



Department  
of Health

# Guidance on implementing the overseas visitor charging regulations

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# Introduction

This manual of guidance supersedes and replaces all previous guidance on the implementation of the Charging Regulations.

This guidance seeks to provide help and advice on the implementation of the National Health Service (Charges to Overseas Visitors) Regulations 2015, which has been amended most recently by the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017. However, it cannot cover all circumstances and is not intended to be a substitute for the Regulations themselves, which contain the legal provisions. Relevant NHS bodies are advised to seek their own legal advice on the extent of their obligations when necessary.

Not everyone is entitled to free NHS hospital treatment in England. This guidance explains what should happen when an overseas visitor needs NHS treatment provided by an NHS hospital in England. The guidance is intended for staff at relevant NHS bodies, including clinicians, senior managers and clerks, and in particular staff with a responsibility to identify and charge overseas visitors. The Department of Health strongly recommends that relevant NHS bodies have a designated person/s – hereafter referred to as an Overseas Visitor Manager (OVM) – to oversee the implementation of the Charging Regulations. All staff, including clinicians and managers, have a responsibility to ensure that the charging rules work effectively.

The success of the charging rules also depends on NHS staff being aware and supportive of the role of the OVM. The OVM should be given the authority to ensure that the charging rules can be properly implemented in all departments.

Main amendments made to Guidance since Charging Regulations came into force in 2015:

Date updated	Summary of Change	Reference (para)
From 23 October 2017	A requirement on all providers of NHS-funded secondary care to, where no exemption applies, recover an estimate of the charges in advance unless doing so would prevent or delay the provision of immediately necessary or urgent services	8.13 11.3 11.4
From 23 October 2017	A requirement on all providers of NHS-funded secondary care, including non-NHS organisations to make and recover charges from overseas visitors where relevant services have been provided to them and no exemption applies	Exec summary 14, 2.17
From 23 October 2017	Introducing an exemption from charges for palliative care services that are provided by a registered charity or community interest company	4.3

21 August 2017	Amendment to the following exemption from charge categories: <ul style="list-style-type: none"> <li>immigration health surcharge and</li> <li>transitional arrangements in respect of the surcharge</li> </ul> so that the exemption from charge does not apply in respect of assisted conception services	5.44
21 August 2017	A requirement on NHS trusts and foundation trusts to record when a person is an overseas visitor on that persons 'consistent identifier' (i.e. against their NHS number)	11.43
21 August 2017	Addition of reciprocal healthcare agreements to the list of those exemption categories that, should they cease to apply to a person, they will also cease to apply in respect of any on-going course of treatment the person is having	2.22
21 August 2017	Clarification of the exemption in relation to the dependents of refugees, asylum seekers and some supported failed asylum seekers	1.2, 2.26, 2.29
21 August 2017	Removal of the exemption for relevant services provided outside a hospital or by its staff	Row 7 of the table beginning on page 23
21 August 2017	Addition of services that are provided as part of the NHS111 telephone advice line to the list of services for which no charge is to be made	4.3
21 August 2017	Removal of the exemption for workers on UK-registered ships (although the shipowner is liable)	n/a
1 October 2016	Removal of the reciprocal healthcare agreement with Barbados	10.7
February 2016	Changes in relation to victims of female genital mutilation (FGM)	2.29, 7.10-7.16
February 2016	Modification of the exemption for victims and suspected victims of human trafficking to include victims and suspected victims of modern slavery	7.50- 7.59
February 2016	Changes to the exemption for failed asylum seekers supported by Local Authorities	7.37-7.45

February 2016	Addition of Middle East Respiratory Syndrome (MERS) to list of exempt diseases	4.3
January 2016	Removal of certain reciprocal healthcare agreements (some former U.S.S.R countries)	

### Frequently used abbreviations

A1 – the portable form issued to a posted worker confirming cover by the issuing state. The A1 accompanies a valid European Health Insurance Card for qualifying posted workers.

Charging Regulations – means the National Health Service (Charges to Overseas Visitors) Regulations 2015, the National Health Services (Charges to Overseas Visitors) (Amendment) Regulations 2015 and the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017.

