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Committee of Public Accounts

NHS treatment for overseas patients

Thirty-seventh Report of Session 2016–17

Report, together with formal minutes relating to the report

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The Committee of Public Accounts

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Summary

The NHS will always provide immediately necessary and urgent care to any patient who needs it. However, hospital trusts have had a statutory duty for over 30 years to recover the cost of treating overseas visitors who are not eligible for free care. It is clear that the NHS has been recovering much less than it should, and only in the last few years has the cost of treating overseas visitors become a priority for the Department of Health (the Department). Since the Department launched its overseas visitor and migrant cost recovery programme in 2014, the amount charged has increased (from £97 million in 2013–14 to £289 million in 2015–16) but most of that progress has resulted from changes in the charging rules, rather than from trusts implementing the existing rules more effectively. The Department and the NHS are still a long way from meeting the target to recover up to £500 million a year by 2017–18.

The systems for cost recovery appear chaotic. The Department told us it was planning further changes relating to policy and regulation, good practice and IT, but we are not convinced that enough is being done to identify and charge overseas patients. If the NHS does not recover the cost of treating patients who are not entitled to free care, then there is less money available to treat other people and even more pressure on NHS finances. The Department and the NHS need to do more to promote public confidence that the money due to the NHS is being recovered, and that the system is fair to taxpayers and to patients who are entitled to free care.

Introduction

Whether patients are supposed to pay for treatment depends on whether they are resident in the UK and on the type of treatment. Some treatments, including GP appointments and accident and emergency care, are currently free to all patients and some patients, such as refugees and those applying for asylum, are exempt from charges. In other cases, statutory regulations require hospital trusts to make and recover charges in respect of the cost of treating overseas visitors. Most hospital care is chargeable.

Trusts should charge visitors from outside the European Economic Area and Switzerland (EEA&S) directly, and report when they treat visitors from the EEA&S so that the UK can recoup charges from other member states, for example under the European Health Insurance Card (EHIC) scheme. Research for the Department for Health (the Department) in 2013 indicated that the NHS recovered less than a fifth of the amount it could have charged. In July 2014, the Department launched an overseas visitor and migrant cost recovery programme with the aim of increasing the amount recovered, from £73 million in 2012–13 to £500 million a year by 2017–18, by extending the scope of charging and implementing the existing regulations more effectively. New rules extended the charging regime in April 2015, so that students and temporary migrants from outside the EEA&S now have to pay an immigration health surcharge as part of their visa application.

Conclusions and recommendations

1. **We are not confident that the Department for Health (the Department) is taking effective action to recover more of the costs of treating overseas visitors.** Since 1982 the NHS has had a statutory obligation to identify and charge overseas visitors who are not eligible for free care. Yet in 2012–13 the NHS still charged only around 65% of what it could have charged to visitors from outside the the European Economic Area and Switzerland (EEA&S), and 16% of what it could have charged for visitors from the EEA&S. The amounts being charged have increased since then—to £289 million in 2015–16 compared with £89 million in 2012–13. In practice, the amount recovered will be less than the £289 million charged because trusts do not get back all of the amounts that they invoice to patients directly. Most of the gains so far have been from changes in the charging rules, in particular the introduction of the immigration health surcharge which generated £164 million in 2015–16. The Department for Health (the Department) has set a target to recover up to £500 million a year by 2017–18, but in October 2016 forecast that only £346 million would be charged. The Department referred to plans it had for policy and regulatory changes, work to identify and share good practice, and improvements to IT systems, but accepts that there is still a lot more to do to apply the existing regulations more effectively.

   Recommendation: ***The Department of Health should publish, by June 2017 at the latest, an action plan setting out specific actions, milestones and performance measures for increasing the amount recovered from overseas visitors. The action plan should name senior individuals in the Department and NHS Improvement whom the Committee can hold to account.***

2. **Progress in increasing the amounts recovered, particularly for patients from other EEA&S countries, is hampered because the NHS is not effectively identifying chargeable patients.** In 2012–13, the NHS charged an estimated 65% of the amounts it could have charged to overseas visitors from outside the EEA&S, and only 16% of what it could have charged for visitors from the EEA&S. The Department forecast in October 2016 that the NHS would charge £72 million in 2017–18 for patients from within the EEA&S, well below its original ambition to recover £200 million. The UK recovers far less from other EEA&S states than these countries claim from the UK: in 2014–15, the UK recovered only £50 million but paid out £675 million. While some of the difference can be explained by the cost of treating British state pensioners who live abroad, it is clear that hospitals are not identifying all the overseas patients they treat. A person's chargeable status is primarily determined by whether they are 'ordinarily resident' in this country, and can change over time. NHS Improvement argues that it can therefore be extremely difficult, in busy clinical areas, to identify chargeable patients because there is no single document or piece of information, such as a passport or NHS number, that confirms whether or not a person should be charged for NHS treatment. The Department highlights that some trusts, for example in Peterborough, are now requiring patients to prove their identity by showing passports and utility bills. However, these documents do not demonstrate entitlement to free NHS care. The biggest challenge is that there is no single easy way to prove entitlement. In addition, we are conscious that some people who live in this country and are eligible for free healthcare may struggle to provide passports

and utility bills and it is important that their access to care is not compromised. The Department should consider a system that would allow verification without compromising patient care.

Recommendation: ***The Department should do more to build on existing systems, such as the NHS number and electronic patient record, to flag to trusts when people are entitled to free care as well as when they are not. This could help tackle both the very low levels of cost recovery for EEA&S patients, and the problem that some people resident in this country may find it hard to show documents that indicate their entitlement. Government should work with other agencies public and private to make clearer in advance of people coming to the UK what health insurance should be taken out and individual liabilities.***

3. **The extent of unexplained variation between trusts, both in the amounts they charge and the debts they recover, suggests that some hospital trusts have scope to make substantial improvement.** The Department and NHS Improvement recognise that some trusts are charging and recovering much more than others, but cannot explain why this is the case. Just 10 out of the 154 acute and specialist hospital trusts accounted for half of the charges to visitors from outside the EEA&S in 2015–16. Eight trusts did not charge any visitors from outside the EEA&S and 22 trusts did not report any cases under the EHIC scheme. Larger trusts and those in regions with more visitors are likely to charge more, but the variation between trusts is not fully explained by factors such as trust size and location. Debt collection rates also vary significantly, from 15% to 100%, even after excluding outliers (the top and bottom 10% of trusts). Increasing the amount recovered depends on action by hospital trusts, but only 11 of 50 trusts that responded to a consultation thought that their income from overseas patients would increase significantly in future.

   Recommendation: ***NHS Improvement should benchmark trusts, identify which are doing well compared with similar trusts, share this information with senior trust executives and boards, and set out what it will do to promote best practice. An additional incentive would be to develop a system that more directly rewards those institutions which most efficiently collect monies owed.***

4. **While the statutory responsibility to identify and charge overseas patients lies with trusts, other parts of the health system also have an important role and are not yet doing enough to support cost recovery.** The arrangements for recovering the cost of treating overseas visitors involve national oversight bodies, and also healthcare commissioners (NHS England and clinical commissioning groups) that bear the cost when trusts do not identify chargeable patients. These organisations need to support trusts to identify and charge overseas visitors. The Department recently introduced financial incentives, which appear to have helped increase the amounts charged to some extent. NHS Improvement told us it is planning to monitor charging and cost recovery, and intervene when it considers trusts are not fulfilling their statutory obligations. Commissioners have powers to audit trust recovery processes and are not liable to pay for treatment if a trust has not taken reasonable steps to identify chargeable patients and recover charges. It has been reported that more stringent tests of eligibility for maternity care put in place by St George's Hospital in London were in response to the clinical commissioning group's

refusal to pay for overseas patients that it thought should have been charged directly. This suggests it may be possible to take effective action when there is the will to do so. However, there are no clear, consistently applied, sanctions when trusts do badly.

Recommendation: ***NHS Improvement should collect and share data on the performance of trusts in charging patients and recovering money, and intervene when performance is clearly falling short. At local level, clinical commissioning groups should scrutinise the performance of their local trusts, and use their powers to audit trusts if they are not confident that trusts' charging processes are robust.***

5. **GPs could do more to help the NHS increase the amounts recovered for treating chargeable overseas patients.** GPs are not contractually obliged to identify chargeable overseas visitors, but some share relevant information when referring patients for hospital treatment. There is also scope for GPs to report EEA&S patients through the EHIC scheme, which would allow the UK to recover costs from other EEA&S countries and thereby increase income for the health system. The Department is keen to support any GP surgeries that wish to pass on information, but there are no systematic arrangements in place for GPs to do so.

   Recommendation: ***NHS England should clarify what it expects of GPs in relation to identifying chargeable overseas patients, and issue guidance by the end of June 2017. The guidance should set out the role of GPs in the charging system and how they might best fulfil this role.***

1 The shortfall in amounts charged and recovered

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and NHS Improvement.[1]

2. The NHS provides immediately necessary and urgent treatment to any patient who needs it.[2] Some treatments, including GP appointments and accident and emergency care, are free to all patients and some patients, such as refugees and those applying for asylum, are exempt from charges. However, patients who are not 'ordinarily resident', such as people visiting from abroad, former residents who live overseas and short-term migrants, may have to pay for the hospital treatment they receive.[3] NHS trusts and NHS foundation trusts have a statutory responsibility, in accordance with the relevant regulations, to make and recover charges in respect of treatment for overseas visitors who are not entitled to free healthcare.[4]

3. The charging rules are complex. Broadly, there are three systems for different visitor groups. Trusts should charge visitors from outside the European Economic Area and Switzerland (EEA&S) directly. For people resident in EEA&S countries, with the exception of state pensioners, trusts should report details to the Department of Work & Pensions, so that the UK can recoup costs from other member states. In April 2015, new legislation extended charging to a third group of visitors (students and temporary migrants from outside the EEA&S) who now have to pay an immigration health surcharge as part of their visa application.[5] The Department told us that the complexity of the system, which had built up over a considerable time, was one of the big challenges for trusts.[6]

Under-recovery of costs

4. The statutory obligation for the NHS to make and recover charges for treating overseas visitors was first implemented by regulations made in 1982, under powers introduced by legislation in 1977. The Department told us that in the following three decades very little happened to put this statutory obligation into effect, but it could not explain why there had been so little focus on the issue for so long.[7]

5. Research for the Department in 2013 suggested that in 2012–13 the NHS charged an estimated 65% of the amounts it could have charged to overseas visitors from outside the EEA&S, and only 16% of what it could have charged for visitors from the EEA&S. The NHS charged £89 million in total, compared with an estimated £367 million that it could have charged. Of this, an estimated £73 million was recovered as cash.[8] The research

1 C&AG's Report, *Recovering the cost of NHS treatment for overseas visitors*, Session 2016–17, HC 728, 28 October 2016
2 Q 1; C&AG's Report, para 1
3 C&AG's Report, paras 1.2, 1.3 and Figure 2
4 Q 3
5 Q 4; C&AG's Report, para 1.4 and Figure 3
6 Q 5
7 Qq 10, 16, 85–88
8 C&AG's Report, paras 1.9, 1.12,and Figure 4

also estimated that the total cost to the NHS of treating people who were not ordinarily resident in this country was around £2 billion a year but, because of exemptions, under the regulations not all of this amount was recoverable.[9]

6. In July 2014, the Department launched an overseas visitor and migrant cost recovery programme with the aim of increasing the amount recovered to £500 million a year by 2017–18, by extending the scope of charging and implementing the existing regulations more effectively.[10] Increasing income from overseas visitors is one of several measures intended to reduce the financial deficit of trusts, which reached £2.45 billion in 2015–16.[11] The Department explained that the £500 million target should not be regarded as overly scientific, and was a top-down calculation based on assumptions about the number of visitors and the amounts charged. This was the best estimate, as the Department did not have bottom-up data about the gap between what was charged and what should have been charged.[12] The Department emphasised, however, the underlying principle that the NHS should charge the right amount, which might be higher or lower than £500 million a year. It viewed £500 million as a stretch target to create a culture within the NHS where people did charge the right amount.[13]

7. The Department told us that more progress had been made in the last three years than in the previous 30 years, in terms of both improving knowledge and recovering cash.[14] Charging increased from £97 million in 2013–14 to £289 million in 2015–16. We note, however, that most of this increase was due to changes in the charging rules. In particular, the new immigration health surcharge generated £164 million from students and temporary migrants in 2015–16. Most temporary migrants from outside the EEA&S pay a surcharge of £200 a year, and students and applicants under the youth mobility scheme pay £150 a year.[15] The Department said that the surcharge is a simple, flat-rate charge that was intended to be simple to administer.[16]

8. The Department noted that, in setting the level of the surcharge, government had sought to strike a balance between what was fair to the overseas visitors concerned and what was fair to the UK taxpayer, and that some of the people who came to this country to work would also pay taxes. It could not confirm how far the immigration health surcharge covered the full cost of the healthcare provided to students and temporary migrants from outside the EEA&S. The research for the Department in 2013 suggested that the average cost of the treatment accessed by this group of people was £736 per person per year. Not all visitors who pay the surcharge access NHS services, but only very limited data are available to show the services that have been used in practice and how much they cost. The Department told us that it was working with NHS Digital to make improvements to address this information gap where it was financially proportionate to do so.[17]

9 Q 6
10 C&AG's Report, paras 8 and 1.12
11 C&AG's Report, para 1.17
12 Qq 7, 9-10
13 Q 37, 39
14 Q 10
15 C&AG's Report, paras 1.15 and 2.2
16 Qq 99, 101
17 Qq 98, 105; Department of Health (TOP0010) paras 3 and 4, Annex A; Professor Meirion Thomas (TOP0002)

