Department of Health

Making a fair contribution

Government response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England

February 2017

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Making a fair contribution

Government response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England

Prepared by the Visitor and Migrant NHS Cost Recovery Programme

February 2017

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Foreword

Our NHS is the envy of the world and we have no problem with overseas visitors using it - as long as they make a fair contribution, just as the British taxpayer does. My ambition is that by 2020 no-one will get NHS care for free if they should be paying, just as we tackle the perception of a minority of overseas visitors that the NHS is a form of cheap health insurance.

The NHS has made real progress in identifying and charging liable overseas visitors and migrants (or their home country) for their healthcare in the last three years, more than trebling income identified from £89m to £289m. But there is further to go.

That is why I am setting out plans to charge overseas visitors for NHS care they can currently access for free. We will ensure that for the first time it becomes a legal obligation to pay up-front and in full for any non-urgent treatment on the NHS. We also plan to put an end to overseas visitors from outside the EEA benefitting from free prescriptions, dental care and optical vouchers without paying the health surcharge or otherwise being exempt from charge.

Of course there will be exceptions, so the most vulnerable groups of overseas visitors to whom we have international welfare obligations or some who are supported by the State will continue to access free NHS care. We will also protect public health by ensuring that services like the diagnosis and treatment of infectious diseases remain free to all.

However, at the moment, it is largely only NHS treatment delivered in hospitals (and outside emergency departments) for which overseas visitors are subject to charge and we need greater parity across the NHS and to make the rules as simple as possible for patients and NHS staff.

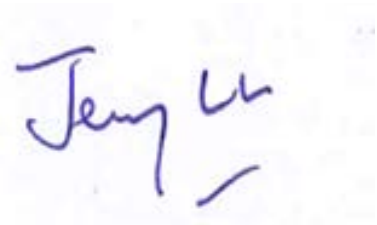
Staff working in the NHS have told us that extending charging across the NHS may be more difficult in some areas than others. For this reason we will implement these changes in stages so that we have time and knowledge to work through the practical implications for charging overseas visitors and migrants for some services. In the case of A&E and ambulance services, we are still considering the points raised by respondents and exploring the feasibility of implementing the proposals. We will therefore respond on those points later in the year.

The NHS must get better at identifying patients who should be charged for their healthcare at an earlier stage of their treatment. This is why we are setting out our aim to not only extend charging into other areas of healthcare but to ensure that information on a person's eligibility for free healthcare is captured at their first point of contact with the NHS, regularly verified and available to other NHS organisations where necessary. This means that we should all expect to be asked questions that confirm our eligibility for free healthcare from time to time.

We recognise that the Charging Rules are still considered by Trusts to be complex and difficult to implement and we are therefore committed to providing the support and guidance that the NHS needs to effectively identify and charge overseas visitors and migrants without discrimination. NHS Improvement will work intensively over the coming months with Trusts who have the most potential to recover costs depending on their geography and size. This work will focus on helping Trusts to improve their cost recovery processes and pilot new innovations that could make it easier and quicker to take payment when someone is not entitled to free NHS care.

As we prepare to exit the European Union we will also have to consider the best deal for British people living and travelling in EU countries and any reciprocal healthcare arrangements we might put in place for EU nationals visiting the UK. This work is out of scope of this consultation. Until we leave the EU, the current rules apply and we expect the NHS to maximise the identification of these patients and collect the necessary information to enable cost recovery.

Charging those who should pay for their treatment is one way we can ensure the NHS is sustainable for us all in years to come. The NHS should never withhold potentially life-saving treatment from overseas visitors or migrants because of their inability to pay. But it is right that people who are not resident here make a fair contribution to the cost of their NHS care and the plans set out in this document will ensure this happens.



The Rt. Hon. Jeremy Hunt MP, Secretary of State for Health

February 2017

Executive summary

Overarching Principles

The Government has set out in this consultation and elsewhere its view that our health system is overly generous to those with only a temporary relationship with the UK. Funded in the majority by general taxation, the NHS is free at the point of delivery to all people ordinarily resident in the UK. Whilst overseas visitors can access its services, in order for the NHS to be financially sustainable it is vital they make a fair contribution towards the cost of those services. It is therefore our intention to make sure that only people living here and contributing financially to this country will get access to free NHS care.

The overarching principles we have followed when considering a system for charging overseas visitors for NHS care are:

- Making a fair contribution to the NHS – the NHS is under increasing pressure and it is right that in the future everyone who benefits from its services makes a fair contribution to ensure it is sustainable and only those who are living here and contributing financially are entitled to receive free NHS care.
- A workable and efficient system – any new rules and systems must enable the NHS to recover charges and to use its public funds appropriately. In doing so, it must not compromise the efficient, cost-effective and safe delivery of quality healthcare or place undue burdens on staff. The role of NHS staff should not extend to immigration control, and clinicians should not be diverted from treating patients.
- That the Secretary of State has a duty to have due regard to the need to reduce inequalities relating to the health service. In developing these proposals we shall ensure the needs and interests of vulnerable or disadvantaged patients are protected.
- A system that ensures access for those in need and protects public health – no person should be denied timely treatment necessary to prevent risks to their life or permanent health, or put the public's health at risk.

Main achievements to date

In 2014, following an initial public consultation entitled *Sustaining Services, Ensuring Fairness*[1] which proposed changes we thought necessary to ensure appropriate financial contribution from overseas visitors and migrants, we set out a four-stage implementation plan[2] to be delivered by a national Overseas Visitor and Migrant NHS Cost Recovery Programme.

[1] www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs

[2] www.gov.uk/government/publications/recovering-costs-of-nhs-healthcare-from-visitors-and-migrants

The first stages of the plan started with improving the contribution overseas visitors and migrants make towards funding the NHS. We did this by:

- Supporting the Home Office in introducing the Immigration Health Surcharge (IHS) for visitors and migrants subject to immigration control (most non-European Economic Area (EEA) nationals) at the point that they apply for a visa to extend their stay or enter the UK for 6 months or longer
- introducing a financial incentive for trusts to improve the rate at which they recover costs from visitors from EEA countries with European Health Insurance Cards (EHIC)
- introducing a risk-sharing arrangement for trusts to seek charges at a higher rate (150% cost of care) from visitors from outside the EEA while having the assurance that commissioners will pay 75% of these costs should the visitor fail to pay
- simplifying the system, by streamlining the number of exemption from charge categories for overseas visitors, and by providing information on the summary care records of those who were covered by IHS arrangements, reducing the necessity for NHS staff to check in detail the eligibility of as many patients

We have estimated that since the Visitor and Migrant Cost Recovery Programme was launched in July 2014 the income identified from overseas visitors and migrants in England (and, in the case of the IHS and EEA income, in Scotland, Wales and Northern Ireland as well) has risen from £89 million in 2012/13 to £289 million in 2015/16. A significant portion of this increase resulted from the introduction of the Health Surcharge which recovered £164 million in the first year of its introduction (2015/16).

We have made a positive start towards our ambition of recovering up to £500 million a year from overseas visitors and migrants for the NHS, but we now need to focus on the final stage of our original implementation plan.

The NHS is getting better at identifying patients who are not entitled to free NHS hospital treatment, but too often this is happening after treatment has started when it becomes more difficult to recover the costs from patients. We need to go further and implement changes to the Charging Rules that require NHS organisations to identify whether someone is chargeable before non-urgent treatment is given and to encourage a culture change so that a patient's eligibility for free NHS care is checked more regularly than is currently the case.

The final stage of the implementation plan set out our intention to extend charging to areas of healthcare currently free to all overseas visitors so that a consistent approach to charging is applied across the NHS, and only those people living here and contributing financially receive free NHS care.

What we proposed

The 2015 consultation entitled *Making a Fair Contribution*[3] examined the principle of extending charging, and proposed applying a consistent approach to charging which would mean that we can recover the direct costs of treatment provided by GP practices, in A&E facilities and

[3] www.gov.uk/government/consultations/overseas-visitors-and-migrants-extending-charges-for-nhs-services

healthcare delivered within the community. Also, taking a consistent approach across the NHS will make it easier for hospitals to recover costs because overseas visitors will know at every stage of their healthcare whether they are chargeable for the treatment they will receive.

The consultation proposed that overseas visitors who are chargeable under the NHS (Charges to Overseas Visitors) Regulations:

- should become chargeable for primary medical care (except GP/nurse consultations)
- should not be entitled to free NHS prescriptions, dental care or eye sight tests/optical vouchers because they happen to meet the exemption from charge criteria in each of those areas
- should become chargeable for care in A&E settings (i.e. A&E departments, Walk-in Centres, Urgent Care Centres and Minor Injuries Units) and ambulance services
- should become chargeable for community care and NHS-funded care delivered by non-NHS organisations

Also, proposals were put forward that:

- overseas visitors should not be entitled to NHS funded assisted reproduction services, even if they have paid the IHS or are otherwise in an exempt from charge group in the Charging Regulations (except UK armed forces members and their spouses/civil partners)
- individuals who provide third party support to an overseas visitor as part of their visa application should be liable for the overseas visitor's unpaid NHS bills
- EEA nationals should not be considered ordinarily resident here in cases where another member state is responsible for their healthcare costs (the 'country of applicable legislation')
- The employers of overseas visitors working on UK-registered ships should become liable for their employees' NHS healthcare costs, in the same way as owners of ships not registered in the UK are currently liable

These proposals, as set out in our consultation and elsewhere, are not about restricting access to treatment for conditions that are life-threatening to the individual or might pose a wider public health risk. It is about making sure that only those who live here and contribute financially receive free NHS care, and that everyone else is subject to the Charging Regulations. It is right that for those patients accessing the NHS who are chargeable, that they know this at the earliest opportunity including when they visit GP practices and A&E facilities or are referred to healthcare in the community. It is right that we continue to exempt certain vulnerable groups from charges and that we make it clear that immediately necessary and urgent treatment will always be provided even if someone is not able to pay straightaway.

We asked respondents whether they agreed with the proposals as well as, in some areas, if they had any comments on how best to implement them, whether there were any particular services that should or should not become chargeable, and whether they had any further information to provide.

What we heard

Most of the Government's proposals were supported by the majority of respondents. By this we mean that, of those who answered each question on a particular proposal, more than 50% replied that they either 'agreed' or 'strongly agreed' with it.

Many respondents said that it was right and fair that overseas visitors to the UK should pay for the majority of services they access, with one saying, "We should not just give away our services for free when there is no need. There should be exemptions obviously… but the general rule should be that we charge". Another respondent said "I find it astonishing that in these days of NHS cutbacks we continue to provide primary care free of charge to the whole world. British tax payers should not be providing such huge subsidies to residents of other countries".

However, two of the proposals had more than 50% of those who answered the question answer 'disagree' or 'strongly disagree'. These were:

- charging overseas visitors for treatment provided in A&E departments, Walk-in Centres, Urgent Care Centres and Minor Injuries Units
- charging overseas visitors for treatment delivered by NHS Ambulance Trusts and for air ambulances

A number of respondents had concerns about the practicalities of charging in such a high-pressure environment and the potential delays to necessary treatment as eligibility was established. Concerns were also raised about people choosing not to call an ambulance or go to A&E through fear of charging. These were countered by many international examples of high-quality care being provided where charging of non-residents or indeed all patients is expected and a matter of routine.

There were also concerns across all proposals from those who disagreed with them due to the possible negative impact on the health of those individuals who might decide not to take up NHS care, the impact on the public's health if people did not receive treatment for infectious diseases and the impact on NHS staff of having to operate charging rules in areas of care not used to doing so.

Our response and plan for the future

Having considered the views put forward, we intend to proceed with the extension of charging overseas visitors for most NHS services they can currently access for free, although this will be taken in a staged approach.

In the case of A&E and ambulance services, we are still considering the points raised by respondents and exploring the feasibility of implementing the proposals. We will therefore respond on those points later in the year.

Consultation proposals that will change from April 2017

We intend to amend the law from April 2017 in the following ways:

- Non-exempt overseas visitors will become chargeable for
    - NHS secondary and community care services provided outside hospitals, and
    - NHS-funded secondary care delivered by non-NHS bodies, where these are funded in their entirety by NHS commissioners

unless the service provided is one that will remain free to all, eg the diagnosis and treatment of specified infectious diseases

- Visitors and migrants who are entitled to an exemption from charge for NHS services under Immigration Health Surcharge arrangements will no longer be able to receive free NHS-funded assisted reproduction services (such as IVF) as part of their exemption

- Overseas visitors working on UK-registered ships will no longer be exempt from charge and their employer will become liable for their NHS costs

Other Regulation changes from April 2017

In addition to the proposals set out in our consultation we intend to place the following new statutory requirements on all providers of NHS-funded services:

- to charge overseas visitors upfront and in full for any care not deemed by a clinician to be “immediately necessary” or “urgent” and/or cease providing such non-urgent care where payment is not received in advance of treatment beginning
- require relevant NHS bodies to identify and flag an overseas visitor's chargeable status, starting with NHS trusts
- We also intend to take the opportunity to amend the Charging Regulations so that, if a person is no longer exempt from charge under the terms of a reciprocal healthcare agreement (e.g. if the agreement is terminated or they no longer meet the conditions), then, unless another exemption applies, charges will thenceforth apply, including for outstanding services being provided as part of an on-going course of treatment. This is an exception to what is often referred to as the "easement clause" where, in many cases, people who stop benefitting from an exemption category nevertheless are not charged for the remainder of a particular course of treatment already underway

Alongside the above legislative changes we will continue to work with our arm's length bodies, particularly NHS England, NHS Improvement and Public Health England, as well as the NHS frontline and other key stakeholders to develop operational guidance on how to implement the planned changes to the Charging Regulations. We will also continue to work with the NHS to address any operational challenges faced in implementing the Charging Regulations.

We will ensure that the implementation of these proposals mitigates public health concerns and operational challenges as far as possible and we will work with colleagues at Public Health England in particular to achieve this. We will also ensure that outcomes of the evaluation of the Programme, led by Ipsos Mori and the recent report by the National Audit Office inform the next phase of our work.

Planned legislative changes that we will take forward subject to further consideration

We see the need to have a balanced approach to charging across the whole of the NHS and for primary care to play its part in a proportionate way.

We also recognise that there are challenges to charging in other parts of the NHS, particularly in primary care, that mean we need to think further about the best way to approach this. While we believe that primary care has an important role in establishing chargeable status and charging overseas visitors and migrants we will take a phased approach to implementing this over a longer time scale.

- We will work with stakeholders including the Royal College of GPs, the BMA's General Practitioners' Committee and the General Dental Council to consider how best to extend the charging of overseas visitors and migrants into primary care. We believe that this starts with being able to determine whether a patient is chargeable when they register at a GP practice and that putting in place the processes for charging for primary care services will take longer to implement. We will then move to amend the rules around qualifying for an exemption

from prescription charges, primary dental care and optical vouchers so that overseas visitors from outside the EEA who are not exempt in the Charging Regulations do not benefit from these exemptions and entitlements that are in place for UK residents

- We will work with the BMA GPC to consider how we extend charging to primary medical services so that overseas visitors and migrants not exempt in the Charging Regulations will have to pay for these services, (excluding GP/nurse consultations)

The pace of this work will need to take into account contractual amendments and additional legislative changes beyond those set out in the Charging Regulations.