EEA resident – refers to visitors and migrants who reside in any countries which are in the European Economic Area. A summary of these countries can be found in Chapter 9. Throughout this guidance, reference to EEA states or EEA nationals or residents should be understood to include a reference to Switzerland or Swiss residents as appropriate, except in relation to the operation of the Cross-border Healthcare Directive (discussed in Chapter 9) which does not apply to Switzerland.

EHIC – the European Health Insurance Card (previously E111).

Non-EEA resident – refers to visitors and migrants who reside in any countries which are outside the European Economic Area.

PRC – Provisional Replacement Certificate, issued to eligible EEA residents in cases where an EHIC cannot be produced.

S1 – issued to pensioners, posted or frontier workers, and their family members, (previously E121, E109, E106). The term ‘pensioner’ includes those in receipt of a qualifying long-term benefit. If an original form is presented to an OVM, this should be sent to the Overseas Healthcare Team in Newcastle for registration (the holder may also have a copy for personal use).

S2 – payment guarantee from the issuing country for planned treatment (previously E112).

# Executive summary

1. The National Health Service (Charges to Overseas Visitors) Regulations 2015 (the Charging Regulations) came into force on 6 April 2015 and apply to all courses of treatment commenced on or after that date. The Regulations have subsequently been amended, most recently on 21 August 2017 by the NHS (Charges to Overseas Visitors) (Amendment) Regulations ("the 2017 Amendment Regulations").
2. Whilst most regulations within the 2017 Amendment Regulations came into force on 21 August, regulations relating to some provisions will not come into force until 23 October 2017. The main changes as a result of the 2017 Amendment Regulations are presented in a table at the end of Chapter 2.
3. The NHS is a residency-based healthcare system and eligibility for free NHS hospital care is based on the concept of "ordinary residence". An overseas visitor is any person who is not "ordinarily resident" in the UK. A person will be "ordinarily resident" in the UK when that residence is lawful, adopted voluntarily, and for settled purposes as part of the regular order of their life for the time being, whether of short or long duration. Nationals of countries outside the European Economic Area (EEA) must also have indefinite leave to remain in the UK in order to be "ordinarily resident" here. A person who is "ordinarily resident" in the UK must not be charged for NHS hospital services.
4. The Charging Regulations place a legal obligation on NHS trusts, NHS foundation trusts and local authorities in the exercise of public health functions<sup>1</sup> in England (referred to as 'relevant NHS bodies'), to establish whether a person is an overseas visitor to whom charges apply, or whether they are exempt from charges. From 23 October 2017 this legal obligation will also apply to any provider of NHS-funded community and secondary care including non-NHS organisations, at which point the term will change to 'relevant body'.
5. When charges apply, a relevant NHS body must make and recover charges from the person liable to pay for the NHS services provided to the overseas visitor. From 23 October 2017 relevant bodies (which will then include non-NHS organisations providing NHS funded secondary care) will be required to recover these charges in full in advance of providing them, unless doing so would prevent or delay the provision of immediately necessary or urgent services.
6. A list of exempt services and exempt categories of overseas visitor is provided in Chapter 1, with a more detailed list of exempt services at Chapter 4.
7. One significant exemption is for temporary migrants coming to, or remaining in, the UK for six months or more from outside the EEA. They are required to pay the immigration health charge (referred to as the health surcharge) unless an exemption applies or the charge is waived. People who have immigration permission to be in the UK and have paid the surcharge (or who are exempt from paying it (except where the exemption is because they

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<sup>1</sup> Referred to as 'relevant bodies' or 'relevant body' in the Charging Regulations, as the context requires

are visiting the UK for a short period) or in respect of whom it has been waived), are generally entitled to NHS care on the same basis as a person ordinarily resident in the UK. The exception to this is that from 21 August 2017 NHS-funded assisted conception services to surcharge payers (or equivalent) are not free when provided unless another exemption applies. More on this group and how to recognise them can be found in Chapter 5.

