PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

IMMIGRATION BILL

First Sitting

Tuesday 29 October 2013

(Morning)

CONTENTS

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Saturday 2 November 2013

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The Committee consisted of the following Members:

Chairs: †Sir Roger Gale, Katy Clark

† Bain, Mr William *(Glasgow North East)* (Lab)
† Baker, Norman *(Minister for Crime Prevention)*
† Dowd, Jim *(Lewisham West and Penge)* (Lab)
† Doyle-Price, Jackie *(Thurrock)* (Con)
† Hanson, Mr David *(Delyn)* (Lab)
† Harper, Mr Mark *(Minister for Immigration)*
Hillier, Meg *(Hackney South and Shoreditch)* (Lab/Co-op)
† Huppert, Dr Julian *(Cambridge)* (LD)
† Jones, Helen *(Warrington North)* (Lab)
† Kirby, Simon *(Brighton, Kemptown)* (Con)
† McFadden, Mr Pat *(Wolverhampton South East)* (Lab)
Mills, Nigel *(Amber Valley)* (Con)
† Milton, Anne *(Lord Commissioner of Her Majesty's Treasury)*
† Opperman, Guy *(Hexham)* (Con)
Paisley, Ian *(North Antrim)* (DUP)
† Patel, Priti *(Witham)* (Con)
† Robertson, John *(Glasgow North West)* (Lab)
† Smith, Henry *(Crawley)* (Con)
Soames, Nicholas *(Mid Sussex)* (Con)
† Syms, Mr Robert *(Poole)* (Con)
† Wilson, Phil *(Sedgefield)* (Lab)

John-Paul Flaherty, Matthew Hamlyn, *Committee Clerks*

† attended the Committee

Witnesses

Professor J. Meirion Thomas, Senior Surgeon and Professor of Surgical Oncology, The Royal Marsden

Jacqueline Bishop, Brighton and Sussex University Hospitals Trust and Co-Chair of the Overseas Visitors Advisory Group, NHS

Professor Vivienne Nathanson, Director of Professional Activities, British Medical Association

Clare Gerada, Chair, Royal College of General Practitioners

Professor Terence Stephenson, Academy Chairman, Academy of Medical Royal Colleges

Sir Andrew Green, Chairman, Migration Watch UK

Matthew Pollard, Executive Director, Migration Watch UK

Public Bill Committee

Tuesday 29 October 2013

(Morning)

[Sir Roger Gale *in the Chair*]

Immigration Bill

8.55 am

The Chair: Before we begin, I have a few preliminary announcements. Hon. Members may remove their jackets if they wish to do so. Can we please ensure that all electronic devices—I will check my own as well—are switched off or on silent mode during all Committee sittings, not just the hearings this morning? When we move on to the further proceedings in Committee—the deliberations on the Bill itself—I and my fellow Chair, Katy Clark, do not intend to call starred amendments, which have not been tabled with adequate notice. The notice period is three working days, so amendments should be tabled by the rise of the House on Monday for consideration on Thursday and by the rise of the House on Thursday for consideration on the following Tuesday.

Not everyone is familiar with the procedure for Public Bill Committees, so perhaps I should explain what will happen today and thereafter. First, the Committee will be asked to consider the programme motion on the amendment paper, on which debate is limited to half an hour, although I hope that it will not take that long. We then proceed to a motion. Then there is an amendment to the programme motion, which has been tabled at the request not of the Minister, the Government or, indeed, the Opposition, but of one set of witnesses. That should be a formality. We then proceed to the motion to report the written evidence and then a motion to permit the Committee to deliberate in private in advance of the oral sessions. I hope that we can take that formally, which means without debate. Assuming that the second of those motions has been agreed to, the Committee will move into private session. Once the Committee has deliberated—I apologise to members of the public; this is the way we have to proceed, so I will have to ask you in due course to leave the room—the witnesses and members of the public will be invited back into the room and our oral session will begin as swiftly as possible. If the Committee agrees to the programme motion, the Committee will hear oral evidence this morning.

Motion made, and Question proposed,

That—

(1) the Committee shall (in addition to its first meeting at 8.55 am on Tuesday 29 October) meet—

(a) at 2.00 pm on Tuesday 29 October;

(b) at 11.30 am and 2.00 pm on Thursday 31 October;

(c) at 8.55 am and 2.00 pm on Tuesday 5 November;

(d) at 11.30 am and 2.00 pm on Thursday 7 November;

(e) at 8.55 am and 2.00 pm on Tuesday 12 November;

(f) at 8.55 am and 2.00 pm on Tuesday 19 November;

(2) the Committee shall hear oral evidence in accordance with the following Table:

TABLE

Date	*Time*	*Witness*
Tuesday 29 October	Until no later than 9.45 am	Professor J Meirion Thomas, The Royal Marsden; Jacqueline Bishop, Brighton and Sussex University Trust and co-chair of the Overseas Visitors Advisory Group, NHS
Tuesday 29 October	Until no later than 10.45 am	British Medical Association; Royal College of General Practitioners; Academy of Medical Royal Colleges
Tuesday 29 October	Until no later than 11.25 am	Immigration Law Practitioners' Association; MigrationWatch UK
Tuesday 29 October	Until no later than 3.00 pm	National Landlords Association; Residential Landlords Association; UK Association of Lettings Agents
Tuesday 29 October	Until no later than 3.30 pm	Crisis
Tuesday 29 October	Until no later than 4.00 pm	Universities UK
Thursday 31 October	Until no later than 12.00 noon	JUSTICE
Thursday 31 October	Until no later than 12.30 pm	Liberty
Thursday 31 October	Until no later than 1.00 pm	Joint Council for the Welfare of Immigrants
Thursday 31 October	Until no later than 2.45 pm	Home Office

(3) proceedings on consideration of the Bill in Committee shall be taken in the following order: Clauses 1 and 2; Schedule 1; Clauses 3 to 8; Schedule 2; Clauses 9 to 15; Schedule 3; Clauses 16 to 47; Schedule 4; Clauses 48 to 53; Schedule 5; Clauses 54 to 57; Schedule 6; Clause 58; Schedule 7; Clauses 59 to 62; Schedule 8; Clauses 63 to 66; new Clauses; new Schedules; remaining proceedings on the Bill; and

(4) the proceedings shall (so far as not previously concluded) be brought to a conclusion at 5.00 pm on Tuesday 19 November.

—(Anne Milton.)

Amendment made:

That the Resolution of the Programming Sub-Committee of Thursday 24 October be amended as follows.

(a) In the Table, in the third entry for Tuesday 29 October leave out "Immigration Law Practitioners' Association".

(b) In the Table, after the last entry for Tuesday 29 October, insert the following entry:

Date	*Time*	*Witness*
Tuesday 29 October	Until no later than 4.30 pm	Immigration Law Practitioners' Association

—(Mr Harper.)

Main Question, as amended, put and agreed to.

Ordered,

That—

(1) the Committee shall (in addition to its first meeting at 8.55 am on Tuesday 29 October) meet—

(a) at 2.00 pm on Tuesday 29 October;

(b) at 11.30 am and 2.00 pm on Thursday 31 October;

(c) at 8.55 am and 2.00 pm on Tuesday 5 November;

(d) at 11.30 am and 2.00 pm on Thursday 7 November;

(e) at 8.55 am and 2.00 pm on Tuesday 12 November;

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(4) the proceedings shall (so far as not previously concluded) be brought to a conclusion at 5.00 pm on Tuesday 19 November.

Resolved,

That, subject to the discretion of the Chair, any written evidence received by the Committee shall be reported to the House for publication.—*(Mr Harper.)*

The Chair: Copies of the memorandums that the Committee receives will be made available in the Committee Room.

Resolved,

That, at this and any subsequent meeting at which oral evidence is to be heard, the Committee shall sit in private until the witnesses are admitted.—*(Mr Harper.)*

8.58 am

The Committee deliberated in private.

Examination of Witnesses

Professor J. Meirion Thomas and Jacqueline Bishop gave evidence.

9.3 am

The Chair: Once again, good morning, ladies and gentlemen. We shall now hear evidence from Professor J. Meirion Thomas, of the Royal Marsden, and Jacqueline Bishop, from the Sussex University Trust and co-chair of the Overseas Visitors Advisory Group of the NHS. Thank you all for joining us. It is a pleasure to have you with us, and thank you for your time.

Before calling the first Member to ask a question, I should remind all Members that questions should be limited to matters within the scope of the Bill and that we must stick strictly to the timings in the programme motion that the Committee has agreed. I hope that I do not have to interrupt in mid-sentence and, as I have already indicated privately to the Committee, I would like to think that we can afford our guests the opportunity of a final word before I have to call a halt. We will certainly do our best.

Q1 Helen Jones (Warrington North) (Lab): Professor Thomas and Ms Bishop, welcome and thank you for coming to give evidence to us today. I want to begin by trying to elicit some facts about the people we are actually treating who are not normally resident in this country. Do you have any indication of how many of those people are foreign nationals and how many of them are expatriate Brits coming back from abroad to make use of the NHS?

Professor Thomas: No one has any idea whatever. I have always described health tourists as coming from one of three groups, and the first group is expats who come from abroad. I am the hub for information from 50 or so overseas visitor officers, so I know of examples. For example, I know of an American who came back after 30 years, spent two months in hospital for two bone marrow transplants and then went away again. I know of people who have been away for up to 48 years before they come back, have their treatment and then go away again.

There is absolutely nothing to stop those people. They are almost invisible, because they have an NHS number from birth and may well have an address or be able to use a friend's address. They can use the same GP practice as they did before, or can get temporary GP registration. They are absolutely unstoppable, and no one has any idea of the extent of the problem.

Jacqueline Bishop: Health tourists come in many guises. There is the accidental health tourist, who comes on holiday without insurance because they think everything is free. There is the health tourist who plans to and then comes here specifically for treatment. There are those who come through loopholes, such as coming over here to study, who bring their family for their fertility treatment, or maternity care, or liver transplants—that kind of thing.

There are then the other health tourists, who we as a nation actually invite to come in, because as Meirion said, if you have an NHS number and an address in the UK, you are then on the list for everything: once you get to 50 you have access to breast screening, once you are over 60 the poop scoop comes through for bowel cancer and so on. You have access to all the health checks you need. In addition, once you have an NHS number and a UK address you can apply for a European health insurance card.

We are inviting health tourists to come. When I challenge patients, they say, "Well, you sent me a letter. You asked me to come in for this test." Now, all these people have EHIC cards as well, which you can get once you have an NHS number.

Q2 Helen Jones: So it would be fair to sum up by saying that we are dealing with two different problems, which we are unable at the moment to distinguish between: foreign nationals who come over for treatment or who come over and find that they need treatment, some of whom would be subject to the provisions in the Bill; and British expats who have lived outside the country for many years and have not paid taxes here, who would not be subject to the provisions in the Bill because they have an NHS number.

Professor Thomas: There was a suggestion that if you paid tax for seven years and then went abroad, you could walk back in.

Jacqueline Bishop: That is not strictly true. If you worked continuously in the UK for 10 years or are in receipt of a UK state pension, you may be eligible for care for a condition that arises while you are back here. That does not include elective or planned care, so you could not just think to yourself, "I need a new hip, so I am going to hop back home for it." However, if you are on holiday here in the UK and fit one of those two categories, you may be eligible for free treatment as a result of an accident.