Proposals for further consideration

We will also further consider:

- if NHS services provided in NHS Accident & Emergency departments, Walk-in Centres, Urgent Care Centres and Minor Injuries Units should no longer be free to all overseas visitors
- if services provided by NHS Ambulance Trusts, such as treatment given by paramedics and ambulance journeys, should become chargeable to overseas visitors
- if NHS continuing care and NHS-funded nursing care should become chargeable to overseas visitors
- if the entitlement that exists for free eye-sight tests should be removed for overseas visitors
- if individuals who provide third-party support to an overseas visitor as part of their visa application should be liable for the overseas visitor's unpaid NHS bills, and work with the Home Office to do so
- if areas of care which are part-funded by charitable donations (e.g. hospice care) should become chargeable

We will work with stakeholders to ensure that - if these proposals are taken forward in the future - that they are done so in a proportionate and cost-effective manner.

Proposals we do not currently propose to take forward

In light of the EU referendum result and the necessary negotiations around the UK's withdrawal from the EU, we do not currently propose to legislate to amend the ‘ordinary residence’ test in relation to EEA visitors and migrants. More detail can be found in the EU referendum section below.

Improving performance in NHS trusts

We have considered the findings of the formative evaluation of the Cost Recovery Programme undertaken by Ipsos Mori and the recent review by the National Audit Office (NAO). Alongside the legislative and policy package we are proposing, we are launching an intensive programme of work led by NHS Improvement to focus support on a cohort of trusts who have the highest opportunity of cost recovery, based on their geography, size and expenditure. To help deliver this, we are recommissioning the Cost Recovery Support Team who will conduct intensive visits to the Trusts concerned and help them to improve their systems, processes, and ultimately their outcomes.

NHS Improvement will also bring NHS overseas visitor and migrant cost recovery within its wider regulatory regime to drive up levels of senior engagement in Trusts. This will be achieved through:

- a core cost recovery minimum data set being collected and displayed through the Model Hospital Dashboard. For the first time this performance information will be available to Trusts to enable them to benchmark and track progress and share best practice
- using Trust performance data to better target regulatory activities and support. NHS Improvement will do this by identifying a first cohort of Trusts with the most opportunity to improve cost recovery, and targeting the efforts of the Cost Recovery Support Team, seconded from the NHS accordingly
- working with the Department of Health and Trusts to extend and strengthen the evidence-base for cost recovery, particularly on securing payments from directly chargeable patients
- working with the Department of Health to appoint National Clinical Champions for NHS overseas visitor and migrant cost recovery, who will promote and support delivery of the Programme amongst NHS clinicians and other frontline staff

The EU Referendum

While the people of the UK have voted to leave the European Union, until exit negotiations are concluded, the UK remains a full member of the European Union and all the rights and obligations of EU membership remain in force. We will therefore continue to support the NHS to get better at identifying patients from other EEA countries with EHIC, S1 and S2 entitlement, recognising that it will be at least two years before we exit the EU. It is through recording the details of these entitlement documents that the UK is able to recover the cost of providing healthcare to the document holder.

Furthermore, in light of the referendum result and the necessary negotiations around the UK's withdrawal from the EU, we do not currently propose to legislate to amend the ‘ordinary residence’ test in relation to EEA migrants. Instead, we will be looking at options for whether and how reciprocal healthcare arrangements with other EEA countries will operate and what opportunities there may be following our exit from the EU. This preparatory work is outside the scope of this consultation.

Our work with the Devolved Administrations and the Crown Dependencies

The NHS (Charges to Overseas Visitors) Regulations are made under devolved powers - that is to say that they cover only NHS-funded healthcare provided in England. The Devolved Administrations of Scotland, Wales and Northern Ireland have their own rules. We will continue to work with colleagues in the Administrations to increase the reporting of EHIC, S1 and S2 activity and to support them in any changes they wish to make to their charging regulations where these align with ours.

We are grateful to the Crown Dependencies who submitted responses to the Government Consultation on behalf of the residents of the Bailiwicks of Guernsey and Jersey and the Isle of Man. The issues they raise are specific to arrangements that exist between the Crown Dependencies and the NHS in England and we will continue to work with them to address these on a bilateral basis.

Definitions used

For the purposes of this consultation the following definitions apply:

Residency definitions

- UK residents: people who are "ordinarily resident" in the UK. Being ordinarily resident currently means people living here lawfully, voluntarily and for a settled purpose as part of the regular order of life for the time being. The Charging Regulations currently do not apply to people who are ordinarily resident in the UK. Under the Immigration Act 2014, people who are subject to immigration control (most non-EEA nationals) must also have the immigration status of Indefinite Leave to Remain in the UK in order to be considered ordinarily resident here
- EEA residents: People who are ordinarily resident in the European Economic Area (EEA), or Switzerland. This includes UK nationals who have moved to live in an EEA country or Switzerland
- Non-EEA residents: People who are ordinarily resident outside the UK, EEA or Switzerland. This includes UK nationals who have moved to live in a non-EEA country
- Chargeable overseas visitors or non-exempt overseas visitors: People who are subject to the Charging Regulations and who are not exempt from charge due to their particular circumstances. This includes people who would normally be chargeable but who are accessing some services under the Regulations that are free to all, e.g. treatment needed for an infectious disease
- The Charging Regulations: The NHS (Charges to Overseas Visitors) Regulations 2015, as amended. These Regulations place a duty on relevant NHS bodies to make and recover charges from overseas visitors when an exemption from charge category does not apply. They set out which services are exempt from charge and which groups of overseas visitors are exempt from charge

European healthcare agreement definitions

- EHIC: European Health Insurance Cards (EHICs) are used by visitors and students from countries in the European Economic Area (EEA). EHICs allow the UK to recover costs of NHS healthcare provided to visitors during their stay, from their home country
- PRC: If a patient is entitled to an EHIC but doesn't have one, they can apply for a Provisional Replacement Certificate (PRC) from their home country, which can be used in the same way as an EHIC
- S1 forms: Issued to people who live in one EEA country, but have their healthcare costs covered by another EEA country. People entitled to apply for an S1 include state pensioners and those in receipt of certain benefits. For example, a Spanish pensioner who retires to the UK may be ordinarily resident in England but a contribution towards their healthcare costs can be reclaimed from Spain. Registering an S1 form allows the UK to claim around £4,500 per person, per year, towards their healthcare costs, regardless of how much healthcare the person needs

- S2 forms: Issued to people who choose to have their healthcare, usually planned hospital treatment, in a different EEA country to the one where they live. These forms are processed by the hospital where the individual is receiving treatment. They are more likely to be presented in secondary care as most pre-arranged treatment takes place in hospitals. The patient's home country will pay the costs of this treatment
- The country of applicable legislation: EU Social Security Coordination Regulations mean that only one EEA member state is responsible for a person's healthcare provision at any one time - the 'country of applicable legislation'. This is usually the country in which they work or are 'habitually resident', which is the country in which a person's 'centre of interest' lies

Immigration Health Surcharge (IHS) definitions

- Immigration health surcharge: Since 6 April 2015, non-EEA nationals who apply for leave to enter the UK for more than six months, or who apply to extend their stay, in most immigration categories pay the Immigration Health Surcharge, with the income going to the NHS. The current rate of the surcharge is £200 per person, per year (£150 for students/youth mobility scheme visas). Most non-EEA nationals who do not have indefinite leave to remain in the UK are required to pay the charge
- People who have paid the health surcharge (or for whom the health surcharge is waived, part refunded or who are exempt from paying it e.g. asylum seekers): these patients are exempt from under the Charging Regulations for the duration of their visa and so, currently, they do not face any additional charges for the NHS healthcare they receive other than those which would be paid by a UK resident
- People to whom health surcharge arrangements do not apply: this group have not paid the surcharge (e.g. they are not eligible to do so because they will be in the UK for less than 6 months). Under the existing Charging Regulations they are usually chargeable for any secondary healthcare they receive unless an exemption applies

NHS definitions

- Primary Care: Care provided by those who act as a first point of contact for patients, except in emergencies, e.g. dentists, GPs
- Primary Medical Care: Healthcare services provided in NHS General Practice (GP) surgeries, primary care Walk In Centres, and Out Of Hours services
- Secondary Care: Care provided by medical specialists who generally do not have first contact with patients, except in emergencies
- Free NHS Care: Care which is provided to patients free at the point of use. Patients who are eligible for such are ordinarily resident in the UK and typically contribute to the NHS via general taxation

Urgency of treatment definitions

- Immediately necessary treatment: This is treatment that a treating clinician considers a patient needs:
    - to save their life; or
    - to prevent a condition from becoming immediately life-threatening; or
    - promptly, to prevent permanent serious damage from occurring

Immediately necessary treatment must always be provided irrespective of whether the patient has been informed of, or agreed to pay, charges, and it must not be delayed or withheld to establish the patient's chargeable status or seek payment. All maternity services, including routine antenatal treatment, must be treated as immediately necessary.

- Urgent treatment: This is treatment that clinicians do not consider immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to return home. NHS bodies should make every effort to secure payment in the time before treatment is scheduled. However, if that proves unsuccessful, the treatment should not be delayed or withheld for the purposes of securing payment

Treatment is not made free of charge by virtue of being provided on an immediately necessary or urgent basis. Charges found to apply cannot be waived and if payment is not obtained before treatment then every effort must be made to recover it after treatment has been provided.

- Non-urgent treatment: treatment that the treating clinician considers could wait until the patient can reasonably be expected to return home, including, for example, most routine elective treatment

1. Introduction

1.1. This is the Government's response to its public consultation entitled *'Making a Fair Contribution'*[4] that ran from 7 December 2015 to 7 March 2016 on extending charging for overseas visitors into areas of NHS care that are currently free to all. The consultation also proposed some measures relating to assisted reproduction services; circumstances when another EEA member state should fund a person's healthcare; workers on UK-registered ships and recovering debts owed by certain types of overseas visitor.

1.2. This built on a previous consultation entitled *'Sustaining Services, Ensuring Fairness'*[5] in 2013 that set out the view that the NHS should not be free of charge to those with only a temporary relationship with the UK. The Government believes that free NHS services should, in general, be reserved for those with a sufficient connection with the UK. Certain groups of non-residents should continue to be exempt from charge due to our international obligations, where their circumstances mean that they are recognised as being particularly vulnerable or in the case of those working overseas for the UK Government. Certain services should continue to be free to all on the same basis as residents to ensure that the public continues to be protected from communicable diseases such as TB or HIV. The overarching principle of the Government's response to the consultation in 2013 was that visitors and migrants should make a fair contribution towards the health services they access.

1.3. Whilst the 2013 consultation and its response signalled that it was the Government's expectation that charges would apply to overseas visitors for more types of NHS services, initial efforts were focused on achieving the following changes which came into force in April 2015:

- The definition of ordinary residence (the principle criterion by which a person currently qualifies for free NHS hospital treatment in England) was modified for visitors and migrants who are subject to immigration control (most non-EEA nationals), so that they are now required to have permission to live permanently in the UK (known as Indefinite Leave to Remain) to be a qualifying resident
- The launch of the Immigration Health Surcharge (IHS) for non-EEA nationals subject to immigration control who come to temporarily reside in the UK and who do not, yet, have Indefinite Leave to Remain, so that they make a direct contribution towards the NHS with their visa application
- The overhaul of the Charging Regulations which set out the rules under which groups of overseas visitors (meaning those people who are not ordinarily resident in the UK) are not to be charged. This meant that exemptions considered superfluous or which did not align with the residence principle were removed, but exemptions were also extended to protect some particularly vulnerable groups

[4] www.gov.uk/government/consultations/overseas-visitors-and-migrants-extending-charges-for-nhs-services

[5] www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs

1.4. The NHS (Charges to Overseas Visitors) Regulations 2015 (the Charging Regulations) came into force on 6 April 2015[6].

1.5. More recently, we have supported the Home Office to change the rules on when NHS debt information must be provided to them. Previously an NHS body was required to notify the Home Office (via the Department of Health) where a debt of £1,000 or more had been outstanding for 3 months. Changes to the rules in April 2016 mean that the Home Office must be notified of debts of £500 or more, which have been outstanding for two months. The Home Office will usually refuse an application for leave to enter or remain in the UK if they have been notified that the debtor has an outstanding NHS debt. This assists the NHS in recovering funds it is owed, by encouraging more people with NHS debts to repay them promptly.

1.6. The Charging Regulations do not apply to all parts of the NHS as they currently only cover care provided by hospitals or their staff. Therefore, the 2015 consultation sought views on the Government's proposals for overseas visitors to be subject to charges in a range of services that are currently not covered by the Charging Regulations, and also in some areas that the Charging Regulations explicitly exempt from charge.

1.7. The Government proposed that chargeable overseas visitors should also become chargeable for:

- NHS primary medical care, other than GP and nurse consultations
- NHS prescriptions (even if they otherwise meet the criteria for a prescription exemption)
- NHS dental care (even if they otherwise meet the criteria for an exemption from dental charges)
- NHS sight tests and optical appliances, e.g. glasses (even if they otherwise meet the criteria for an entitlement to a free sight test or optical appliance)
- NHS funded services provided by a non-NHS body
- NHS services provided outside an NHS hospital, e.g. community care
- Services provided in NHS Accident & Emergency departments, Walk-in Centres, Urgent Care Centres and Minor Injuries Units
- Services provided by NHS Ambulance Trusts, such as treatment given by paramedics and ambulance journeys. The consultation also asked if treatment provided by air ambulances should become chargeable to overseas visitors

1.8. The Government also proposed that for residents of the EEA who hold EHICs from another EEA country, we should reclaim from that country:

- the cost of drugs and appliances over and above the NHS prescription charge paid by the patient

[6] Further amendments were made to the Charging Regulations, which came into force on 1 February 2016, to correct or update exemptions relating to Female Genital Mutilation and Government supported failed asylum seekers, broaden the exemption for victims of human trafficking to encompass victims of modern slavery, add Middle Eastern Respiratory Syndrome to the list of infectious diseases the diagnosis and treatment for which no charge is to be made to an overseas visitor, and to remove twelve countries from the list of those with which the UK has reciprocal healthcare agreement, following their termination on 1 January 2016

- the cost of NHS dental treatment over and above the banded charge paid by the patient

1.9. The Government put forward other proposals relating to charging overseas visitors for NHS care:

- To require both partners to be ordinarily resident in the UK to be able to receive free of charge NHS-funded fertility treatment and to remove this treatment from the scope of the exemptions from charge for people who have paid the immigration health surcharge (or in respect of whom the surcharge is waived, part refunded or who are exempt from paying it) meaning that they will not be entitled to receive such services without further charge
- To redefine the ordinary residence requirement in relation to EEA nationals so that those for whom another member state is responsible for funding their healthcare are excluded from the definition
- To allow payment for NHS charges incurred by an overseas visitor to also be sought from the person who has supported their visa application when the overseas visitor fails to pay
- To remove the exemption in the Charging Regulations relating to overseas visitors employed on UK registered ships so that their employer is liable for any charges for NHS care

1.10. Finally, the Government also asked:

- for information on circumstances in which overseas visitors access NHS continuing healthcare and NHS-funded nursing care and opinion on if these areas should be covered by the Charging Regulations
- if there were any other healthcare services that should be considered for charging
- for comments on the assumptions made in the accompanying impact assessment

1.11. This document is the Government's response to the replies we received to the consultation from NHS staff, NHS bodies, third-sector organisations, members of the public and other groups. It:

- Outlines the consultation process and key statistics
- Summarises the responses received
- Provides the Government's response to what we heard
- Sets out next steps

1.12. A more detailed overview of responses in relation to individual questions can be found in Annex A.

2. The consultation process

2.1. The Government undertook a 13-week public consultation from 7 December 2015 to 7 March 2016. The proposals within it applied to England only. It explored a range of potential measures to further extend charging of overseas visitors and migrants who use the NHS in England.

2.2. The Department of Health sought responses from a wide-ranging audience including healthcare professionals and other NHS staff; professional bodies; charities and migrant welfare groups and the public. The consultation was launched by the Secretary of State through a press release and further publicised during the consultation using Government digital channels and social media. In addition, the Department supported a number of meetings to discuss the issues raised. We are grateful to everyone who took part or contributed their views directly.