9. The Department accepted there was still a lot more to do to apply the existing regulations effectively.[18] It forecasts that, were it to take no further action between now and the target date, charging would reach £346 million by 2017–18, short of its ambition to recover up to £500 million.[19] It referred us to plans it had for policy and regulatory changes, work to identify and share good practice, and improvements to IT systems, and also said that it would be responding shortly to the consultation on extending the charging regime to other NHS services, such as accident and emergency and some primary care. The Department thought these steps would close the gap between its forecast and its ambition, but could not quantify the likely effect of the different measures.[20] It told us that it would continue with the process of trying things and seeing if they worked and, if they did, going further with them and, if not, trying other things..[21]

10. The result of the EU referendum creates further uncertainty for the health system. The Department could not explain what impact Brexit might have on the charging regime. We challenged the Department on whether it was worth investing in systems to increase EEA&S charging when the EEA&S health schemes might not apply to the UK in two years' time. The Department told us that the system changes it was planning were designed to improve identification of overseas visitors, and that it believed they would help the NHS regardless of the outcome of Brexit negotiations.[22]

Identifying chargeable patients

11. The biggest shortfall in amounts charged, compared with the ambitions for amounts recovered set out in the Department's implementation plan, relates to charges for EEA&S visitors. Most of these visitors are covered by schemes such as the European Health Insurance Card (EHIC) and their country of residence pays for their treatment. The Department now forecasts that the NHS will charge £72 million in 2017–18, having aimed for £200 million.[23] The Department explained that this issue was purely one of identifying chargeable patients, as distinct from recovering debts. The NHS needed to identify more EEA&S patients and record their EHIC number, and government could then go about reclaiming. The Department said that, in contrast to systems in countries where everyone is charged, the NHS is not set up to check identity and charge people.[24]

12. It is striking that the UK paid £674 million to other EEA&S member states in 2014–15, but recovered only £50 million.[25] The Department said that much of the difference related to the cost of treating state pensioners.[26] Because of the way the system works, the UK pays for healthcare for UK state pensioners regardless of where in the EEA&S they live. In 2015–16, the UK paid other EEA&S states £565 million, of which £429 million was for the healthcare of UK pensioners abroad. Income for treating EEA&S pensioners in the UK was £13 million in 2015–16, out of total income of £56 million from other EEA&S member states.[27] The Department told us that the UK paid for 190,000 UK state

18 Q 10
19 Q 12; C&AG's Report, para 1.16
20 Qq 35, 125
21 Q 126
22 Qq 129, 130
23 C&AG's Report, paras 3, 1.16 and Figure 5
24 Q 15
25 C&AG's Report, para 2.15
26 Q 27
27 Q 54

pensioners living abroad, mainly in Spain, France and Ireland, but there were only 5,500 state pensioners from the EEA&S living in the UK.[28] However, it could not explain the difference for other countries—for example in 2014–15, Poland claimed £4.3 million from the UK, and the UK claimed £1.5 million from Poland.[29] The Department agreed that the UK is not collecting as much from other EEA&S states as it should. Stripping out money relating to state pensioners, the Department said that this country paid out about £130 million and got back around £40 million, and that it would expect these two numbers to be more balanced.[30]

13. NHS Improvement explained that it is extremely difficult, in busy clinical areas, to identify chargeable patients.[31] There is no single document or piece of information, such as a passport or NHS number, that confirms whether a person should be charged for NHS treatment. This is because, unlike in other countries, a person's chargeable status is determined primarily by residency and can change over time.[32] The Department highlighted that, working with the Home Office, it had tightened the residency criteria such that people from outside the EEA&S had to have indefinite leave to remain in the UK in order to be classified as 'ordinarily resident' and automatically entitled to free care.[33]

14. The NHS does not routinely ask people to prove their identity.[34] The Department has been working with NHS Digital to make changes to IT systems, including the summary care record application, to help trusts identify whether a patient is likely to be chargeable or entitled to free NHS care.[35] It also told us that some trusts, such as Peterborough, were now asking patients for two forms of identification, including one form of photo ID, although it recognised that asking all patients to prove identity was a controversial thing to do.[36] St George's Hospital in London was piloting asking women to bring a passport and proof of address to check their eligibility to free maternity care. The Department said that these initiatives had not yet been evaluated.[37] NHS Improvement told us that it needed to identify best practice and then make that best practice available to all.[38]

15. There may, however, be some UK residents who, because of their personal circumstances, cannot provide the documents they might be asked for. We heard evidence, including from Doctors of the World, raising concerns about the impact of charges on vulnerable groups, the cost and burden of implementation, and the consequences for public health. NHS Improvement assured us that it was working with cohorts of organisations to determine good process that was proportionate, minimised burden and appropriately discharged organisational responsibility to identify and recover appropriate costs.[39]

28 Qq 48, 49
29 Qq 29, 30
30 Qq 32, 42
31 Q 66
32 C&AG's Report, para 3.5
33 Q 111
34 Q 20
35 C&AG's Report, para 16
36 Qq 19, 25
37 Qq 25, 113
38 Q 68
39 Qq 118, 119; Doctors of the World UK (TOP0003), paras 2 and 3

2 Responsibilities across the health system

16. Only 11 of 50 trusts responding to a National Audit Office consultation said that they expected income from overseas patients to increase significantly in future. The Department for Health (the Department) said that number needed to go up.[40] It acknowledged that there was a long way to go, both to ensure that all trusts dealt with overseas charging with the seriousness it deserved, and that the Department did enough to help trusts get better at tackling the issue.[41] In particular, the Department told us that it wanted to foster a culture where everybody who works in the NHS feels responsible not only for patient care, but also for financial rigour.[42]

Variable performance across trusts

17. There is significant variation in the amounts that individual trusts charge. Just 10 of the 154 acute and specialist hospital trusts accounted for half of the charges to visitors from outside the EEA&S in 2015–16. Eight trusts did not charge any visitors from outside the EEA&S and 22 trusts did not report any cases under the European Health Insurance Card (EHIC) scheme. Larger trusts and those in regions with more visitors are likely to charge more. However, trust size, type and location can explain only around half the variation in the amounts trusts are charging overseas visitors.[43]

18. Once they have charged patients, trusts have varying success in collecting payments. Nationally, trusts collect only around half of the amounts they invoice to overseas visitors directly. However, performance varies significantly from trust to trust, with some collecting just 15% and others collecting 100% of the amounts they charge (even after excluding the top and bottom 10% of trusts).[44] The Department suggested that one technique was for trusts to be clear to patients about charging and the likely cost of treatment, and ideally secure payment for non-urgent treatments up front. It described this as an element of best practice that it wanted to see adopted more widely.[45] The Department suggested that debt collection was a service that might well be included were groups of trusts to join up their back-office functions. It also highlighted that trusts could link through to the Home Office system and a record of bad debt could be taken into account the next time a person applied for a visa.[46] The Department told us that it hoped to see the amounts of bad debt written off go down, but it did not have any projections for what it expected, or wanted, the level of written-off debts to be.[47]

19. The Department and NHS Improvement recognised that some trusts were charging and recovering much more than others, but could not explain why this was the case. They told us they were unsure whether trusts that charged and recovered more were actually doing well, or whether they just appeared to be doing well relative to the poorer performance of other trusts. NHS Improvement had, however, identified the cohort of

40 Q 60; C&AG's Report, para 2.2
41 Q 63
42 Q 33
43 C&AG's Report, paras 2.16–2.20
44 C&AG's Report, para 3.33
45 Q 140
46 Qq 141–142
47 Q 140

trusts where there appeared to be the biggest gap between what the demography suggested the trust should be charging and the actual amount charged.[48] It said that it needed to benchmark trusts, identify best practice and share this information across the system. It also indicated that it would use the information it gathered to develop helpful improvement tools for trusts to use.[49]

20. The Department told us that it had added benchmarking information on cost recovery for overseas visitors to the 'model hospital' data it made available to trust governing boards. In future it therefore ought to be much more explicit to the boards of trusts when trusts were out of line with where they should be. It would also give those charged with oversight and intervention the opportunity to inquire and ask questions and allow more targeted follow-up.[50]

The wider health system

21. The Department has introduced financial incentives to encourage trusts to improve their processes and increase charging. There are two incentives: one for the EHIC scheme, and one for visitors from outside the EEA&S. The Department argued that the EHIC incentive, introduced in October 2014, has had a positive effect, with trusts reporting more treatments. The rise in reporting had not led to an increase in charging, but the Department told us that it expected charging would go up.[51] The non-EEA&S incentive, introduced in April 2015, allows trusts to charge patients 150% of the normal NHS tariff price. The amount charged has increased much in line with the change in prices, but there is no evidence that trusts are identifying more chargeable patients from outside the EEA&S.[52]

22. Healthcare commissioners (NHS England and local clinical commissioning groups) bear the cost when trusts do not identify chargeable overseas patients, and have powers to audit trusts to ensure they have appropriate policies and procedures in place. The NHS standard contract makes clear that clinical commissioning groups should not have to pay for treatment provided to chargeable overseas visitors if a trust does not make reasonable efforts to recover the costs.[53] It is the responsibility of commissioners to challenge hospital trusts to show they are identifying and charging all the overseas patients they should.[54]

23. It has been reported that the more stringent tests of eligibility for maternity care put in place by St George's Hospital in London were prompted by the local clinical commissioning group's refusal to pay for overseas patients that it thought should have been charged directly. The Department described this as commissioners doing exactly what they were supposed to do.[55] NHS Clinical Commissioners told us that clinical commissioning groups recognised their role, and suggested that targeted data and training for commissioners would go a long way in helping the health system to achieve the aims of the cost recovery programme.[56]

48 Qq 24, 26
49 Q 116
50 Q 116
51 Qq 21, 47; Department of Health (TOP0010), Annex A
52 C&AG's Report, para 3.32 and Figure 6
53 NHS Clinical Commissioners (TOP0007) para 3.3
54 Q 122; NHS England (TOP0005)
55 Q 113
56 NHS Clinical Commissioners (TOP0007) paras 5.1, 5.3

24. NHS Improvement, as the regulator of trusts, has the potential to influence trusts' behaviour. It told us that it needed to ensure that appropriate processes were in place throughout the acute sector. Building on its work to collect data and benchmark trusts, it planned to intervene where it thought organisations were not fulfilling their obligations and needed support to do so. It agreed that there also ought to be clear, consistently applied, sanctions when trusts that needed to improve did not do so.[57]

The role of GPs

25. The Department explained that GPs were not contractually obliged to do anything to identify overseas visitors.[58] Its charging guidance does recommend that GPs should note in the referral letters they send to hospitals if they know that a patient is an overseas visitor, holds an EHIC or might be directly chargeable.[59] We note that, in practice, some GPs do provide hospitals with information to indicate that patients might be chargeable, but the capability for systematic data sharing is not built into NHS IT systems.[60]

26. At our evidence session, the Department was unsure about the arrangements for reclaiming the costs of primary care, such as GP appointments, from other EEA&S states. It subsequently confirmed the legal basis for charging for primary care under the EHIC scheme. The cost of all 'needs arising' treatment carried out, subject to valid documentation being presented, can be reclaimed. This includes services currently exempt from charges under domestic legislation, such as GP care and also accident and emergency services. Were GPs to identify EEA&S visitors, the UK would be able to recover the costs of treatment from other EEA&S member states, increasing income for the health system. The Department told us that it did not collect information on whether GPs were identifying EEA&S patients and that, while it was keen to support any GP surgeries that wished to pass on relevant information, it was not able to mandate any systematic reporting.[61]

57 Qq 116, 123–124
58 Q 148
59 Department of Health (TOP0010), para 6
60 C&AG's Report, paras 3.10 and 3.21
61 Qq 148–150; Department of Health (TOP0010), para 5, para 6

Formal Minutes

Wednesday 25 January 2017

Members present:

Meg Hillier, in the Chair

Mr Richard Bacon	Anne Marie Morris
Philip Boswell	Bridget Phillipson
Charlie Elphicke	John Pugh
Kevin Foster	Karin Smyth
Kwasi Kwarteng	Mrs Anne-Marie Trevelyan
Nigel Mills	

Draft Report (*NHS treatment for overseas patients*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 26 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Thirty-seventh of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 1 February 2017 at 2.30pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Monday 21 November 2016	*Question number*
Chris Wormald, Permanent Secretary, **David Williams**, Director General, Finance and Group Operations, Department of Health, and **Bob Alexander**, Executive Director of Resources and Deputy Chief Executive, NHS Improvement	Q1–161

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

TOP numbers are generated by the evidence processing system and so may not be complete.

1 Department of Health (TOP0010)

2 Doctors of the World (TOP0003)

3 Global Recovery Alliance (TOP0011)

4 J M Thomas (TOP0002)

5 Maternity Action (TOP0008)

6 NHS Clinical Commissioners (TOP0007)

7 NHS England (TOP0005)

8 Royal College of General Practitioners (TOP0009)

9 The Royal College of Midwives (TOP0004)

List of Reports from the Committee during the current session

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2016–17

First Report	Efficiency in the criminal justice system	HC 72 (Cm 9351)
Second Report	Personal budgets in social care	HC 74 (Cm 9351)
Third Report	Training new teachers	HC 73 (Cm 9351)
Fourth Report	Entitlement to free early education and childcare	HC 224 (Cm 9351)
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HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: NHS Treatment for Overseas Patients, HC 771

Monday 21 Nov 2016

Ordered by the House of Commons to be published on 21 Nov 2016.

Watch the meeting

Members present: Meg Hillier (Chair); Mr Richard Bacon; Philip Boswell; Charlie Elphicke; Chris Evans; Caroline Flint; Meg Hillier; Kwasi Kwarteng; Nigel Mills; Karin Smyth; Mrs Anne-Marie Trevelyan.