Q3 Helen Jones: That contradicts what you just told us about people who come back, get an address here and, because they have an NHS number, are able to access all the treatments, and we have no way of identifying them.

Jacqueline Bishop: Exactly. There is no way of identifying them. You have hit the nail on the head.

Professor Thomas: I agree.

Q4 Helen Jones: What evidence can you provide us about the numbers of people who come here deliberately to use the national health service, as opposed to those who come here and find themselves ill, but who have not made proper provision? Do we have any method of tracking those people?

Professor Thomas: The people who come and have accidental or incidental illnesses, I do not even regard as health tourists. That is perfectly genuine and good samaritan care as a doctor, as far as I am concerned. To me, a health tourist is someone who comes with a pre-existing illness, and the purpose of their visit is to access free NHS care. We have no idea how many such people there are. The research conducted by Creative Research recently does not take us anywhere near the total amount. The only way we could ever do that would be to target problem hospitals.

There are problem hospitals. You could look at those specific hospitals by speciality and by nationality. For example, some hospitals are targeted for maternity tourism, which is probably one of the biggest problems in London. We would need to look at, say, two or three dialysis units to look at who is having dialysis. That would not be a difficult thing to do, if the motivation and commitment were there to do it, but we have not done that.

We need to look at some HIV units and see who is having HIV treatment, especially since the changing of the rule on 1 October 2012, after which anyone coming into this country can have free HIV treatment. One of the scary, scary, scary statistics I have uncovered recently is that, in London, we spend twice as much on anti-HIV treatment as we do on anti-cancer chemotherapy. That is a very scary statistic.

Q5 Helen Jones: Miss Bishop, can you tell us why the NHS is so bad at identifying such people and ensuring that they pay for their treatment? What would be needed to get better at tracking and identifying people?

Jacqueline Bishop: The NHS does not have a robust enough system of administration to do that, nor do we have the staff.

We do not have any encouragement. I generate a loss—that is my job. Like it or not, that is the fact. Every overseas visitor whom I identify I cannot charge the clinical commissioning group for. We therefore have two choices: get it off the patient, or write it off. There are NHS trusts out there that do not identify overseas visitors, because it is not in their best interests. While we are being penalised for identifying overseas visitors, you will never ever get a true figure.

Q6 Helen Jones: That is an interesting point.

In your experience, what kinds of treatment are people coming here for deliberately—Professor Thomas has mentioned some—as opposed to treatments for people who do not have the right insurance and find themselves having an accident?

Jacqueline Bishop: As we have centres of excellence throughout the country, each area will have different problems. In my hospital, I do not think we have one particular area that people come for. Maternity is rife throughout. Anyone who says that they do not have overseas visitors in maternity either are not doing their job properly or just have their head in the sand.

Helen Jones: Although perhaps in an area that does not have many visitors—

Jacqueline Bishop: Yes. There are various types of health tourist. It is not about failed asylum seekers or the vulnerable groups who need our support. We have to put them aside. We are talking about people who are coming just for care, not to stay permanently.

I have an example of a student who came over here—I cannot remember from which country—on a visitor visa to apply to go to university. He was accepted at the university, although he had not signed on the dotted line. Unfortunately, he became ill while he was on his visitor visa. In his luggage, he had the details of his problems and medical history—I have the last paragraph here. His doctor in his home country had said:

"Given the patient's underlying disease and his current frailty, I would strongly recommend that this surgery be done overseas in a facility that can perform Keyhole surgery."

That was his doctor saying that.

Q7 Helen Jones: My final question is, if the current system tends to deter hospitals from identifying patients who ought to be charged, what do you suggest should be done instead? How can you identify these people as they walk through the door, and what do you need to follow up and collect the charges?

Jacqueline Bishop: I am quite keen on central registration. You will always need somebody similar to myself in a hospital. You will get the accident and emergency people coming through, so you will always need somebody there. People get referred to us via GPs and other places such as walk-in clinics, and if we are to prevent overseas visitors from using our continuing care in nursing homes and other care in the community, which at the moment is not identified and is given freely under the GP hat, we need a central body with registration in one focal point so that we can identify everyone who wants to use the NHS.

I always refer to the Blockbuster pact. How many of you here used to hire a video from Blockbuster in years past? You had to take your entire filing cabinet to hire "The Sound of Music", which cost less than a fiver, but for the NHS you do not have to take anything; you just have to say, "I'm ill."

We need a central point. As soon as you want to register with a GP, there should be one central point where you go with all your documents to prove that you are who you are. That would also stop drug abuse; it would hit not just the health tourists but identity fraud and a whole lot of other areas.

The Chair: That sounds like an appropriate point to bring in the Minister.

Q8 The Minister for Immigration (Mr Mark Harper): I am grateful, Sir Roger. Helen Jones raised two issues that we are tackling. One of them. charges for people here as temporary migrants—people coming here as students or workers—is tackled in the Bill with a surcharge. The second issue that she correctly identified is overseas visitors who are already supposed to pay for their care, but the NHS is not brilliant at collecting the money. I think you both agreed on that.

Jacqueline Bishop: That is to put it mildly.

Mr Harper: On incentives, Ms Bishop, I understand that the Secretary of State plans to bring in measures to change incentives for hospitals. At present, if you identify a foreign national, you will immediately lose money if you cannot collect all of that income. Do you think that a change of incentive structure would change the way that hospitals deal with patients?

Jacqueline Bishop: Most definitely. At the moment, there are hospitals out there without an overseas visitor co-ordinator or manager or officer—there are different titles; I am referred to as a co-ordinator. They are told only to look at those who come in without GPs or NHS numbers and, if they have got either, not to go through the validation process. We really should be validating every single new episode of care.

We have got the pre-attendance form, which I pioneered about five or six years ago in Brighton, which has now been developed; the Department of Health has taken that on board, and that is in its guidance. If that was given for every new care episode, that would be a starting point, but it is not. In our hospital, it is not given to every new episode of care. Should it be? Yes. Are some of the clerks selective in who they give it to? Yes. Should they be? No. We are not perfect. Obviously I try, but we need a robust system in place and the support of the CCG.

Perhaps centralised debt collecting is the way forward. Obviously, it should not be from the word go; for the first two or three months you have got to be responsible for trying to collect your own debts. At the moment, we are only allowed to report debts of £1,000 or more to the Department of Health, but that does not stop hospital surfers, because they may come to us for £200 or £300 of care. Once I write to the patient, the chances are that they will start to DNA and not attend their appointment. Then they will go on to the next hospital. We will therefore write off only £200 or £300 for that episode of care—if we knew about them in the first place—and they will go to the next hospital and travel around the country to get their care.

Professor Thomas: I have a slightly different view on this. I do not think that we should have what are called chargeable patients. I think that health tourists should not be in the NHS at all. One thing that people do not understand is that when they are charged, only 20% pay—we know that—but they are charged on what is called the NHS tariff, which is the baseline amount of money that hospitals recover from CCGs for the treatment of proper NHS patients. The NHS tariff is about 25% of exactly the same care in a private hospital, so these patients are getting very cheap treatment—they know that—and anyway, they do not have to pay because nobody chases them up. There should be no chargeable patients in the NHS. In other words, they should all be identified before they get to the hospital and excluded from NHS care.

One of the things in the Bill is that apparently we are going to have a director of deficit recovery. In other words, it is accepted that there will be a deficit and we will have someone who is going to collect £500 million a year. What we need is some sort of personal identification, so that people do not get into hospital—they do not get as far as seeing me. The answer is exactly what happens in France, Germany, Holland, Scandinavia, Canada or Australia—namely, some sort of personal identification for entitlement to free NHS care. I am holding here my driving licence, which has got my picture and my Driver and Vehicle Licensing Agency number. Nothing could be simpler. Ultimately, that is what we are going to have to have. We are going to have to have some sort of personal identification.

Q9 Mr Harper: Can I ask both of you: do you both agree with the Bill's proposals to amend the ordinary residence test, so that you get free NHS care only if you are a permanent resident of the United Kingdom? Do you agree that other people should either be charged—we can argue about what sort of tariff they should be charged—or, if they are here as a migrant, having come here as a student, for example, they should have to make a contribution to their NHS care?

Professor Thomas: The definition of OR has been the biggest loophole of all, so yes is the answer. It has got to be some sort of indefinite leave to remain or some sort of statement of permanent residency in this country.

Jacqueline Bishop: In the Department of Health guidance, I think that the words "ordinary residence" should be removed, because there are different ways of interpreting that. Some people may say, "I have lived here for two years." They may have lived here illegally for two years, but for all intents and purposes they are ordinarily resident and they will challenge that, or they will get their solicitor to challenge it. That wording just should not be there. You are either here legally or you are not. It is as simple as that.

Q10 Mr Pat McFadden (Wolverhampton South East) (Lab): I would like to rewind a little bit and ask you to explain to us in simple terms how this is supposed to work at the moment. Let us say we have someone who is not entitled to NHS treatment, and we can identify them as such. How are they charged, and why are we in a situation where we think we recover only 20% of the eligible money?

Professor Thomas: Those are the facts. First of all, if I recognise a patient as being ineligible, I am not allowed to declare that, because the minute that patient walks in to see me, I have a duty of confidentiality to that patient. I cannot even tell my OVO that I am suspicious that the patient is there illegally; I can only hope that because the patient has not got an NHS number, they have been recognised by the OVO before they get to me. Of course, one of the bits of research that is very useful from Creative Research is that there are hospitals in this country without OVOs, or other hospitals with an inadequate number of OVOs. The loopholes are phenomenal.

I always say that if anybody wants to breach the system, it is so easy to do so. For example, the reason why I got interested in this in the first place was that a patient complained to the General Medical Council about me and I had a fitness to practise charge made against me. That is what led to me writing my first *Spectator* article. What I did not understand about this guy until the very end was that not only had he come to me with this CT scan from outside the EU dated 10 days before, but he had been to three hospitals. So he had got through at least two, because he got through us in the end, but he did not come to us. He went somewhere else, where he had obviously been given a better offer. This chap had never lived or worked in this country; he was a doctor from abroad. He reported me to the GMC, and the GMC started a fitness to practise charge against me.

Q11 Mr McFadden: How do we try to recover money if we can identify people as not being eligible for NHS treatment but they have had NHS treatment?

Jacqueline Bishop: In the first instance we would raise an invoice, present it to the patient and hopefully try to get some money while they were an in-patient, which is difficult in itself. We have to rely on the health care resource group charges—the national tariff—and that tariff or code does not come into play until the notes are coded. We cannot code the notes until the patient has been discharged, so that in itself proves difficult. I have a very supportive coding manager who will go along—or send one of his team—and guess the coding for me, so that I can get some form of deposit, but not everybody gets the support from their coding department that I do. That is a challenge in itself, because you cannot give the exact price. Then you raise the invoice, and you get on your knees and pray that you are going to get it, because that is the best option you have got. Some people who are on holiday may be covered by their insurance, but insurances are only as good the small print. If pre-existing conditions are not covered, you just have to do your best to get it from the patient.

Q12 Mr McFadden: From what you are saying, it does not happen very often.

Jacqueline Bishop: What does not happen very often?

Mr McFadden: I am trying to summarise what you are saying, which is that it does not happen very often and when it does, there is not much means of enforcing it.

