is extensive – familiarize yourself with the list of infectious diseases for which investigation and treatment are free of charge.

Table 3. Diseases for which no charge is to be made for NHS treatment

Acute encephalitis	Acute poliomyelitis
Anthrax	Botulism
Brucellosis	Cholera
Diphtheria	Enteric fever (typhoid and paratyphoid fever)
Food poisoning	Haemolytic uraemic syndrome
Human immunodeficiency virus (HIV)	Infectious bloody diarrhoea
Invasive group A streptococcal disease and scarlet fever	Invasive meningococcal disease (meningococcal meningitis, meningococcal septicaemia and other forms of invasive disease)
Legionnaires' disease	Leprosy
Leptospirosis	Malaria
Measles	Mumps
Pandemic influenza	Plague
Rabies	Rubella
Severe acute respiratory syndrome	Smallpox
Tetanus	Tuberculosis
Typhus	Viral haemorrhagic fever
Viral hepatitis	Whooping cough
Yellow fever	

Treatment for health problems associated with rape and torture can be difficult to ascertain for a clinician, as this may not be immediately obvious as the cause of ill health. These subjects are difficult to discuss for both the clinician and the patient, especially if only reviewing a patient for a brief amount of time. It is paramount that clinicians make themselves familiar with how to recognize such patients, and become comfortable with asking relevant questions. Each trust should have an accessible safeguarding lead who any case can be escalated to. It is also paramount that if a patient does disclose that he/she is a victim of torture or sexual violence, this is documented clearly in the notes as this may help prevent the patient from being unlawfully charged at a later date. The Royal College of Nursing (2016) has launched a pocket guide to help health-care workers identify victims of trafficking and modern slavery, with online training also available in the NHS elearning for health platform.

Conclusions

These new changes to charging regulations carry implications for the doctor–patient relationship. Health-care professionals now have the responsibility to establish eligibility and urgency of care before care is given. This can compromise the doctor–patient relationship and affect vulnerable patients' ability to access care (Marmot, 2010; Rafighi et al, 2016; Doctors of the World, 2017; Hiam and McKee, 2017). Being aware of this, and counselling patients appropriately, will help maintain trust between health professionals and patients, and help patients make an informed decision about accessing health care. Health care is a holistic science, and we need to appreciate the social risks patients take when choosing to access care. **BJHM**

Conflict of interest: Dr L Murphy, Dr J Dobbin and Dr S Boutros have volunteered with Doctors of The World and the MedAct Refugee Solidarity Group.

TOP TIPS

- If you believe a patient may be a victim of torture or sexual violence then it is important to raise this with the patient, or seek help elsewhere if you feel unable to.
- Download the Royal College of Nursing pamphlet for recognizing victims of modern slavery and trafficking, or complete your trust's e-learning on the subject.
- If a patient discloses sexual or domestic violence, torture or trafficking to you, document this thoroughly or raise it early with the overseas visitors manager if he/she is involved – it may be key in assessing the patient's eligibility for treatment later.
- Know where to signpost patients for financial and legal support, and help registering with primary health-care services.

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