Sir Amyas Morse, Comptroller and Auditor General, Adrian Jenner, Director of Parliamentary Relations, National Audit Office, Laura Brackwell, Director, National Audit Office, and Marius Gallaher, Treasury Officer of Accounts, were in attendance.

Questions 1-161

Witnesses

Chris Wormald, Permanent Secretary, Department of Health, David Williams, Director General, Finance and Group Operations, Department of Health, and Bob Alexander, Executive Director of Resources and Deputy Chief Executive, NHS Improvement.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General

Recovering the cost of NHS treatment for overseas visitors (HC 728)

Examination of witnesses

Witnesses: Chris Wormald, David Williams and Bob Alexander.

Chair: Good afternoon, everybody, and welcome to the Public Accounts Committee on Monday 21 November 2016. Today we are looking at the funding of NHS treatment for overseas patients and how the NHS recovers the cost of that treatment for people who are not resident in the UK.

Our witnesses this afternoon are David Williams—welcome back, Mr Williams—the director general of finance and group operations at the Department of Health. He is the man who managed to balance the budget this year; I am sure a knighthood is winging its way to you from the Government. This Committee, as you know, has concerns, so we are particularly watching this area of funding.

Chris Wormald is the permanent secretary at the Department of Health. Welcome to you, Mr Wormald; we haven't seen you for a few weeks. Bob Alexander is the executive director of resources and deputy chief executive of NHS Improvement. Welcome. I think this is your first Committee with us, Mr Alexander.

Bob Alexander: Yes.

Chair: Welcome. We are a friendly bunch—honestly. Aren't we, Mr Wormald?

Chris Wormald: Oh yes.

Q1 **Chair:** Our hashtag today is #nhs. We are looking today at this Report by the National Audit Office on the use of the NHS by overseas visitors.

To be clear, the NHS provides immediately necessary and urgent treatment for any patient who needs it. There is quite a complex category of who should pay and who shouldn't. A number of overseas visitors will pay. The NHS has a duty to recover costs, to defray the costs to the British taxpayer. It is relatively small in the context of the NHS budget, but we watch the pounds very closely, as I know you do, Mr Williams and Mr Wormald. If overseas visitors do not pay, that is a dent in the budget accounts of about half a per cent of the NHS budget. Is that right, Mr Williams?

Chris Wormald: It is about that.

Q2 **Chair:** But you never know—it might be more. We will uncover that in the

hearing.

We want to know this afternoon why the Department has not met the target for cost recovery. We want to particularly touch on the difference between charging and what you actually collect, because I know there are quite big differentials there; that is certainly one of the issues for my own hospital at Homerton. We want to know what you are doing to tackle the barriers to those on the frontline who have to start the process of logging the correct money and making sure that people are billed. We then want to know how well prepared the Department is, post-Brexit, when we are going to see a number of changes to the already complex categories of who qualifies for free treatment and who does not. Caroline Flint is going to kick us off.

Q3 **Caroline Flint:** Welcome, everybody. Mr Wormald, for the Committee and people watching, could you explain what the statutory responsibility is for those working in the NHS to recover payments from overseas patients?

Chris Wormald: There is a statutory requirement on NHS trusts to identify and recover, in accordance with the relevant regulations. We issue guidance on how to do that, but the statutory responsibility is on trusts.

Q4 **Caroline Flint:** Could you say a little bit more about how the charges apply and how they should be recovered, for the benefit of all of us and those watching?

Chris Wormald: It is, as the Chair said, an extremely complicated picture. I think the National Audit Office did an excellent job of laying out how it works. I should say straight away that we thought this was a very fair Report that correctly identified where we have made progress and where we have further to go. There are basically three systems that we run in this area. The first and simplest is the visa surcharge, which we charge to anyone who applies for a visa lasting over six months. That is paid as part of the visa system, before people get anywhere close to the NHS. That is probably the simplest part of the system.

The second part of the system is that which applies for people who come to the UK from the European economic area, where there are several schemes in operation, but the basics of all of them is that for people who are resident in other European countries, it should be the sending country that pays, with the exception of old-age pensioners, which we might come back to later. As I say, there are several schemes, as set out in the National Audit Office Report, that apply in that area.

The most complicated category for trusts is where people who have not paid the visa surcharge, are not from the European economic area and are not otherwise exempt need to be identified and then charged individually by a trust. Certainly at trust level—I think it is fair to say, Bob—those are the most complicated category for our hospitals to deal with. Sorry, that is a very brief—

Q5 **Chair:** So you underline the complexities, Mr Wormald.

Chris Wormald: Yes. As I say, the National Audit Office has done a fine job of setting out the complexities in this area and, as I am sure we will address in this hearing, the complexity of the system, which was built up over quite some considerable time, is one of the big challenges here. We all know why these things become complicated, but when you are an individual trust trying to apply the system, it is a complicated picture.

Q6 **Caroline Flint:** For the record, there have been some improvements in collection in this area, and some of the incentives seem to be producing a result, but compared with what has been estimated as the cost to the NHS—earlier this year, on 1 February 2016, Lord Bates, I think, who was then a Minister in the Home Office, said that based on the 2013 figures, the NHS was losing something like £2 billion a year from non-payment for treatment that should be charged.

The trajectory that you established was to recover £500 million and, while there have been some inroads into that, more recently you have had to adjust that to make it less than £5 million[1]. So what is your understanding about the cost to the NHS of not recovering what is owed to it from overseas visitors?

Chris Wormald: Just to be clear about that £2 billion number, which comes from research carried out by the Department: that is the total cost to the NHS of people who are not ordinarily resident. That is not the same as the chargeable amount, because we have, in one way or another, decided—this is all done through parliamentary regulation—to exempt a whole series of categories of charging.

So we do not charge for any primary care for anyone, for very good public health reasons, and that is all included in the £2 billion. We do not currently charge for accident and emergency treatment, for ambulances, for a lot of community treatment or for a lot of mental health treatment—also included in that £2 billion. So there is a total cost, which was estimated—and it is a very rough estimate, and I am sure we will come back to some of these questions—at £2 billion. I don't want to overplay the science of this, but out of that we came to the figure of £500 million as the chargeable amount—up to £500 million, which is what we therefore set as—

Q7 **Caroline Flint:** So how did you work out the £500 million?

Chris Wormald: As I said, I am not going to overplay the science of this—*[Interruption.]* I thought that might amuse Mr Bacon, but I thought I should say it straight up before you said it.

Caroline Flint: May I help you out? Because my colleague, Ms Smyth, has some useful information about how the NHS, since its inception, has applied formulas to this area.

Q8 **Karin Smyth:** Bevan, when he looked at this in 1948, asked the Department to do some estimates of what the cost of overseas visitors

[1] Correct figure is £500 million

was, and he came up with £200,000, which was roughly 0.5% of the NHS total budget and which this figure currently seems to be lingering around—at roughly 0.5%.

Chris Wormald: The history of this is indeed interesting—

Q9 **Caroline Flint:** Would you agree with my colleague that you are still using the same formula as Bevan used in 1948?

Chris Wormald: What we did in 2013—as I said, no one had really looked at this question before we did those stats—was to do a top-down analysis. We had some consultants who did it for us. The analysis came up with these numbers, which are calculated top-down, based on a series of assumptions about the number of people here and the charging amount. One of the things that we have not had previously, and still do not have fantastically, is bottom-up data about what is really happening. So all the numbers we are quoting are done by top-down calculation. The history of this is indeed—

Q10 **Caroline Flint:** Is that because they are not collecting the information locally?

Chris Wormald: Well, the only information that we currently collect is about who is charged right now. Given that we know that there is a gap between who is charged right now and who should be, we have to find an estimate, which we did via that top-down process, of what the gap is. As I say, I do not want to put too much science behind it, but it is the first and best estimate we have had.

As you say, the history is interesting, because the first charging regulations were introduced in the national health service in 1982. Essentially, there were then three decades when very little happened. We have made much more progress in the last three years than we had made in the previous 30, both to enrich our knowledge on this and to get more cash in, but we fully accept—this goes with your question and the National Audit Office Report—that although we have done a lot, there is an awful lot more to do before we can say, hand on heart, that we are doing our duty to the taxpayer in this area. We think we have achieved a lot, and a lot more than has been done previously, but we are not at all defensive about the fact that we have a lot further to go.

Q11 **Caroline Flint:** I fully accept that you are starting from a low base and, to be honest, the culture has not really existed in our NHS to apply the sort of machinery that is necessary to find, identify and treat people fairly. That is the other issue: we want everybody to be treated fairly and it is very important how information is collected.

Perhaps we could go on to the target of £500 million. Determining how that was arrived at has been interesting, but now, even though more money has been recovered in the last few years, you are reassessing the trajectory and are going to make it lower than the £500 million—

Chris Wormald: No, we haven't changed our target.

Q12 **Caroline Flint:** Your expectation of what you are going to get.

Chris Wormald: What we did—the National Audit Office correctly quoted this—is, from our internal monitoring, set a trajectory of what we would expect to charge if nothing changed. So, if we took no further action between now and the target date, what would we expect to happen? That is the trajectory that gets us to basically about £350 million of charged expenditure, which is obviously short of where we want to be.

The question we then have to ask ourselves is, what further action on top of what we are doing already do we need to take to move us towards that up to £500 million? That is a piece of internal monitoring of how well we are doing right now, which shows exactly what you said it shows, which is that we have more to do. I can say a bit about what those things are, if you like.

Q13 **Caroline Flint:** We are going to explore how the system can be improved and what more could be done at a local level to identify and follow through, but could I ask you to look at figure 5 on page 23? We can see here the Department's ambition for cost recovery and internal forecast for amounts charged. Looking at some of the forecasts on EEA, non-EEA and the surcharge, will you say something about how that is broken down and particularly about what you expect should be charged for treating patients from the EEA? Let us be clear that this is not about charging individuals directly, but about reclaiming from the EEA country of origin.

Chris Wormald: That is exactly right, and this chart clearly shows the nature of our challenge. Going from the top, the amount raised by the surcharge is simply a function of how many visas of over six months there are. It will go up and down with that and I am sure that people will debate whether a high number is a good thing or not.

Q14 **Chair:** That is easy for you to collect.

Chris Wormald: That was the centrepiece of our strategy. It is much easier for the NHS—

Q15 **Chair:** We know that; it is the other bits we are interested in.

Chris Wormald: The issue in the non-EEA part of the block there is both about identification and recovery. Those are our two issues in that area. In the bottom block, our issue, as you say, is purely one of identification, where what we need to do is identify more EEA people, get their EHIC number out of the system and then go about reclaiming. Once we have that information, the reclaiming bit is actually pretty easy. The question—right down in the nuts and bolts, and Bob might want to say a bit about this—is about how trusts identify the people.

As you said a few moments ago, this is very difficult for the NHS. As the NAO points out, the system is not set up to check identity and charge people. It is much easier for systems that are set up to check identity and charge people to do that as a natural course of business. Were we in the United States, where everyone is charged, it would obviously be much easier to identify them. Our system is not set up like that.

Q16 **Mr Bacon:** How long has there been a statutory obligation to identify?

Chris Wormald: As I said, the first regulations that we found that introduced charging were in 1982.

Q17 **Mr Bacon:** So there has been an obligation for 34 years?

Chris Wormald: Yes. As I said, at an individual trust level, given that you don't routinely check the identity of who walks into A&E or who you're treating, it is something you have to do on top of what you would normally do.

Q18 **Chair:** There is possibly one exception to that: dentists, where people have to pay. Opticians are slightly different, because they are private.

Chris Wormald: Yes, exactly, but for the majority of free healthcare, hospitals do not routinely either check identity or charge, so we are trying to introduce this system.

Q19 **Mr Bacon:** With respect, I think that is complete nonsense. I've been treated in hospital myself in the past five years. Both of my children have. My wife has. Other members of my family have. I don't recall a single occasion when we were not asked who we were. The idea that it is something extra—

Chris Wormald: Obviously, people are asked who they are, but they are very rarely asked—we have some examples now of where we're doing this—for example, to produce two forms of ID, including one form of photo ID.

Mr Bacon: I accept that, but you are saying that it is just not routine for people to be asked to be identified.

Chris Wormald: I should have been more specific in my answer.

Q20 **Mr Bacon:** Is that not part of the problem? For 34 years, you've had this statutory obligation.

Chris Wormald: Sorry. I will be more specific with my answer: the NHS does not routinely ask people to prove their identity; it of course asks for their identity, you are correct.

Q21 **Caroline Flint:** On this issue around charging visitors from within the EEA, perhaps I could move us to figure 4 on page 19 of the Report, which shows the reported amount charged in 2012-13 and the potentially chargeable amount estimated by research that was done in 2013 as well. I presume that part of this research underpins the changes you are trying to make to recover more. It really stands out, doesn't it, how much we are not getting back, even of the money we are due from the country of origin? Would you agree with that?

Chris Wormald: Yes, and since we introduced the incentive scheme that you mentioned earlier, and the various changes to the NHS IT that we've made over the past two years, we have seen the number of EEA treatments identified going up.

Q22 **Caroline Flint:** Where would figure 4 be if it was drafted today, based on what you've just said? What would it show, in terms of what is potentially chargeable and the reported amount for now?

Chris Wormald: That is the amount—

Laura Brackwell: Page 9, figure 1.

Chris Wormald: That number is going up. The number of EEA nationals being identified is going up, but it is not going up fast enough. We accept that, and that is one of the things we need to take further action on.

Q23 **Caroline Flint:** Have you taken a close look? Obviously, we have got a problem in our system because, I think you would agree, it is nowhere near where it should be. Have you had a look at other countries and how they are making claims against the UK for UK nationals receiving treatment in their countries? Have you had a close look at that and thought about what they are doing that we could do better?