2.3. The consultation document is available online at: www.gov.uk/government/consultations/overseas-visitors-and-migrants-extending-charges-for-nhs-services

2.4. The Department of Health received a total of 418 formal responses to the consultation, predominantly though the online Citizen Space portal but also through hard copies sent to the Department and comments emailed to nhscostrecovery@dh.gsi.gov.uk. We also received some informal comments which we have reviewed but not included in the 418 figure. Only those organisations that have subsequently confirmed that they are content to be quoted in this response have been named in this document. An estimated breakdown of respondents by main groups is set out in the table below.

Respondent type (where identified)	Number of Replies
Members of public	162
NHS organisation staff	146
Charities and migrant welfare groups	48
Professional bodies	18
Other	44
Total	418

2.5. Annex B lists the organisations that responded.

3. What we heard: summary of responses

3.1. Most of the Government's proposals were supported by the majority of respondents. By this we mean that, of those who answered each question on if they agreed with the particular proposal, more than 50% replied that they either 'agreed' or 'strongly agreed' with it. Two of the proposals had more than 50% of those who answered the question answer 'disagree' or 'strongly disagree'. These were:

- Charging overseas visitors for treatment provided in A&E departments, Walk-in Centres, Urgent Care Centres and Minor Injuries Units
- Charging overseas visitors for treatment delivered by NHS Ambulance Trusts/air ambulances

3.2. An analysis of the areas under consideration is provided at Annex A. However, this chapter discusses a number of overarching themes which emerged from the responses. These themes tended to apply to all areas under consideration within the consultation.

Fairness to UK residents

3.3. There was recognition from many respondents that a lack of charging for overseas visitors in many areas of NHS care is unfair to residents because the NHS is principally there for UK residents' benefit, not the benefit of overseas visitors. Providing free NHS care to overseas visitors impacts on residents because less funding is then available for the services residents require. It can also have a detrimental effect on NHS waiting times. Even when services are already chargeable to overseas visitors, many people find it unacceptable that sufficient rigour may not always be applied in order to establish whether or not a person is entitled to free NHS care, or whether reimbursement is due to the UK from another EEA member state. They felt this meant public funds were not being adequately protected.

3.4. Therefore many people supporting the proposals put forward views that extending charging into other areas of NHS care, or limiting the NHS services that overseas visitors can access without charge, is the right thing to do. Many thought overseas visitors should ensure they have adequate funds or insurance to finance their stay in the UK and should not rely on the tax payer to fund their healthcare needs.

3.5. These views tended to come most often from members of the public or staff from NHS organisations, but some professional organisations, whilst not agreeing with all the proposals, also recognised the need to have limits on entitlement to free NHS care to protect scarce resources.

Impact on patients and public health

3.6. Several respondents, including those from professional organisations, raised issues about the potential impact of the proposals on the health of the patient and on the public.

3.7. Some were concerned that charging for services will mean that those in need of them will not access them, or will only do so if their condition worsens to the extent that they need an emergency - and possibly more costly - intervention. Concern was also raised about unsupported failed asylum seekers or other undocumented migrants who are not within the 'exempt from charge' groups of overseas visitor, and are likely

to have little money, and/or be wary of engaging with public sector bodies that ask them about their immigration status.

3.8. Consequently, calls were made for more groups of overseas visitors to be exempt from charge for all their treatment needs and more types of service to be exempt from charge for all, such as maternity and mental health care.

3.9. Some who were opposed to extending charging to new areas of NHS care for overseas visitors raised concerns in relation to public health. Some respondents felt discouraging people from taking up healthcare, by charging them for it or requiring them to provide information they might not want to reveal, might mean that opportunities to detect infectious diseases are lost, with infections then being more likely to spread in the community. Many said that retaining free GP and nurse consultations was not enough to protect the public's health and called for diagnostic tests and investigations to also be exempt. The Government is clear that, for the wider public benefit, diagnostic services to detect specified infectious diseases and the treatment of those diseases will remain free to all.

Cost-effectiveness

3.10. The Impact Assessment accompanying the consultation was criticised by some respondents who felt that it did not accurately reflect the actual costs that might be involved in extending charging. This meant not only the costs of treating more emergency cases if overseas visitors' health deteriorates having not accessed primary care, but also the costs associated with new processes and systems that might be necessary to operate the charging rules effectively, and with the training of staff who would have to become familiar with them. Chapter 4 provides more information and explanation of the conclusions of the Impact Assessment.

Implementation

3.11. Some migrant welfare groups commented on the difficulty NHS hospital staff have currently in correctly identifying if an overseas visitor is exempt from NHS hospital charges under the Charging Regulations, claiming this leads to people being incorrectly charged. Often this is due to the difficulty the patient has in providing suitable evidence of exemption. Consequently, there is a concern that this problem may also arise in areas that become subject to charging.

3.12. Some professional bodies and GP practices were concerned that GP practice staff would find it too burdensome to assess new patients' chargeable status or apply charges and recover money for providing services that become chargeable. This was especially so in the face of rising workloads and if there was to be no remuneration for doing so.

Evaluation of the Programme

3.13. Some respondents said the Department of Health had failed to properly evaluate the impact of the Visitor & Migrant NHS Cost Recovery Programme on the NHS and patients, and consequently it was inappropriate to propose the extension of charging to other services until that had been done and taken account of. We explain our decisions and intentions on evaluation and review in the next Chapter.

Equality and discrimination

3.14. Concerns were raised by some respondents that the Department of Health had not considered equality impacts because these groups felt the proposals would impact disproportionately on protected characteristic groups, for instance in relation to race and pregnancy. Later in the document we explain what we have done to consider the equality impact of our proposals.

4. Department of Health reply

4.1. The Government and Department of Health is very grateful to all those who submitted responses to this consultation, many of which were detailed, providing considered insight into many areas.

4.2. It is clear the issue of charging overseas visitors for NHS care invites strong opinion and one on which not all agree. Many people feel, on the basis of fairness and sustainability of the NHS, it is essential that scarce NHS resources are used principally for UK residents, and that efforts are made to charge overseas visitors or their home countries, as appropriate, regardless of the type of NHS care they access or in which location. Comparisons are also frequently made about what UK residents can expect when needing medical treatment abroad.

4.3. However, others think charging overseas visitors, especially in areas currently outside the scope of the Charging Regulations, is wrong. These concerns are often due to their views on the impact on the health of vulnerable people living in the UK without immigration permission, or because it is feared that there will be unintended consequences on the ordinarily resident population, for instance in terms of discrimination or infectious disease control.

4.4. We have carefully considered the responses and whilst recognising clear opposition, our view is it is not right that only NHS care provided at an NHS hospital, or by their staff, should be chargeable to overseas visitors. We need a consistency of approach that protects resources for residents and ensures that only those people living here and contributing to the country financially get access to free NHS care.

4.5. Other than for A&E and ambulance services, for which more reflection is necessary, it is therefore our intention for all NHS funded care to be chargeable to those not living here or making a financial contribution to the country, except where there are good reasons for some services to be freely available to all overseas visitors, for example because of the need to protect public health. However, in recognition of the need to ensure these major changes can be implemented effectively, we will take a phased approach to extending charging into new areas of NHS care.

Measures to extend charging into the NHS from April 2017

Non-NHS Providers of NHS Secondary Care; Out-of-Hospital Secondary Care

4.6. We intend to change the law so that, in the future, overseas visitors who are not exempt under the Charging Regulations are charged for all NHS-funded services provided by a non-NHS organisation or outside an NHS hospital, except for any services that remain free to all which currently includes primary care.

4.7. These new rules will mean all providers of acute, mental and community NHS health services (except primary care provided under certain types of contract or agreements) will be required to charge overseas visitors and migrants who are not charge-exempt under the Charging Regulations, such as those who have not paid the Immigration Health Surcharge. This will be regardless of where the service is delivered.

4.8. The exception to this will be certain services that are sometimes only partly funded by the NHS, with some of the funding coming from charitable donations,

e.g. palliative care provided by hospices. We will take a final decision on this at a later date pending the outcome of further work.

Assisted Reproduction

4.9. We also intend to change the law from April 2017 so that overseas visitors who are exempt from charge under surcharge arrangements will be charged for assisted reproduction services that are provided.

4.10. We intend to do further work to establish whether a similar approach to the above should be adopted for other categories of overseas visitor who have a temporary or short-term relationship with the UK. We will consider any necessary exemptions to this rule (such as members of the HM armed forces working overseas) in any development of necessary Regulations.

Overseas visitors working on UK-registered ships

4.11. We do not think it is fair that the NHS should fund the healthcare needs of ship workers just because the ship is registered in the UK. Under the Charging Regulations, when the ship is not registered in the UK it is the owner of the ship that is liable for the cost of their employees' healthcare. We intend therefore to remove this exemption from charge category from the Charging Regulations from April 2017.

4.12. This will not mean such employees become chargeable for their treatment, since there is a requirement in the International Labour Organisation Maritime Labour Convention 2006 for seafarers to see, at no cost to themselves, a qualified doctor in ports, where possible. The liability to pay the charge will be with the owner of the ship, in the same way as is currently the case for overseas visitors working on ships not registered in the UK.

New requirements on providers of NHS-funded services

4.13. In addition to the proposals set out in our consultation, we will place other new statutory requirements on all providers of NHS-funded services in relation to charging responsibilities and processes. These are as follows:

Charging upfront for non-urgent care

4.14. We intend to amend the law from April 2017 so that NHS providers must charge patients upfront and in full for any care not deemed by a clinician to be “immediately necessary” or “urgent” and/or cease providing such non-urgent care where full payment is not received in advance. This is to ensure that, when it is clinically safe to do so, treatment is not provided to chargeable overseas visitors unless and until they have paid in full. We expect this to occur when treatment can wait until the patient can reasonably be expected to travel home and continue their course of treatment there.

Requiring an overseas visitor's chargeable status to be flagged

4.15. We will also require relevant NHS bodies and providers of NHS-funded care to identify and flag an overseas visitor's chargeable status, starting with NHS Trusts and Foundation Trusts. As part of this work we will consider whether any additional or enhanced data sharing powers are required and then proceed appropriately if so.

Areas for further development

Accident & Emergency (A&E) care and ambulance services

4.16. Many respondents said anyone coming here from outside the UK should contribute towards the costs of their healthcare treatment. Some felt all areas of the NHS should be chargeable to non UK residents, and that it would seem fairer and logical to extend charging into A&E as well. They felt A&E was a gateway into NHS hospitals and that identifying chargeable individuals within A&E would help recover costs at the earliest opportunity.

4.17. However, a number of respondents had concerns about the practicalities of charging in such a high-pressure environment as A&E and the potential delays to necessary treatment as eligibility was established.

4.18. There were also respondents who, whilst supportive of the principle of charging within A&E, were concerned at administering the charging of patients within the A&E setting. Many thought that identification of chargeable overseas visitors in an A&E setting could be difficult, especially in emergency situations. They were also concerned about how the system would be implemented and the potential complexity of charging with many suggesting very simple models.

4.19. In relation to ambulance services, many of the same concerns were given as in relation to charging for A&E care.

4.20. Therefore, in the case of A&E care and ambulance services, we are still considering the points raised by respondents and exploring the feasibility of implementing the proposals. We will therefore respond on those points later in the year.

4.21. A more detailed description of respondents' views will be provided when we respond with a final decision on charging overseas visitors for A&E and ambulance services later in the year.

Primary care

4.22. In this section, 'Primary Care' refers to services delivered by GPs and their staff, community pharmacy, community (or 'high street') dentistry and community (or 'high street') eye care services.

4.23. We see the need to have a balanced approach to charging across the whole of the NHS and for primary care to play its part in a proportionate way. This is because recovering charges from overseas visitors is most effective when a patient has been identified as chargeable as soon as possible in their care. It also makes it being easier for patients to understand rules when there is a consistency of approach and in light of the fact that in many countries there is not the same divide between primary and secondary care as there is in England.

4.24. We also recognise there are challenges to charging in other parts of the NHS, particularly in primary care, that mean we need to think further about the best way to approach this. While we believe that primary care has an important role in establishing chargeable status and charging overseas visitors and migrants we will take a phased approach to implementing this over a longer time scale.

4.25. We will work with stakeholders including the Royal College of GPs, BMA's General Practitioners' Committee and General Dental Council to consider how best to extend the charging of overseas visitors and migrants into primary care. We

believe that this starts with being able to determine whether a patient is chargeable for secondary care when they register at a GP practice and that putting in place the processes for charging for primary care services will take longer to implement. We will then move to introduce charging for primary medical services (except GP/nurse consultations) which will need to take into account contractual amendments and additional legislative changes.

4.26. We will also move to change the rules, which will also need to take into account contractual amendments and additional legislative changes, so that overseas visitors who are not exempt from charge under the Charging Regulations do not benefit from the exemptions that are in place for UK residents in relation to:

- Prescriptions
- Primary dental care
- Optical vouchers

Exemptions from charge

4.27. We will undertake our proposal so that exempt groups of overseas visitors who are covered by exemptions from charge as set out in the NHS (Charges to Overseas Visitors) Regulations (both current and upcoming versions) will also be exempt from charges where appropriate within the new areas of healthcare covered by this consultation as and when they become chargeable.

Other areas of charging

4.28. We will consider further the options listed below, where additional analysis is required to better understand the potential usage of certain services by overseas visitors and migrants and establish a robust cost/benefit case before deciding whether to pursue charging in these areas:

- If NHS continuing care and NHS-funded nursing care should become chargeable to overseas visitors
- If introducing charges to overseas visitors for NHS sight tests is implementable and cost-effective
- If individuals who provide third party support to an overseas visitor as part of their visa application should be liable for the overseas visitor's unpaid NHS bills, and work with the Home Office to do so
- If areas of care which are part-funded by charitable donations (e.g. hospice care) should become chargeable to overseas visitors

Operational impact

4.29. We are clear it should not be down to clinical staff to decide whether a patient should pay for their healthcare, nor to make and recover charges from them. However, clinical staff should still be aware of the fact that NHS healthcare is not generally free of charge to non-UK residents or those not otherwise exempted from charges under the Charging Regulations.

4.30. Also, clinical staff do have a role to play in assessing whether urgent treatment is needed to establish if it is to be given prior to receiving payment or not, and they should cooperate with those whose job it is, typically Overseas Visitor Managers (OVM), to apply the Charging Regulations. Where clinical staff think a patient may be chargeable (i.e. the patient informs them they are in the UK temporarily on holiday or visiting family), they should refer the matter to an OVM. The Department of Health- in

conjunction with Health Education England - has produced a video explaining the role of clinical staff in cost recovery http://www.e-lfh.org.uk/programmes/overseas-visitors-cost-recovery/watch-our-video/

4.31. However, we recognise it is challenging for other, non-clinical staff to operate the charging rules, and staff in areas not used to applying these rules will need training and support to do so.

4.32. One aspect of this support will be to further develop the system that, in conjunction with the Home Office and NHS Digital, we introduced in April 2015, in relation to demonstrating payment of the Immigration Health Surcharge. Currently the green banner indicates that the NHS need not undertake further investigation for charges and the red banner indicates that the patient's chargeable status needs to be investigated and confirmed as chargeable or exempt. We have enabled Overseas Visitor Managers, who have completed cost recovery specific training, to be able to directly update a patient's chargeable status, creating a national picture of chargeable patients.

4.33. NHS Digital are developing system enhancements to enable secondary care IT suppliers to display the chargeable flag in their Patient Administration Systems, making the flag visible by all NHS staff.