Jacqueline Bishop: Oh, it happens loads of times—hundreds, thousands of times on a daily basis, in every hospital. I could probably raise an invoice in my hospital three or four times a week. Do I raise invoices three or four times a week? No, because I do not have time and not all the patients are identified. If they were all identified, I would be doing one every day.

Q13 Mr McFadden: Forgive me, when I said that it does not happen very often, I meant giving the person the invoice, not the treatment.

Jacqueline Bishop: Sorry. They will get invoices, but whether we receive payment is another matter.

Q14 Mr McFadden: If they do not pay and they leave the hospital, what happens then?

Jacqueline Bishop: I will invoice them and do my best to chase it up. I will be the big bad debt collector, as people think I am, and try to get the money.

Q15 Mr McFadden: Do you think that the weakness in that system is why we think we get only 20% of charges?

Jacqueline Bishop: Yes, definitely. Having said that, since the new system has been in place, where we can report debts of £1,000, it has made a difference to my trust, because perhaps people's families who actually live in the UK will start a payment plan. Money will come in.

Mr McFadden: Can you explain that?

The Chair: Order. I am sorry but I must try to be fair to both sides. I will endeavour to come back to you if I can, Mr McFadden.

Q16 Henry Smith (Crawley) (Con): Welcome to you both, Professor Thomas and Ms Bishop. From your evidence, and also from Freedom of Information Act requests that I sent to every health trust last year, it seems that what system there is to recover costs from overseas foreign nationals being treated on the NHS is haphazard at best and non-existent in most circumstances. From what you are saying, the NHS is clearly not geared up in any way, shape or form to recover such

costs. Professor Thomas, you mentioned systems that exist elsewhere in Europe and in countries such as Australia and Canada, giving the example of your driving licence. Are there any provisions in such countries that are not in the Bill that you would like to see added?

Professor Thomas: I would come back to the point that we must have some sort of NHS passport. We must have some form of personal identification that entitles us to care. We are living in a country of 65 million people—it is so easy to breach the system. It is awful for me as a doctor to have to treat someone who I know is ineligible. I was saying to Jackie as we came in that one of the most awful things that happens to me is that I have to cancel surgery for a legitimate patient because of a health tourist who is ineligible for care who is breaching the NHS rules for 62-day care—we must begin treatment within 62 days. Sometimes I have to cancel a genuine patient to allow a tourist to come through. That really, really bothers me. I know exactly what happens then: they do not attend their follow-up appointments. Why? Because they have gone back to Thailand or wherever they have come from. It really happens so often—weekly, I would say.

Jacqueline Bishop: It comes back to the robust administration system, which is what we want and nobody has. Any hospital that says that they have it, I do not know what land they are on, but they are not on this planet, because nobody has a robust system. You only know about the ones you know about.

The professor was just saying that he has to treat these patients. We need that patient identified before they get that far. We need to identify them at the first point. If you have a leaking tap, you do not put a bucket under it; you turn it off. We have got to do it from the very beginning, so that they do not get that far. A clerk might identify a patient, or a consultant in our hospital might identify a patient and they might get a letter anonymously in the internal post saying, "Jackie, I think you might need to look at this patient." That is being selective, which is what we are trying to avoid. We need to look at every single patient.

If I write to a patient and ask them to come in with their documents or send me a photocopy—the circumstances would depend on what I would actually ask for—they do not turn up for their appointment. They do not turn up for their hospital appointment and they do not turn up to see me. That is fine, because that means they are not coming to our hospital any more, because they know that we are on to them, for want of a better word. We need to identify those patients before they get as far as the professor's and all the other consultants' rooms.

Again, it goes back to the point about central registration. In some countries, you have to register—I think that is true in Spain; I do not know the rules, and immigration experts can speak on that. If you are going to live in the country for three months or more—if that is your plan—you have to go to the town hall to be registered. We have nothing like that at all. We do not know how many people are here.

Q17 Henry Smith: I appreciate that you cannot speak for the whole of the NHS; you are representing your positions at the Royal Marsden and Brighton and Sussex University hospitals. Can you give an idea from your experience of the percentage of foreign or overseas patients you are treating through your various different institutions? Are we talking 5%, 10%?

Jacqueline Bishop: I think the professor has the figures.

Professor Thomas: Nobody has those figures. I would say it is about 5%. If you go to the obstetrics and gynaecology department at Guy's and St Thomas' across the river, they will talk about the Lagos shuttle, for example. I think there is organised crime behind this. By that I mean that people pay an amount of money to come into the country, they are given accommodation and they are told exactly how to answer the right questions when they get to the hospital.

With maternity tourism the biggest problem is west Africa; there is no doubt about that. Why? We have Human Fertilisation and Embryology Authority rules here where only two fertilised ova can be put back at any one IVF cycle. There you can put as many as you like, so they get a high incidence of multiple births. That is one of our big problems in this country. Some of those cases have been highlighted in the papers recently.

I will give you a quick example of women coming with the same name, same age, same address, but different blood groups. As you know, the first thing that happens when you are going to have your baby is that your blood group is tested for rhesus incompatibility. There is obviously identity fraud going on. What I do not understand is why, once that is spotted, the NHS fraud people do not target it and investigate these people. These people know that there is no penalty.

Mr McFadden asked about recovering money. There is no penalty to defrauding the NHS. If you try to defraud the welfare system it is a crime. There is no penalty in defrauding the NHS. You just walk out of the country—no problem. Why should you pay anyway? If your mate has got away without paying, why should you pay?

Q18 Mr William Bain (Glasgow North East) (Lab): Clearly we want to make policy on the basis of evidence, so can we turn to some of the evidence in last year's review conducted by the Department of Health? The review found that the very low recovery rates, which both of you have alluded to, are down to only 30% to 45% of the chargeable income being identified and 60% of the charges that are levied not being recovered. Can you comment on whether anything in clauses 33 and 34 would change that?

Jacqueline Bishop: I would need to see the text.

Professor Thomas: The answer is that as long as we have the system of chargeable patients, we will not solve the problem, because the concept of charging patients who are ineligible for care is wrong at its most basic level. I repeat: there should be no chargeable patients in the NHS. They should be identified and not allowed to get into the clinical arena. In other words, to accept that there are loopholes and that these people can come in by the back door and then to try to identify and charge them is the wrong way of doing things. That is not how supermarkets or anyone else works.

Q19 Mr Bain: The review last year also found that while you can improve certain practices, the visitor charging system might be at best generating a small net gain, but possibly no gain whatever. Do you see anything

[Mr Bain]

in the Bill that changes that position? Are you concerned that we are yet to see the Government's impact assessment of the costs of enforcement or any reliable estimates of additional revenue that might be obtained through clauses 33 and 34?

Jacqueline Bishop: Charging overseas visitors is not an income-generation exercise; it is about preventing loss of income. There is no profit there at all: you are charging the patient exactly the same as you would charge the CCG for anyone who came in. There will not be any profit, because there is no profit. We are not allowed to make profit.

Q20 Mr Bain: But in terms of recovering those moneys that might otherwise be lost, is it your experience on the ground that the Bill would help you avoid that loss to the NHS?

Jacqueline Bishop: I have not read the Bill completely, so I would need to read it again, but from what you are saying, I think it is most likely that it would.

Q21 Priti Patel (Witham) (Con): May I ask you both—we have touched on health tourism and debt recovery—about our hospital trusts and CCGs, where there is clearly an issue? From your experience, can you share with us some insights into what hospital trusts and, in particular, CCGs could do to address some of the challenges on, dare I say it, charging and debt recovery, and what practical steps they can take when they know that people are coming in and, frankly, abusing these services?

Jacqueline Bishop: Again, it is obviously about identifying people as soon as they come in, but the CCGs will not pay us for these patients. If the CCGs paid us, or if there was some body that paid us for these patients so that we were not penalised, we would identify more of those patients.

Q22 Priti Patel: On that point, who should be doing the identification? Should it be at GP level? Is that the first port of call?

Jacqueline Bishop: It should be the first time they enter the NHS system. If that is the GP, it is the GP. If it is A and E, it is the A and E area, which comes down to secondary care. Wherever you go, they should be identifying the patient. If you go to the opticians with a problem, they will refer you to the local eye hospital for a follow-up. All the opticians are private sector, so they are on a win-win and they will still get paid. The private optician will refer the patient, but you cannot expect them to identify that patient. It has to be done as soon as they enter the NHS system.

Perhaps we can put a new system in place and worry about the history another day, because we cannot catch up with every NHS number. From now on, everyone who comes in should not get a proper official NHS number until they have gone through the registration process. Their number should have a "T" in front of it for temporary. That cannot be that hard to do.

We have got the central spine. I am not sure whether you are familiar with it, but it is accessible to most people in the NHS. It does not have your medical history—although there is some somewhere, I would not have access to that—but it has your GP history, all your addresses and every time that that has changed. If you are identified as a temporary person, that could go on to the central spine. We have the systems, but we are making barriers that are not there. We have all these computer systems—we just need to tag it on.

It would not have to be an essay about the patient. You could have a red flag for a temporary patient from overseas, a green flag for a student and another colour for a non-resident, so when you go on to the spine, you can identify the patient straight away. We already have the systems. Presumably some IT person up there has the technology to advance the systems that we have got.

Professor Thomas: Ms Patel, I think that is a very good question, and there is a solution to it. At the moment the OVOs are the lowest of the low—not Jackie, because she does other duties. Lots of the OVOs look after private practices and that sort of thing, but they are paid at grade 4 or 5—they are the lowest of the low. In the NHS there are tiers until you get to senior management.

One suggestion I could make in answer to your question is that there should be a direct management structure—a much closer management structure—between senior management and the OVOs. There should be an accountable person in senior management who is directly responsible for the OVOs. At the moment senior managers knowing nothing about what is going on down below, which is a kind of untouchable level. I know that is the case because I spoke to a divisional manager recently—a divisional manager in the NHS is quite high; there is a chief executive, then a divisional manager—and he did not know what an OVO is. That proves it to me.

I have met these ladies—it is mostly women, but there are one or two men—and they are incredibly motivated, committed, fantastic people, but they are unsupported and there are not enough of them. If we had more of them, and if they had a motorway form of communication up to senior management, that would make a huge difference to the problem of health tourism. That is what I would like to see, and that is what I wrote in my article in *The Spectator*, which is coming out on Thursday. You might like to read it.

The Chair: Thank you for the plug. I am afraid this is going to have to be the last question.

Q23 Dr Julian Huppert (Cambridge) (LD): We have had some interesting conversations about how you might reclaim money. Can I be clear about what the process ought to look like in theory—I know practice is different—for a prospective patient? What should they be asked, when and by whom? I realise it does not often happen, but in theory, when somebody shows up, are they supposed to answer questions about their residency status, and at what stage? How is it supposed to work?

Jacqueline Bishop: They should complete the pre-attendance form as a starting point. I have one here, if somebody wants to photocopy it and send it round. The first question is, "Do you have a UK passport, an EU passport or Home Office papers?" I think it still says UKBA, and I think there is "other" on there as well. You should bring ID with you on your first appointment, but it is very difficult for a clerk on the front desk of the fracture clinic, which is normally one of the busiest

clinics, to ask somebody for their passport or some sort of ID if there is a queue of people. That is why you need central registration, so there is just one point. As soon as somebody is referred to the hospital, they should bring in their documents to prove who they are.

We need to educate the country. We need to have a different culture so that everybody knows that, when they go to a new hospital or register with a GP in a new CCG area, they have to take their home office—as in office in your home—papers: their passport, driving licence and utility bills. They will know that that is what they have to do to register with the NHS in their area.