Chris Wormald: In most cases, and the National Audit Office reported on this in its Report, they have a system that has charging built into it from the beginning. It is obviously much easier if you are charging everybody, either through insurance or through direct payment.

Q24 **Chair:** Is there an example anywhere in the country that is doing really well at this that you think is worth highlighting?

Chris Wormald: I do not think we have found a comparable system to ours, and I don't think the NAO did either.

Chair: Mr Alexander, do you know of anywhere that is doing a particularly good job?

Chris Wormald: Within the UK? Yes, we do have examples. I misunderstood your question.

Bob Alexander: In the analysis that we've done to support the Department and the Home Office, and using Trust information, there are certainly particular trusts that are markedly recovering more than others. The thing that we don't know yet, which is something we need to find out, is whether they are just doing better relatively because other trusts are quite poor, for want of a better word—that is a pejorative line—or, how much more can they do? That is a piece of work that we are actively engaging with an initial cohort of significant trusts about.

Q25 **Chair:** I partly raise it because my own finance director says a greater access to identified best practice in this area would be a great help, just to highlight that. That is the Homerton. In the past two years, they have billed £830,000 for non-residents in receipt of NHS treatment. Of that sum, payments of £127,000 have been received. That highlights a couple of things: they are wondering whether there is better practice they can learn from; and when they are billing, they are only getting a fraction of it back.

Chris Wormald: Yes. The first task, of course, is to ensure that we are billing everyone. There is then, as I said, the second task: actually getting the cash in. That sounds like a particularly low number. We normally see higher numbers than that. They may have particular issues with the demography of their area. We have some trusts that are looking at more radical approaches, and some of those are mentioned in the NAO Report. We do have some trusts that are now, either for some services or more generally, asking for two forms of ID before treatment. That is obviously a controversial thing to do, but in terms of how you get those numbers up, those are the kinds of things you will look at. We do not have evaluated results of those things yet. What those trusts are reporting is that that does lead to an increase in identification, although you might still have the collection problem that you mentioned at Homerton.

Q26 **Caroline Flint:** I have some DWP data on EHIC reporting for 2015-16. I find that for my own trust—Doncaster and Bassetlaw Hospitals NHS Foundation Trust—there was nil reporting in 2015. There were 22 trusts—some acute and some specialist—that did not report any cases under the EHIC scheme. What do you think about that?

Chris Wormald: As Bob said, we have a long way to go on these issues. I do not know the demography of Doncaster, but it seems quite unlikely that the number should be zero. One of the things we have done is identified the cohort of trusts where we think there is the biggest gap between what the demography would suggest they should be reporting and the actual amount. I do not know whether Doncaster is on that list, but we will be focusing our good practice work on that cohort of trusts. Do you happen to know, Bob?

Bob Alexander: No[2].

Q27 **Caroline Flint:** Again, it is interesting to see the two-way process that happens across the EEA community. In answer to a written question on 29 February, the then Minister, Alistair Burt, provided a useful table, from which the NAO has drawn its figures. That shows that we reclaimed something like £49 million against other EEA countries plus Switzerland, but close to £675 million was reclaimed back the other way against us. Do you think that is unrealistic in terms of what we should be getting back?

Chris Wormald: That number is hugely driven by the number of UK state pensioners who live abroad. Because of the way the system works, if you are a UK state pensioner, we are responsible, regardless of where—

Q28 **Caroline Flint:** How many British pensioners are living in Poland?

Chris Wormald: I do not happen to know.

Q29 **Caroline Flint:** The figures for Poland show that the Polish Ministry of Health claimed £4.3 million against the UK and we claimed £1.5 million

[2] Note from witness: The response "no" meant that Doncaster are not on the initial list, not "no" as in "I don't know".

for people receiving treatment here. Does that not sound a bit odd? For young Poles here who are working fit, we have claimed £1.5 million, and they have apparently claimed £4.3 million from us for people from the UK in Poland.

Chair: It should be familiar to you, Mr Wormald, but for ease of reference, the Clerk is going to provide a copy of the written answer.

Q30 **Caroline Flint:** And the Irish Government have claimed £215 million against the UK, and we have claimed about £19 million back.

Chris Wormald: I am not sure that those numbers are correct. I will go away and check. I had those numbers the other way around.

Caroline Flint: It is a written answer to a parliamentary question.

Chair: It is a written answer from your Department.

Chris Wormald: Right. They are not the numbers I have here, but I will go away and check. That clearly needs to be resolved.

Q31 **Caroline Flint:** When I looked at this table, my eyes immediately went to Spain. I understand what you are saying; we have a lot of older people living in Spain. I get that, but I don't quite understand some of the other numbers in here. Can we send you the table that was provided by your Department, for you to give us some ideas on it?

Chair: To be clear, if that is not correct, you obviously will need to lay a correction in Parliament, as that was a parliamentary document. On Spain, one of the issues that raises is habitual residents, which we will get on to.

Q32 **Charlie Elphicke:** I posed a freedom of information request of your Department, which I got back in October this year. That also included those figures, which say that Poland claimed £4.3 million from the UK in 2014-15 but that the UK only claimed £1.5 million from Poland. Do you not think that the taxpayer is being taken for a ride not by tourists but by political correctness and a non-charging culture in the NHS?

Chris Wormald: I will say two things. I will come back to that general point. On the pensioner point, which we did not quite cover, we have about 190,000 pensioners—

Caroline Flint: Could you just answer the question about Poland? I think we all accept that there is an issue around pensioners, and there is another issue about residency tests and things like that, but this is a particular point.

Chris Wormald: The general point that we are not collecting as much as we should from the EEA is one we agree with. That is why we set out this plan in the first place, to get those numbers up. Overall, if you exclude the pensioner question, we pay out about £130 million and get back about £40 million. We think those figures should be much more balanced, which is why we want to increase our charging in the way that our plan has set out. I can't comment on the individuals of Poland, but on your general

point about whether we charge enough through the EHIC scheme and the other scheme, no, we don't.

Q33 **Caroline Flint:** If there was one thing you would ask those on the frontline of the NHS to do, what would it be?

Chris Wormald: Bob may say more about this, but I should say that we are not here to criticise NHS front-line staff. It is a very, very difficult job that they are doing.

Caroline Flint: I'm not saying that.

Chris Wormald: No, but I want to make that clear. What we want—it is not just about this scheme, although it goes for this scheme as well—is a culture in the NHS where everybody who works in it feels not only the responsibility we want them to have for patient care and so on but also a financial rigour responsibility. That is the thing we want most of all from trusts. We are doing quite a lot to try to make it easier for trusts to do that through our IT changes and good practice, but we do need that culture within the NHS, which is not particularly about this issue but is about being careful with the tax pound. Would that be your answer, Bob?

Bob Alexander: Yes, it would.

Q34 **Caroline Flint:** It is the case, though, that if the trusts are not following the procedures and the guidance provided—there may be questions about how complicated the guidance and the systems are, which I totally understand—they then are reimbursed by the clinical commissioning group, which has to pay out of its budget for whatever treatment the trust asks it to pay for. Fundamentally, if that money is not then recovered, it is a loss to the clinical commissioning group for not only potential hospital treatments but primary care and public health services.

Chris Wormald: Yes. That is exactly the reason why we set ourselves this objective in the first place. We didn't think that the levels of recovery in 2012, of about £80 million, were anywhere near what we needed. That was the whole purpose of the programme we set out: to begin to address those questions, for exactly the reason you say.

Q35 **Kwasi Kwarteng:** Obviously you set yourself the £500 million target for charging. I understand you have altered that target.

Chris Wormald: No.

Kwasi Kwarteng: Do you feel you can attain that target?

Chris Wormald: As I explained earlier, we have a trajectory that currently does not get us to that number, so there are various things we need to do in response to that. Some of those are policy and regulatory changes, which are dependent on the House agreeing, and we have a consultation out, which we will be responding to shortly, about that. Some of it is around the good practice I was describing earlier, particularly focusing on that cohort of trusts which have the biggest gap, and some of it is in the IT changes we are making, to enable people.

So our intention—and this is the way this policy works: the decision that was taken in 2013, which I think is the right one, was to say we don't know as much as we really want to about this; we've got some evidence but we just need to get going and then—

Kwasi Kwarteng: Let me just get this right—

Chris Wormald: So we are not backing off the £500 million.

Q36 **Kwasi Kwarteng:** So the target is still the same. You haven't shifted the target.

Chris Wormald: Well, it is set out in the governing party's manifesto.

Q37 **Kwasi Kwarteng:** But you are hoping to reach it, even though you are slightly behind schedule.

Chris Wormald: Just to be clear, the target is—I was going to use the word "symbolic", but that is not quite right: what we want, and this has come out of the questions that have been asked, is for the NHS every year to charge the right amount. We have set "up to £500 million" as our stretch target in this area, but if the right amount is £450 million they should charge that; and if the right amount is £550 million they should charge that. We are using the target to try and get to a culture where people charge the right amount.

Q38 **Kwasi Kwarteng:** I want to pin you down on that—forgive me; because you have set yourself a target, and it seems to me that you are sort of waving it away and it was symbolic, I think the word was.

Chris Wormald: No, I said I wouldn't use the word "symbolic".

Q39 **Kwasi Kwarteng:** Forgive me: the word you avoided was "symbolic". I just wanted to know: why did you set that target, and why do you think you are not on the right trajectory?

Chris Wormald: As I say, the decision taken in 2013 when the Government decided to highlight this issue—and it was a proactive decision by Government to do so—was it should make, even on what was undoubtedly limited evidence, its best estimate of what we should be able to get in; and to set a stretching target that would help us change the culture of the NHS in the way that a number of Members have pointed to.

The evidence we had at the time suggested that £500 million was in the right ball park. It was phrased as "up to £500 million"; as I say, I am not going to say that there was a glorious formula that sat behind it, but it was to set the expectation of the sort of step change we wanted the system to make. As I say, the ultimate target is, as various people said, to pay what should be paid.

Q40 **Charlie Elphicke:** Let me take you to figure 5 on page 23, where it sets out this target of £500 million. Will you confirm that £200 million of that target is from EEA?

Chris Wormald: Yes.

Q41 **Charlie Elphicke:** Right, and that figure was set as a target in 2013. In that year we collected from other EEA countries £52.9 million. Is that correct?

Chris Wormald: I think that is right.

Q42 **Charlie Elphicke:** Okay. This is a target for 2017, so let us look at how you have been doing. In 2013-14 we collected £52.3 million. In 2014-15 we collected £49.7 million and then in 2015-16 we collected £56.2 million. We are light years away from achieving £200 million, aren't we?

Chris Wormald: Yes, we are.

Q43 **Charlie Elphicke:** This is not going to be met, is it?

Chris Wormald: Well, as I say, if we do the changes that we want to make—and we have not been running this programme for very long—we do believe that we can get our current trajectory, which as has been said is about £350 million, up towards that £500 million.

Q44 **Charlie Elphicke:** Are we going to make the £200 million from EEA: yes or no?

Chris Wormald: I am not going to guarantee that we will make that £200 million, because it is dependent on a whole range of factors. What we are doing—

Q45 **Chair:** So you are not going to guarantee it—that is the answer to Mr Elphicke's question.

Chris Wormald: Yes, just as a statement of fact.

Chair: That is fine—we appreciate the honesty.

Q46 **Charlie Elphicke:** The point I am making is it seems that no progress has been made and the whole thing is a complete shambles.

Chris Wormald: We are talking about a situation where we have gone overall from collecting about £80 million to collecting about £280 million a year.

Q47 **Charlie Elphicke:** But on the EEA we are not making any progress at all.

Chris Wormald: Well, with the bit we have targeted—because that number: some of it is numbers driven around the other schemes. The actual EHIC bit has gone up from us identifying about 5,000 treatments a year to us identifying about 18,000 treatments a year under EHIC over two years. Now, we haven't seen that show through in the cash amounts yet, but we do expect that to go up. Are we going to get to £200 million? Well, as you have said, that is clearly a tough ask, given where we are right now; but we are going to keep at it.

Q48 **Charlie Elphicke:** Last year they collected from us £565 million didn't they; so they seem to be really effective at this. We are not making any progress.

Chris Wormald: As I said earlier, the vast majority of that is paying for the 190,000 pensioners that we have living abroad, whereas the number of EEA pensioners in the UK is, I think, 5,500 and that is what drives the massive distinction.

Q49 **Chair:** You mentioned pensioners a couple of times—not as a "get out of jail free", but as a cause of a chunk of the money. We have the habitual residency test here, so that as soon as someone arrives in the country, as we understand it, they can say, "Now I am going to be settled here." Even a week in they can say, "Right, I am looking for work," or, "I have got work," or, "I am renting a place," or, "I have bought a place". They immediately qualify for NHS treatment, but if they are visiting with an EHIC card, they do not. What about pensioners in Spain? When do they qualify to be under the Spanish health system? Have we got a reciprocal arrangement?

Chris Wormald: Under the current European rules, if you are a state pensioner of a country, that country pays for your healthcare regardless of where you live in the EEA. So if you are in receipt of a UK state pension, and that is your only state pension—that is the 190,000 people who live mainly in Spain, France and Ireland—the UK pays for your healthcare regardless, because—

Q50 **Chair:** That is reciprocal—just to be absolutely clear. If I was a Spanish pensioner living in the UK, the same would apply. Do you have any comparative figures—

Chris Wormald: Yes, of whom there are 62. At our last count, there are 62 Spanish—

Q51 **Mr Bacon:** Not 62,000?

Chair: Sixty-two Spanish pensioners? You are kidding me.

Chris Wormald: Sixty-two Spanish pensioners live in the UK, and about 70,000 British pensioners live in Spain. That is where the vast—

Q52 **Chair:** Sixty-two?

Chris Wormald: We are not the retirement place of choice.