4.34. By increasing the number of relevant NHS staff who can see the chargeable status of patients, and supporting this system change with training, guidance and communications about the banner and its meaning to the NHS workforce, we hope to increase awareness of chargeable patients, and start to change the behaviour of NHS staff to seek payment for NHS treatment where a patient is known to be chargeable.

4.35. A number of respondents also said we should make those wanting to visit the UK aware of charging within the NHS, including A&E, prior to them travelling here. They should also be reminded of the possible sanctions in place should a debt not be paid.

4.36. Information about the charging rules and how they apply to overseas visitors or migrants looking to settle in England are available on NHS Choices but we know this information is not sought out on this website before visitors travel to the UK. We will therefore work with the Foreign and Commonwealth Office to communicate to overseas visitors coming to the UK the fact that NHS treatment is not usually free of charge and that they should therefore travel with insurance to avoid charges and potential impacts on future visa applications. We will also work with the FCO to make sure that British ex-patriates are provided with information about their entitlement to free healthcare or whether they will need to pay.

Consideration of other points raised by respondents

Impact on patient health

4.37. The majority of NHS services should be chargeable to overseas visitors who are not themselves exempt from charge. This is regardless of the setting in which the services are delivered or by which type of organisation. But we are clear, and will continue to be clear, that immediately necessary or urgent treatment will be provided regardless of whether the patient can pay for it. The NHS will not withhold this treatment from chargeable patients. Except in the case of maternity services which are always to be provided, regardless of whether the patient can pay, the level of

urgency is for clinicians to decide, based on the condition of the patient and in light of when they can return home for treatment.

4.38. We have, however, listened to concerns shared with us by NHS frontline staff about the difficulties they face in recovering costs from chargeable patients receiving maternity care. We intend to work with the Royal College of Midwives and other key stakeholders to determine if there are any maternity services that should, in future, be considered as "non-urgent", such as antenatal classes, and therefore charged in full before they are provided. We are clear that any changes to how maternity charging is managed will continue to ensure the safety of both the mother and her unborn child/children.

4.39. Consultation respondents who were opposed to the proposals often cited confusion within the NHS on how to apply the existing rules as a risk to patients' health. Regarding entitlement to register with a GP practice as an NHS patient, NHS England updated guidance on GP registration, including who can register for free NHS primary care services, in November 2015 in the document *Patient Registration Standard Operating Principles for Primary Medical Care (General Practice).*

4.40. This document clarifies that anyone in England can register with a GP practice and receive NHS treatment. The publication of this guidance should ensure that overseas visitors are not prevented from being registered with a GP practice as NHS patients. This mitigates some of the concerns raised about some overseas visitors being refused registration as an NHS patient. We will continue to work with the NHS to ensure the principles that immediately necessary and urgent treatment will not be withheld or delayed are understood and applied.

4.41. We will also work to improve visitors and migrants' understanding of what their rights and obligations are regarding their access to NHS care, including encouraging them to present for treatment or advice in the most appropriate place and timely manner.

4.42. We think that there are many wider benefits of understanding more about a patient and their particular circumstances. We believe that it is very important for the NHS to know who it is treating; failure to do so has patient safety implications, as well as a potential impact on limiting patient choice.

4.43. We expect that all patients using the NHS will be asked questions on their chargeable status where this hasn't already been established or where a patient has not been in contact with the NHS for some time.

4.44. We also intend to pilot initiatives in specified areas of healthcare where all patients accessing these particular services will be asked to prove their identity and demonstrate their entitlement to NHS services free at the point of use. We know that some NHS trusts have begun testing such a process, and others are keen to do the same. We strongly believe that the benefits of asking all patients the same questions vastly outweigh any potential inconvenience, not least as it avoids discrimination. We expect that any new processes will provide reassurance to patients and service users that NHS resources are being properly managed. If the pilots are successful, we will look to expand them to other areas of the NHS where proportionate and cost-effective.

4.45. We recognise that demonstrating entitlement is harder for some patients than it is for others. Where someone is unable to provide information upfront, or does not have physical ID documents, we will support healthcare providers to work with the patient

to determine their eligibility. No one will be denied urgent or immediately necessary healthcare, even if they cannot provide any documentation. In developing this policy, we are determined to ensure there is minimal burden on UK residents and intend to work with the NHS frontline, third-sector organisations and other key stakeholders to implement processes that are cost-effective and proportionate. We will ensure that appropriate guidance is available to clarify these rules.

Impact on the public's health

4.46. Our proposal in the consultation to retain free-to-all GP and nurse consultations was principally based on recognition that they are best placed to routinely monitor and assess several conditions that might have an impact on the public's health. We are clear that we want to ensure initial access to a GP is open to all overseas visitors so that their needs can be assessed and risks to public health mitigated.

4.47. This measure was widely supported by respondents but many argued this was not sufficient, and diagnostic tests and investigations should also be free to all. In relation to sexually transmitted infections and the infectious diseases listed within the Charging Regulations, not only will the treatment[7], wherever it is provided, remain a free to all service, so too will any diagnostic tests or investigations necessary to rule out such a disease or infection. There will be no charge for such diagnostic tests or investigations even if the result is negative so that overseas visitors are not discouraged from being tested, and then treated, for infectious diseases on the basis of cost.

4.48. Calls were also made for childhood immunisations to be free to all on the basis of local public protection being predicated on 'herd immunity.' We agree that it is right for children's parents not to be charged for childhood immunisations as part of the standard national programmes where this will result in a reduced risk to the wider population, so intend to exempt this service from charge.

4.49. We will continue to work with Public Health England to develop mitigating actions for potential risks to the public's health following the extension of charging across the NHS.

Impact on vulnerable groups

4.50. There were calls within the consultation responses for more groups of visitors, such as children and pregnant women, to benefit from an exemption from charge category within the Charging Regulations, particularly in relation to those living here without immigration permission.

4.51. We believe the groups of exempt from charge overseas visitors on vulnerability grounds within the Charging Regulations are the correct ones. Exemptions were created in 2015 for services needed as a consequence of domestic and sexual violence, female genital mutilation (FGM) and torture. In February 2016 the exemption relating to victims of human trafficking was widened to encompass victims of modern slavery.

[7] As for residents, NHS prescription charges may still apply.

4.52. However, we will continue to assess the emerging needs for any new or modified exemption categories, e.g. in relation to changes in how other government departments provide support to certain groups. For instance, the Immigration Act 2016 makes amendments to the system of support to be provided to, amongst others, failed asylum seekers. We have recently engaged with relevant stakeholders whether any change to the exemption from charge in the Charging Regulations applicable to failed asylum seekers receiving support from the Home Office (regulation 15) is appropriate.

4.53. In many cases, people who are victims of FGM, torture, domestic violence or sexual violence might first be identified as such during a GP or nurse consultation. This is another reason why we believe keeping this service free to all is necessary, so that these important safeguarding issues can be identified. This would have the effect of any treatment that was necessary as a result of that violence also being free of charge, except in rare circumstances, such as if the person had travelled to the UK seeking treatment.

4.54. Those residing in the UK without permission will still be provided with immediately necessary and urgent treatment, even if they cannot pay for it upfront, or at all, although the charge will still be applied. This includes all maternity treatment, including antenatal care. Furthermore, they will still be able to register with a GP and be seen by the GP or nurse free of charge and be tested and treated for infectious or sexually transmitted diseases without charge.

4.55. Children with irregular immigration status not covered by one of the exemption categories will still be provided with any urgent or immediately necessary healthcare, even if the person with parental responsibility for the child does not pay, and they too will be able to access GP/nurse consultations and testing and treatment of infectious diseases without charge. Children will also be able to access childhood immunisations without charge due to the need to protect public health and ensure 'herd immunity'.

Equalities and discrimination

4.56. Some respondents felt our proposals would have disproportionate effects on those with protected characteristics under the Equality Act 2010 more generally, and criticised the fact that an Equality Analysis document was not published alongside the consultation.

4.57. We have carefully considered the impacts of the measures in this consultation and are of the view that the benefits of the proposals are significant and mitigating action can be taken to reduce any adverse impact on individuals. We will continue to analyse the equality impact of the proposals as they are developed before, during and after implementation. We will work closely with our stakeholders to do this.

4.58. We have already committed to some important measures that will mitigate potential impacts on groups with protected characteristics and address equality concerns. We are also proposing to keep some services free to protect public health including childhood immunisations and diagnostic tests for communicable diseases. We are also maintaining the important principle that urgent or immediately necessary treatment will never be denied even if someone does not have the means to pay. We also continue to preserve important exemptions from charge, such as those for people who are victims of modern slavery or for treatment needed as a consequence of domestic violence or Female Genital Mutilation. We believe that all of these

measures and others outlined in the Government's response will help to alleviate some of the concerns there may be about equality impacts.

Costs and Impact Assessment

4.59. In taking forward proposals to extend charging into new areas, we also need to consider the costs associated with this. A number of respondents to the consultation expressed concern that the Impact Assessment that accompanied the consultation did not adequately assess any costs involved.

4.60. The consultation Impact Assessment estimated potential costs and benefits of extending the charging of visitors and migrants. As part of the consultation, we sought views on these estimates and on whether additional data sources and evidence exists that we could use to better inform the estimated impacts.

4.61. Evidence shared via the consultation has included data from trusts, CCGs, the Devolved Administrations, NHS Arm's Length Bodies, medical professional bodies, consultancies, and national and EU-wide bodies. We are now using the shared evidence and perspectives to further inform and refine the estimated costs and benefits.

Evaluation of the Programme

4.62. The Department of Health commissioned Ipsos MORI to conduct a formative evaluation of the Overseas Visitor and Migrant NHS Cost Recovery Programme during the course of the programme. This was carried out between July 2014 and July 2016. The primary aims of the evaluation were to:

- determine whether there has been an early change in culture and behaviour amongst frontline staff and other relevant stakeholders
- learn lessons about what works in improving cost recovery, and
- help refine the Programme through continuous feedback and inform decisions before proceeding with each stage of the Programme. The evidence on which the evaluation is based includes a survey of over 2,000 NHS staff, visits to NHS trusts and in-depth interviews with key stakeholders

4.63. The evaluation was conducted in two stages. Stage 1 was conducted between July 2014 and March 2015 and sought to set a baseline for NHS cost recovery activity at the start of the programme and assess early progress in implementing the programme ahead of the major legislative changes made to the programme in April 2015. Stage 1 of the evaluation indicated that the NHS was implementing the programme at a slower pace than intended. This was a reminder of the scale of the changes required across the NHS, and the extent of the behaviour change required.

4.64. Stage 2 of the evaluation commenced in December 2015 and has evaluated the impact of the legislative changes made to the programme over the last year. We will use the findings from this research to consider how we implement the extension of charging to overseas visitors.

4.65. In summary, Ipsos MORI concluded that overall, the Cost Recovery Programme had made progress during the first two years but there were some key issues to address that might undermine the work already achieved. The most pressing was to ensure that wherever possible trusts were charging overseas visitors upfront for any treatment they received. The Programme has already gone someway to address this concern through the launch of two new e-Learning modules in July 2016 that addresses the practical issues of charging upfront for care, issuing timely invoices to

patients, recovering payment from patients and reporting individuals who do not pay to the NHS Debtors Scheme.

4.66. Ipsos MORI also recommended further support for OVMs on implementing cost recovery processes, underpinned by the need for increased senior buy-in at trust level. DH with NHS Improvement will work with trusts on the ground over the next year providing an intensive support package to a cohort of trusts. We will be asking those trusts to help with the development of a robust evidence base for cost recovery which can be shared with the wider NHS.

4.67. The report by Ipsos MORI Overseas Visitor and Migrant Cost Recovery Programme: Formative Evaluation, Final Report is available to download at www.gov.uk/dh/nhscostrecovery

5. Legislating for cost recovery

5.1. As previously outlined, the Government's intention is to make sure that only those who meet the residence conditions and are contributing to the country financially get free NHS care. However we need additional legislative powers in place to deliver this objective.

5.2. In 2016 the Queen's Speech announced the Government's intention to bring forward primary legislation on cost recovery. However, in light of the EU referendum vote we paused work on the Bill to reconsider our approach. The Secretary of State for Health recently confirmed[8] that there will not be a Cost Recovery Bill in this Parliamentary session. Instead, we intend to bring forward Regulations from April 2017. We intend that the Regulations will:

- Introduce charges for overseas visitors who are not within an exemption category within the Charging Regulations for the following services
  - NHS secondary and community care services provided outside hospitals
  - NHS-funded secondary care delivered by non-NHS bodies (except certain services that are co-funded by charitable donations)
- Remove NHS-funded assisted reproduction services (such as IVF) from the scope of the exemption applicable for overseas visitors who have paid the Immigration Health Surcharge (meaning that a charge will apply for these services)
- Remove the exemption from charge from overseas visitors working on UK-registered ships
- Require NHS providers to charge patients upfront and in full for any care not deemed by a clinician to be “immediately necessary” or “urgent” and/or cease providing such non-urgent care where payment is not received in advance
- Require relevant NHS bodies to identify and flag an overseas visitor's chargeable status Remove reciprocal healthcare agreements from the group of exemption categories to which the "easement clause" in the Charging Regulations applies

5.3. In relation to primary medical services, we will move to introduce charging at a pace which will need to take into account contractual amendments and additional legislative changes. As previously mentioned, we will engage with stakeholders to consider how best to do this.

5.4. We will also move to remove exemption categories for prescriptions, dental treatment and optical vouchers from overseas visitors who are not themselves exempt from charge under the Charging Regulations, taking into account contractual amendments and additional legislative changes.

[8] http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/brexit-and-health-and-social-care/oral/46148.html

6. Next steps

6.1. The legislative and policy package we are proposing goes hand-in-hand with an intensive programme of work to ensure effective implementation of the changes. Some of the main areas of focus for the Department of Health will be as follows:

Improving performance in NHS trusts

6.2. As discussed in the Executive Summary, we are working with NHS Improvement to begin a programme of intensive work with a cohort of Trusts that have the most potential to increase their cost recovery rates.

6.3. NHS Improvement are mobilising their resources to achieve this, supported by Department of Health officials who are re-commissioning the Cost Recovery Support Team who will conduct intensive visits to the Trusts concerned and help them to improve their systems, processes, and ultimately their outcomes. As part of this intensive programme of support NHS Improvement will be working with Trusts to pilot new ways of improving their cost recovery outcomes, such as seeking two forms of identification when patients present for care.

6.4. NHS Improvement will also work with the Department of Health to appoint National Clinical Champions for NHS overseas visitor and migrant cost recovery, to promote and support delivery of the Programme amongst NHS clinicians and other frontline staff.

IT improvements

6.5. We will further develop the system that, in conjunction with the Home Office and NHS Digital, we introduced in April 2015, in relation to demonstrating payment of the Immigration Health Surcharge. We have enabled Overseas Visitor Managers, who have completed Cost Recovery specific training, to be able to directly update a patient's chargeable status, creating a national picture of chargeable patients. NHS Digital are building on this now and developing system enhancements to enable secondary care IT suppliers to display the chargeable flag in their Patient Administration Systems, making the flag visible to all NHS staff.

Working with partners and stakeholders

6.6. We recognise that introducing these changes effectively will require much work and collaboration with our partners and stakeholders. We will work with them over the coming months to ensure that we implement these changes effectively.

Impact on patients and staff

6.7. As set out earlier, we will collaborate with Public Health England and other key stakeholders to work through and mitigate any potential risks to public health and burden on staff, particularly in relation to emergency services, as we develop our implementation plans.

Charging in new areas of care

6.8. We will work over the coming months on the best way for charges to be collected from overseas visitors accessing care in areas that will become subject to the Charging Regulations for the first time.