Dr Huppert: So in theory—

Q24 The Chair: I am sorry. I am going to have to give the last word to Professor Thomas, then I must bring the session to a close.

Professor Thomas: I agree, is the short answer. It is going to require absolute vigilance and absolute identification to prevent people from walking through any number of loopholes.

Jacqueline Bishop: It needs to be compulsory. At the moment there are guidelines. You can send out instructions—a template document was sent out years ago about how to wash our hands, which was compulsory—but you cannot send out compulsory details to a trust and say, "This is what you have to do to identify all your patients." It is guidance, and it is up to us whether we do it or not.

The Chair: Ms Bishop, Professor Thomas, thank you both very much indeed. The Committee is indebted to you. If you wish to make any further submissions in writing to the Committee, including a copy of *The Spectator* article, Professor Thomas, the Committee would be pleased to hear from you.

Examination of Witnesses

Professor Vivienne Nathanson, Clare Gerada and Professor Terence Stephenson gave evidence.

9.45 am

Q25 The Chair: We now take evidence from the British Medical Association, the Royal College of General Practitioners and the Academy of Medical Royal Colleges. Good morning, Gentleman, Ladies, would you like to identify yourselves?

Professor Nathanson: I am Vivienne Nathanson, director of professional activities at the British Medical Association.

Clare Gerada: I am Clare Gerada, chairman of the Royal College of GPs and also a practising GP.

Professor Stephenson: I am Terence Stephenson, practising paediatrician and chairman of the Academy of Royal Colleges.

Q26 Helen Jones: Welcome, and thank you for coming to give evidence today. The Bill makes changes to the definition of people who are not ordinarily resident in the UK. Will that in practice help you to identify people who should not be accessing the NHS for free?

Professor Nathanson: The difficulty with it is understanding exactly what the new test will be to prove your resident status. Indeed, that is the current problem with "ordinarily resident", which often affects many of the people looking into these questions. For example, we need to recognise that there are people whose lifestyles are such, who have chaotic personalities, mental illness or who are homeless and so on, who would find it difficult to prove their status in either the current test or the incoming test. We think it is particularly important that there is a clarity about what the tests are and that that system would absorb the need to ensure that we can care for those people whose mental health status—let us say, as that is usually the problem—is such that they would find it difficult to prove in any sense what their status is. Those are the people who are eligible in either the current or the projected circumstance. So the test is variable and the problem with the current test is more that people do not understand what it is and what is needed to prove it. It is not so much that we need a new test, it is more that we need to understand better and to have better clarity and to make it able to deal with those people who do not necessarily have proof of who they are and where they live.

The Chair: I apologise for interrupting. Minister, do you want to come in on this point?

Mr Harper: No, thank you.

Q27 Helen Jones: That point is what I want to explore with you. The figures that we have seen for people using the NHS who should not be eligible for free treatment seem rather vague. Also, as I raised with the earlier witnesses, they do not seem to distinguish between foreign nationals coming here and British expats. Proving that someone is not ordinarily resident if they have an NHS number, as we heard earlier, is quite difficult. Do you have any suggestions that might help us to deal with that problem?

Clare Gerada: Thank you for that distinction between those who are ordinarily resident or entitled to NHS care and those who are gaming and, as we heard in the previous evidence, defrauding the NHS. We sometimes get muddled. The third group are those who become acutely unwell while they are here. We may need to deal with them separately. Dealing with the first group first, which is those who are entitled to NHS care within the current guidance, it is very complicated. As you said, it is not just whether you are "ordinarily resident", but whether you have lived in the UK or intend to live in the UK; or whether you are a student, or have failed asylum seeker status or pending asylum seeker status, so it is very complicated. When a patient attends our practice, I cannot distinguish between who is and who is not entitled within that group, because it is so complex. We would welcome clarity around that.

On the second group, we do come across those who are gaming it. I would be a fool and naive to say that, over the 25 years that I have worked in south London, there is no fraud or gaming. We used to have a problem with so-called suitcase addresses, where you might have 60 to 70 people registered at the same address. With paper records, it was quite difficult to find those, because they would be dotted around in different carousels, but with computer records it is a lot easier. We started to identify them and the then health authority would start to investigate.

If somebody walks into the surgery and has chronic diseases, yet has no previous medical record and is a new registration in my practice, that alerts suspicions. I

would personally ask that patient, "Can you just tell me a little bit about yourself?" and then I would ask whether they were intending to stay in the UK for the requisite amount of time. If they are, I have to treat them. I cannot ask them whether they can prove to me that they are going to stay for the next six months. It is impossible, and I am certainly not going to ask them to bring their passport and to see their visa. It becomes very complicated.

So we can pick things up, as you heard in the previous evidence, around the NHS number. If you have a new NHS number and no previous record and you are not a baby, where have you been for the past 30, 40 or 50 years? It is not that it is impossible to pick up; it is just that it becomes very complicated at the point of the GP practice to be doing that sort of scrutiny for every single patient walking through.

Professor Stephenson: I was not clear whether your question was about whether the system, or front-line doctors and nurses could detect them. If it is the latter, it is bewildering. In the documents sent out, there are nine different categories, none of which say, "person on holiday". They use terms such as "migrant", "indeterminate leave to remain", "tier 4" and "tier 2". I am faced with a mother and child. She is French. The dad is working in Britain. The child is three. Are they migrants? Do they have leave to remain? The child is ill. Do I see them now? It is bewildering for front-line staff. I have no doubt that, with both IT systems and dedicated staff, you can drill down through the complexity, but not for people who are in first-line contact with patients.

Q28 Helen Jones: I am trying to get through some of the fog that surrounds all this. The one thing we have discovered is a problem with getting accurate data.

However, I want to ask you to comment on another provision of the Bill. The Bill provides for imposing a charge on people coming into the United Kingdom: persons who apply for immigration permission. In your experience, would that deter people coming here as health tourists? I do not mean people who have an accident while they are here, but people coming here deliberately to get treatment. If so, how high would it have to be to provide that deterrence?

Professor Nathanson: It is extraordinarily difficult to know how high it would have to be to deter someone. I guess, if you are saying that there is a group of people coming here to get medical care and for no other reason, it would depend on the nature of the medical treatment they were coming to get. If they were coming to get something that would cost them thousands of pounds in their own country, clearly the surcharge would need to match that. That is why it becomes difficult. That is why you actually need to know why people are coming, where they are coming from and what the costs are, but of course you cannot then adjust the surcharge to be sensitive to that. Many people may come for what is relatively inexpensive treatment—all these things are relative—but obviously costing more than the £200 or whatever is being thought about at the moment.

The £200 might, however, act as a disincentive to people who are thinking of coming here to work. I am thinking particularly, within the NHS, of, say, junior doctors, who have jobs in, say, Scotland, where they have to move regularly between different jobs as part of their training programme. They are giving a service to the NHS, but every four to six months they have to apply for a new visa because of the sponsorship scheme. There is no national sponsor in Scotland; it is the individual employer. That means that they may have to pay the surcharge repeatedly over a period. If they are given the choice between doing that and paying once or not at all—paying into, say, a private insurance scheme—they may well go to countries that give them the same quality of training, but do not apply a surcharge. That could be very significant in relation to providing NHS services.

Professor Stephenson: A flat levy is clearly a nonsense; £200 would not pay diddly-squat for one consultation. A single inhaler for asthma costs £55 without you even seeing a doctor to examine you and make the diagnosis. As Vivienne has pointed out, it is such a low level. If you were coming for something that cost anything at all, it would seem extraordinarily attractive to pay that levy, enter the UK and get free care—free at the point of delivery—just by presenting yourself, so it does not make any sense at all. You would have to match the cost to what people were taking out of the system for it to make any sense.

Clare Gerada: I would agree with that. You heard the previous evidence about people coming for multiple births. I suspect that the cost of having triplets across the road from here at St Thomas' would amount to hundreds of thousands of pounds by the time you have factored in all the costs within that, plus the aftercare. I think what you end up with from this levy is an insurance scheme whereby anybody who wanted to have health care would buy that insurance forthwith, because, as Terence said, the minimum costs would not be covered by it; and you would end up deterring people from coming. If there is organised crime, certainly it is not going to deter the organised crime, because it then opens the floodgates for anybody who wants to come and have free health care, because you are saying that if you pay £200 or £250, you can get what you like. Even if you put a ceiling on that, you would have to put the ceiling at a rate that was only just above that; otherwise, what sort of insurance scheme would that be? It would rapidly become a nonsense.

Q29 Helen Jones: Thank you; that was a very interesting answer. I shall ask you my final question. We have heard lots of evidence about the difficulty of following patients up—first, of finding patients who are not entitled to free NHS treatment and then of collecting the funds. Have you any recommendations—you might not have, but I shall ask you—about how that could be done better if the charge in this Bill is not to be a deterrent?

Clare Gerada: As you heard before, it is mainly around hospital care. Again, it is not that difficult in general practice to identify people, because you would have to newly register them. That is assuming that they have not been here and fraudulently registered in the past. I think there were discussions about having new registrations to get an NHS number taken outside the GP surgery. Perhaps you do it, rather like when you apply for a passport, through a post office. There, you present whatever ID the Government choose to use and that ID is scrutinised, not by the GP; and that then entitles you to an NHS number. If you are not entitled,

a Z can be put on it. We do have Z numbers, which are for those who have not yet got a permanent NHS number. That is the first thing.

The other thing is that, with respect to general practice, the issue is not the cost of seeing me. It is not like in hospitals, where we are doing very expensive tests. It is actually, I suspect, the cost of medicines. Once you have a fraudulent NHS number, for argument's sake, you essentially have unlimited prescriptions as long as you come to the country every two to three months. If you are on expensive medication, that would probably be something that you would do, but it is not just those people defrauding the system. There is a whole bunch of expats who live abroad and come back perhaps twice a year for their health checks—for whatever—and they are almost impossible to identify, because they are people who have lived in the UK and may well have retired overseas. I predict that there is going to be an explosion of this group, because as people become older in Spain—and various other places—they will return to the UK and want the treatment that they cannot afford over there. Again, that is a group that we are not yet dealing with, but one that I would be quite worried about.

Q30 Helen Jones: That is interesting. Do either of you have evidence from your experience about the balance between expats coming back here for treatment and foreign nationals coming here?

Clare Gerada: While knowing about this issue I have been following my own surgery. I do not have evidence nationally, but out of my last six surgeries—and I see on average 30 people a surgery—I have had one expat coming in wanting a health check, their meds and their investigations and one person who is not entitled to healthcare who was a new registration. I quietly and politely said to the person: "I am very happy to deal with your immediate and necessary treatment, but for your medicines you will need a private prescription". That is a scale of one on one, but the issue for general practice of fraudulent registration is decreasing. It is much harder to do it now with computerised records. I am not sure about pitching up at A&E. I suspect that this is still a big issue.

Q31 Mr Harper: May I make just one point that is meant to be helpful in terms of clarification? The health surcharge, which is in the Bill, is not a charge for visitors to the United Kingdom. It is only for people coming here on a visa. So, to pick your example, if you were the woman who was pregnant with triplets, to get access to our healthcare by paying a surcharge you would either have to establish that you had come here on the basis of getting a job with a sponsored employer and were employed in the United Kingdom; or you would have to get a tier 4 visa as a student, be accepted at a British university and pay the rather quite significant fees for studying as an overseas student. So it is not intended for this to be a charge for anybody in the world who fancies rocking up in the UK for five minutes to pay £200 and have access to the health service. They will be overseas visitors, eligible to be charged in the usual way. Just to put people's minds at rest: it is not a free entry to the UK.