Q53 **Chair:** That is clearly an opportunity for the Tourism, or Tourism Retirement, Minister or whoever.

Chris Wormald: The unbalances are enormous; it is 190,000 against 5,000.

Q54 **Chair:** Can I just be clear? Just the comparative cost of treatment—Mr Williams, on this figure.

David Williams: In terms of what we pay for UK pensioners abroad, for 2015-16 as a share of that £565 million you mentioned, our costs were £429 million. The income that we received as part of the 56 was 13.

Q55 **Chair:** There is a comparative cost of treatment. Let us say you break your leg in Spain—do you know how much it costs to put it in plaster and

treat it, compared to what costs in the UK? Is there any comparison done by your Department about the relative costs?

Chris Wormald: I don't have that with me. There will be one, so we can go and—

Chair: We'll get on. I'm not going to interrupt the flow, because we want to get on to the issues around the tariff.

Karin Smyth: There is a degree of sophistication to NHS costing, that the answer is not just—

Q56 **Mrs Trevelyan:** Mr Elphicke is asking about the gap in trying to get to that £500 million. That is presently being filled by the surcharge, which is a very useful way to get to a target, but if we could take the target out, and say you are way off getting anywhere, can you confirm that you are charging the NHS tariff rate to other countries, not the actual cost of what it might be?

Chris Wormald: We set the tariff for overseas visitors higher than we do for NHS patients.

Q57 **Mrs Trevelyan:** So are you charging the actual cost—if BUPA were to charge, there would be an actual cost of the operation—or are you charging a tariff figure that may or may not relate to the actual gross cost of whatever the treatment was?

Bob Alexander: My understanding is that it is NHS tariff for EEA.

Q58 **Mrs Trevelyan:** So not necessarily the cost. Can you confirm that those two are not always the same thing?

Bob Alexander: They are not the same thing, although they are built up by the costs of treatment in the service. However, it is not specific to the event in Trust X—

Q59 **Mrs Trevelyan:** So we are not fully charging the total cost to the NHS of whatever that treatment was for either an EEA or a non-EEA person. Although there is a surcharge, it is not necessarily the total cost.

Chair: For a non-EEA person it is a surcharge of 50% on top of the tariff, but that still may not be full cost.

Mr Bacon: Mr Alexander, is that a yes?

Bob Alexander: Yes, it is.

Q60 **Caroline Flint:** On page 24, in part 2 of the NAO Report, paragraph 2.2 says, "Of the 50 trusts that responded to our consultation,"—that is 50 trusts out of 154 acute trusts, so it is quite worrying that only 50 could be bothered to reply to the consultation—"only 11 expected income from overseas patients to increase significantly in future." What do you think about that?

Chris Wormald: That number clearly needs to go up.

Caroline Flint: What do you think about that, as a ringing endorsement of the system by 11 trusts?

Chair: What are you going to do about it? Now you know you want it to go up—

Q61 **Caroline Flint:** There is a serious point here. You talked before about not blaming the front line—of course not. The crucial part in this process is the capture of information as and when people enter the NHS for the parts of which we are expected to recover a payment. If we are talking about only 11 out of the 50 trusts that replied, when 154 could have replied, that is worrying, isn't it?

Chris Wormald: Oh yes, it is.

Q62 **Caroline Flint:** It is not exactly a ringing sound of confidence in the system.

Chris Wormald: No.

Q63 **Caroline Flint:** Or even a sign that they are taking it seriously.

Chris Wormald: As I have said all the way through this hearing, we agree with the National Audit Office that we have a long way to go on these things, both to ensure that all trusts deal with it with the seriousness it deserves, and so that we are doing enough to make it easy for trusts to do so. We have an extensive work programme around good practice and particularly IT changes to do so, but the bottom line is that we do need trusts to get better at doing this and we need to help them do so.

Q64 **Caroline Flint:** Let's talk about changes. You have mentioned IT changes several times. Can you outline for us what will change?

Chris Wormald: The things we have done—there are two big things. The first is that we are much more linked up with Home Office systems around the visa charges, so that people who are on the visa scheme are now flagged on the NHS IT system.

Secondly, and probably more importantly from this point of view, we are making it much more explicit on the NHS record where someone has been identified as being chargeable, and we are allowing the overseas visitor managers within trusts to directly amend that record so that when they have identified somebody who has been identified for charging in one part of the health service, forever more they will be charged wherever they then present. Those charges are quite significant, but what they don't get to, obviously, is how you identify people in the first place. That is the bit where we need to make a lot of progress.

Q65 **Kwasi Kwarteng:** I am looking at the table of the amounts you are getting in and your targets—and I'm giving you the immigration surcharge, so let's not talk about that; let's strip out the £200 million, so you have £300 million. And let us strip out the visitors from outside the EEA; let uws look just at visitors from within the EEA. There is obviously a huge gap between the £56 million stated for 2015-16 and the £200

million target, so I am going to re-ask the question, but just looking specifically at that portion of people within the EEA. How do you think you can essentially quadruple the amount of money that you are getting in from EEA visitors in two years?

Chris Wormald: I'll ask Bob to comment as well, because unfortunately this is all in the practicalities of how individual trusts identify people when they present. There is no getting round this. When somebody appears in hospital, does that trust identify them as somebody who should be charged, regardless of whether they are in the EEA or outside the EEA, and then take the appropriate action in the case of the EEA people to alert us so that we can charge the country concerned? I would love it if there was an easy answer to that question, but it is in the practicalities of what a trust actually does when somebody arrives there. Bob, do you want to say a bit about the trust operations part?

Meg Hillier: Mr Alexander, in answer to Mr Kwarteng's question—

Q66 **Kwasi Kwarteng:** Let's hear from Bob.

Bob Alexander: It is extremely difficult, in busy clinical areas, always to identify. As you rightly said in an earlier point, there is something about the extent to which we have been able as yet to appropriately embed full cost awareness throughout the workforce.

Q67 **Chair:** Can we just be clear about this? The questions you are asked when you arrive anywhere are your name and address.

Bob Alexander: Absolutely.

Q68 **Chair:** So it would be quite simple for the script online or on the piece of paper—the form—also to have the question: do you expect to pay, or are you an NHS patient?

Karin Smyth: You would just say, "What country are you from?" The practicality is that you would have to ask somebody what country they were from and perhaps have identification via passport.

Caroline Flint: Why can't you ask for a passport?

Bob Alexander: There are obviously organisations that do that. What we need to do is to work with organisations that are obviously identifying and collecting appropriate charges from foreign visitors and migrants. We need to identify what that best practice is and then, first, make that best practice available to all and, secondly, through a process of reporting and intervention, ensure that appropriate processes are, first, in place throughout the acute sector, for the moment, and secondly, report on that on a regular basis and appropriately intervene through oversight arrangements and performance management to ensure that that happens.

Sir Amyas Morse: This is probably completely off field but, when I buy a train ticket, I have to identify myself by putting my credit card or debit card into the machine. The most convenient way to tell who somebody is is that virtually everybody uses electronic payment. I am not saying that

they should necessarily pay but, as an easy identifier, it is about the most effective thing available. Would that just be completely off limits, to ask people to stick their card in a machine to verify who they are?

Chris Wormald: As I said earlier, we are looking at whether trusts should do more on the upfront identification. What a credit card does not do is tell you whether you are ordinarily resident—

Sir Amyas Morse: I think you would probably find it could do that quite easily, if you really wanted it to.

Chris Wormald: I am not aware. We can discuss that offline. The general question is, are we are looking at whether trusts should proactively ask people to prove identity? Yes, we are looking at that. As I said, there are individual trusts such as Peterborough that are doing that and reporting that it makes a big difference. There they do say, "Please come with two forms of identity: your passport and your address." They use that to check whether people are eligible. That is obviously quite a controversial thing to do; to say to the entire population, "You now have to prove identity."

Q69 **Karin Smyth:** But if we listen to Mr Bevan, what he said was that you would have to separate the sheep from the goats. That would be in order to determine whether I am a foreigner or you are a foreigner. Essentially, you would need to go down the ID card route in order to separate out people who are entitled or not. Is that what you're thinking?

Chris Wormald: Right, yes. I don't think I will debate ID cards with the Committee at this time.

Chair: I am going to bring in Mr Kwarteng, Mr Elphicke, Ms Trevelyan and Mr Bacon on quick points and then we will go back to Caroline Flint.

Q70 **Kwasi Kwarteng:** I have a very quick point on figure 1. I want to understand it. This is not a trick question. The bit I am slightly confused about is, for whatever reason, with the visitors from outside the EEA you are 69% there in terms of the target. Whereas, with the visitors from within the EEA, you are falling very short. That begs the question: was the target too ambitious for visitors from the EEA? There is a big discrepancy, you will understand, if you follow me, between where you are with the targets you have set yourselves and your attainment, with respect to visitors from outside the EEA, and visitors from the EEA.

Chris Wormald: I think—I'll ask Bob to comment—that that probably arises because, as it stands at the moment, the incentive structure on trusts is much greater to identify people from beyond the EEA than within the EEA. That is one of the things we need to look at for good practice. Is that correct, Bob?

Q71 **Chair:** I think one of the factors is that the charging is relatively easier because you are not chasing an individual; you are chasing a Government. So it should be easier.

Chris Wormald: The key difference is when it is an out-of-EEA patient, it is the trust itself that receives the income. When it is the EEA, it is the Government.

Q72 **Chair:** So what you are saying is, it is the incentive that is driving the performance not the ease at which it might be to track down an individual versus a Government.

Chris Wormald: It will be a mixture of both but I think it is true that the incentives are about that.

David Williams: Both categories require identification of the treatment by the provider.

Q73 **Chair:** And that is the sticking point.

David Williams: The financial incentives for the provider are stronger for the out of EEA, particularly with 150% surcharge.

Q74 **Chair:** Mr Alexander, briefly on that, and then I am going to Mr Elphicke.

Bob Alexander: I absolutely accept that answer, Chair.

Q75 **Charlie Elphicke:** We have talked a lot about trusts, but that is secondary. Let us talk about primary care. I read a report in the *Daily Mail*—that excellent family newspaper—on 16 April that asked, "Does a visitor to the UK from any other EEA country who does not have an EHIC have to register as a patient?" It says "Mr Burt"—the then Health Minister—"replied that holding an EHIC card is 'not required' to register with a GP and that practices 'cannot legally refuse' to register any applicant even if they don't have any identification.

He also warned GPs against only asking migrants for ID, saying it could be 'discriminatory' and that they should ask all patients." Is there not a massive hole here? If we go to EEA areas, we get charged by primary care and have to show our EHIC cards, yet they do not here. Isn't that something that should change and needs to change? What are your plans to change it?

Chris Wormald: We are here to implement the system as is currently set out in law, which does not charge for primary care, as I said right at the beginning. The arguments made—it is a question of the law rather than of our implementation—are that the public health risks of putting up barriers to people seeking primary care are greater than the benefits. Now, people can debate that, but, as I say, it is a question of the law. What we focus on is applying the law and getting people who are currently required by the law to pay. That is currently limited basically to being in hospital. So your point is correct, but it is a question of where we choose to draw the line—

Chair: I think we should leave this issue for a minute, because it is a policy matter, which Mr Wormald cannot stray beyond—

Q76 **Charlie Elphicke:** On an operational level, my GPs raised this with me and complained to me about it. They said they felt this was due not to a

policy matter but simply a culture of political correctness. They were cross because the British taxpayer is being taken for a ride. Do you not think it is something that ought to be looked at and investigated?

Chris Wormald: In the consultation we have live at the moment we are looking at the range of things that should be charged for and whether we should charge for A&E, ambulances and those sorts of things. As a matter of policy, we do not currently have primary care on that list. I am sure people will debate it, but, for the reasons you say, it is not really a question I can comment on, I am afraid.

Chair: If I can interject, I have GPs with different views on this, but when you hear the stories about what some people get from the GP it is not all about public health. I throw that in just as a thought.

Q77 **Mrs Trevelyan:** I think all of us here and those watching will be bemused. Will you clarify that it is your view that it is difficult to identify people at the point of entry within our acute system? Let's park the primary care area. I took a French cousin of mine to my local hospital last Christmas. They were not on the NHS system because they are not resident here, so my hospital asked them for identification, which was provided, and the broken bone was fixed. I assume that my hospital was then able to bill France for that treatment.

Are you telling me it is not standard procedure across every hospital in the land that if you turn up and you are not on that system—because you are not a local person on the NHS register—this is a difficult thing to follow through on? I am not saying anyone is going to be charged, but are you telling me that you do not find it possible to identify that individual?

Chris Wormald: Clearly not. The numbers, as various people around the Committee have—

Q78 **Mrs Trevelyan:** So we are treating patients who we have not identified.

Chris Wormald: Yes. Not in—

Mrs Trevelyan: In large numbers.

Chris Wormald: It is quite clear from the numbers, the expectations we have set and the research we did in 2013 that there are patients who should be charged who are not currently being identified—

Q79 **Mrs Trevelyan:** They are not identified at the point of arrival at the hospital, in order for us to follow that through.

Chris Wormald: Yes, not identified as being a patient who should be charged.

Q80 **Mrs Trevelyan:** But if a patient is not on the NHS system with a British NHS number, by definition he probably will be in that category.

Chris Wormald: No. Those individuals are the most likely to be identified, but an NHS number does not prove eligibility; anyone can get an NHS number. So once you—

Q81 **Mrs Trevelyan:** No, but if you follow that through, you have an identifiable marker attached to that treatment cost.

Chris Wormald: This is the IT change we were describing earlier. We can now track that through the system, so it should become easier, but has that been standard practice? No, it hasn't—that is the straight answer to your question.