8. Overseas visitors who are visiting the UK for six months or less, (including those on multiple entry visas), non-resident UK nationals, or those who are in the UK without immigration permission must be charged for services they receive at the point of accessing care, unless they are exempt from charges under other categories of the Charging Regulations.
9. Overseas visitors who reside in an EEA state (including non-EEA nationals) may be insured under the public healthcare insurance system in their resident member state, or country of work for posted or frontier workers. They will consequently be exempt from charges for any medically necessary treatment they receive under the Charging Regulations, as long as they present the appropriate EEA healthcare document. This is because the UK can recover the cost of their care from the relevant insuring member state, if the details of their healthcare form are recorded. Costs can be recovered wherever this treatment is provided, including for services that are 'free to all' e.g. in A&E departments, or for NHS primary care.
10. The way in which a person qualifies as insured varies depending on their country of residence (or country of work if they are a posted/frontier worker). However, in every case where someone is insured under the public system they will have, or should be entitled to hold, a European Health Insurance Card (EHIC) or Provisional Replacement Certificate (PRC) from the EEA state in which they are insured. Each family member, including children, will have their own EHIC or PRC. EEA residents may also be issued an S2 form if they wish to seek pre-planned treatment in another EEA member state.
11. If the visitor has not come to England specifically to seek healthcare, and cannot show their EHIC, they may instead produce a PRC to prove entitlement to free healthcare in the UK under the EU Regulations. It should be for the patient or their representative to arrange the issue of the PRC from the EEA state/Switzerland that would issue their EHIC, but the OVM may assist with this if needed.
12. EEA residents who are visiting the UK on a temporary basis or to pursue a course of study, and who are insured by their resident state, should present a valid EHIC or PRC from that country to access free medically necessary treatment. This includes British nationals who are insured in another EEA state. The EHIC/PRC is issued by the country of residence or work, which is not necessarily the person's country of citizenship.
13. When a relevant NHS body treats an EEA insured patient they must inform the Overseas Healthcare Team at the Department of Work and Pensions of details of the EHIC/PRC/S2 document held by that person. This information is necessary to allow the UK to recover the cost of treating EEA residents from the relevant EEA country. This will continue to be the case after the UK has formally initiated proceedings to leave the EU, until further notice. See Chapter 9 for more information.



14. Those visitors from the EEA to the UK who do not have a valid EHIC, PRC or S2 and who are not covered under another exemption category under the Charging Regulations must be charged for services they receive at the point of accessing care.
15. A relevant body also has human rights obligations, so chargeable treatment which is considered by clinicians to be immediately necessary must never be withheld from an overseas visitor or delayed, even when that overseas visitor has indicated that they cannot pay. This does not mean that the treatment should be provided free of charge. Charges will still apply, and, if not yet recovered, should be pursued after the treatment is provided. Treatment which is not immediately necessary, but is nevertheless classed as urgent by clinicians, as it cannot wait until the overseas visitor can be reasonably expected to return home, should also be provided without delay regardless of the patient's ability to pay. Every effort should be made to obtain payment or a deposit in the period before treatment starts.
16. From 23 October 2017 relevant services must not be provided to a chargeable overseas visitor until the estimated full cost of treatment has been secured upfront, unless doing so would prevent or delay the provision of immediately necessary or urgent treatment. See Chapters 8, 11 and 13 for more important information about how and when to ask for payment from chargeable overseas visitors.
17. All relevant NHS bodies, as public authorities, and all relevant non-NHS bodies when carrying out a public function, must comply with the public sector equality duty in the exercise of their functions. More details on this, and on resources which can be used to assist NHS organisations to do this, can be found in Chapter 11.
18. This guidance does not cover treatment provided by a general practitioner (GP), dentist or optician, although there is some comment on GP registration in Chapter 11. Nor does it concern charging arrangements in Wales, Scotland and Northern Ireland as these are governed by separate legislation under the jurisdiction of the respective devolved administration.
19. The information above sets out the general position only. These general principles do not apply in all cases, and relevant NHS bodies must ensure that they understand the full scope of the Charging Regulations when making and recovering charges from overseas visitors.
20. A relevant body in England may seek help and advice about any aspect of the Charging Regulations and this guidance by using the OVM online forum<sup>2</sup>. Ultimately, the decision that a patient is liable for charges legally rests with the relevant body providing the treatment. In cases where a patient's circumstances are unclear, unusual or appear not to be provided for in this guidance, relevant NHS bodies should seek their own legal advice as to the application of the Charging Regulations to the patient.
21. This guidance may be amended on occasion to reflect changes to the Charging Regulations. Relevant NHS bodies should ensure that they refer to the latest version. The Department of Health has also published a toolbox of supporting information, which will continue to be reviewed and refined. The aim of the toolbox is to help relevant NHS bodies discharge their