Communications, Guidance and Training

6.9. In expanding the Charging Regulations to cover areas of care not used to having to consider charges, and overseas visitors not used to having to pay for them, it will be necessary to communicate the key messages and requirements to relevant audiences. It will also be necessary to issue guidance and provide support to staff working for organisations that are used to applying the Charging Regulations as well as those who will be new to these rules. We will be expanding the remit of existing training materials accordingly.

6.10. We will also work to improve visitors and migrants' understanding of what their rights and obligations are regarding their access to NHS care, including encouraging them to present for treatment or advice in the most appropriate place and timely manner. We will continue our engagement with voluntary sector organisations who work directly with vulnerable people to ensure they have the necessary information to support their clients and stakeholders' understanding of the charging rules.

6.11. Finally, we will work with the Foreign and Commonwealth Office and UK Visas and Immigration to communicate to overseas visitors coming to the UK the fact that NHS treatment is not usually free of charge and that they should therefore travel with insurance to avoid charges and potential impacts on future visa applications.

Annex A: What we heard - responses to consultation questions

In order to provide further background, the responses to each of the consultation questions are addressed in turn below.

Where implementation ideas and points for consideration have been provided, these will help us inform guidance documents and implementation plans.

Equalities and Health Inequalities

What we asked: Question 1

QUESTION 1: We propose to apply the existing secondary care charging exemptions to primary medical care and emergency care. Do you agree?

What we heard: Question 1

Question 1	Numbers	Percentage[9]
Strongly agree	161	39%
Agree	73	18%
Disagree	38	9%
Strongly disagree	119	29%
Not answered	26	6%

Overall, most responses strongly agreed or agreed with the proposal to apply existing secondary care charging exemptions to primary medical care and emergency care (57%).

It should be noted that one person raised with us their concern that question 1 was not clearly worded and that respondents may not have understood it. The question aimed to probe if our intention to have the existing secondary care exemptions apply in primary and emergency care, in the event that they became chargeable services, was supported. However, some may have answered negatively because they disagreed with the principle to extend charging to these services at all, regardless of exemption categories. Furthermore, it cannot be inferred that a person who supported this proposal was also supportive of proposals to charge those not covered by an exemption. Given the potential for confusion, the answers to this question should be treated with some caution.

We set out our decision on this question in the sub-section Exemptions from Charge.

[9]Percentage figures in each table may not add up to 100% due to rounding.

What we asked: Question 2

QUESTION 2: Do you have any views on how the proposals in this consultation should be implemented so as to avoid impact on:

- people with protected characteristics as defined under the Equality Act 2010;

- health inequalities; or

- vulnerable groups?

What we heard: Question 2

The majority of those who responded to this question were supportive of having exemptions across the NHS for those who are most vulnerable. However, concerns were raised about the application of these exemptions (with questions of proof, consistency and fairness) and stakeholder responses called for more exemptions for pregnant women and children in particular. Stakeholders called for greater consideration of equalities and health inequalities duties when making final decisions on the consultation proposals.

Implementation ideas: opportunities and risks

Improve identification of exemptions

A significant number of responses focused on the need to improve the identification of exemptions. NHS staff from General Practices (GP) and Clinical Commissioning Groups (CCGs) reflected on the difficulty of identifying chargeable or exempt status. Questions of interpretation and inconsistency, with implications for inequalities, were raised.

One GP proposed a central Department of Health (DH) 'hub' with immigration experts, Home Office data and specialist advice, that overseas visitors could contact to get a reference number, thereby allowing the patient to get treatment according to their status at their GP practice. Other respondents suggested providing those who are exempt with a card or document, to make identification easier in all areas of the NHS. This would also help vulnerable groups to access NHS services without fear of charging and would address worries about discrimination in asking questions of patients.

A CCG noted the need for consistency and understanding: '*The charging needs to be fair and transparent and needs to apply to everyone. If there are lots of different exemption groups, then it is more difficult to implement and creates a negative impact on patients who do genuinely need it'.*

Many responses called for system improvement, pilot programmes, clearer DH direction to minimise time required to investigate, stronger immigration controls, identification for those exempt to be provided by the government, recovery of costs from Local Authorities responsible for the welfare of vulnerable people, and a centralised system to save the need for different areas of the NHS to investigate entitlement.

We recognise that understanding when to apply exemptions from charge can be difficult for healthcare providers and patients alike. We address these concerns in the sub-section on Operational Impact. Our response to the choice of exemption categories is outlined in the sub-section on the Impact on Vulnerable Groups.

Improve awareness

A central theme was that of improving awareness of who and what is chargeable and/or exempt. An NHS organisation flagged the importance of engaging with communities and their leaders to ensure understanding.

Another organisation suggested:

- Wider communication with the Third Sector and Public Sector to reduce confusion and misinformation;
- A public campaign providing clarity;
- A multi-language helpline to give advice to the public and providers of health services; and,
- Letters to patients from their GP following registration to make them aware of their situation and potential exempt or chargeable status.

Some respondents said that effort to improve awareness among patients and providers would be required, in ensuring the rules and exemptions are applied consistently and fairly.

One NHS Trust spoke about successful introduction of charging in secondary care, with staff asking questions consistently and fairly and that these models of success should be used to raise awareness elsewhere. Similarly, an NHS Foundation Trust said: '*The current regulations meet the needs of vulnerable groups, addresses health inequalities and those with protected qualities. Any extension on the current charging regulations should be reflective of the current to avoid exclusion or discrimination*.'

Respondents said we need to ensure all migrants and overseas visitors understand their rights in accessing care, and where to do so. It was also recommended that all NHS staff are trained in eligibility and exemptions, to encourage awareness, understanding and sensitivity.

Suggestions for implementation also included safeguards to ensure people get the NHS care they are entitled to. One organisation thought this particularly important for trafficked women or undocumented migrants.

The Department of Health is clear that as charging is extended to new areas of care, operational guidance will be provided and stakeholder engagement will be undertaken to ensure rules are understood and implementation is supported. We discuss this in more detail in the chapter 6: Next Steps section.

Suggestions of further exemptions

One respondent called for voluntary and community providers to be exempt from the Charging Regulations, calling them the only or most accessible point of healthcare contact for vulnerable individuals.

Several responses from missions and charities called for exemptions for UK nationals working and volunteering overseas in the humanitarian, development and mission sector, some of whom currently might not meet Ordinary Residence definitions. Some charities, migrant welfare groups and professional organisations called for further exemptions for:

- All immunisations;
- Children's healthcare;
- Pregnant women's healthcare;
- Mental healthcare; and
- A broader range of victims of human trafficking: inclusion of those suspected victims yet to be referred into the National Referral Mechanism, but who are in urgent need of support.

It should be noted that the upcoming Regulations will only apply to voluntary sector organisations where they are providing services on behalf of and that are fully funded by the NHS. Our response to the choice of exemption categories is outlined in the sub-section on the Impact on Vulnerable Groups.

Implementation ideas: concerns

Perceived barriers or concerns for effective implementation

Many responses raised concerns or talked about barriers to effective implementation. This related both to the exemption categories and to the proposals in the consultation more widely – with concern voiced regarding equalities and health inequalities.

The role of GPs and becoming 'border guards'

One issue raised was General Practice should not be the place for questions about status, or investigation of chargeable status. NHS staff in primary care said they don't have the training to do this fairly and don't feel they are the right people to be asking these questions.

One respondent raised concerns that the measures: '*would turn health professionals into immigration officials*' while another respondent stated that: '*It is not the place of clinicians to create obstacles to care for anyone seeking it. We have a duty to treat anyone who comes to us seeking help*.'

The Government is very clear – we do not expect the NHS medical professions to act as border guards. All staff providing NHS-funded healthcare do, however, have a duty to protect vital services from misuse and ensure that taxpayers' money is spent wisely.

Fear of charging preventing people from accessing healthcare

This was a concern of charities and migrant welfare groups. Even with exemptions in place for the most vulnerable, many felt introducing charging into more areas of the NHS would mean those most vulnerable would fear being charged (or fear their immigration status being investigated) and therefore would not seek healthcare. Respondents said fear of charging might mean they become harder to reach and may not approach primary care, meaning they are unable to access the support and services they need when they may be completely entitled to free of charge.

We are clear that as charging is extended to new areas of healthcare, operational guidance will be provided and stakeholder engagement will be undertaken to ensure rules are understood by patients, service users and frontline staff, in order to mitigate against these concerns.

Complexity of rules and inconsistency applying exemptions

A significant number of responses talked about the complexity of the rules and the charging exemptions, and possible inconsistency of applying exemptions. Respondents were concerned people might not understand the rules and therefore not seek any help.

A public health risk was also highlighted. An organisation said: '*people with infectious diseases may not realise that their care is free. Messages need to be clear but the system and proposed charging is complex for people to grasp. .*'

The Department's reply considers the Impact on the Public's Health within Chapter 4 of this document.

Equality of care

Many charities and migrant welfare groups were concerned about equality of care. There were questions about the practical application of the proposals, with the need for equalities and concern about health inequalities to be central to any decisions about new systems, collection of payments, and the provider's decision-making.

A number of responses referred to concerns including health inequalities, noting that the following groups would be particularly vulnerable:

- Pregnant women;
- Undocumented workers
- Failed asylum seekers
- Children
- Black and Ethnic Minority (BME) groups
- Older people
- Disabled people
- People with mental health problems

The Government responses to these, and the below concerns in the sub-section entitled Equalities and Discrimination.

Race

If every person presenting at A&E or at their GP surgery is asked questions to determine eligibility, chargeable status or exemption, respondents felt this would be time-consuming for staff, unpopular among patients, and certain groups would face more questions than others.

Children

A number of charities talked about the vulnerable position that some children have in society and their need for the best start in life. Many respondents suggested that children should be exempt from charges.

Pregnant women

Many charities and migrant welfare groups called for exemptions for pregnant women, to secure the best health outcomes for women and their children. Their response focused on: migrant women, who have disproportionately poor pregnancy outcomes; black and minority ethnic (BME) women, who are at higher risk of pregnancy complications and maternal mortality; and, the need for access to antenatal care, primary care, prescription medication, diagnostic tests, and other services.

Wider public protection

The impact of the consultation proposals on the wider public's health was expressed in many responses. NHS staff and professional organisations felt if individuals were discouraged from presenting at A&E or a GP practice, their illness might have implications for wider public health, as often infectious diseases or illnesses (including HIV) are only noticed in routine appointments.

Primary care as gateway to other services

Concerns were raised that the introduction of charging into primary care would have a significant impact elsewhere, with respondents noting primary care is seen as the gateway to other services, and charging could have implications on this route to support. Similarly, primary care was acknowledged to be the point for access to vital immunisations.

The Department of Health's reply considers the impact on patient and the public's health within the relevant sub-sections in Chapter 4.

Primary care > Primary Medical Care

What we asked: Questions 3, 4, 5 & 6

QUESTION 3: We propose recovering costs from EEA residents visiting the UK who do not have an EHIC (or PRC). Do you agree?

QUESTION 4: We propose recovering costs from non-EEA nationals and residents to whom health surcharge arrangements do not apply. Do you agree?

QUESTION 5: We have proposed that GP and nurse consultation should remain free to all on public protection grounds Do you agree?

QUESTION 6: Do you have any comments on implementation of the primary medical care proposals?

What we heard: Questions 3, 4 & 5

Question 3	Number of respondents	Percentage of all
Strongly agree	174	42%
Agree	56	13%
Disagree	37	9%
Strongly Disagree	121	29%
Not Answered	29	7%

As can be seen, most respondents supported this proposal, with 55% of respondents agreeing or strongly agreeing.

Question 4	Number of respondents	Percentage of all
Strongly agree	175	42%
Agree	37	9%
Disagree	41	10%
Strongly Disagree	136	33%
Not Answered	28	7%

Again, this proposal was supported with 51% agreeing or strongly agreeing with it.

Question 5	Number of respondents	Percentage of all
Strongly agree	194	47%
Agree	90	22%
Disagree	60	14%
Strongly Disagree	50	12%
Not Answered	23	6%

This proposal was strongly supported with almost 70% agreeing or strongly agreeing.

What we heard: Question 6

This question was 'open' and asked for comments on how these proposals could be implemented. Respondents took the opportunity to discuss broader issues than implementation as to why they supported, or, more often, opposed, the proposals. We address many of the concerns outlined below in Chapter 6 of this document, and will provide further operational detail when we respond to the areas for future development in due course.

The following ideas were put forward as things to explore if implementing the proposals:

Awareness and guidance

Some respondents felt it important clear and simple guidance for primary care staff was available, both on which groups would be chargeable and for what services.

Processes and IT changes

Some thought it shouldn't be too difficult for primary care to assess for charges, pointing out some practices have had systems in place in the past to identify overseas visitors, but others disagreed, and IT changes were put forward as necessary. A CCG said '*General practice clinical systems need to be changed to enable primary care to capture and flag the information above and share with the spine'*.

Who should identify chargeable patients?

Whilst some thought GP staff could do this fairly simply with guidance and support, others disagreed. Some respondents felt a central agency should be set up for patients newly registering with the NHS to have their entitlement to free care assessed. Some respondents felt it would be wise to harness the decision making experience already in place in hospitals, with one NHS Foundation Trust saying: '*it makes sense for these departments [in secondary care] to extend their services to Primary Care offering to check if patients meet the Ordinarily Residence criteria or exemption from charge in accordance with the regulations'*.

What to charge?

Most who commented thought it would be best to keep charges simple, with one saying: '*keep payment process uncomplicated and have a simple scale of flat rate charges payable before treatment is given*'. However, it was pointed out the charge would have to be high enough to cover the administration costs involved, whilst one requested '*the difference in price between primary care and A&E is not set at a level that acts as an unintended financial incentive which encourages patients to access A&E services as a first course of action when it is inappropriate for them to do so*'.

Identification

Some respondents thought an NHS card or documentation showing entitlement would be necessary.

Other ideas

There were suggestions to align residence tests and eligibility to other areas of government so information could be securely shared to provide evidence of entitlement, whilst one respondent suggested cost recovery become part of GP Practice Managers' job description in order for it to be taken seriously.

Opinion on the proposal to retain free GP/nurse consultations for all

Support for this proposal was widespread, but not without some opposition that it would mean the UK remained overly generous. There was much recognition that seeing GPs is an effective way to ensure that infectious diseases and other public protection issues are identified, so that this was often supported both by those who were opposed to other services becoming chargeable and those who were not. One organisation said, *'Maintaining free GP and nurse consultations to all is a sensible measure to ensure that opportunities to identify infectious disease during routine consultations are not lost'*.

However, some felt there was no need for all consultations to be free of charge to all in order to protect the public. One organisation said they agree *'that the initial consultation should be free to comply with public protection requirements, but believe subsequent visits should incur charges, unless the presence of infectious disease or sexual health infection has been diagnosed.*' Another respondent said: '*we feel that initial GP consultations should remain free to all, however Nurse Consultations should be chargeable*.'

Supporting the proposals to recover charges for primary medical services

Many of those who supported the proposals were members of the public or were from NHS organisations, including some from GP practices. Those who provided reasons often cited the impact on resident patients as a reason for limits to be placed on what non-residents should be able to access free of charge in a primary care setting, with one saying, '*far to [sic] many GP appointments are being given out to people that do not live here and it impacts on patients that do live in the UK and can't get an appointment with the GP due to shortage of appointments'*.

Some said that other countries charge for similar services so saw no reason why England should not also do so, whilst others thought that people who are visiting or staying in the UK should ensure they have health or travel insurance to cover their needs, instead of relying on the UK taxpayer.