Q82 **Mr Bacon:** Mr Wormald, you started an answer to Caroline Flint's first question by saying there was a statutory obligation to identify patients. More recently in your evidence, about five to 10 minutes ago, you said, "We are looking at whether trusts should do more in terms of up-front identification." Given that there is a statutory obligation—it is not a choice; they have to do it—why is it a case of whether trusts should do more in terms of up-front identification?

Chris Wormald: What I was describing was the method by which you do up-front identification and whether you require—

Q83 **Mr Bacon:** Actually that's not what you said. You said, "We are looking at whether trusts should do more in terms of up-front identification." That suggests two possibilities. First, that they do do more, and secondly, that they don't do more.

Chris Wormald: We certainly want them to do more. I may not have worded my answer to you absolutely correctly. The question I was getting at was whether, as some trusts are looking at, you require people to prove identity by bringing a passport and some other form of ID with them—which, as you said, is not the culture of the health service up to now and would mean a change.

Mr Bacon: I don't think I said that, but someone did. It might have been you.

Chris Wormald: That is what I was referring to—whether more trusts should be going down the route that some trusts within London and elsewhere have gone down, of causing people to prove identity, and where that is proportionate. As we have said, this does locate in some quite specific places in the country, so it is about whether you want to apply that rule to the whole country. Those are the questions we are looking at.

Q84 **Mr Bacon:** But it is clear that the obligation to identify exists and is a statutory obligation; you said that right at the beginning. That is correct, isn't it?

Chris Wormald: Yes.

Q85 **Mr Bacon:** Can you tell us under what legislation that obligation exists?

Chris Wormald: The original legislation was in, I think—

Mr Bacon: I think you said 1982.

Chris Wormald: It was in 1977, to allow charging. That was implemented by regulations in 1982.

Q86 **Mr Bacon:** There is a difference between allowing and requiring. By all means send us more than this. I notice that in the Report, there is a reference to the immigration rules that give the power to the Secretary of State to charge, but I am asking a different question about the obligation to identify, which sounds to me not like a choice but something you are obliged to do.

Chris Wormald: I will write you out the full legal history, but as I say, the first regulations coming into force requiring charges were in 1982. There have been a whole series of Acts.

Q87 **Mr Bacon:** And prior to that there were some opportunities or possibilities, but then it became a legal obligation.

Chris Wormald: I am not aware that there was anything legal before 1982, but if I may, I will get one of my lawyers to write to you.

Q88 **Mr Bacon:** Send us a legal narrative. I am looking at the National Health Service (Charges to Overseas Visitors) Regulations 2015, which I imagine are an update or later iteration of something before. A thorough summary of that would be helpful. What strikes me, listening to all this, is how extraordinary it is that if there has been a legal obligation to identify for several decades, most NHS trusts, most of the time, are still struggling with the basic question of identifying, when they have had 30 years to get used to the idea. That is what I can't understand.

Chris Wormald: As I said before, if you look at those three decades, it is clear from the amount of money collected that there was not a huge amount happening. We have had a much greater focus since 2013, and we believe we are beginning to see the results. Why wasn't there that focus in the previous 30 years? I don't think I can answer that question. I could speculate, but I don't know why people didn't choose to focus on it in previous decades.

Q89 **Mr Bacon:** There are two parliamentary questions. One is from 29 February 2016, and it sets out the amount claimed by states against the UK and the amount claimed by the UK against other states for the EEA and Switzerland. It is very helpful and sets out it out very clearly. There is another PQ that was also tabled by Mr John Mann, the Member for Bassetlaw, about 10 other countries that are not EEA or Switzerland—they are listed there: Russia, China, Nigeria, America, India, Australia, Pakistan, Brazil, New Zealand and Canada—for which no information was given about the cost. It was from around a similar date; in fact, it was 4 March, only five days later. Is that because you don't have the information? I understand from the earlier answers that actually things are going better for non-EEA than they are for EEA. I think that was in figure 5. Why was there not more detail in your answers when they were given only a few days later?

Chris Wormald: For the European ones—for those that are claimed—we have all the information because we are reclaiming from those countries,

so it all goes through the Department. For non-EEAs, we have traditionally collected very little data indeed.

Q90 **Mr Bacon:** Why? Because it is simply held at the trust level?

Chris Wormald: Yes. Those will be held at the trust level.

Q91 **Mr Bacon:** Are you planning to ask the trusts to tell you what they're doing on this?

Chris Wormald: We have already increased the data we receive on cost. We have not gone into individuals and nationality in the same way, and that is one of the things that we're looking at.

Q92 **Mr Bacon:** The question is, "To ask the Secretary of State for Health, how much was recharged to—", and then there is a list of countries. To Mr Mann's question, there is no answer. There are a couple of big paragraphs of stuff but there is no answer.

Chris Wormald: The data are not held at national level.

Q93 **Mr Bacon:** Are you planning to get into a position where you can answer that question?

Chris Wormald: We are looking at what data we collect. We are not collecting that information at the moment. It is, of course, a question of whether we should.

Q94 **Mr Bacon:** You are looking at it. Are you planning to be in a position to answer that question?

Chris Wormald: As I say, we have not taken the decision to change the data that we are collecting from trusts at the moment. We try to change what we collect from trusts very rarely, for reasons you will understand, but it is something we keep under review.

Q95 **Chair:** Can I just be clear: to break the data down to answer a question of that nature, you would actually have to have every trust asking the nationality, whereas some of those patients would presumably just be dealing with their insurance company and the nationality would not be a primary question. Is that one of the issues here?

Bob Alexander: That is correct.

Q96 **Caroline Flint:** I am going to ask a few questions about the immigration health surcharge. Looking at the various figures in the Report, if it wasn't for the immigration health surcharge, the trajectory would look a lot worse than it does. Is that correct?

Chris Wormald: That's correct. It's a central part of our policy.

Q97 **Caroline Flint:** Every non-EU student, or migrant with a UK visa for more than 6 months on or after 6 April 2015, has to pay this surcharge. I understand it is £150 for each student and £200 for migrants. That gives those people full and free access to our NHS. Is that correct?

Chris Wormald: Yes, that's correct.

Q98 **Caroline Flint:** I understand that, in 2013, the Department of Health commissioned work to estimate the baseline cost, and the consultants that you were using came to the view that a realistic cost per year was actually going to be £736 per person, but it was fixed at £150 to £200. Why?

Chris Wormald: In these cases we are striking a balance between what we think is fair to individuals and fair to the UK taxpayer. Of course, a number of people who are here working for over six months would also be taxpayers and contributing to the economy, but we also do not recognise that £736 figure. I recognise that that is what they estimated, but this is quite a vexed area and it does look like that is high.

Q99 **Caroline Flint:** According to some figures I have got, between 6 April 2015 and 14 March 2016, the cash raised was around £175.6 million, but 423,278 student migrant visas were issued in that time. The expectation is that that sort of level of applications is likely to continue. That is a lot of application, and £175.6 million sounds a lot of money, but am I also correct that, in applying the surcharge, no questions are asked of the individuals of any pre-existing conditions?

Chris Wormald: I think it is just a flat-rate charge.

Q100 **Caroline Flint:** What I am trying to get at is, if you applied for health insurance for a holiday or something—or for any sort of insurance policy in the UK—you would be asked about any pre-existing conditions such as kidney problems. They might even ask if you were pregnant, for example, or any other matter. That is not asked at all of any of these people who, for £150 or £200 a year depending on what status they are coming in on, can get full and free access to our NHS.

Chris Wormald: As I understand it, the decisions—

Q101 **Caroline Flint:** Also, if students bring members of their family with them, I understand that they pay the same rate as well.

Chris Wormald: Yes, I think we charge it to every person there. The idea, as I understand it—this slightly pre-dated me—was to have a very simple system that was easy to administer. Of course, as you say, the entire cost—

Q102 **Caroline Flint:** Do you think there should be a question about pre-existing conditions to ensure that we are not being possibly taken for granted by someone applying for a course because they have a pre-existing condition and can get care better or cheaper here?

Chris Wormald: If I am honest, that is not a question I have asked, so I will not give you a view.

Q103 **Caroline Flint:** Are you considering it as part of your review? You are looking at a review at the moment, aren't you?

Chris Wormald: I do not think it is being considered at the moment.

Q104 **Chair:** Is it something that you would be able to identify in the data? For

someone having kidney treatment, the condition could have just come on.

Chris Wormald: As will be clear from my answers, this is not a question that I have thought about or particularly briefed myself on. May I go away and think about it?

Chair: Thank you. We appreciate that.

Q105 **Caroline Flint:** I have a last point on the data. If I get the terminology wrong, forgive me. From what I understand, once a student or a migrant with a six month-plus visa pays a surcharge, they get what is called a green banner on their NHS records. But that means that we cannot track how much people are treated. Some people might come in, pay £150 and not use the NHS at all, which is fair enough. But we do not have any sense of being able to track what treatment—or not—they have had from the NHS, and trusts are not obliged to keep any costs about what that treatment involved for that surcharge. Is that correct?

Chris Wormald: They certainly will not be required to keep costs because, of course, we are not charging. We ought to be able—I will go away and check this answer—to see who is flagged and how much treatment they actually take, even if we cannot get a cost. I think we get some information, but I will go away and check.

Q106 **Chair:** Will you write to use with that?

Chris Wormald: Yes.

Q107 **Caroline Flint:** Thank you. The figures state that 423,278 visas were issued to students and migrants between April 2015 and March 2016. That is a lot of applications. Potentially within that, every year, there is a lot of use of our NHS, whether at primary care or at trust level. Isn't that the case?

Chris Wormald: Yes, but just to be clear, this is an addition to the system that we have introduced previously. Those people would have been in the systems that are not collecting cash that we have just been describing. This is net addition to what HMG gets to fund the health service.

Q108 **Caroline Flint:** I appreciate that. It is obviously quite worrying, from the earlier questions, whether the changes to the systems and the recovery of money is relying quite a lot on this particular surcharge to make things look better than they actually are.

Chris Wormald: I do not accept that. We had a strategy.

Q109 **Caroline Flint:** It is new money. It is not recovery of what we should have got anyway.

Chris Wormald: No. When we set out the policies to address this question, the surcharge was a fundamental part of this, and it was a reflection that we have not been great at recovering costs. Having this

very simple mechanism that gets in really quite a lot of cash, and has done very quickly, is an important plank of the policy.

Q110 **Caroline Flint:** Are there any examples of other countries that have a similar surcharge for students or people on a six month-plus visa? Do they ask about pre-existing conditions?

Chris Wormald: No, most countries are insurance-based, so that would be the equivalent process. I am not aware of any other country that does a surcharge quite like this but, as I say—

Chair: From my time on the Immigration Bill, I think you are right.

Chris Wormald: Yes, you probably know more about this than I do.

Q111 **Caroline Flint:** My last question is about the ordinarily resident status because that sets us out pretty much from every other country in that most countries operate on a contributory principle, not because someone happens to be resident in that particular country. Will you be looking at the ordinarily resident status and whether that needs to be tightened up as part of your review?

Chris Wormald: We have already tightened it significantly in one regard: non-EEA residents are only counted as ordinarily resident if they have indefinite leave to remain. That is quite a big tightening of the system. I don't think that is one of the things we are consulting on, is it?

David Williams: I don't think so.

Chris Wormald: I don't think that's one of the things we are consulting on at the moment.

Q112 **Caroline Flint:** Because it does mean that somebody can come in and basically, through their resident status—without having any other identification or anything—get access to our GP services and everything else.

Chris Wormald: That is the line that the law draws at the moment. It applies the ordinary residence test. As I said, we have tightened it once around the non-EEAs, but that is how the law works at the moment; it is based on that residency test.

Q113 **Caroline Flint:** St George's hospital in Tooting has received quite a lot of coverage recently because of some changes in how they were looking at recovery for the use of their maternity services. It was reported that half the 1,783 overseas women who gave birth in St George's in 2015-16 were entitled to free care, but action was only taken when the commissioners refused to reimburse the hospital for treating ineligible patients. What is your sense of what is going on at St George's, in terms of how it is applying its rules, and is it not a bit worrying? If they had been actively engaging beforehand, maybe the recent changes they have made would not have been such a media story.

Chris Wormald: What you describe the commissioners doing is exactly what commissioners are supposed to do. Indeed, the National Audit Office

made a recommendation in this area on commissioners being more vigilant, and NHS England has accepted it. St George's is one of the hospitals that is looking, in maternity, at the two forms of identification before treatment. Should they have done that earlier? That is a question you can always ask in these circumstances.

Q114 **Caroline Flint:** But part of this again comes back to early identification.

Chris Wormald: Yes, it does.

Q115 **Caroline Flint:** We are not talking about an emergency service, but about people coming in for their antenatal classes and all the build-up to having a baby. I presume there will be quite a lot of record-taking during that period as well.

Chris Wormald: As I understand it—Bob may know more—that is exactly what St George's do. On first contact now, they write out, saying, "You will need to bring two forms of identification to your first—"

Q116 **Caroline Flint:** But why do you think it takes the commissioners to start refusing to reimburse the hospital for that sort of action to be taken? I think that is what people find really difficult about this. We are always filling in forms for this, that and the other, whatever we do. We have all shared experiences of having to provide information when we have been in hospital ourselves. What is the big barrier to this, given that this is money for our health service?

Chris Wormald: I am not sure I can add much to what I have said. Clearly, there has not been the focus on these issues that there is now and there are quite a lot of things like that that could have been done earlier. One thing that ought to make a difference is that we have added to what we call "the model hospital"— which is basically all the benchmarking information that we make available to boards—benchmarking information on recovery rates for overseas visitors, so in future, it ought to be much more explicit to the boards of trusts when they are out of line with where they should be. I do not really think this is a satisfactory answer to your question, but I think it is probable that in a very busy hospital, these issues simply have not been surfaced before—until the focus that we have had in the last few years—in a way that has caused people to deal with them. I do not think that is really satisfactory answer to your question but I suspect that is what has been happening. Bob, you have had several cracks at this.