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<sup>2</sup> If you would like an invitation to be part of the forum, please email [nhscostrecovery@dh.gsi.gov.uk](mailto:nhscostrecovery@dh.gsi.gov.uk)

cost recovery duties more effectively and it contains a wide range of documents including standardised best practice pre-attendance forms for all patients to fill in when being admitted. The Charging Guidance and toolbox is available at [www.gov.uk/dh/nhscostrecovery](http://www.gov.uk/dh/nhscostrecovery). Relevant NHS bodies should check the website and toolbox regularly for information which may update and augment this document. A table of subsequent changes made to this guidance will be compiled as they arise, and will appear in any updates. A list of other relevant materials is set out below.

## Documents/materials available to assist OVMs in carrying out their role

Document/item name	Type	Location
The Overseas Visitor Manager Toolbox	Policy document	<a href="https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants">https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants</a>
The Overseas Visitor Manager Online Community	Web forum	If you would like an invitation to be part of the forum, please email <a href="mailto:nhscostrecovery@dh.gsi.gov.uk">nhscostrecovery@dh.gsi.gov.uk</a> The on-line forum can be found here <a href="https://dhexchange.kahootz.com/connect.ti">https://dhexchange.kahootz.com/connect.ti</a>
Visitor & Migrant NHS Cost Recovery Programme's Twitter feed	Social media	<a href="https://twitter.com/nhscostrecovery">https://twitter.com/nhscostrecovery</a>

Resources available on the overseas visitor manager online community web forum	
Policy Documents	Guidance on implementing the overseas visitor hospital charging regulations 2015, as amended (the Guidance).
	Summary of changes made in 2015 to the way the NHS charges overseas visitors for NHS hospital care
	Surcharge Guidance: guidance on the Immigration Health Surcharge and Biometric Residence Permits
	Information sharing with the Home Office: guidance for overseas patients
	Overseas chargeable patients, NHS debt and immigration rules: guidance on administration and data
	Ways in which people can be lawfully resident in the UK

	Ordinary residence tool: determining if a person is properly settled in the UK in order to establish if they are ordinarily resident here
	Equality analysis: the National Health Service (Charges to Overseas Visitors) Regulations 2015
	Equality analysis: immigration sanctions for those with unpaid debts arising from the NHS (Charges to Overseas Visitors) Regulations 2011
	Information about the cross-border healthcare directive
	How to complete the NHS debtors spreadsheet
Templates	Example pre-attendance form
	Letter – request for advice from doctor/dentist
	Immigration information request form
	Example undertaking to pay form
	Letter – request for patient information
	Letter – reminder for patient information
	Letter – document acknowledgement – patient non-chargeable
	Letter – document acknowledgement – patient chargeable
	Letter – no documents received – patient chargeable
	Letter – payment request
	Letter – advice to doctors and dentists
Other useful resources	Guide to EHIC incentive scheme
	EEA countries and contact points
	Poster: map of EEA countries
	Overseas Visitor Manager code of conduct
	Useful contacts for NHS overseas visitor managers
	Poster: S1 forms
	Poster: S2 forms

# 1. Exempt services and individuals

**This chapter sets out details of all services which are free of charge to patients, and of all groups of individuals who are entitled to receive healthcare on the same, or similar, basis as an ordinarily resident person.**

## Exempt services

1.1. The following services are free at the point of use for all patients. A charge cannot be made or recovered from any overseas visitor for:

- accident and emergency (A&E) services, this includes all A&E services provided at an NHS hospital, e.g. those provided at an accident & emergency department, walk-in centre, minor injuries unit or urgent care centre<sup>3</sup>. This does not include those emergency services provided after the overseas visitor has been accepted as an inpatient, or at a follow-up outpatient appointment, for which charges must be levied unless the overseas visitor is exempt from charge in their own right;
- family planning services (does not include termination of pregnancy);
- diagnosis and treatment of specified infectious diseases (listed at Chapter 4);
- diagnosis and treatment of sexually transmitted infections;
- from 23 October 2017, palliative care services provided by a registered palliative care charity or a community interest company;
- services that are provided as part of the NHS111 telephone advice line;
- treatment required for a physical or mental condition caused by:
  - torture;
  - female genital mutilation;
  - domestic violence; or
  - sexual violence,

except where the overseas visitor has travelled to the UK for the purpose of seeking that treatment.

## Exempt categories of person

1.2. The following categories of overseas visitor are exempt from charge:

### Those who have paid the health surcharge or are covered by transitional arrangements

- Non-EEA nationals, who are subject to immigration control, are exempt from charge (see below) if one of the following applies to them while their leave to enter/remain is valid:

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<sup>3</sup> Making a fair contribution: Government response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England (published 6 February 2017) stated that the Government is still considering its proposal to extend charging for overseas visitors to services provided at an A&E unit or similar, with an intention to respond later in the year.

- they have paid the surcharge; or
  - they are exempt from payment of the surcharge<sup>4</sup> or have had the requirement waived or reduced, or have had part (but not all) of the surcharge refunded to them; or
  - they would have been covered under one of the above, but for the fact that they applied for leave to enter or remain in the UK before the start of the surcharge (this will include some people already resident here without indefinite leave to remain, and a small number of people arriving after 6 April 2015 who applied for leave before that date).
- From 21 August 2017, assisted conception services are *not* included (unless the services are provided by NHS England to armed forces members, veterans and their families, in accordance with the terms of the armed forces covenant, or the services form part of a course of treatment that began before 21 August 2017).
  - A child born in the UK to an above mentioned exempt person is also exempt from charge up to the age of three months provided that the child has not left the UK since birth.

### Those with an enforceable EU right to free healthcare

- Anyone insured for healthcare in another EEA member state and who, for medically necessary treatment, presents either an EHIC from that member state or a PRC (see Introduction for definitions), or, if coming to the UK specifically for treatment, presents an S2 form for that treatment (see Chapter 9 for more details).
- Anyone who has a UK-issued S1 form registered in another EEA member state or Switzerland except for family members of frontier workers.
- The spouse/civil partner and children under 18 of the above are also exempt when lawfully visiting the UK with them, unless they have an enforceable EU right in their own right.<sup>5</sup>

### Vulnerable patients and those detained

- Refugees (those granted asylum, humanitarian protection or temporary protection under the immigration rules) and their dependents.
- Asylum seekers (those applying for asylum, humanitarian protection or temporary protection whose claims, including appeals, have not yet been determined), and their dependents.
- Individuals receiving support under section 95 of the Immigration and Asylum Act 1999 (the 1999 Act) from the Home Office.

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<sup>4</sup> Except when the exemption is because they have a visitor visa under part 2 of the immigration rules, or because they are visiting for 6 months or less.

<sup>5</sup> That is, the exemption only applies where EU law does not provide them with a right to an EHIC or PRC of their own – in practice this is likely to be only when their same-sex marriage or civil partnership is not recognised by the insuring member state.

- Failed asylum seekers, and their dependents, receiving support under section 4(2) of the 1999 Act from the Home Office or those receiving support from a local authority under Part 1 (care and support) of the Care Act 2014 or section 35 or 36 of the Social Services and Well-being (Wales) Act 2014, by the provision of accommodation.
- Children who are looked after by a local authority.
- Victims, and suspected victims, of modern slavery<sup>6</sup> as determined by a designated competent authority, such as the UK Human Trafficking Centre or the Home Office. This includes their spouse/civil partner and any children under 18, provided they are lawfully present in the UK.
- An overseas visitor who has been granted leave to enter the UK outside the immigration rules, in whose case the Secretary of State for Health determines there to be exceptional humanitarian reasons to provide a free course of treatment. This exemption will also apply to their child and/or companion who is authorised to travel with them, for whom the exemption is limited to treatment, the need for which arose during the visit, and cannot await their return home.
- Anyone receiving compulsory treatment under a court order or who is detained in an NHS hospital or deprived of their liberty (e.g. under the Mental Health Act 1983 or the Mental Capacity Act 2005) is exempt from charge for all treatment provided, in accordance with the court order, or for the duration of the detention.
- Prisoners and immigration detainees.