Reasons for not extending charging into primary medical service

The overall response was in favour of the proposal to extend charging into primary medical services, although some opposition was raised. The main themes emerging were:

Interference with patient care

Several respondents felt charging for primary medical services will impact negatively on the individual health outcomes of patients, particularly patients living in the UK with irregular immigration status who are not otherwise exempt from charge and choose not to be seen at all, or be unable to afford the services they require, which might lead to poorer health outcomes. The main examples of groups this may impact on were:

- Maternity: Several organisations opposed introducing charging for maternity care within primary medical services or community care.

- Children: Many organisations felt extended charges in primary medical services shouldn't apply to children.

Public protection

Many respondents expressed concern at the potential impact on the resident population as a consequence of the proposals. Several respondents also raised the importance of childhood immunisations being freely available to all.

Furthermore, many respondents called for no extension of charges for mental health care in primary medical services or in the community, as discouraging this type of treatment can lead to situations where the public is put at risk, for example a Council said providing free of charge community mental health care is essential to protect both the patient and the wider public.

The Department of Health's reply considers the impact on patients' and the public's health in the relevant sub-sections in Chapter 4.

Increased administration burden

Some respondents were anxious about increased administration burden on GP practice staff, particularly if they would have to identify if a patient was chargeable or not.

Increased confusion

This was also regularly put forward by respondents as a difficulty to overcome. The suggestion was that it can be complicated under the current regulations identifying who is to be charged for what service, so this would be even more so in primary medical services, since there is not the expertise in place. It was feared mistakes in charging could occur due to complexity in the rules.

The Department of Health is clear that as charging is extended to new areas of care, operational guidance will be provided and stakeholder engagement will be undertaken to ensure rules are understood.

Increased costs

Many respondents were concerned the proposals would be costly, suggesting new systems and arrangements, including IT, were necessary.

Doctor/patient relationship

A small number of respondents raised the fear charging for certain primary medical services will damage the relationship between doctor and patient.

Primary care > Pharmacy and prescriptions

What we asked: Questions 7, 8 & 9

QUESTION 7: We propose reclaiming the balance of cost of drugs and appliances provided to EEA residents who hold an EHIC (or PRC) (over and above the prescription charge paid by the patient) from the EEA country that issued the EHIC/PRC. Do you agree?

QUESTION 8: We propose removing prescription exemptions for non-EEA residents to whom surcharge arrangements do not apply and who are not in one of the charge-exempt categories identified in the Equalities and Health Inequalities section. Do you agree?

QUESTION 9: Do you have any comments on implementation of the NHS prescriptions proposals?

What we heard: Questions 7 & 8

Question 7	Number of respondents	Percentage
Strongly agree	169	41%
Agree	99	24%
Disagree	34	8%
Strongly Disagree	77	19%
Not Answered	38	9%

Most responses to this question were supportive. Those who agreed and strongly agreed made up 65% of respondents.

Question 8	Number of respondents	Percentage
Strongly agree	155	37%
Agree	56	13%
Disagree	36	9%
Strongly disagree	136	33%
Not answered	34	8%

Answers to question 8 had more mixed responses. However, there was slightly more support in favour of the proposals than against (50% of respondents agreed or strongly agreed with the proposals, while 42% disagreed or strongly disagreed and 8% did not respond).

What we heard: Question 9:

With regards to the open question, a number of themes were identified. We address many of the concerns outlined below in the Chapter 6 of this document, and will provide further operational detail when we respond to the areas for future development in due course.

Facilitate identification/ design an effective system

Ideas for implementation from NHS staff focused on system improvements to identify chargeable or exempt patients, ranging from better information feeding through from the Home Office on immigration status, to a new tick-box on prescription forms, or even an alternative prescription form which would flag to pharmacists the different status of the patient. The suggestion was also made that charge-exempt individuals should be provided with a card or identifier. Similarly, the point was raised that there is a tick-box on blood test forms currently that requires the clinician to advise the lab if the patient is an NHS patient or a private patient and a similar system may suffice.

One organisation provided information on the current provision of NHS Prescription Services, supplied by the NHS Business Services Authority. It stated it: '*seems eminently sensible to use the NHS BSA as the best way to implement these proposals, but working with all stakeholders before publishing an implementation plan*.'

In terms of easing identification, the system and the data required were highlighted as areas to develop. One respondent commented on the data, saying: '*implementing these proposals will require pharmacies to be able to legitimately access accurate and up to date data about whether individuals should be charged or not.. Consideration must be given to what data pharmacies will need to collect or access, how this should be done, and whether they will have any legitimate need to hold and retain the information – and if so, how.*'

Another organisation's response talked about ensuring the proposed system does not add unnecessary administrative tasks to the community pharmacy sector and, ideally, that opportunities are taken to alleviate existing burdens such as those caused by the lack of an auto-populated field on prescriptions identifying the exemption status of UK residents.

An organisation advised clearer definition of who would be chargeable, and advocated the decision about eligibility being made by the GP surgery or the clinic, i.e. before the point of prescribing. They welcomed the suggestion of a checkbox or 'flag' to identify a chargeable or exempt patient

Improve communications to encourage awareness

Suggestions were made by members of the public and NHS staff that more should be done to communicate the message that some people may be chargeable or may need to use their EHICs. Posters in GP surgeries, in chemists and in pharmacies were recommended.

Fairness

One organisation said: '*the NHS is largely funded from general taxation of the public with a small amount being contributed by National Insurance payments. This finite budget is under ever increasing pressure but overseas visitors do not contribute to the budget. We therefore believe it is only fair that overseas visitors should make a contribution to the cost of any NHS prescriptions they receive, and that the current exemptions from a charge are disproportionately generous to individuals who are in the UK on a temporary basis*.'

Opportunity to increase consistency across the NHS

Some NHS respondents saw the proposals as an opportunity to increase consistency throughout the NHS, aligning with charging in secondary care. An NHS Trust said: '*as at*

present any visitor coming to the UK over 65 is exempt from the prescription charges, when they are charged for the secondary care it causes lot of problems as the patients try to inform us due to their age they are exempt for prescription therefore the same should apply to the secondary care. If they are charged for all care provided it will be more consistent and make it easier to charge them for secondary care.'

Other ways to approach

Members of the public expressed a variety of views regarding how best to implement. This included issuing all visitors and migrants with private prescriptions. A further respondent advised the NHS only provides prescriptions for infectious diseases, but provides written advice on other prescriptions for visitors to seek when they return home. We were also advised to explore European models. It was also noted that we must develop a fair system in which we, for example, prevent people's relatives coming to the UK to collect free prescriptions then leaving.

One NHS Trust added we should ensure the costs of appliances are recovered by charging a deposit on these items so we can ensure they are returned.

Complexity of categories and exemptions

The complexity of exemption categories, and identifying who would and wouldn't be chargeable was raised as a concern in this section, particularly among NHS staff and in relation to where patients' immigration status could fluctuate. The cost of training all NHS staff and pharmacy staff in the exemption categories and charging entitlement was raised as a real concern.

Short term vs long term cost

Some respondents raised the consideration short-term investment in prescriptions for those in need would be better value than treating longer-term health conditions. One NHS staff member said: '*the majority of prescriptions will be for low cost medications for treating conditions early or managing long-term conditions which if not treated will deteriorate and they will require more expensive, invasive treatment and there will be a risk to their health*.'

Risk to individual health

This was an area of concern for many respondents, particularly charities and migrant welfare groups. They felt introducing prescription costs for those who are currently exempt would mean those who don't have regular incomes would not be able to afford healthcare, at risk to their longer-term health.

Risk to the public's health

As well as the risk to individual health, there was concern about risk to the wider public's health. Vaccinations were raised as a key area for consideration, with the implications of introducing charging for vaccinations feared to mean the spread of disease.

The Department's reply considers the impact on patients and the public's health in Chapter 4.

Concern about adding burden to pharmacists

Concerns were raised about putting a burden on community pharmacists, who might not have the time, capacity or training to ask eligibility questions, to determine chargeability, or to recover money through the EHIC portal.

Calls for continued exemptions

Many organisations, charities and migrant welfare groups called for continued exemptions in the new charging rules. Of particular concern were maternity, children, and those who have been refused asylum.

Primary care > Primary NHS Dental Care

What we asked: Questions 10, 11 & 12

QUESTION 10: We propose reclaiming the balance of cost of NHS dental treatment provided to EEA residents with EHICs or PRCs (over and above the banded charge paid by the patient) from their home country.

QUESTION 11: We propose removing NHS dental charge exemptions from non-EEA residents to whom surcharge arrangements do not apply and who are not in one of the charge-exempt categories identified in section three.

QUESTION 12: Do you have any comments on implementation of the primary NHS dental care proposals?

What we heard: Questions 10 & 11

Question 10	Number of respondents	Percentage of all
Strongly agree	170	41%
Agree	86	21%
Disagree	32	8%
Strongly Disagree	83	20%
Not Answered	45	11%

The majority of those who answered this question strongly agreed with this proposal.

Question 11	Number of respondents	Percentage of all
Strongly agree	155	37%
Agree	48	12%
Disagree	44	11%
Strongly Disagree	126	30%
Not Answered	43	10%

The majority of those who answered this question strongly agreed with this proposal.

What we heard: Question 12:

With regards to the open question, a number of themes were identified. We address the concerns outlined below in Chapter 6 of this document, and will provide further operational detail when we respond to the areas for future development in due course. We also consider the impact on patient and the public's health, as well as the impact on vulnerable groups in the relevant sections of Chapter 4.

Support and implementation suggestions

The majority of respondents were in favour of charging for primary dental services, along the same lines as is done in secondary care.

Some respondents suggested dental hospitals should be included in charging for dental services, to deter chargeable patients from using dental hospitals as a way of avoiding charges. A number of respondents suggested emergency dental care should be free to all, with non-emergency care being chargeable. However, it was noted that this could be hard to define, particularly in relation to any required follow-up work.

Possible Barriers to Implementation

One response expressed concern about the costs and organisation of the additional administration function contained in these proposals, citing the potential for having to invest in new IT systems or recruit more staff to do the work. Several respondents also expressed concern about ongoing administration costs of introducing and running any new system, and fear it could be at the expense of front-line services.

Some organisations expressed concern that, under the proposals, pregnant women will have to pay, and could be deterred from seeking treatment. They emphasised dental treatment for women in pregnancy and the first twelve months after birth is for medical reasons and unwillingness to visit the dentist for financial reasons could have serious impacts on the pregnancy.

Responders highlighted the importance of dental care as an indicator of the existence of any complications with other medical conditions, such as HIV. They commented that missing these could lead to further (and more expensive) treatment later on.

Primary care > Primary NHS Ophthalmic Services

What we asked: Questions 13 & 14

QUESTION 13: We propose removing eligibility for an NHS sight test and optical voucher from non-EEA residents to whom surcharge arrangements do not apply and who are not in one of the charge-exempt categories identified in section three.

QUESTION 14: Do you have any comments on implementation of the primary NHS ophthalmic services proposals?

What we heard: Question 13

Question 13	Number of respondents	Percentage of all
Strongly agree	158	39%
Agree	52	13%
Disagree	42	10%
Strongly Disagree	120	29%
Not Answered	44	11%

More respondents either strongly agree or agree with the proposal for removing eligibility for an NHS sight test and optical voucher from non-EEA residents who are not exempt from charge than disagree or strongly disagree.

What we heard: Question 14:

With regards to the open question, 132 responses were received. The majority of responses to the open question were from those against removing eligibility for NHS-funded sight tests or optical vouchers. Reasons given from those who were in favour of removing eligibility were that those visiting should not have an urgent need to access NHS sight tests and the cost of such a test along with glasses/contact lenses is a low cost so shouldn't be out of reach of most people.

We address many of the concerns outlined below in Chapter 6 of this document, and will provide further operational detail when we respond to the areas for future development in due course. We also consider the impact on patient and the public's health, as well as the impact on vulnerable groups in the relevant sections of Chapter 4.

Implementation ideas - opportunities identified or suggested

Implementation ideas were limited, with most coming from NHS staff who were largely supportive of removing eligibility. Two responses recognised this area should be easier to implement and manage as Opticians are already set up to charge. One respondent suggested the same charging rules in place for secondary care within hospitals should be used for ophthalmology services, whilst another raised concerns about the risk of fraud, highlighting the need for sufficient deterrents.

One NHS Foundation Trust said primary care providers would require administrative support to implement proposed changes. They added current NHS staff responsible for cost recovery should be consulted on supporting the rollout of new policies in primary care.

Perceived barriers or concerns for effective implementation

Not Cost Effective

Issues were raised, especially amongst the charities/migrant groups, that the proposal to remove eligibility for NHS sight tests and optical vouchers would not be cost effective, as evidenced in the Impact Assessment that accompanied the consultation, and by implementing this proposal, the NHS would produce a significant financial loss. Another organisation raised a further issue that should the proposals be taken forward, the risk of legal challenge due to its proportionality would be increased.

A community optician said, *'given that the proposal has a negative net present value of -£32.7m over five years, we see no reason why the Department should wish to proceed with this proposal, especially since the proposed gain in income for the NHS of only £0.2m per year must be considered marginal at best*.'

We have been looking again at the processes we would need to put in place for this to be operationalised, including the cost burden, and will be working with national bodies and high street providers over the next few months to ensure changes are cost-effective.

Removing eligibility would increase the chances of conditions not being spotted earlier and could lead to more costly treatment later on

Several respondents said removing eligibility for an NHS eye test and optical voucher would reduce early detection of diseases, including glaucoma and diabetes, and that certain ethnic minority groups may have a higher propensity for these conditions. Other respondents raised concerns around women and children, stressing the need to be able to detect early changes in sight during pregnancy, particularly for women with diabetes, since pregnancy can bring about changes in existing eye conditions and ophthalmologists play an important role in pre-conception screening and management.

Secondary Care > Accident and Emergency (A&E)

What we asked: Questions 15, 16, 17 & 18

QUESTION 15: Our proposal for A&E is to extend charging of overseas visitors to cover all treatment provided within all NHS A&E settings, including Walk-In Centres, Urgent Care Centres and Minor Injuries Units.

QUESTION 16: If you disagree or strongly disagree with the proposals in question 15, do you agree that charging should cover care given within an NHS A&E setting if an individual is subsequently admitted to hospital, or referred to an outpatient appointment?

QUESTION 17: Are there any NHS-funded services provided within an NHS A&E setting that should be exempt from a requirement to apply the Charging Regulations (e.g. on public protection grounds)?

QUESTION 18: Do you have any comments on implementation of the A&E proposals?

A description of respondents' views will be provided when we respond with a final decision on charging overseas visitors for A&E services later in the year.

Secondary care > Ambulance Services

What we asked: Questions 19, 20 & 21

QUESTION 19: Our proposal for ambulance services is to introduce charging for all treatment delivered by NHS Ambulance Trusts. This would include any cost incurred for treatment delivered by NHS paramedics, including at the site of an accident, any use of ambulance services, and any treatment carried out outside an A&E department or equivalent.

QUESTION 20: Do you agree that the Government should charge individuals who receive care by air ambulance?

QUESTION 21: Do you have any comments on implementation of the ambulance service charging proposals?

A description of respondents' views will be provided when we respond with a final decision on charging overseas visitors for ambulance services later in the year.

Secondary Care > Assisted Reproduction

What we asked: Questions 22, 23, 24 & 25

Question 22: Our proposal for assisted reproduction is to create a new mandatory residency requirement across England for access to fertility treatments where both partners will need to demonstrate they are ordinarily resident (in the case of non-EEA citizens this includes having Indefinite Leave to Remain in the UK) in order for any treatment to begin. Do you agree?

Question 23: We propose removing the right to access NHS funded fertility treatment from those who have paid the health surcharge. This will not affect any other care given by the NHS. Do you agree?

