Charging for overseas visitors

In 2015 the Government significantly changed the way NHS trusts charge overseas visitors who receive NHS treatment during their stay in the UK. Since then, a number of updates have been made to these regulations, with the most recent amendments coming into force in October 2017. This article outlines the most important changes, their significance and the implication they have for trusts.

Key headlines

- Since October 2017 NHS trusts are required by law to charge overseas visitors in advance for non-urgent treatment. If payment is not received, trusts are mandated to withhold treatment from the patient.
- For the first time since the regulations were introduced, non-NHS providers (such as those in the voluntary and private sectors) involved in the delivery of NHS services are also required to charge upfront.
- Treatment in A&E departments and at GP surgeries remains exempt from these regulations.

So, what has changed?

Following the introduction of the NHS (Charges to Overseas Visitors) Regulations 2015, the Government advised trusts to reclaim the cost of delivering treatment for overseas visitors – that is, a person, of any nationality who is not ordinarily resident in the United Kingdom¹.

The changes implemented in October 2017 superseded this guidance; trusts are now legally required to charge overseas patients upfront and in full. If an overseas patient cannot pay for treatment in advance, trusts should not provide care until payment is received. There are a number of caveats around this, detailed below.

Non-NHS providers are also required to charge upfront for the same NHS services. This applies to both voluntary and private organisations who are delivering NHS services. Before October 2017 these organisations had not been allowed to apply charges to these patients. As of now, all providers of acute, mental, community and NHS health services are required to charge overseas visitors and migrants up front.

Who should be charged?

Overseas visitors should be charged for their NHS treatment if they are visiting the UK for six months or less (these will most likely be tourists). In addition to this, non-resident UK nationals (expats) also need to be charged, as will those in the UK without immigration permission. Long stay students will have paid the health surcharge (see below), but short stay students (those studying for six months or less) will be subject to payment up front.

¹ A more comprehensive definition can be found in this Parliamentary briefing: http://researchbriefings.files.parliament.uk/documents/SN03051/SN03051.pdf
Not all overseas patients, of course, are expected to pay as they walk through the hospital door. Some patients will have paid an immigration health charge as part of their visa application to enter the UK, whilst other patients may be resident in a county that has a reciprocal healthcare agreement in place with the UK. EU citizens are entitled to a certain level of care under EU regulations, provided they can produce the relevant health documentation, such as a European Health Insurance Card (EHIC) or Provisional Replacement Certificate (PRC).

The **Department of Health and Social Care guidance** outlines five steps a provider should make when determining whether a patient is chargeable:

1. **Determine if the patient is ordinarily resident in the UK.** But in doing so, a provider must avoid discriminatory measures.

2. **Determine if the patient is insured in another European country and has access to an EHIC or PRC.**

3. **Determine if the patient is covered by an exemption because of their status or treatment.**

4. **Recover charges from those deemed chargeable.** Remember, this has to be paid before treatment is undertaken otherwise the provider must refuse to treat. This charge will most likely be an estimate of the costs likely to be incurred by the provider.

5. **Record the patient’s chargeable status on the NHS record.**

**What services shouldn’t be charged?**

Charges only apply for non-urgent care; that is, for treatment that is not deemed by a clinician to be “immediately necessary” or “urgent”. If a patient stops paying part way through treatment, clinicians should stop providing care only when it is safe to do so.

Some services remain free to all, even if a patient is expected to pay for other NHS services. For example, it’s important to treat certain contagious diseases, such as tuberculous or cholera, to prevent their spread. These exemption services include:

- Accident and emergency (A&E) services, including walk in centres, urgent care centres or minor injuries units.
- Primary care services.
- Family planning services.
- The diagnosis and treatment, including routine screening and routine vaccinations, for a variety of communicable diseases.

**When is care urgent?**

Trusts should only recover the costs in advance of patients receiving non-urgent treatment. That is, treatment that can wait until the patient leaves the UK. But there is also a subtle difference between care that is deemed immediately necessary and care that is deemed urgent. Immediately necessary treatment will be needed in order to save a patient’s life, or to prevent a condition from becoming immediately life-threatening, or to prevent permanent serious damage from occurring. Urgent treatment, meanwhile, may not be immediately necessary, but nevertheless cannot wait until an overseas patient can reasonably be expected to leave the UK. On both occasions, treatment should go ahead even if payment is not received upfront. If payment is not received in advance, it should...
nevertheless be obtained subsequently. The decision on the patient’s need is only for clinicians to make. More detail is available in the guidance.

What does this mean for the sector?
It remains critical for trusts to do all they can to become more efficient to support the sustainable delivery of high quality patient care. Some trusts are already making good progress in the effective recovery of costs incurred for the delivery of care to overseas visitors. Nevertheless, putting in place the correct systems, processes and training required for upfront charging will be a challenge for some trusts. The administrative burden associated with implementing these systems will require investment, and there are significant challenges in identifying the patients who need to be charged. Trusts need to explore all options for increasing their revenue. But a proportionate approach should be taken given the relatively small amount of revenue available from charging overseas visitors.