### UK Government employees and war pensioners

- UK armed forces members, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK (even if they are on a visit visa).
- UK Crown servants who are in the UK in the course of their employment, or who were ordinarily resident prior to being posted overseas, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK.
- Employees of the British Council or Commonwealth War Graves Commission who are in the UK in the course of their employment, or who were ordinarily resident in the UK prior to being posted overseas, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK.
- Those working or volunteering in employment overseas that is financed in part by the UK Government who are in the UK in the course of their employment, or who were ordinarily resident in the UK prior to being posted overseas, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK.
- Those receiving war pensions, war widows' pensions or armed forces compensation scheme payments, plus their spouse/civil partner and children

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<sup>6</sup> Modern slavery includes human trafficking, as well as slavery, servitude or forced or compulsory labour.

under 18 when these family members are lawfully visiting the UK with the recipient of this pension/payment.

### **Those covered by reciprocal healthcare agreements (as listed in Schedule 2 of the Regulations) and other international obligations**

- Anyone entitled to free healthcare in the UK under the terms of a reciprocal healthcare agreement with a country outside the EEA (usually limited to immediate medical treatment); see Chapter 10 for more details.
- Nationals of states that are contracting parties to the European Convention on Social and Medical Assistance or the European Social Charter and who are lawfully present here and without sufficient resources to pay. Free treatment is limited only to that which cannot wait until the overseas visitor can return home and provided the person did not come to the UK for the purpose of seeking treatment.
- NATO personnel, when the services required cannot readily be provided by armed forces medical services, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK.

## 2. The law in England

### Statutory provisions

- 2.1. [Section 175 of the National Health Service Act 2006](#) (the 2006 Act) allows the Secretary of State for Health to make regulations for the making and recovery of charges in relation to any person who is not ordinarily resident in Great Britain. It also gives the Secretary of State the power to calculate charges on any appropriate commercial basis.
- 2.2. The power to charge for NHS services in section 175 has so far only been used in relation to NHS hospital services. The Charging Regulations are made under those powers.

### The Charging Regulations

- 2.3. The Charging Regulations apply to England only, and replace previous regulations on charges to overseas visitors. A relevant NHS body must only make and recover charges when it determines that the patient is not entitled to free NHS hospital care. A patient is entitled to free NHS hospital care on the basis of being ordinarily resident, or because the person is exempt from charges under the Charging Regulations. The obligation to undertake reasonable enquiries is an important part of the duty to make and recover charges from overseas visitors, and:
  - ensures that patients who are not ordinarily resident in the UK are identified;
  - assesses liability for charges in accordance with the Charging Regulations;
  - charges those liable to pay in accordance with the Charging Regulations; and
  - recovers payment from those liable to pay.
- 2.4. Relevant NHS bodies must undertake the following steps to identify and charge chargeable overseas visitors:

#### **Step 1: Determine if the patient is insured by another member state**

The UK is able to recover the cost of treatment provided to any patient who is insured by another EEA country, including those patients who are ordinarily resident in the UK or covered under another exemption category. All patients should be asked if they have an EHIC, PRC, S1 or S2 (see Introduction for definitions). It is possible that a patient may be ordinarily resident in the UK but still continue to be insured by another state. Chapter 9 provides further information about identifying persons who have an EU right to free healthcare in the UK and the process for recovering the cost of their healthcare from the insuring member country.

If the patient is not insured by another member country, proceed to step 2.

#### **Step 2: Determine if the patient is ordinarily resident in the UK**

All patients must be assessed against the test for ordinary residence in the UK. More information on how to determine whether a patient is ordinarily resident in the UK, including suggested questions to be asked, can be found in Chapter 3. If the patient is ordinarily resident in the UK they must not be charged.