Question 24: Are there any other services that you think we should consider removing access to for those who have paid the health surcharge?

Question 25: Are there any groups of individuals who you believe should continue to have the right to access NHS funded fertility treatment, even if they are not ordinarily resident, and (in the case of non-EEA citizens), do not have Indefinite Leave to Remain in the UK?

What we heard: Questions 22 & 23

Question 22	Number of respondents	Percentage of all
Strongly agree	180	43%
Agree	70	17%
Disagree	36	9%
Strongly Disagree	86	21%
Not Answered	46	11%

Question 23	Number of respondents	Percentage of all
Strongly agree	166	40%
Agree	65	16%
Disagree	44	11%
Strongly Disagree	97	23%

What we heard: Question 24

Question 24	Number of respondents	Percentage of all
No	257	48%
Yes	105	38%
Not Answered	56	14%

The following section covers the suggestions we received in terms of services which could be removed from what the Immigration Health Surcharge gives automatic access to free at the point of use.

All elective care

Some NHS staff and members of the public responded that all elective healthcare should be considered for removal from access by those who have paid the health surcharge.

For example, an NHS Foundation Trust responded they '*would support the review of all treatment that is not deemed to be clinically immediately necessary or urgent. For example gender re-assignment, Bone Marrow Transplants, non-urgent chemotherapy or radiotherapy*.' Some of the responses said that the health surcharge should only cover urgent and immediately necessary healthcare.

Other services

Other responses listed the following services that the Government should consider removing access to for those who have paid the health surcharge:

- treatment for pre-existing conditions/illnesses
- cosmetic surgery
- obesity treatment
- organ transplants
- gender reassignment
- NHS continuing healthcare
- maternity care
- termination of pregnancy
- contraception
- high cost treatments
- service(s) within the NHS where demand exceeds what is available
- cancer treatment
- renal treatment
- routine health screenings
- mental health services

In justifying the removal of access to these services, many members of the public said that as the per capita average cost of healthcare was much higher than the £200 surcharge fee, these expensive treatments should not be accessible for surcharge payers. A common theme amongst responses was that the level of the surcharge did not match the range of expensive healthcare services currently available. The low clinical benefit of some of the services listed above was also used to justify removing them from access.

Some NHS staff and members of the public responded that maternity services should be removed for up to nine months on entry to the UK, to prevent a pregnant woman deliver her baby at low cost.

Others felt that the health surcharge should be removed altogether.

No further services

A common theme amongst respondents to this section was the feeling that restricting access to any services for those who have paid the surcharge was unfair as surcharge payers effectively pay twice towards the cost of their NHS treatment, through the surcharge and through any taxes they pay whilst in the UK.

What we asked: Question 25

QUESTION 25: Are there any groups of individuals who you believe should continue to have the right to access NHS funded fertility treatment, even if they are not ordinarily resident, and (in the case of non-EEA citizens), do not have Indefinite Leave to Remain in the UK?

What we heard: Question 25

Question 25:	Number of respondents	Percentage of all
No	248	59%
Yes	102	24%
Not Answered	68	16%

Some responses thought that no further groups should be able to access NHS-funded fertility treatment because it would be unfair to ordinarily resident individuals who may be unable to access these rationed services. Others felt there should be no restrictions and all should continue to have access to it on the current basis.

Some did provide specific groups who should continue to have the right to access NHS-funded fertility treatment. They included:

- individuals infertile due to rape, torture, FGM, domestic violence, human trafficking, war
- individuals who cannot access fertility treatment in their home country
- individuals working in the UK
- students
- British nationals
- ex-patriates

- Christian missionaries
- refugees
- asylum seekers
- non-EEA citizens
- all tax payers and their spouses

The Government's response on exemptions can be found in the relevant section in Chapter 4.

Potential for discrimination

Some respondents raised the possibility of discrimination in relation to people with health conditions that can lead to infertility, or those living with HIV no longer being able to access assisted reproduction. There was also mention that any restrictions on assisted reproduction could interfere with Article 8 of the Human Rights Act.

We are clear that no-one will be denied access to assisted reproduction services if they wish to obtain them whilst living in the UK. However, people who have paid the immigration health surcharge will not be able to obtain NHS funding for these and will have to pay for the services they require.

Partners of ordinary residents

A point raised was it was wrong for a UK resident to be unable to access NHS-funded fertility treatment due to the fact they have a non-ordinary resident as a partner. A NHS clinician asked, '*why should a British person not be allowed access to reproductive technology simply because he/she has chosen to have a non-British partner*?'

We are clear that no-one will be denied access to NHS assisted reproduction services, but patients subject to the Charging Regulations may have to pay for them upfront if not otherwise exempt.

Insufficient evidence

A common theme amongst responses, especially from professional bodies, was that all groups of individual should continue to have the right to access NHS-funded fertility treatment because there is not enough evidence to suggest the rights of access need to change from current rules.

One organisation said, *'we do not believe that sufficient evidence is presented as to why fertility treatment should be excluded from the health surcharge and have doubts that applying an additional residency criterion would help to address the problems associated with accessing treatment that the consultation document highlights*.'

Non-NHS providers of NHS Care and Out-of-Hospital Care

What we asked: Questions 26 & 27

QUESTION 26: Our proposal for non-NHS providers and out-of-hospital care is to standardise the rules so that NHS funded care is chargeable to non-exempt overseas visitors wherever, and by whomever, it is provided.

QUESTION 27: Are there any non-NHS providers that should be exempt from a requirement to apply the Charging Regulations?

What we heard: Question 26

Question 26	Number of respondents	Percentage of all
Strongly agree	154	36.93%
Agree	65	15.59%
Disagree	32	7.67%
Strongly Disagree	128	30.70%
Not Answered	38	9.11%

Whilst the answers to Question 26 were mostly in favour of standardising rules so that NHS-funded care is chargeable to non-exempt overseas visitors wherever, and by whomever, it is provided, implementation ideas were limited.

What we heard: Question 27

Just over half of respondents (54%) to Question 27 did not agree that there were any non-NHS bodies that should be exempt from charging regulations. However, there were a significant third that suggested that certain types of non-NHS bodies should be exempt from a requirement to apply the charging regulations such as registered charities, voluntary and community organisations, and social enterprises.

Many of these respondents argued these services provide an alternative source of care, which both helps to relieve the burden on NHS services, and facilitates access to timely and appropriate care for migrant groups. In many cases these organisations take on the provision of NHS services specifically to reach hard to reach groups, including vulnerable or destitute migrants.

We address the issues raised in the relevant sub-sections of Chapter 4 and in Chapter 6.

Main themes:

Implementation ideas - opportunities identified or suggested

Many hospices felt there was a lack of capacity in the hospice sector to determine a patient's chargeable status. Therefore, many thought it should be the responsibility of the referrer to hospice care to record a patient's status. It was suggested, if this is not possible, the Government provides additional funding to enable hospices to collect this data.

It was highlighted the NHS provides only part of charitable organisations' expenditure, with the rest from donations and other charitable endeavours. It was felt any requirement imposed on

hospices to charge people would require Clinical Commissioners to provide a specific tariff for palliative care within the block grant that they provide. Without this, or a similar model of defining services and their value, it would be impossible to be definitive about which specific services a person has received through a hospice which were chargeable. One response said: *'there is no way of knowing how much NHS money has been spent on a particular patient. It would not be appropriate for the NHS to try to recover the total cost of care to the patient as that would include charitable funds that the NHS had not spent*.'

Respondents said non-NHS bodies would need clarity in guidance about whether they are able to choose not to charge a migrant accessing their care and instead use their charitably raised funds. We are committed to working with non-NHS bodies to support them in implementing the Charging Rules for the first time.

Perceived barriers or concerns for effective implementation

One organisation said that in order to apply the proposed charging requirements hospices would need to implement a number of new administrative procedures in order to check the status of people accessing their services.

A significant number of respondents did not believe any extension of charging could be cost-effective. Given the complexity of immigration status determinations, many organisations would wish to see compelling evidence that any extension to charging would not cost more than it would save.

In addition, it was suggested many of the people reached by voluntary or charitable services do not have the means to pay and organisations would not turn away a patient, but would instead use more of their charitable funds to make up the shortfall.

Some respondents said that voluntary organisation often struggle to obtain sufficient funding to run their much needed services. They thought the additional administrative tasks demanded by the proposals are likely to place a financial burden on voluntary and community organisations, which they may not be able to cover.

The majority of respondents to Question 27 did not agree that there were any non-NHS bodies that should be exempt from charging regulations. However, there were a significant number that did provide certain types of non-NHS bodies that should be exempt from a requirement to apply the charging regulations such as registered charities, voluntary and community organisations, and social enterprises.

Hospices

An organisation said '*we feel that hospices should be exempt from migrant charging on the grounds that hospices are not non-NHS providers of care, but charitable providers of care with an element of NHS funding*.' Those organisations representing Hospices added the majority of their care is delivered by charitable donations and NHS funds make up a very small proportion of the care that they provide.

Many Hospices were also concerned charging for services would be against the charitable mission of voluntary providers of care. Many argued that should charges be extended to hospices they would be unlikely to be enforced. Hospices in practice could choose to fund a migrant care charitably.

The issue of older non-EEA residents requiring palliative care whilst visiting their families in England was considered to be rare. However, where it did happen hospices argued on humanitarian grounds these people should not be charged.

The Government's decision on charging in hospice care and for other services that are only funded in part by the NHS is outlined in the sub-section on other areas of care in Chapter 4.

Voluntary and community organisations

Some respondents said other non-NHS providers of care target the most vulnerable sections of the community such as disabled groups and those with mental health conditions. There was concern that if they depended on charging rather than on commissioning by local authorities and NHS Trusts, the services they offer would become unviable. Some added it would also be beyond the capacity of such providers to deal with the classification of clients/patients into chargeable and not chargeable.

There was also concern the proposals would be too onerous to apply in community services such as drop-ins – this would impact on the cost effectiveness or even the viability of the service. One respondent considers that '*charging should not be extended to third party providers…as these bodies are often providing crucial services to hard-to-reach and vulnerable sectors of society*.'

Organisations that provide Maternity Treatment

Some respondents felt organisations providing antenatal care to vulnerable women should be exempt from charging due to the higher risks of maternal and infant mortality and morbidity.

Another concern was that women should be given the opportunity to disclose domestic abuse in an environment in which they feel secure. They were concerned primary care settings in the community, which they said are effective at building relationships with vulnerable women, will become less secure if they charge, giving women even fewer places to disclose abuse and leaving them at risk of continuing domestic violence.

Termination of pregnancy services are frequently provided by non NHS providers. A number of responses suggested they should continue to be exempt from charging to ensure all women can access safe abortions.

Organisations for Vulnerable Groups

There was concern the proposals may harm the trust between voluntary and community organisations and service users, because staff will be required to ask intrusive questions regarding their immigration status.

What we asked: Question 28

QUESTION 28: Are there any NHS-funded services provided outside hospital that should be exempt from a requirement to apply the Charging Regulations (e.g. on public protection grounds)?

What we heard: Question 28

A small majority of respondents to this question did not believe any NHS-funded services outside hospital should be exempt from a requirement to apply the charging regulations. However, a significant number did think certain services should be exempt from a requirement to apply the Charging Regulations. These included:

Community Services

Many respondents felt Primary care services should be exempt from a requirement to apply the charging regulations on public protection grounds. Concern was raised that should access to these service be discouraged by the introduction of charges there could be implications for individual health, and transmission of diseases to the wider public or drug-resistance, which has both health and cost implications.

Maternity services

A number of respondents suggested antenatal care for minority and migrant women should be exempt from charge.

Sexual health services

One charity said all health services provided by third sector organisations including HIV and sexual health prevention, outreach, testing, support services and advice should be exempt.

Drug and alcohol services

A number of respondents said services providing needle exchange and opioid substitution therapy, which can have a major impact on the spread of HIV and hepatitis C, should also be exempt from charge. Individuals who are entitled to free care but have a chaotic lifestyle will find it difficult to prove entitlement.

Mental Health Support

A number of respondents suggested services providing mental health support should be exempt from charge.

What we asked: Question 29

QUESTION 29: Are you aware of any data on the number of overseas visitors that access NHS funded care provided by non-NHS bodies, or outside the hospital setting (and when the providers of that care are not hospital employed or directed staff)?

What we heard: Question 29

Many Hospice organisations suggested the proportion of migrants that would access hospice care would be extremely small.

Many organisations said they did not routinely collect information on the immigration status of people who access their care, thus there is no available data on how many people may be affected by the proposed charging requirements.

One response cited data which suggested many overseas patients did not routinely register with a GP, despite requiring urgent care. Fear of costs was one of the main barriers cited among patients for not GP services. It was argued these statistics illustrated the need for such services to remain free to all.

A response suggested it might be possible to obtain data on overseas patients accessing NHS-funded care through non-NHS bodies from a survey of care providers conducted by the Office of National Statistics under its powers under Statistics of Trade Act 1947

We address points on implementation in the Government's response set out in Chapter 4.

NHS Continuing Healthcare & NHS-Funded Nursing Care

What we asked: Questions 30 & 31

Question 30: Are you aware of circumstances where someone who may not be ordinarily resident in the UK is receiving NHS Continuing Healthcare or NHS-funded Nursing Care?

Question 31: Do you think NHS Continuing Healthcare and NHS-funded Nursing Care should be covered by the NHS Charging Regulations?

What we heard: Question 30

Question 30	Number of respondents	Percentage of all
No	300	72%
Yes	76	18%
Not Answered	41	10%

Of those respondents who were aware of circumstances where someone not ordinarily resident in the UK is receiving NHS Continuing Healthcare (CHC) or NHS-funded Nursing Care (FNC), NHS staff working in trusts, CCGs and GP practices gave anonymised examples of individual cases.

Some said that queries were regularly received about whether CHC funding should be provided for patients who may not be ordinarily resident in the UK and that there may be an increasing trend of patients arriving from overseas who seek funding for longer care for pre-existing conditions. There was a suggestion of a possible increase in trend of individuals who would not be considered ordinarily resident but who nonetheless trying to obtain NHS CHC.

A consistent theme amongst those who responded ‘no’ to the question suggested those receiving NHS CHC and FNC will most likely be ordinarily resident and not a short-term visitor due to the nature of the care provided.

What we heard: Question 31

Question 31	Number of respondents	Percentage of all
No	201	48%
Yes	159	38%
Not Answered	57	14%

Main themes

Support for extending the charging regulations to NHS Continuing Healthcare and NHS-funded Nursing Care

A major theme in justifying why the charging regulations should cover this area of healthcare care came from a number of respondents working in NHS CHC and FNC within the NHS, particularly from NHS CCGs. In favour of extending charging, some CCG staff suggested the high costs associated with CHC and FNC mean even a small number of cases in an area could

have a significant impact on their budget. For example, an NHS Continuing Healthcare professional said: *'care packages for those individuals that meet the eligibility for NHS continuing care are by definition required to meet complex, intensive and unpredictable care needs and as a result are often expensive.* '

Fairness in providing services

Another theme highlighted in the responses was the charging regulations should be extending to NHS CHC and FNC based on a principle of fairness to those with a long term relationship with the UK. These respondents were in favour of extending the charging regulations as there are stringent criteria in place for eligibility to access NHS CHC and FNC for UK residents. For example, a Continuing Healthcare professional said, '*you can be funded for CHC in a care home bed next door to a person who is not quite eligible… The non-eligible person, who has paid taxes all their life, has just had to sell their home to fund their long term care. I accept that it is because they are not quite eligible, but it is certainly not right that we have thousands of people in the country paying for long term care, when somebody who has just arrived, and albeit has slightly more needs, will get their care free of charge.*'

Some NHS staff added the inconsistency between the charging regulations in secondary care and NHS CHC and FNC meant there were sometimes delays in discharging patients from hospital into community care as there is a lack of clarity over chargeable status. The lack of clarity also means the funding of CHC and FNC can lead to cases of litigation. Furthermore, they said the current lack of equity, where a patient is chargeable in secondary care but not CHC and FNC, could lead to additional demand pressures on CHC and FNC.