Of course, both of those groups—migrant workers and students—currently have complete access to the NHS once they get here, for zero cost. So what we are proposing is to make them pay a modest contribution to health care, for which we do not currently charge them.

The point I wanted to establish was twofold, because I am a little confused. This morning, particularly you, Dr Gerada, have accepted that not everybody should get free NHS treatment and that we should distinguish between those eligible and those who are not. I do not think that this seems to be in line with some of the public comments that I have seen you quoted as saying, such as that the NHS should be available for all the people. May I be clear from all three of you? Do you agree that the NHS is primarily a national health service and that we should have rules in place for determining who is and who is not eligible? We should not be making it possible just to treat people from anywhere in the world.

Clare Gerada: What the Royal College has said is two main things. One is that we do not want to turn GPs into border agents. That is absolutely clear. Secondly, we should not turn people away at the front door because of their inability to pay. If you are saying: "Does that mean there should not be laws?" then of course there should be laws and there are rules. At the moment we try to implement them and if there was absolute flagrant abuse of the rules then of course as GPs we would point out to an individual that they were not entitled to free health care. The commonest thing in terms of general practice is people coming from overseas on holiday and forgetting their medicines. If they are here for two weeks, they are not entitled to those medicines free from the state because they are here on holiday and we will give them a private prescription, so there is no issue.

There should be laws, but we are saying that this needs to be sorted and we cannot turn people away at the front door. Whatever system is put in place it must make sure that we are able to provide immediate and necessary treatment to patients who require it, plus a safety net for those individuals who, for whatever reason, fall through the net.

Professor Stephenson: Clearly, as a UK taxpayer I do not want to fund the health care of people who do not contribute to my system. I quite accept that principle. What we are talking about is the difficulty in proportionality of implementing it. If it costs more in time and money to recover those costs, the NHS has much bigger fish to fry at the moment. If you can recover substantial costs without putting much in, then that is wholly desirable. However, I see emergencies; I spent all last week seeing emergencies. I do not want to be a citizen in a health care system where someone has to show their credit card before I attend to their immediate needs. To me, that would be wholly unacceptable and would not be becoming of the profession of which I am a member.

Professor Nathanson: I agree completely with Professor Stephenson and Professor Gerada. The key issue for doctors is to assess the need of a patient for immediate care, and to be able to offer that care. Separately, yes, the NHS should find a system for recovering money from those who should be paying for that, but that is not for the doctors to do.

For doctors, it is much more important that we see patients who need care. There are so many things that could go wrong and end up costing us all as taxpayers more if we actually do not see people who need immediate

care; whether that is because of the spread of an infectious disease, or because somebody's illness that needs immediate care becomes so serious that they end up, for example, requiring intensive care that will cost many times more than the immediate care would have cost. There is both the ethical reason but also a financial reason. Luckily, for once, they happen to be side by side and going in the same direction.

Q32 Mr Harper: I have one follow-up question to that. First, picking up Professor Stephenson's point, I think the research that was done by the Department of Health recently demonstrated that it was quite a significant sum of money—at least £2 billion of health treatment provided to visitors and migrants by the NHS—of which a significant bit is not recovered. I want to probe a bit. I agree with you that for urgent necessary treatment that is where you should provide the treatment and then worry about it afterwards. I agree with you. Picking up on your point about not turning away, Dr Gerada, if someone turns up at a GP's surgery—not someone who needs urgent serious treatment—and they are not entitled to NHS care, should you not be turning them away and saying, "No. You are not entitled to free NHS care and I am not providing it to you."? Should you not be turning them away? Is that not the right thing to do for the taxpayer?

Clare Gerada: It depends on the situation. For example, if you have a relative coming to visit a friend, for example, from Nigeria. They come and they have got a bad hip. They are here on a two to three-week holiday and say that they want to be referred to the hospital for their hip, we would say, "Sorry, you cannot be. You are not entitled to health care. I am happy to refer you privately but you are not entitled."

However, say that same person comes to see you and says, "I am here on a six-month visa." For whatever reason they have been allowed a six-month visa, so I will refer them. Within the law, I will have to refer them. It just depends. As Dr Nathanson said, we are not there to fund the whole of the world's health care, but equally we are there to deal with what we see in front of us and make the judgment within the law.

Q33 Mr Harper: So you are quite clear. If the law was changed—I absolutely accept the point that we have to ensure that the rules are easy and straightforward to operate for front-line staff. I also accept that it may not be doctors and health professionals who are making those judgments. We had evidence, when I know a couple of you were here, that it will be the overseas visitor manager or, in the GP practice, it may be the practice manager who does the checks.

Clare Gerada: We cannot do those checks in general practice. We would not be equipped. The checks would have to be pretty onerous.

Q34 Mr Harper: I was listening to your evidence carefully and I thought you said earlier that you did not think it would be very difficult for GPs to assess whether patients were entitled.

Clare Gerada: I said that you would be registering outside the GP practice. The checks would be done rather like in a passport check, scrutinised by an external person, who would then allocate the entitlement to an NHS number, in order to be registered. If you have somebody coming straight into the surgery who has never been seen, we would make an immediate and necessary assessment of that individual for immediate and necessary care, and we would put them on the system as a temporary resident. If, however, you are asking us in the future to make an assessment, with the expected level of scrutiny, of every single person who wants to register with a general practitioner permanently, including looking at passports and passport stamps, and whether they have been in and out of the UK, that is not something that a GP practice could do.

Q35 Mr Harper: Will you be happy for someone else to do that and present you with a decision on whether you should treat the patient?

Clare Gerada: If that was proportionate, as you heard, and if that was the law—you make the laws—then of course we would agree, because it is not for us to breach the law, but that should not be done in the GP surgery. Registration of that complexity would have to be done outside. You heard in earlier evidence how enormous hospitals struggle to do that, let alone GP practices where we struggle to do the day job. We do not want our practice managers, who are incredibly highly trained and doing all sorts of other things, to be doing work to that effect.

Professor Nathanson: I think that at the beginning of the question you said that somebody coming to a GP surgery was unlikely to have an immediate and necessary requirement for treatment. I would dispute that. It is incredibly important that you understand that GPs see everything from the trivial to the incredibly serious. For example, let us think about somebody who is in the UK for a period who has just been to the Hajj, or in the middle east generally, and who comes into the GP surgery with a cough and a fever. We expect those GPs to be thinking, "Is this MERS?"—the middle east respiratory syndrome, an illness similar to SARS, the severe acute respiratory syndrome that we are all so worried about now. They may come in with many other things that could be the first signs of illness—a headache that is clearly the early stages, luckily, of meningitis.

GPs see all sorts of things. With meningitis, it is the patent's life that is at risk; with a SARS-like illness, we could risk a community epidemic. GPs see urgent cases, which is why they feel very strongly that they need to assess the patient first; that is their first and foremost duty. They may find that the patient has a trivial illness, but they could find something highly significant to that patient, or to the community.

Q36 Mr Bain: May I put to the panel what the Department of Health's review last year concluded? It said that

"the NHS is not currently set up structurally, operationally or culturally to identifying a small subset of patients and charging them for their NHS treatment. Only a fundamentally different system and supporting processes would enable significant new revenue to be realised."

Does the panel see any evidence of any such new system in the Bill's provisions? Would not one of the possible implications be that new burdens and costs will be imposed on NHS practices and hospitals, without any extra assistance from the Government to help deal with those?

Professor Stephenson: I already said that there needs to be far more detailed economic analysis of the costs required to recover, vis-à-vis the income one will get. The figure of £2 billion was quoted, but my reading of that quantity of analysis is that it was hedged by caveats and wide confidence limits. Indeed, much of that £2 billion could be recovered without any change in legislation; it just was not being chased up. From the Department of Health's document, it seems that the additional sums of money that will come in owing to the new legislation will be much less than £2 billion. That is not a particularly easy document to understand, but that was my take on it.

The Chair: Professor Nathanson, you are nodding.

Professor Nathanson: I agree completely. We think that the best way to recover more money would be to use the current system with better clarity about what is "indefinite leave to remain" and, particularly, "ordinarily resident", which is the test that we are often told people at hospital level find terribly difficult to interpret because of all the caveats and so on. In particular, the people at hospital level recovering that money need the information to be able to do so, and to make that easy. That also means that we need to look carefully at the frequency with which we change immigration rules, with the different tiers, eligibility and so on, because that is also an important part of this. That is the evidence that we hear.

At hospitals, there is usually potential for economy of scale. That is not always the case, as there will be some small hospitals that rarely see overseas visitors and probably will not have much cost to so-called health tourism. However, there are clearly hospitals that are already recovering a significant sum of money. I would really like to see somebody ask how they manage to be so successful at, say, Guy's and St Thomas's, which we know are pretty successful in recovering most of the money from the overseas patients whom they treat.

Clare Gerada: I am a partner in quite a large primary care organisation in the capital, and we run a large number of practices across some of the most deprived boroughs. I am trying to think how we would actually do this. For a start, we would have to have wi-fi installed in every practice. We would have to put the machinery in every practice to start getting money by credit card. We would then have to have the infrastructure and the people there to start getting the money. We would have to have the space to do it, and in some of our practices, space is very limited. Although it might sound simple, if these provisions were to go through and we were having to recoup some of the costs, I do not know quite how we would do it.

Some people say that general practitioners recoup costs anyway, and there are some things for which we do take money from patients. For example, there are certain vaccines that people have to pay for, and certain processes, such as private medicals, for which people pay. However, that is a tiny proportion, and to do that at scale would put a big pressure on general practice. I do not think we have the infrastructure to do it, and without significant investment, we would not have that infrastructure.

The Chair: One more question from Mr Bain.

Q37 Mr Bain: What assessment have you made of the implications for public health if the system in clauses 33 and 34 were to be adopted?

Professor Nathanson: We have been talking to a number of people. The real concern is that people who are not well and who might have a contagious disease may not turn up. There will inevitably be misunderstandings about whether people are eligible. Regardless of whether the system is the current one or the proposed one, there will be a small group of people who are not eligible, and do not have a right to treatment, who will fail to come forward. There is a real worry, therefore, about including primary care in particular, because that is where we "catch" most of the contagious and infectious diseases. I know those diseases are meant to be exempt, but the fact that there is a new system may stop people from coming forward. That is enormously important.

There are broader public health concerns, not in terms of infectious disease, but in terms of the cost of changes in disease. I would also be very worried about people who live on the margins of society, who do not have an organised lifestyle and will find it difficult to present to GPs' surgeries if their identity is being questioned. If they have not been registered, there is an inevitability, to a certain extent, that they might get questioned. The question then is whether we would worsen health inequalities. Given that health inequality is quite rightly a major strand of all our work in health at the moment, as well as a major strand of policy, I think that is an extraordinarily worrying consequence.

Clare Gerada: There are two issues. I imagine we would have to find mechanisms for scrutinising the other access points. For example, a lot of care is now provided online and through telephone advice. Are you going to park that and just ignore it?

I also think that if you start charging at the front door of general practice, you will probably find that those patients end up at another front door, be that at the emergency department, or services for sexually transmitted diseases, or pharmacy services. You would have to look at it in the total.