Bob Alexander: What I hear you describe is poor business process and management of regulation. Chris is absolutely right about the things that the Department is trying to do, and as the Report said, NHS Improvement have to get alongside and operationalise some of this stuff, and we are committed to doing that. We were talking about the initial cohort of organisations to engage with. They have opportunity and may or may not have good process—St George's, Tooting is in that cohort because of opportunity—and inevitably, in the way you describe, there is opportunity to improve process. The model hospital reporting does more than Chris described, and it will certainly make things transparent to hospital boards

so that they can compare and benchmark themselves. It will also give those charged with oversight and intervention an opportunity to inquire and ask questions, and it will give us an opportunity, via the best practice process we are going through now, to develop helpful improvement tools for organisations to use: "Here are processes that you should put in place. Have you done that?" That will allow us to follow up in a more targeted way than we have in the past. I say that as somebody who was a finance director in hospitals back in the '90s, when frankly we did not do this at all well.

Q117 **Caroline Flint:** You can appreciate how in these times when there is so much coverage about pressures on the NHS, including the cost of treatment and the expectations on the NHS—in all good faith and in a very human way, a number of exemptions apply within our system for different vulnerable groups—it really undermines people's confidence when, basically, we are not seen to get back what is due in a fair way.

Chris Wormald: Yes, and that is exactly why, as well as getting the cash in, the Government chose proactively to put a huge focus on this issue in 2013. They commissioned the research that has given us a better understanding of what is going on and made all the changes to the regulations and the surcharge. Those are exactly the reasons why we wanted to focus on this. As I hope we have been clear throughout the hearings, we do think they are making a substantial difference both to the cash amounts and to the culture but, as we have discussed a number of times in this hearing, we have a lot further to go before we have the system that we want.

Q118 **Chair:** We had some evidence, including from Doctors of the World—this particularly relates to the St George's, Tooting example—expressing concern that the time required by staff to carry out the eligibility assessments would be an issue. They talked about the direct costs involved in implementing the programme, which have yet to be quantified. There is certainly a lot of anxiety about that from people on the frontline. Mr Alexander, you talk about trying to improve the system. Can you give any reassurance to people on the frontline that what you are trying to introduce will be workable and neither degrading for the patient nor unworkable for the front-line clinician or administrator?

Bob Alexander: That is exactly why we want to do this with cohorts of organisations to determine good process that is proportionate, that minimises burden and that appropriately discharges organisational responsibility to identify and recover appropriate costs.

Q119 **Chair:** The St George's one is to provide photo ID and a utility bill, and I have to say that I would be hard-pressed to find a utility bill.

Caroline Flint: They can always bring it later.

Chair: No, I would be hard-pressed just to find a utility bill with my name on it.

Chris Wormald: You are often putting people in a dilemma. Yes, we want systems that correctly identify who needs to be charged, but we do not want to put an excessive burden either on individual trusts or on individuals who have every right to the NHS. That is the balance we are trying to strike, which is why we are trying to focus on those hospitals that appear to have the biggest opportunity.

Q120 **Caroline Flint:** Can you report back to the Committee? Good practice was mentioned earlier, and there have been a number of submissions about excessive burdens on individuals and trusts to provide information, but it is not quantifiable in any real way. That includes the allegation that the cost of setting up systems to recover outweighs what you will get back. Why can't you do some more work on pinning down some evidence-based answers to those accusations, which are often made by people who do not seem to want us to charge anybody?

Chris Wormald: Yes, and the NAO raised that point, too. We need to do more about that but, as far as we have seen, the costs of setting up a system at trust level are very small indeed. It is normally one person, the overseas visitor manager, who runs the system for that hospital. As I said, if we get the IT right nationally, there is no burden. There certainly should not be a burden on clinicians actually treating people. We only ask clinicians in this system to do one thing, which is to distinguish between those patients who need urgent and emergency care and those who do not, and therefore whether they are charged up front or in retrospect. Obviously, that has to be a clinical decision that only a clinician can take. We do not ask clinicians to do anything else in the system; it should be the hospital administration that identifies who needs to be charged and pursued, not the front-line people treating patients in the system.

Your questions sum up some of the balances that we are trying to strike in these policies about being fair to the taxpayer and to the individuals, and not burdensome to either individuals or individual trusts, while ensuring that we get the contribution that we should for the NHS. That is not an easy set of balances, which is why we do the policy in the way that we do. As you will have gathered from our answers, we decided to get some stuff going and then iterate it with what is happening.

Chair: I think we are hopefully helping you along. I will call Mr Mills now. I should just say that we could be having a vote in the next five minutes, but we have not had any notification yet, so we may be able to carry on.

Q121 **Nigel Mills:** Is the message you are sending out to CCGs, Mr Wormald, that they should be checking whether the hospitals they are funding are doing this job properly, and that if they are not, they should withhold payment?

Chris Wormald: That is to summarise what the National Audit Office suggested in its recommendation. I believe NHS England has written to the Committee saying it supports that recommendation.

Q122 **Nigel Mills:** So that is a yes?

Chris Wormald: It is a role for NHS England, who are not with us, but I understand that they have written to the Committee saying they accept that recommendation.

Q123 **Nigel Mills:** Do you think that trusts should be marked down by Monitor or other people if they do not do it properly? Is the carrot of the extra bit on the fee not enough? Do we need some sticks in the system to say, "If you're not doing this—"

Bob Alexander: I said in an earlier question that the whole point of the drive for better, more regular and more transparent information about both charging and recovery will allow us to intervene appropriately where we think organisations are not fulfilling obligations and need some support to do it, as well as to give people information more regularly and allow them to identify for themselves legitimate comparative performance. I think it is both an improvement opportunity and an intervention tool, in the event that that is necessary.

Q124 **Nigel Mills:** Sorry, was that a long way of saying, "Yes, there ought to be some threat/sanction in the system if trusts that need to improve don't"?

Bob Alexander: Yes.

Q125 **Nigel Mills:** Good; we got there. Before I do a swift attack, Mr Wormald, I am trying to picture how we will get from the £56 million we get from the EEA people to the £200 million that we would like to. Of the interventions you are proposing, can you allocate any numbers to them? The system might get us another £30 million because it will be a bit easier for people to use, and education get another £40 million, and some big sticks will get the rest.

Chris Wormald: It is very difficult to put exact numbers on these things, for the reasons that I have explained already.

Q126 **Nigel Mills:** You must do that in your projections.

Chris Wormald: We think that if we do the things set out in our consultation around what we charge for, and focus on the 20 hospitals where we think there is most opportunity, about £40 million extra, and the benefit of the various IT changes we are making, that will get our internal trajectory into the £400 million to £500 million category, if we make all those changes. Some of those changes are yet to be agreed, because of course the consultation on charging comes to Parliament in regulation, but that is what our estimates are.

As I have said, I do not want to give you exact numbers, because our data are not good enough for exact numbers. We will continue with the process that I have described of trying things out and seeing if they work and if they do, going further with them; if not, trying other things. It is not the kind of programme you just set up at the beginning and watch it roll. That is the kind of thing that we are looking at.

David Williams: That would be both identified and recovered.

Q127 **Nigel Mills:** So you don't fancy just hiking the surcharge to get over the line.

Chris Wormald: Obviously, if our sole purpose was to raise a specific sum of money, the easiest way to collect it would be the surcharge. That would not meet our wider test of "Are people actually paying what they owe?" Obviously the Government can set the surcharge up and down to change numbers, and people may decide that is what they want, but that doesn't get you the system that you actually want, which is one that is charging people what they owe.

Q128 **Nigel Mills:** I think we agree that that is right; so, just to ask you a nice quick and simple question, we may have fixed this EEA problem for you by March 2019, if we just leave the EEA. Then you can just have them all as non-EEA. What is the Department's thinking on how that is going to land? Will we still be giving free healthcare out to citizens of the EEA? Will our 190,000 pensioners still be getting it?

Chris Wormald: Obviously the Department is doing a lot of thinking about that question. There are a lot of decisions to be taken. I am not going to give you, as you would expect, a running commentary on how those discussions go; but what the variables are in that system are actually pretty straightforward.

They are how many people come in on visas; which countries do we or do we not have reciprocal arrangements with, either like EHIC or not, and therefore how many people fall into the charging regime—all governed, of course, by what is the overall level of immigration. So I think we have a clear handle on what the variables are, there. Of course there are a lot of decisions for which health will not be the main driver, as to how that then plays out in practice.

Q129 **Nigel Mills:** But you are spending money on systems to try and get more money recovered from EEA nationals that get healthcare. Presumably if you thought we weren't going to be having any EEA nationals with free healthcare in two years that would be a waste.

Chris Wormald: No; the system changes apply to, at the front end where we are actually making the changes, going for EEA and non-EEA: they are about identifying people who are—

Q130 **Kwasi Kwarteng:** Forgive me, but it is the EEA bit that is failing badly. As far as your targets are concerned two pieces of the pie, two pieces of the picture, are doing quite well. We can have an argument about policy but you are getting 82%—£164 million out of £200 million—on the surcharge; you are getting 69 out of 100, which is your target, on the outside EEA bit; but on the EEA bit, that is where you are falling down.

Chris Wormald: I agree with you; we need to do much better in this area. I was answering Mr Mills's specific question: the systems changes we

are making, the IT systems, allow you to do better with both categories so there isn't any nugatory expenditure regardless of what happens. Then the country to country bit we do, that is comparatively easy.

Q131 **Nigel Mills:** At this stage you have got no insight for us on who may or may not be entitled to free healthcare in the UK in two and a bit years' time.

Chris Wormald: As I said, there are a lot of decisions to be taken in that area; so, no.

Q132 **Chair:** I have a couple of quick questions. We may well—or we may not—have a vote. We will keep going for a little bit if we can. Can I just check what systems you think you need to have in place? You have talked about the IT system. I just want to pin you down. Perhaps this is for Mr Alexander: when you have gone through this cohort of different types of trusts, will it be just an IT thing that pops up on a screen, and an administrator just asks a scripted set of questions to make it easier? How are you going to make it manageable for people on the front line? What systems need—perhaps you could just lay out in very simple terms, in general terms without being more specific.

Bob Alexander: It will have to be general terms, Chair, because specifically it might have to be different in different types of organisation.

Q133 **Chair:** I know, but are you not talking about some sort of common approach that might be in the NHS IT system? For example, if you take a child to A and E they immediately see if you have taken the same child to another A and E because there is a system in place to log people.

As other colleagues have commented, you track if someone has had treatment somewhere else. Surely it is a question of updating that system so that when you ask the questions, in there somewhere there is a prompt—"Are you normally resident?" Some people, from insurance-based countries, might just expect to pay. When we travel abroad, we expect to be charged. So can you be clear? Have you got any specifics you can share with us?

Bob Alexander: Not particularly. I have not got a specific set here, but you are absolutely right: on presentation you expect there to be both appropriate flags that questions need to be asked and a process whereby you can record, in right formation, both for the purposes of that organisation and also to flag for future reference. And you would want to have a set business processes that the organisations ensure adherence to and then a way in which others can audit compliance around those processes.

You also need to make sure that there are business processes within the organisation that do not impinge on clinical time that ensure appropriate charging, once identified, is appropriately recovered. That should be a set of business processes that either take money up front or deposits are made, and are clear about who the billing party is and what the business process is for recovering money from those billing parties.

David Williams: The changes we have made to date have been mainly focused around improving the transparency of information to the management side of providers, particularly those overseas visits managers both individually and as a network. One of the things we want to look at is whether we can embed that in the more generic clinical patient administration systems, which is the main bit of IT that front-line staff use through the organisation.

Chair: One of the issues at my local hospital over the years has been impersonation, which usually does not get picked up until there is a blood test. So there are a number of issues.

Caroline Flint: Fraud.

Q134 **Chair:** I suppose it is fraud, but this is people from overseas who would not be entitled or are worried that they would not be.

To pick up another point, earlier we raised the issue of St George's and the photo ID and utility bill, which I pointed out can be challenging for some people. I have constituents who have not got photo ID. Because they have never travelled, they have no passport. They have no driver's licence because they have never driven. And they still live at home because they cannot afford to move out, so they have never had a utility bill in their name. They find it hard to do a lot of things in this world. How will you ensure that people like that—British born, British resident—who are perfectly entitled to healthcare have access easily to the national health service without having to go through a humiliating and impossible-to-meet set of demands?

Chris Wormald: This is why we are going very, very slowly on some of these questions. Individual trusts are trying these out, and I know that has been key to those trusts' thinking about how they do it. I think probably the best thing is that we write to you about how the individual trusts who have been trying things out have addressed—

Q135 **Chair:** So effectively they are individuals piloting different models.

Chris Wormald: Yes. It is up to an individual trust as to how they wish to discharge their duties.

Q136 **Chair:** Is there any thought about modifying the NHS number? At the moment it is not a sign that you are still entitled—you are given an NHS number at birth if you are born here. Is that anyone at birth? Does that go to foreign-born—

Chris Wormald: Pretty much everyone at birth, but all an NHS number does is link you to your patient record regardless of whether you are chargeable.

Q137 **Chair:** But because you have got a whole infrastructure and registration system set up in 1948 that you can track people through, surely there must be some identifier you can attach to that that allows somebody who is British and got that to be proved to qualify, and then there might be a flag that rises with others. Have you thought about that? You could say

ID cards.