Finally, a consistent theme in the responses from NHS staff and members of the public was that all NHS funded healthcare, regardless of the setting, should be chargeable.

Cost-effectiveness and perceived lack of evidence

In justifying opposition to extending the charging regulations to CHC and FNC, a prevalent theme came from equalities, vulnerable and migrant representative groups, who felt as this care is only available to those with the highest healthcare needs, charging them for their care will have a significantly detrimental impact on their health. This was based on the assumption that extending the charging regulations will reduce access to CHC and FNC.

A consistent theme amongst many respondents was the charging regulations should not be extended to NHS CHC and FNC due to the lack of evidence that any non-ordinarily resident patients are receiving this type of care. Migrant representative groups also questioned the cost-effectiveness of extending charging, as they argue if visitors and migrants were unable to pay and access this type of care they would subsequently be admitted to hospital at a higher cost.

In objecting to the extension of charging, one organisation said: *'the number of cases would be extremely small and this would add complexity to a system that is already very difficult for patients to gain access to.*'

Defining Residency for EEA Nationals

What we asked: Question 32

Question 32: Our proposal for defining residency for EEA nationals is to exclude EEA nationals from being considered ordinarily resident in the UK for the purposes of receiving free NHS healthcare if another member state is the country of applicable legislation or otherwise responsible for funding their health care. Do you agree?

What we heard: Question 32

Question 32	Number of respondents	Percentage of all
Strongly agree	149	36%
Agree	91	22%
Disagree	45	11%
Strongly Disagree	88	21%
Not Answered	44	11%

This question was clearly supported with 57% agreeing or strongly agreeing. However, some respondents did express some concern about this proposal, with one saying, "*It is unclear how it would be determined that another member state has responsibility for funding the healthcare*" and "*NHS staff, particularly in General Practice staff should not be expected to make decisions in what is a complex area of legislation*".

Respondents from organisations that support people who volunteer overseas or work as missionaries, were concerned generally about the Ordinary Residence test and how it may not be being applied accurately in some case by the NHS, particularly in the case of those whose main place of residence remains the UK. One organisation felt that amending the definition simply to exclude two groups from the definition "*will only add further to the confusion for those determining OR*".

Recovering NHS debt of visitors resident outside the EEA

What we asked: Questions 33 & 34

QUESTION 33: Our proposal for recovering NHS debt of visitors resident outside the EEA is that where NHS debt is incurred and is not repaid by a visitor, payment should be sought from the individual providing third party financial support of their application when the visitor can not otherwise show that they have sufficient funds available whilst they are in the UK. Do you agree?

QUESTION 34: Do you have any evidence on the impact of this proposal on NHS cost recovery or any comments on the implementation of such a proposal?

What we heard: Question 33

Question 33	Total	Percent of All
Strongly agree	142	34%
Agree	74	18%
Disagree	33	8%
Strongly Disagree	120	29%
Not Answered	48	12%

What we heard: Question 34

We received 370 responses to this question and 137 of those respondents provided a response to the open-ended question asking for evidence on the impact of this proposal on NHS cost recovery or any comments on the implementation of such a proposal. More people were supportive of this proposal (52% strongly agreed or agreed) than disagreed (37% strongly disagreed or disagreed) with 12% of respondents choosing not to answer this question.

Evidence on the impact of this proposal or comments on implementation

The consultation asked for evidence on whether this was a significant enough issue for the NHS to warrant considering the proposal further. Members of staff from NHS Trusts and Foundation Trusts wrote about how NHS debt from visitors and migrants currently affects their organisation, with one saying*'32% of our total raised overseas visitor invoices remain unpaid by patients; a significant percentage could have been recovered from their sponsors. Seeking recovery of debt from sponsors would act as a deterrent against assisted immigration abuse.'*

Concerns regarding the complexity of introducing the proposed measure

One organisation flagged their concern that the proposal to recover debts from a third party would raise issues of confidentially. Another had concerns regarding the impact upon sponsoring family members, and that it would be an unfair burden on family members to accept liability for unpredictable medical emergencies.

Some respondents pointed out the potential negative impact to business and our ability to attract visitors to England if these proposals were implemented. Some also said the costs of making the required changes to immigration systems and implementing the programme might be financially greater than the return.

Overseas visitors working on UK-registered ships

What we asked: Question 35

QUESTION 35: Our proposal for overseas visitors working on UK-registered ships is to remove their exemption from NHS charges.

What we heard: Question 35

Question 35	Number of respondents	Percentage of all
Strongly agree	106	25%
Agree	74	18%
Disagree	53	13%
Strongly Disagree	118	28%
Not Answered	66	16%

There is a fairly even split between those in favour of removing the specific exemption for overseas visitors working on UK registered ships and those who wish to see it retained, with a slight majority supporting the former. This split is based along NHS (where 74% of respondents wish to see the exemption removed) and Trade Union/Professional body (where 64% of respondents wish to retain the exemption) lines.

Key themes in responses

A number of shipping professional bodies cited the International Labour Organisation Maritime Labour Convention (MLC) 2006 on UK registered ships as a reason for retaining the current exemption. One respondent said: '*the MLC requires flag states to "give seafarers the right to visit a qualified medical doctor or dentist in ports of call, where practicable". Such provision must also be "free of charge to seafarers"*.'

There was a concern that removal of this specific exemption may introduce further complexity in inspection and regulation of MLC compliance amongst UK registered vessels, and for non-UK registered vessels visiting UK ports, as the vast majority of the global fleet is registered in countries that have ratified the MLC. There was also concern that the smaller commercial fleet might suffer financially.

It was claimed that seafarers working on UK-registered ships will be very likely to pay more into the Exchequer by way of National Insurance Contributions (NICs) than those on ships registered outside the UK. It was also suggested that the current exemption gives ship owners an incentive to register their ships in the UK. Removing this incentive might well reduce the revenues accruing to the UK, if it leads to fewer ships being registered in the UK.

One shipping body was concerned about what will happen if the employer does not pay and would be keen to see provision inserted into the legislation, making it clear that seafarers will not be liable to actually bear the costs of their treatment should their employer (for whatever reason) fail to pay. There was also concern that removal of the current exemption may increase existing levels of exploitation of non-EEA seafarers working on UK-registered ships and could serve to increase recruitment of non-EEA crew, at the expense of UK colleagues. We are clear that it is the ship owner, and not the seafarer (whatever their nationality) that is liable for paying costs to the NHS.

Further areas for consideration

What we asked: Question 36

QUESTION 36: Do you think there are any other healthcare services not mentioned in this consultation that you feel we should consider for the extension of charging?

What we heard: Question 36

There were 59 responses to this part of the question. The majority of responses came from NHS staff, who offered suggestions for healthcare services across primary, secondary and community care settings.

Suggestions for implementation

The view that 'all NHS-funded services' should be chargeable was made by a few respondents working in the NHS. Suggestions included:

- Social care
- Social workers
- Community care
- Patient transport services
- Translation and interpretation services
- Specialist clinics (NHS physiotherapy, chiropody, acupuncture, glaucoma)
- Automatic prescriptions or prescriptions not requiring the patient to be present (with concerns that family members living abroad access NHS prescriptions)
- Termination services
- Automatic screening programmes (cancer, regular health checks)

Charities and migrant welfare groups did not offer any comments in this section of the consultation response. In terms of views raised by the public, suggestions were wide-ranging and included:

- All NHS-funded services
- Mental health services
- Rehabilitation services

Some other suggestions included charging for drug-induced, alcohol-induced or antisocial behaviour-induced healthcare needs; and charging for those who had cosmetic surgery in other countries and required corrective surgery.

The suggestion was also made that, whatever charges we introduce, we run an EU advertising campaign to raise awareness and encourage understanding.

Barriers

One response provided context to any further areas for consideration. It focused on the need for awareness, for information to alleviate fears of charging, for consistency in applying the rules, for providing accessible information, for giving practical advice to NHS staff, and for providing sufficient training to avoid unlawful discrimination. It also recommended monitoring arrangements and evaluation.

Responses flagged that much more may need to be done to raise awareness of charging exemptions amongst migrants, asylum seekers and NHS frontline staff. It was suggested that lack of awareness can mean that people don't seek help they need, and are entitled to, because of fear of being charged, and that NHS staff might make decisions which wrongly deny people services.

Another respondent strongly recommended the Government ensures accessible information is provided for migrants and asylum seekers about the health services they can use free of charge, to help ensure migrants and asylum seekers seek timely medical assistance.

Others recommended that future guidance on implementing charging of overseas visitors and migrants for NHS services contains practical advice for NHS staff on how to avoid unlawful discrimination in determining whether a patient should be charged. These respondents recommended the Government ensures NHS staff are provided with appropriate training on avoiding discrimination.

We address the principle issues raised here in the relevant sub-sections of Chapter 4 and in Chapter 6: Next Steps.

Annex B – List of organisations that responded

38 degrees NHS Group Coastal West Sussex
38 Degrees North Lancashire NHS group
A Plunket Consulting Ltd
AIM International
ASDA
Ashford and St Peter's Hospital NHS Foundation Trust
Association of Ambulance Chief Executives
Asylum Education and Legal Fund
Barking Havering and Redbridge University NHS Trust
Barts Health NHS Trust
Beddington Medical Centre, Croydon, London
Bevan Healthcare Community Interest Company
BHA for Equality
Birmingham Cross City Clinical Commissioning Group
Birthrights
Block Lane Surgery, Oldham, Lancashire
Boots UK
Bradford Action for Refugees
Bradford Teaching Hospitals NHS Foundation Trust
Brigstowe Project
British Dental Association
British Fertility Society
British Medical Association
British Pregnancy Advisory Service
Buckinghamshire Healthcare NHS Trust
Calderdale Clinical Commissioning Group
Camden Clinical Commissioning Group & London Borough of Camden
Canterbury Road General Practice Surgery
Chelsea and Westminster Hospital NHS Foundation Trust
Chiltern Clinical Commissioning Group
City of Westminster Guide Lecturers Association
Cobham Health Centre, Cobham, Surrey

Coram Children's Legal Centre
Countess of Chester Hospital NHS Foundation Trust
DHL International UK Ltd
Dispensing Doctors' Association
Dispharma Retail Ltd
Doctors of the World UK
Doncaster Clinical Commissioning Group
Dorset Clinical Commissioning Group
East and North Herts NHS Trust
Emmanuel International UK
Figges Marsh Surgery, Mitcham, Surrey
Flagship (Dorset) Ltd
Franklin Consulting
Freedom from Torture
Frimley Health NHS Foundation Trust
Global Connections
Great Western Hospitals NHS Foundation Trust
Grovelands Medical Centre, London
Guild of Healthcare Pharmacists
Guy's & St Thomas' NHS Foundation Trust
Health Education North West
Health Watch Bedford Borough
Healthcare
Healthwatch
Healthwatch Devon
Healthwatch Newham
Healthwatch, Enfield
HELIOS Medical Centre, Bristol, Avon
Herne Hill Group Practice, Herne Hill London
Home Office
Hospice UK
Immigration Law Practitioners' Association
Imperial College Healthcare NHS Trust
Inclusion London
iNet Trust Ltd
Integrated care partnership

Isle of Wight NHS Trust
J Reed ltd
Japan Christian Link
Jetsol pharmacy, London
John Carlisle partners
Joint Council for the Welfare of Immigrants
Justice for Women
Keep Our NHS Public (Merseyside)
Keep Our NHS Public, Tavistock
Kent and Medway NHS and Social Care Partnership Trust
Kings College Hospital NHS Foundation Trust
KPMG
Lakeside Medical Practice, London
Lancashire Teaching Hospitals
Latin American Women's Rights Service
Latin Link
Leeds City Council
Leeds Institute of Medical Education
Liverpool Clinical Commissioning Group
Liverpool Heart and Chest Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
London North West Healthcare NHS Trust
Maidstone & Tunbridge Wells NHS Trust
Manchester Congolese Organisation
Marie Curie
Maternity Action
Medway NHS Foundation Trust
Mencap
Middlesbrough Council
Migrants Resource Centre
MIND
Mission and Public Affairs Council, Church of England
Mission Aviation Fellowship UK
Monitor
Moorfields Eye Hospital
National AIDS Trust

National Ambulance Commissioners Network
National Association of Midwives
National Childbirth Trust
National Union of Rail, Maritime & Transport Workers
Nautilus
Neasham road GP surgery, Darlington
Newcastle Clinical Commissioning Group
Newcastle University Hospitals NHS Foundation Trust
NHS England Continuing Healthcare team
NHS Leeds South and East Clinical Commissioning Group
NHS Oxfordshire Clinical Commissioning Group
NHS Providers
NHS Surrey Downs Clinical Commissioning Group
NHS Swale Clinical Commissioning Group
NHS West Suffolk Clinical Commissioning Group
NHS Wirral Clinical Commissioning Group
Norfolk & Norwich University NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust
North West, Regional Asylum Activism Project
Northern Devon Healthcare NHS Trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Oasis Church Lee crescent, Edgbaston
Oldham Unity's Destitution Food Project
Optical Confederation
Orchard Court Surgery, Darlington
Patients4nhs
Penny Lane Surgery, Liverpool
Pharmaceutical Services Negotiating Committee
Portsmouth Hospital NHS Trust
Project 17
Queen Mary University of London
Race Equality Foundation and Partners
Regional Asylum Activism Co-ordinator for Yorkshire & Humberside
Royal Brompton & Harefield NHS Foundation Trust
Royal College of Obstetricians and Gynaecologists
Royal Cornwall Hospitals NHS Trust

Royal Devon & Exeter NHS Foundation Trust
Royal National Orthopaedic NHS Trust
Save the Children UK
Scottish Women Against Pornography
Sheffield Children’s Hospital NHS Foundation Trust
Sirona Care & Health
South Tees Hospitals NHS Foundation Trust
South Yorkshire Migration and Asylum Action Group
SP Energy Networks
Springer Nature
SSP Health
St Georges Healthcare NHS Trust
St George's Medical Centre
St Mungo's
States of Jersey
Statham Grove Patients participation group
Steppes Travel
Still Human Still Here
Sue Ryder
Surrey & Sussex NHS Healthcare Trust
Sussex Democratic Involvement
Sussex HIV Clinical Network
Taunton & Somerset NHS Foundation Trust
Terrence Higgins Trust
The Castle Practice
The Children's Society
The Connections at St Martin's
The Equality and Diversity Forum
The Fishermen’s Mission
The Leeds Teaching Hospitals NHS Trust
The Limehouse Practice
The Newcastle-upon-Tyne Hospitals NHS Trust
The Roseland Surgeries
The Royal College of Midwives
The Royal College of Surgeons of Edinburgh
The Royal Marsden NHS Foundation Trust

UNISON
University College London
University Hospital of North Tees and Hartlepool NHS Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University of Leicester
University of Sheffield
Villa Care Ltd
Voluntary sector agencies in the West Midlands
Wadham College Oxford
Warrengate Medical Centre, Wakefield, Yorkshire
Warrington Borough Council
Warrington Clinical Commissioning Group
West Suffolk NHS Foundation Trust
Western Sussex Hospitals NHS Foundation Trust
White Ribbon Alliance UK
Women's Health and Equality Consortium
World Horizons
Wrightington, Wigan and Leigh NHS Foundation Trust
Wycliffe UK
Youth With A Mission
Zaphod ltd