I am still struggling, because if this is about fraudulent practice, people will always find way of dealing with fraud measures and will always find ways through. You may still not hit the very issue that you are trying to hit, which I imagine is what you were hearing about before, namely the expensive, potentially organised crime of people coming through for treatment. I think that is rare, but if that is what you want to stop, these measures are not a way forward.

Q38 Henry Smith: We heard earlier that countries such as France, Spain, Germany, Canada and Australia manage to recover the costs of treating overseas visitors and foreign nationals and are able to screen their treatments. Indeed, when I was abroad this summer, I had to access primary health care; I paid the bill and recovered the costs on my health insurance. Why can we not do that in this country?

Professor Stephenson: Fundamentally, those countries do not have an NHS, free at the point of delivery. So when I go to those countries I have had the same experience. But everybody in those countries is either showing some kind of identity card or health insurance system. If you have had a skiing accident or you have

been ill, you have to demonstrate your capacity to pay. So I am not against that, but it is a very different culture. Let me illustrate this with a real case last week which shows that it is all rather grey.

A three-year-old from east Africa came with his mother into our hospital in central London with a fever. We want people who might have infectious diseases to come to see us. Would a charge have deterred them? Probably. They came. It subsequently transpired that the child did not have anything infectious but a scan showed an abnormality. The surgeons recommended that that child have a follow-up scan within a couple of weeks. There then ensued a very difficult conversation—English is not their first language—with the distressed mother and the distressed child. As they were on holiday here for another two weeks, could they have the follow-up scan here? If not, should they wait until they got back to east Africa, in which case they could not have the scan as it not available in rural east Africa.

That illustrates the problem with this idea of there being urgent and non-urgent and eligible and non-eligible and people being conversant with really quite complicated things. For a practising doctor confronted late at night with a screaming child and a distressed mother, it is not as simple as it would be for me as an intelligent, articulate, affluent person having a skiing accident in Verbier and showing my insurance. It is not transferable.

Clare Gerada: I would repeat that. I have seen several examples. We have one of the most cost-effective health services in the world. It is certainly far more cost-effective than Germany's and far more cost-effective than those of other countries that charge such as the United States. You could say that that is in spite of having, as you said, a £2 billion potential cost for those who are not entitled to health care or are entitled but may be charged through different systems. One could say that starting to introduce charging systems, with the transaction costs and the costs of collecting in relation to fraud, which you heard about in the previous evidence, would far outweigh the costs that you would ever recoup. Plus, it would turn our health system into a very different system from the one we have all been brought up in, which is free at the point of use. It would start to deter people who need the health care, as Professor Stephenson has just said.

Q39 Henry Smith: Turning to public health, are the provisions in the Bill sufficient to ensure that treatments for conditions like tuberculosis are properly covered?

Professor Nathanson: It is difficult to know. Yes, they are in theory because the provisions say that infectious and contagious diseases will be exempt. The difficulty is whether the potential patient will know and understand that the condition they are presenting with is exempt. If somebody has a cough, their first thought may not be that it is TB. They may think it is asthma or something else, in which case they may not turn up. While the theory is that it is covered, in practice people do not present saying, "I've got a cough; I think it is a contagious disease and therefore I am exempt." They say, "I've got a cough. I don't know what it is." It could be a number of different things.

Professor Stephenson: I think the academy has already accepted the principle that people who do not contribute should, ideally, pay. The Bill tries to protect the public against infectious diseases. I should like to add that public safety can also be compromised by people with mental health problems. They can be a danger to other people. It is crucial that the Bill recognises that people with mental health problems are unlikely to have insight into their condition and may well be deterred from seeking appropriate treatment if they have to pay. The subsequent treatment may be less effective and more expensive for the UK taxpayer in the long run and they may have harmed other people by the time they present. With those caveats, I think the Bill tries to address that problem.

Q40 The Lord Commissioner of Her Majesty's Treasury (Anne Milton): On a point of clarification, as a former public health Minister, I should say that there is no intention to change access to emergency and urgent treatment, or treatment for infectious diseases. In fact, I am proud that we widened access to HIV treatment, which was the right thing to do; it was previously excluded.

Professor Stephenson's point about the east African child raises some tricky issues for the doctors seeing the child and their mother. Who do you think should pay for that scan? What do you think should happen?

Professor Stephenson: That is for our sovereign Government.

Q41 Anne Milton: I know, but you are here because you have wide experience, and you have raised an undoubtedly tricky situation, so I would be grateful for your view. How do you think it should be paid for?

Professor Stephenson: My view is immaterial. With my expertise as a doctor, I do not want to try to undertake that transaction late at night. If you can put together a proportionate system that can recover the cost, and the British public think it is fair—I can see that there is a legitimate view about people who come here on holiday, though the child was not here as a health tourist; they fell ill—I am happy to stand by that. I just do not want us to go down a road where I spend a disproportionate amount of time with that family when there are other children waiting to be seen who need my care. That is my fundamental point. We are a democracy. If the Government decide we should have a system for recovering that, I would have to say to the person, "I'm dreadfully sorry. You can have the scan, but the rules are this." I just do not want to be the person doing the transaction.

Q42 Anne Milton: Just for clarification, you are happy to abide by any system; what you are saying, understandably, is that you as a medical professional do not want to get drawn into that dialogue or transaction, which is fair enough. I can understand that.

Professor Stephenson: I am a UK citizen in a democracy. I obey the speed limits; I do not drink and drive. If the rules are that the costs will be recovered from people, I am sure that they will be recovered. If they are not, the people will go to prison. I just think you need to be sensible and proportionate about this, not emotional.

Q43 Anne Milton: I think that is what Dr Gerada is also saying. I challenge your assertion that general practitioner practices cannot manage this, because GP practices bill Government. They have charging systems

built in. They are private businesses, there is a contract between them and the state, and they are for ever charging the state.

Clare Gerada: They are not taking money.

Anne Milton: I would have thought it was not beyond the wit of man to build in appropriate—*[Interruption.]*

The Chair: Order. Let us have questions and answers, not a conversation. Finish the question, Ms Milton, and then we will take the answer.

Q44 Anne Milton: Are you saying that you could not build into GP practices, which are run as businesses, the ability to charge people if it was appropriate to do so?

Clare Gerada: Again, if the law demanded that I had to charge, then we would charge. We would have to develop systems, and we would come to the Government to say, "Help us put the systems in place, because we do not know how far and how much." I think my main point was about registration at that point. That was the main point of contention. It was about having to put in a billing system as the patient comes through, and a system to identify whether they are entitled to health care. That was the main issue. Clearly, as I said, practices do charge.

With respect to the question that you asked earlier about who should pay for the scan, I am quite clear about that case. That was immediate and necessary, and a further problem was then found. That was categorised within immediate and necessary health care, but you could only make that assessment once you started to do the test. That is why, when you start to change the rules, you will open a Pandora's box. It will mean that we start to deny people care once we have identified that there is something wrong, which is almost a worst-case scenario—telling somebody, "You've got a potentially life-threatening illness, but sorry, we can't carry on, because it's not part of your immediate problem." Those are the issues that we as doctors have never been brought up with. If you change the whole system, you will change the whole way that we have been working—me for the last 30 years, and many others for longer.

Q45 Jim Dowd (Lewisham West and Penge) (Lab): First, I apologise to the Committee for my delayed arrival. I know that some of you were here when our previous witnesses gave evidence. Professor Thomas said that it was really not his job to decide who is and is not entitled; they should not be presented to him unless they are entitled.

He showed his driving licence and advocated some similar system of entitlement card. What did you think of that as an idea, given that Dr Gerada in particular said that she does not think that you could work out entitlements at GP surgery level?

Clare Gerada: It depends what the rules are. You set the rules. At the moment, the rules are that you have to present a utility bill that is at least three months old and—it says—possibly a photo ID. That is the entitlement.

If you change the rules, of course we will have to discuss that, but I am saying that it is not as easy as presenting a driving licence. Of course it is not as easy as that; it is not even as easy as presenting a passport, for all the reasons that I gave earlier. You might have a UK passport, but you might not be entitled to UK NHS care. How far are we going to quiz that individual and ask to see proof of travel, for example on the Eurostar? You do not get stamps in a passport anymore.

Q46 Jim Dowd: I did not understand Professor Thomas to be saying that. What I understood him to be saying was that we should decide entitlement by some other system, so that when you present to me, I know that you are entitled.

Clare Gerada: You have that system already. It is called the NHS number. There is already a system through which you can prove entitlement; only, though, if you take off immediate or necessary care, such as the child who presented to the hospital last week. I think everyone has an NHS number. Hospitals do not use NHS numbers, because they prefer their own numbers, but every single person has an NHS number. Therefore you could, theoretically, ask, "What is your NHS number?", and that is your ticket into getting health care.

Professor Nathanson: Just to make it more complicated, at the moment having an NHS number does not entitle you to free NHS secondary care. One example is a UK pensioner who still has an NHS number—you get it for life—but who is spending more than six months of the year in another country in the European Union, or who is registered for care in those countries.

What Professor Thomas was talking about was probably some form of identity card. I know that in the identity card project under the previous Government, there was a concept that it would be an entitlement card to NHS and other services. One can imagine what some of the other services could be.

In a sense, what Clare Gerada was talking about was someone at a central point—the old primary care trust or whoever—saying, "This person is entitled to NHS services" and doing it that way: going through all the complexity of the rules, trying to find out where people live, asking the difficult questions and producing some form of entitlement, perhaps a new NHS number that we start to produce for the future. It does not really matter what it is, but an entitlement thing would help to make it absolutely clear who is entitled.

At the same time, we still need a system at the hospital level—primarily at the secondary care level—that ensures that we are efficient, effective and proportionate in the way that we apply bills, because there will be people who need care but whose secondary care will be paid for afterwards. It needs to be clear to the patient when they present that if they present without an entitlement card, they will be billed.

Q47 Jim Dowd: I understand the general consensus of what you are all saying—if there is such a thing, even though there was some dispute about whether the Department's £2 billion figure was genuine or an optimum or even optimistic assessment—to be that, although the current system is not perfect and does not work in all circumstances, trying to do much about it would be disproportionately costly. Therefore, what we have in the name of the greater public good is a necessary, almost irreducible overhead that we just have to live with because the ultimate public benefit is so much greater. Have I understood it correctly?

Clare Gerada: I think that is correct. In fact, the report said that health tourism—or fraudulent behaviour, which I think is the problem we are trying to solve—was anything between £70 million and £300 million a year. The rest of that £1.9 billion was in recoverable costs, costs in mental health and costs for people who are entitled to health care under the current rules. We need to keep separating those two out. In order to deal with that health tourism bit, the costs of it would far outweigh the costs of recovery.

Because I am interested in the NHS, I looked back to what Bevan said in 1948, and he identified this as a problem. He used different language, and it was very sweet: he basically said that it was something that we would have to put up with, but that those people would spend money on cigarettes, the cinema and something else, so we would get revenue in place. As I understand it, the report that was published last week, after the Department of Health report, also said that the revenue we collect in tax and transport is probably far greater than the revenue you will ever get in trying to recoup some of those costs.

Professor Stephenson: I think we are dancing around three separate things here, which are getting conflated. First, I have absolutely no doubt that you could introduce a system to recover these costs, and I am sure that GPs could introduce a credit card. If you wish to do it, it can be done. It is not beyond the wit of man, but it has a cost.