Chris Wormald: Yes. I am told that in order to do that you basically have to completely rework how that bit of the NHS IT system works and it is extremely complicated. That goes out of my knowledge set quite quickly, but at the moment to get an NHS number does not require you to prove identity—

Q138 **Chair:** It is just that I have got many constituents who were born and brought up in the UK who suddenly find they have to present ID for all sorts of things, and they are puzzled, angry and upset that they are often denied access to services because they cannot provide the ID that, interestingly, foreign nationals often can because they have come to this country all prepared. It is making sure that the balance is there so that British citizens who are entitled do not lose out as a result of trying to get money from overseas visitors.

Chris Wormald: Exactly. As I said earlier, in making policy around these areas we do have to be balancing up those things, which is why we do not want to jump to things that can look like simple solutions—

Q139 **Chair:** It would be a great shame if, in chasing down this money, people who were legitimately entitled also lost out, while we would want to see this money chased down.

Chris Wormald: Let's be clear, because I do agree with you, it is not just people like you and I who can't find a gas bill. Of course, the NHS is dealing a lot with people whose issues are to do with extreme age, dementia and so on, where finding that sort of ID at the point when you need treatment is not necessarily easy. I am really agreeing.

Q140 **Chair:** I am trying to find the section about the written-off debts: paragraph 3.34. I mentioned that my own trust had had trouble. It charges but then trying to recover it is a different matter. I gave those figures earlier.

In the Report, part 3, page 45 at paragraph 3.34, it talks about trusts pursuing debt for a number of years but often being unable to recover it and having to write it off.

"In 2015-16, trusts wrote off £15.7 million of overseas visitor debts relating to charges made in that year and in previous years." That has gone down a little from the previous year but is still a significant amount of money. Do you have projections of where you want to, or expect to, see those written-off debts, Mr Williams?

David Williams: Not specifically. It is one of the four components of level of invoicing, cash in, debt provision and fall against expectation of future payment and then debts written off. We would hope to see that go down. One of the techniques here is about being clear about charging and the level of charging and ideally securing payment for non-urgent treatments up front. If you can do that clearly the debt provision and write-off issue does not arise, so that would be an element of best practice that we want to see more widely adopted, but I do not have a specific number in mind.

Q141 **Chair:** I am puzzled. Dentists do this automatically. You go, they call up your records and you make your payment. I am sure mine is not the only one to do that. Then you do not get seen until you have made the payment, more or less. Obviously, it is not urgent—not usually, though it can be. You have got it on your record if you have not paid for any reason. That is quite a normal systemised approach, but we can't seem to do that in the NHS.

David Williams: It is not particularly the approach we are looking at across the NHS more generally but, as part of what works for those non-urgent treatments, being as clear as you can about costs up front and ideally securing the payment up front, is the direction of travel we want to take. Where that does not work, we have the ability to link through to the Home Office system, so the flag around bad debt at an individual level then becomes an issue next time you want to secure a visa.

Q142 **Chair:** That might be a price people are prepared to pay: come to the country, have an operation, never come back to the UK. That might suit people.

One of the things with the EEA's money, as you say Mr Wormald, is that it goes through the Department and you then pursue the different EEA national Governments for that money to come back. Is it sensible for trusts to chase individually the patients who come from outside the EEA with personal debt collection and so on? How much does that cost the system? Do you have any idea of the aggregate cost? Have you thought about centralising that?

David Williams: I don't have a view of the costs there. It seems to me a service that you might well want to include as part of the wider look at the amalgamation, the joining up, of back-office functions, either on an STP footprint, or between groups of trusts. Financial management issues like this debt recovery could well be—

Q143 **Chair:** It may be the same as for some insurance companies. Some people might claim through an insurance company and it might be cheaper to do a group insurance claim for several patients, rather than individually. So, that is something you are looking at, Mr Alexander.

Bob Alexander: Yes, I would expect that to be part and parcel of what comes out of the best practice piece that we do with trusts, or that we would suggest to them as ways of bringing that piece of service together.

Q144 **Chair:** On the EEA target, which Mr Kwarteng and others have raised a number of times, are you absolutely clear with the EEA target that you have set that all those people should be paying? Because of the habitual residency test, which is quite complicated, it does not take much for somebody not to have to present their EHIC card and say, "Actually, I'm habitually resident; I get it for free." Are you over-egging that target or is it that you are just failing abysmally to reach it?

Chris Wormald: As I have said all along, our data are not as good as we would want, so I cannot absolutely say that it is correct but, when you look at what was found in that 2013 study and repeated in the NAO

Report, and at those discrepancies that Members were pointing to earlier between, even when you strip out the pensioner bit, what we collect as opposed to what we pay out to other countries, that does suggest that there is a gap there, which is why we want to have a stretching target.

Q145 **Chair:** If you had a free hand, would you want more clarity from the Government or Parliament about what habitual residency is? I think it is different in the UK from a number of other countries.

Chris Wormald: I suspect you are much more expert on this question than I am, to be honest.

Q146 **Chair:** But if you had a wish list of things to help you achieve this target, would this be one of the things on it? I'm sure you have a wish list.

Chris Wormald: We are consulting right now, as I have said, on the things we would want to change. That is not one of them. The first thing we would want to do is secure the issues that we have been consulting on.

Q147 **Chair:** Why is it not one of them? I know there are lots of things you could be asking for.

Chris Wormald: I'm not sure that's a question I can answer.

Chair: Okay. We'll leave that one there for now. We might want to pick it up again.

Q148 **Caroline Flint:** Following on from that, are you doing any work to look at those people who register with a GP who may also be liable for charges? I understand that if you are from other parts of the EEA, you can register with a GP, but that can also be claimed back via the agreed cross-Europe health system. Do you have any information or data on that? Although this Report does not cover it, my understanding is that GPs are not identifying those individuals either and are not processing that information back in order to recover moneys.

Chris Wormald: As it stands, GPs are not contractually obliged to do any identification. That is not part of the current GP contract. I don't think we do collect information on that, do we, David?

David Williams: No.

Q149 **Caroline Flint:** Does that mean that if people from other parts of the EEA, who we could claim the money back for, register with a GP, the GP doesn't have any contractual obligation to provide that information, and that might be another source of money we are losing out on? That is the logic of what you just said.

Chris Wormald: That's not an issue that has been raised with us, but I will go away and check.

Chair: If one of us were to go to, say, France, we would have to pay something for primary care.

Mrs Trevelyan: It is €22 to get through the door. I was there this

summer.

Chair: Mrs Trevelyan has French family connections and knows these things.

David Williams: As Mr Wormald said earlier, the regulatory basis here is primarily focused on hospital care, rather than primary care. In that sense, it is not covered by regulations.

Q150 **Caroline Flint:** I understand that, but this is another part of it. Of course, other people—for example, British people living overseas for many years—can sometimes also register with a GP here and come back when needs must for their treatment. There might be other people here on a visa who register for a GP and for whom there might be a recovery for their care at that level. I am correct on that. These are categories where there could be a charge.

Chair: At no cost to patients, and with no denial of treatment.

Caroline Flint: Exactly. I'm right about that, aren't I?

Chris Wormald: Let me go away and check.

Laura Brackwell: We say in the Report in footnote 5 that "the UK can recover the cost of all NHS treatment provided to EEA patients" covered by EHIC, S1 and S2. The exemptions do not apply. My understanding is that if GPs took people's details, and if there was a system by which they could report them, that money could be claimed back. That may not be right, but that is my understanding.

Chris Wormald: Let me check that.

Q151 **Caroline Flint:** Could you write to us on that? This comes back to the patient record. We were talking earlier about changes to the IT system at the hospital end, but if there is a throughput from people at the GP, it should show up there as well.

Chris Wormald: Yes. I agree with that.

Q152 **Charlie Elphicke:** I have a couple of questions on that particular issue. I raised that with you earlier in this session, Mr Wormald, and asked why we are not doing this at primary care level, with GPs. You said there were some obscure public health reasons and it's all a matter of policy. Now you are saying you're going to look at it.

Chris Wormald: That has always been part of the argument about why we focus exclusively on hospitals for this, as opposed to primary care—when you have people who are suffering from infectious conditions, you positively want them to seek medical attention. The line that has traditionally been drawn has been between primary care and A&E, which we haven't traditionally charged for, and hospital treatment, where we do. I was simply stating as a fact that that is the position.

Q153 **Charlie Elphicke:** Will you now review this area?

Chris Wormald: As I say, those are policy questions. What we have been focusing on is implementing the rules and regulations as they stand. I accept that that is a policy question and there is a case people may want to argue.

Q154 **Charlie Elphicke:** As a second point, on an operational thing, what do you think would happen if you said to GPs, "If you go and get these details and an EHIC card, you can keep a quarter of the money?" What do you think would happen, knowing the behaviour of GPs on financial incentives?

Chris Wormald: I can't answer your question directly, because we haven't looked at it, but—

Charlie Elphicke: Speculate.

Chris Wormald: I am not going to speculate beyond saying that when we have introduced financial incentives in the trust sector, as the NAO reported, those have had an effect on behaviour. You can draw your own conclusions.

Q155 **Charlie Elphicke:** Is it not the case that whenever you have used financial incentives in the past with practitioners in general practice, they have followed them with vigour and energy?

Chris Wormald: Very frequently. I agree with you.

Chair: Mr Elphicke, you may want to take this up elsewhere.

Q156 **Philip Boswell:** Mr Wormald, I have a question about the stats. The UK's fund recovery is poor compared with our European colleagues. What lessons have been learned from the apparently much more efficient systems in place across Europe?

Chris Wormald: As I say—I think the NAO says this in its Report—it is almost impossible to compare systems, because almost every other system has built into it from moment one both proving identity and charging. In those systems, the issues we are discussing today would be part and parcel of the normal operation of any hospital. That is not the case with the UK, because we have had this rather unique NHS approach, so we are retrofitting a system on to a system that works in another way, as opposed to going with the grain. We did not find—and I do not think the NAO has found—any systems where you could say it is like that. I think that is fair enough, isn't it?

Laura Brackwell: Yes.

Q157 **Chair:** I just want to ask about Brexit. Mr Mills touched on it earlier. We want to know from each permanent secretary we see what your plans are and how much planning is going on within the Department to prepare. As Mr Mills rightly highlighted, this is one area. You say you are not going to give a running commentary. I think you are getting that from a higher power, if I may say, but nevertheless, you are the man responsible for the NHS budget and that was quite a focus of the debate around the

referendum. What key things are worrying you about Brexit that your Department has working groups, plans and discussions going on to make sure that you are prepared for?

Chris Wormald: Like every Department, we are considering and doing a lot of work on the implications of Brexit and—

Q158 **Chair:** Can you list the top three things?

Chris Wormald: The main issues have all been part of the public debate. It is not a secret that the NHS employs a large number of overseas workers, so that is clearly one issue, both in terms of people who are currently here and future supply. That has been debated by politicians. A number of people have commented on questions about how exactly drug regulation is going to work. That is of course currently done on a cross-European basis, and a lot of it is actually led from the UK, so there are obviously questions around that. The third big area is the one we have been discussing today: what reciprocal arrangements you have with whom. Those would probably be the top three. I do not think there is a secret in terms of what the issues are for the health service. Those are big issues, but I would probably say that, compared with some Departments, they are not the biggest issues in the UK. The health service is a big part of our business, but not a dominant one.

Q159 **Caroline Flint:** How many people in the Department are actually working on plans for Brexit?

Chris Wormald: About 15.

Q160 **Caroline Flint:** Fifteen. Do you think that is going to increase?

Chris Wormald: The bit we are seeking to increase is—we take in secondees from the health service to work on the good practice part. Last year, we had six of those, who were working with individual trusts, and we are looking to recruit, I think, about 15—*[Interruption]*—up to another 15 this year. I don't think we need more policy makers on this; what we need is those people who are actually—this has come out of the hearing—going and looking at what the process going on in the hospital is and how it can be improved. I think that is the bit we need to do more of. Would you agree, Bob?

Laura Brackwell: May I just clarify something? Ms Flint asked how many people you had working on Brexit, and I think you answered on the cost recovery programme.

Chris Wormald: Oh sorry, yes, on cost recovery. On Brexit—sorry, as I was revising all this stuff, I don't have that number with me.

Chair: Will you write to us about it?

Sir Amyas Morse: Is it more than 15?

Chris Wormald: I would very much doubt it.

Q161 **Caroline Flint:** Can you write to us with how many people, whether in

the Department or seconded, are working on our plans for where we are going to be and also on the negotiation side of things? That would be helpful.

Obviously, from the questions today, and from the Report and your answers, we recognise that some changes have been made—probably some long overdue changes—but it would be fair to say that there is still considerable concern that the system is quite chaotic, to say the least. The variability between one trust and another seems to be enormous. It ranges from 15% identification, in some cases, to 100%.

On a bigger level, there is our concern about how seriously this is being taken, given the challenges the NHS faces, and about public confidence—people feeling that every effort is being made to make the money we use in the NHS go further in a smart way, but also to ensure that what the NHS is entitled to is coming back into it. How much of a priority do you see this as, both in terms of public confidence and as a really important factor to make sure the NHS is sustainable for the future?

Chris Wormald: As I said, this is nothing to do with me, because I wasn't here at the time, but the Government in 2013 made this a priority in a way that no previous Government had done for 30 years. It set itself a challenging target. Nobody made it do that. It has heightened public attention and attention within the NHS. So we wouldn't accept that there has been any lack of priority; we think this Government has put more priority on it than ever before. I would not use the word "chaotic", as you did, but the rest of your summing up I think I would largely agree with. We do think we have achieved quite a lot, but we have, as is clear in this hearing and in the NAO Report, a lot more that we need to do to get to where we want to, so I don't think there is a difference between us on that.

Chair: Well, we will continue to watch it. Thank you very much for your time. Our transcript will be on the website in the next couple of days. It is quite possible this report will not be published until after Christmas—we can't be sure—but we will obviously send you a copy. Thank you very much.