Secondly, as a doctor, I am a good samaritan. My preference is to treat people without fear or favour, irrespective of colour, creed or religion. Faced with a young child who is ill, I would prefer not to be drawn into discussions about what country they came from and why they are here. I recognise, however, that that is a personal preference.

Thirdly, I recognise, as a citizen in a democracy, that there will be taxpayers and others, and readers of certain newspapers, who are absolutely incensed by my view that I would be very happy to treat people irrespective of where they come from, their religion or their colour. I recognise that such people believe that we should absolutely bottom out why those patients are here. Are they fit to pay? Are they here fraudulently? Are they here on holiday? If those are the rules you want, I will live with that. The three are related. The cost of getting that money from those patients will be a cost to that same British taxpayer. A detailed analysis of the weighing of the scales as to whether taxpayers will really benefit from this would be wise. If it shows that we would be £2 million better off, that would be £2 million that we could be spending on the care of UK children, on treating cancer or on doing hip operations, which would be fantastic. But if it costs £4 million to get it out, I think that is probably a mistake.

Q48 Jim Dowd: What do you suggest I say, then, to my constituent who has to take their turn for treatment, for which they have paid as a participating citizen, behind people who have not paid? Do I simply say, "That is a structural anomaly in the system. The ultimate benefit is that there is a good health service for everybody, and we should not take it down to the micro level; we should look at the macro benefits across society"? Do you think that they would feel any better if I told them that?

Professor Stephenson: What I would say to them is, "I would hope that if you had a skiing accident in Germany and your leg was in pieces, German people would accept that your treatment would come before their common cold. I would hope that that reciprocity and common kindness would exist." On the other hand, if they have all got common colds, I guess you just have a queuing system. I do not think that people would mind citizens from other countries whose need was great going first.

Professor Nathanson: To add to what Professor Stephenson has just said, the other part of it would be that we in the NHS would be doing our best to get the money back for people who were not eligible or, indeed, for those whose eligibility was due to the fact that they lived in an EU country that should be repaying the NHS. That is also an important source of cost and potential revenue recovery. We would be doing everything we could that was legitimate, but people with an emergency need should be treated humanely. That is really what we are talking about.

The Chair: Do members of the Committee have any further questions for these witnesses?

Q49 Priti Patel: I have one final and straightforward question, which follows on from the witnesses' remarks to Mr Dowd. Do you have any practical solutions to address health tourism and fraud in the current NHS system, in light of your recent comments?

The Chair: I will take that as an opportunity to let you each have a final word, and then we will draw this session to a close. Professor Nathanson first.

Professor Nathanson: I think that it is extraordinarily difficult to set a system in place that will stop organised, deliberate fraud, particularly if people are using agents to help them. I believe that putting a surcharge in place will make that a more profitable system, because people who are reluctant to break the law might think, "Well, this is an insurance." It effectively legitimises it, because they have paid their £200, say, and they fraudulently manage to get the right visa, so they would think that it is no longer fraud in a simple sense. I think it could make it worse.

We have to be very public about whatever we do. We have to ensure that people understand what the exemptions are and what proofs they are going to need to show their eligibility. The more we are public and open about that, the more we will be able to reassure people that people who should not get access are not going to get access, but also ensure that people know that there are certain types of emergency need in which they will be cared for. That will diminish the risk of public health consequences or consequences to individual health. Openness is an extraordinarily important part of this. The other thing it does is encourage the patient who is coming in to be open and to understand when questions are asked about their eligibility that they are not being picked on, because it is a routine part of the way in which the NHS has to operate. That should be done by skilled individuals whose job is about money recovery, not the clinicians who are meeting the patients.

Clare Gerada: True fraud—fraudulent behaviour, rather than confusion about who is entitled or not—I do not think is as common in general practice as it possibly is in hospital care. First, many people from overseas do not understand general practice, so they do not come to us. We know that from the people who should come appropriately, but do not. Secondly, it is relatively easy in a sense to pick up, because if we have a patient coming in with end-stage renal failure, who has never been involved in the NHS before, you say, "Where have you been?" It is not as difficult to pick up as it is in an emergency department, where by the time you have got through the system, you are already plugged into health care.

We are not talking about people who are moribund. The commonest thing, I would say, in general practice in the old days was coming for a hip replacement. It is not difficult to identify. As I said before, we then deal with it in as sensitive a way as we possibly can. If they insist on being referred to hospital, we write, "This patient, as far as we are concerned, is not entitled to NHS care," and we leave it at that.

Professor Stephenson: I think it is a slightly rhetorical question you are asking, because Henry Smith has already given you the answer. There are lots of countries in the world. I am flying to Hong Kong tomorrow, because I have been invited to give a talk about safety in the NHS. If I do not have medical insurance and I am stabbed in the street in Hong Kong, I sincerely hope that if I am taken to hospital, someone will resuscitate me. If I went to a GP in Hong Kong with a sore throat, I suspect they would ask, "Have you paid? Do you have a credit card or any insurance?" I would say, "No." and they would say, "I am sorry, but we can't see you."

You asked whether we have any practical advice on how to have the system. Look around the world. There are dozens of systems. The question is not whether you can do it. The question is, do you want to, and is it economically sensible for our health system? All those other systems routinely ask everybody, including their own citizens, "Have you got coverage?" That is the difference.

The Chair: Professor Nathanson, Dr Gerada and Professor Stephenson, the Committee is indebted to you. Thank you very much indeed for your time.

Examination of Witnesses

Sir Andrew Green and Mathew Pollard gave evidence.

10.45 am

Q50 The Chair: The Committee will now take oral evidence from Migration Watch UK. Good morning, gentlemen. Thank you for joining us. Could you identify yourselves, please?

Sir Andrew Green: Good morning, Chairman. I am the chairman of Migration Watch, Sir Andrew Green.

Matthew Pollard: Mathew Pollard, the director of Migration Watch.

Q51 Mr David Hanson (Delyn) (Lab): Good morning, Sir Andrew and Mr Pollard. I am grateful for your written evidence, which I looked at this morning. You indicate in it that you estimate that the number of illegal immigrants was some 1.1 million in 2010, and you estimate that it is 1 million now. Can you give the Committee the basis on which you have made that estimate?

Sir Andrew Green: Yes. I will be brief. There have been only two major attempts at an estimate. One was in 2005, which made a central estimate of 430,000. We revised that figure to take account of the fact that it was four years old, and we came up with 670,000. The most recent attempt was in April 2009, in a report by the London School of Economics for the Mayor of London that had a central estimate of 618,000. We looked into that in some detail, and we are now at the point that Mr Hanson mentioned. The estimate in that study was that 7,000 people a year overstay their visas out of the 1.5 million visitor visas that are issued. In other words, 99.5% of visitors leave as they should. We did not believe that that was remotely realistic. We put in a higher estimate for that and made some other adjustments. We then came to the figure of 1.1 million, which Mr Hanson mentioned.

We have done one other piece of work that is relevant. We looked at the remittances sent back to Pakistan. We found that they had increased by a factor of six in an eight-year period. In that same period, the increase in the labour force, as recorded by the labour force survey, was only 66%. If you do some arithmetic—this is on our website—it suggests that on a cautious estimate, there are some 200,000 extra workers in Britain who do not appear in the immigration stats. There are roughly 25,000 a year from Pakistan alone. The bottom line is that, while there is a lot of intelligent guesswork in this, 1 million is a cautious estimate.

Q52 Mr Hanson: Whatever the level of guesswork, how many of those 1 million people do you estimate to be currently known to the Home Office, whether that is their address, their telephone number, their texts, their contacts or forms being placed? Do you have an estimate of that? Should you have an estimate of how many of these people's whereabouts or addresses are known to the Home Office?

Sir Andrew Green: Almost by definition, the whereabouts would not be reliable. You could go through the files and estimate the number of people who no longer have leave to be in Britain, but that would not tell you whether they had left.

Q53 Mr Hanson: On the basis of whatever figure you have, how far will the Bill's proposals impact on and potentially reduce the final figure, whether that is a guesstimate or otherwise?

Sir Andrew Green: That is the central point. If I can widen my answer to your question, it is important to understand that an effective system of removal is fundamental to the credibility of the entire immigration system. If you look at that system, you find that the rate of forced removal from the UK has been, on average, 9,000 people a year over the past nine years. Others leave voluntarily, of course, but 9,000 a year is frankly trivial compared with the number of people who enter the UK, initially legally.

As you know, we have 1.5 million visitor visas issued every year. Just 1% of that number would overwhelm our capacity to remove forcibly. We also have 200,000 students

from outside the European Union each year, and 10% of them would overwhelm the present removal capacity. There are then, of course, the illegal immigrants—the "back of a truck" people—and there are no numbers for them.

Given those numbers, our capability to remove forcibly and the scale of people coming to Britain, the only way to address the issue is the way that the Bill addresses it, which is to try to make it more difficult for people to stay in the UK illegally. We do not particularly like the term "hostile environment". It was unfortunate. The reality is that if we have—as we would wish—an open economy and society, then of course you welcome immigration. But it must be controlled, and the deal must be that when your time is up, you go. That is what this Bill tries to do.

Q54 Mr Hanson: I agree with some of your comments in terms of effective enforcement. In a sense, those were the initial opening comments that I wished to make in relation to your estimates—whether they are right or wrong—versus the numbers who are known. Even the enforcement measures in the Bill are implicitly only workable on people who are known to the Home Office. I am interested in trying to get to a figure on that. We will revisit this during the course of our discussions in Committee.

You mentioned the Bill. I want to touch briefly on a number of points in it. On part 2, you said in your memorandum:

"We welcome the reduction in the number of grounds for appeal",

and that you agree that most appeals are

"used simply to frustrate the removal process in cases that have no prospect of success".

Have you any view on the current quality of decision making in relation to those people who, under the Bill, would potentially be removed?

Sir Andrew Green: It all depends on whether you are talking about asylum seekers or applications for extensions and so on. They are very different issues. My basic point is that what the Bill seems to us to be trying to do is prevent the exploitation of the appeals system, which has clearly been going on. All Governments—even the judiciary—have, frankly, been frustrated by some of the cases that they have seen. The aim is to reduce the scope for manipulating the appeal process, and we agree with that.

Q55 Mr Hanson: If I said that approximately 50% of appeals are currently upheld by the first-tier tribunal, which is being abolished, would that worry you?

Sir Andrew Green: Are you talking about asylum?

Q56 Mr Hanson: I am talking about the current provisions in the Bill. On family migration and other issues, roughly 50% of appeals are upheld and they are now going to be abolished. Does that worry you?

Sir Andrew Green: Not especially.

Q57 Mr Hanson: So you are saying that 50% of people are currently given the right of appeal, have that appeal upheld and therefore are legally allowed to stay in the United Kingdom, and it does not worry you that those people will not now have that right of appeal?

Sir Andrew Green: There are two aspects to this. One is that there will be a right of administrative review.

Mr Hanson: There is now.

Sir Andrew Green: Yes, and in respect of visas overseas, that is quite an effective way of doing it. It has been shown to be quite effective. As regards the other 50%, it depends on the case.

Mr Hanson: They are currently upheld.

The Chair: Order. May we have a question and an answer, rather than a dialogue, if that is possible?

Sir Andrew Green: What the Government are trying to do here is change the balance, so that the system cannot be exploited. That is the right thing to do.

Q58 Mr Hanson: You said in paragraph 4 of your written evidence—and I agree with you:

"Not only are they themselves often mistreated but they frequently undercut the wages of British workers".

Do you think that there is scope in the Bill to look at a range of potential labour market issues which might also address that issue? For example, greater enforcement of the minimum wage or a register of migrant workers being recruited by recruitment agencies.

Sir Andrew Green: They are not in the Bill now, and the issues you refer to are not necessarily addressed at illegal workers, they are more inspired by migrants from eastern Europe. I am not against them. There certainly should be enforcement of the minimum wage, and we should not have situations where employment agencies deal only with foreigners. I think your third idea was that there should not be whole areas or shifts in a factory given over to foreigners. Those are perfectly reasonable ideas. Where the Bill comes in is that by dissuading people from staying illegally, it will dissuade people who would otherwise undercut British workers and dissuade the unscrupulous employers, who are almost worse, from competing with honest employers who offer decent wages and decent conditions. That is quite apart from the extra weight on public services, of course.

Q59 Mr Hanson: This is the final question from me. We are going to hear this afternoon from landlords about the landlord provision, the basic principle of which I do not fundamentally disagree with. I am, however, interested in its workability and its potential impact on British citizens who want to rent. Do you have any concerns about the workability of the landlord proposals? Do you have any concerns about identity checks for British citizens who will have to prove their nationality as part of a rental procedure?

Sir Andrew Green: I agree that it is not a simple matter, but the availability of accommodation to people who have no right to be in this country is something that needs to be addressed. At its extreme, this business of beds in sheds is an outrage in all possible respects and must be dealt with. That would be included in what is now proposed.

On the specifics of your question, the mechanics will need to be looked at fairly carefully. There are parallel arrangements, as you know, in respect of employers and those seem to be settling down reasonably satisfactorily. One would hope for the same with landlords.

Q60 Mr Hanson: Do you have any understanding of the number of calls to the Home Office relating to enforcement, advice or assistance on employment issues? Do you have a view on whether the Home Office has the capacity to offer the same to the thousands of landlords in the UK?

Sir Andrew Green: No to both questions. I do not have a view.

The Chair: Order. Just before we proceed, I have been calling Sir Andrew because Mr Hanson has been directing his remarks to Sir Andrew, which seems reasonable, but, Mr Pollard, if you want to interject or intervene at any time, please do indicate.

Q61 Priti Patel: I welcome the witnesses to the Committee. This question is for both to answer. Paragraph 13 of the written evidence you provided touches on the migrant health levy, and you will have heard the other evidence presented to the Committee this morning. What is your view on how far the Bill is going to address such problems, some of which we have discussed this morning? In the light of some of the comments this morning from NHS professionals, what else do you think we could do in practical terms?

Sir Andrew Green: I thought the discussion this morning was very interesting. The bottom line is that I don't think the Bill is going to do very much that is helpful to deal with the central issue. There clearly is a very serious issue. There is the issue of fairness. Not much was mentioned about that. I think one Member referred to the impact on British patients, which is very important, as is the effect on British patience. There is also a question of resources. I note that the latest estimate is that one might save something like £2 billion on health costs. The total cost of immigration control to the taxpayer is £500 million, so we are talking about serious money here. We would want to see much more in the way of resources going both to immigration control and to preventing what is quite clearly a measure of abuse of the health service.

Another point, which I don't think came out in the discussion this morning, is just how wide open the national health service has become. Anyone who sets foot in Britain for 24 hours has the right to treatment by a GP. A GP cannot refuse to put someone on his list unless it is full. If it is full, the local authority allocates the person concerned to another GP. That seems extraordinary, but I certainly accept that you cannot ask the medical profession to act as immigration officers. The complexities of this are enormous and you need specially trained staff. We have for years recommended that a limited number of officers should be tasked with assessing the eligibility of applicants for GP services. That would bring together the expertise needed on immigration with that of the health service. None of that is touched in the Bill. I can only imagine that there was some resistance to it, but it must be looked at again.

Matthew Pollard: I have nothing further to add on that.

Q62 Priti Patel: Going back specifically in the light of your comments, Sir Andrew, there is an issue of public perception and how we address the gulf between that and reality. An earlier panel of witnesses was asked how we explain things to our constituents who cannot access NHS services. The same also applies to areas such as housing. Where do you feel the responsibility should lie? Should it be with central Government legislation—that is, in the Bill—or should it be down to the guidance given by central Government to NHS professionals such as the clinical commissioning groups, which would cover primary care, and to local authorities, which would cover housing?

Sir Andrew Green: Let me take health first. As Professor Stephenson said, it must be a Government responsibility to set the rules, and it cannot be the doctors who interpret them. The Government therefore have a responsibility to provide the administrative framework that will distinguish between those who have a right to treatment and those who do not.

A further interesting point from this morning's discussion is that the major barrier must be secondary care—hospitals. That is where the real cost is and that is where there is very little control. We hear from lots of people, such as Professor Meirion, that somebody turns up at a hospital with an NHS number and nobody likes to ask any questions. That must be stopped. We need to have a situation in which someone in this country has an NHS number that perhaps entitles them to care for a temporary period, to primary care only or to full care. That is an administrative problem, not a medical one. I hope that the next Bill will address it.

Q63 Priti Patel: In terms of the approach, would you apply a similar analogy to access to public housing via local authorities?

Sir Andrew Green: I think public housing is extremely important and that, among those on housing waiting lists, there is very little confidence that it is being dealt with fairly. The way in which it has been dealt with has not been honestly described in the statistics that are available. Perhaps Mr Pollard can add to that in a moment. We have looked at the issue in some detail but were not able to find the correct proportion of foreign-born who are in social housing. That certainly needs attention.

Matthew Pollard: On social housing, local authorities carry out the checks, or they are supposed to, and they have published quite detailed criteria on who is eligible and who is not. The statistics on who is actually getting housing are not published. If we take London, which is perhaps the area with the biggest immigration impact, fewer than half the lets have any nationality data recorded against them. We therefore do not know who is actually getting the housing in, for example, Hackney or Lambeth. That causes a lot of public concern and is a concern when we get contacted.

Sir Andrew Green: Of course, the Government have now strengthened the local connection test, but if we do not have any reliable statistics, we have no idea whether the test is having any effect.

Q64 Henry Smith: Given your extensive research in this area, how much of a draw is our virtually unchecked national health service for people coming to this country, particularly illegally but also more generally?

Sir Andrew Green: It is absolutely bound to be an additional incentive. The main reason that people come and stay illegally is to earn money and send it home, but

the knowledge that they effectively have free medical treatment while they are here must be an additional incentive.

The Chair: Are there any further questions from Members?

Q65 Mr Harper: First, thank you, Sir Andrew, for your welcome for the overall approach to the measures in the Bill. Partly for the benefit of the Committee, I wanted to check your response on the health issues.

I am mindful, Sir Roger, that you told us to talk about what is in the Bill. It is clear that there is a range of health issues—both for visitors who currently have entitlement to the NHS and maybe should not, and for those who do not have entitlement but in respect of whom we are not good at collecting money back. I want to reassure you that the proposals in the Bill are about changing the ordinary residence test to one of permanent residence for non-EEA migrants, and about the health surcharge.

I want also to reassure you that the Department of Health, separately but working with us, will bring forward proposals following on from its consultation to deal with some of the issues associated with visitor charging, both from a policy perspective and addressing some of the points about the practicalities that were made in earlier evidence from Professor Thomas and Miss Bishop. I think that all the NHS witnesses, without exception, said that such measures were complicated and difficult to enforce at the front line. I do not know if you want to respond to those points, which were really more for the benefit of the Committee, so that we keep the debate on track.

Sir Andrew Green: That is very reassuring. Chairman, may I make a major point that has not come out in the discussion so far? It is to do with the rate of inflow. How important is that? Mr Hanson asked about the total number and we discussed that.

There is another issue as to how big inflow is. Is it something we need to worry about? Of course, almost by definition it is hard to know. I would say that if you look at the international passenger survey, which records only those people who say that they are going to stay for a year or more, so they are legal on arrival, for citizens from outside the European Union that has been running at 300,000 a year for the past eight or 10 years. If you look at departures, it is 100,000.

Somewhere there are 200,000 people a year who need to be accounted for. Some of those will have extended entirely legally. Some will have married. You used to be able to go from a work permit to settlement and so on. Part of that will be those who have managed to transfer to a legal position to stay here. Another part will be people who have extended their visas, but you cannot extend them for ever. We are looking at a pretty substantial number who have come in legally and for some reason have not gone.

Our view is that a major part of that is students who have overstayed, and there is quite substantial evidence in that respect. The National Audit Office inquiry found that 40,000 to 50,000 students from the Indian subcontinent had come for reasons other than study in the first year of the points-based system. There have been other studies.

The most recent information was from August, when we found that only 50,000 students had left, while the average arrivals in the past five years have been 150,000. Now, those are all issues that will be further investigated as we have more years' statistics and more detail. The Committee should be in no doubt that we are talking about a substantial annual increase in the number of people remaining in Britain illegally, plus those who enter illegally in the first place.

The Chair: This places me in a little difficulty, because I have imposed upon members of the Committee a restriction to discussing only matters contained in the Bill, not matters omitted from it. However, you have raised the point and it would be discourteous not to allow you to do so. On the basis that we try to remain in order, Jackie Doyle-Price.

Q66 Jackie Doyle-Price (Thurrock) (Con): I want to probe you on paragraph 16 of your evidence relating to marriages and civil partnerships. You specifically refer to enabling registrars to feel confident about raising suspicions. Have you had any feedback from priests or vicars about that? Certainly, given the constraints with which they have to deal in the way that the Church manages marriage, I know that many of them have felt intimidated about raising suspicions. Do you think that what we have in the Bill gives them sufficient protection?

Sir Andrew Green: Yes, that is one of the reasons why these provisions are helpful. It is absolutely clear that if one of the parties to a marriage does not have the right to reside in Britain with indefinite leave to remain, it has to be referred. Again, the extension of the notice period is entirely sensible. We have had ridiculous cases where not only were registrars and priests hesitant to intervene, but there wasn't time for the Home Office to do so. The Home Office's own estimate in their evidence is 4,000 to 10,000 a year. It could be more than that because of the scams that have developed. The Bill is entirely helpful, and I would be very surprised if there was any serious concern expressed about it.

Q67 Jackie Doyle-Price: One of the issues on which I have had representations—it is very difficult to enshrine in law—is the whole idea of marriage by deception. Once the right to remain has been issued, the party who has deceived disappears. Have you any thoughts about how that can be tackled?

Sir Andrew Green: Once it is referred to the Home Office, you already have a deterrent in there. In most of these cases, it is pretty damned obvious that the thing is completely bogus. It has to be done. We mentioned the cost to the taxpayer. These people, once they get through the hoop, which has been wide open, are entitled to a full range of benefits—not just the NHS but anything you can think of. This Bill is absolutely right and should be enough to deal with it.

The Chair: If there are no further questions from Members, that brings us to the end of our business for this morning. Sir Andrew and Mr Pollard, thank you very much indeed for joining us. The Committee will take further evidence at 2 o'clock this afternoon.

Ordered, That further consideration be now adjourned. *—(Anne Milton.)*

11.12 am

Adjourned till this day at Two o'clock.