If the patient is not ordinarily resident in the UK, proceed to step 3.

All relevant NHS bodies must comply with their legal duties when asking questions of patients. In particular, they must avoid discriminatory measures and must not practice racial or nationality profiling to identify chargeable patients or cherry-pick which patients to question. Further information on the legal duties of relevant NHS bodies is set out in paragraphs 2.7 to 2.30 and Chapter 11.

### **Step 3: Determine if the patient is covered by an exemption in the Charging Regulations or if the patient is liable for charges**

Patients who are not ordinarily resident in the UK and are not insured by another EEA country need to be assessed against the exemptions in the Charging Regulations.

### **Step 4: Make and recover charges from chargeable overseas visitors**

Where treatment is non-urgent or elective, this means that the relevant NHS body should obtain full payment or collect a deposit equivalent to the full estimated cost of care in advance of providing treatment. For more information about when and how to collect payment from chargeable patients, see Chapters 8, 11 and 13.

### **Step 5: Record the patient's chargeable status on their NHS Record**

When a patient has been identified as an overseas visitor, NHS trusts and foundation trusts must record this fact on the patient record via the Summary Care Record application and whether or not the overseas visitor is exempt from charge. This should be done as soon as possible, by staff who are accredited to do so. See Chapter 11.

## **The Immigration Act 2014**

- 2.5. The [Immigration Act 2014](#) made changes to the charging rules. These changes are twofold. First, section 39 of the Act changes the meaning of "ordinary residence" in section 175 of the 2006 Act as it relates to non-EEA nationals who are subject to immigration control. Since 6 April 2015, such individuals also have to have indefinite leave to remain in the UK in order to be ordinarily resident here. Chapter 3 provides more information about ordinary residence.
- 2.6. Second, section 38 of the Immigration Act authorised the Home Secretary to introduce an immigration health charge (known as the health surcharge) to be paid by non-EEA nationals, subject to immigration control, who apply to reside temporarily in the UK for six months or longer. The health surcharge is paid at the same time as a visa applicant pays their visa application fee. There are exemptions from paying the health surcharge for certain people, and the Home Secretary has the discretion to reduce, refund or waive all or part of the health surcharge. The health surcharge is payable for new visa applicants who have made an application for a visa on or after 27 April 2015. Chapter 5 explains how to identify and process people who have paid, are exempt, or are waived from paying the health surcharge.

## **Other statutory obligations that apply to relevant NHS bodies**

- 2.7. In addition to their obligations under the Charging Regulations, relevant NHS bodies are also subject to other legal duties when exercising their functions to impose charges on overseas visitors. The duties set out below are key legal duties, with which relevant NHS bodies must comply, and which are relevant to the implementation of the charging rules. It is not an exhaustive list of legal duties to which relevant NHS bodies may be subject.

## The Human Rights Act 1998

2.8. Article 14 of the [European Convention on Human Rights](#), which is incorporated into UK law in the [Human Rights Act 1998](#), prohibits discrimination against a person in the exercise of their rights under the Convention, on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status. Article 14 is not free-standing and can only be invoked in relation to other convention rights (e.g. Article 8 – the right to private and family life which can be engaged when a person seeks healthcare). Not every difference in treatment is discriminatory, provided that it can be shown that there is a ‘reasonable and objective justification’ for the difference in question.

## The Equality Act 2010

2.9. Under the [Equality Act 2010](#), relevant NHS bodies have a general equality duty in the exercise of their functions to have due regard of the need to:

- eliminate discrimination, harassment and victimisation and other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and those who do not; and
- foster good relations between people who share a protected characteristic and those who do not.

2.10. The protected characteristics are:

- age;
- disability;
- gender reassignment;
- marriage and civil partnership;
- pregnancy and maternity;
- race;
- religion or belief;
- sex; and
- sexual orientation.

2.11. The [Equality Act 2010](#) prohibits:

- direct discrimination (section 13);
- indirect discrimination (section 19), unless the discrimination is a proportionate means of achieving a legitimate aim;
- harassment (section 26); and
- victimisation (section 27).

2.12. A relevant body discriminates against a person if, because of a protected characteristic, it treats that person less favourably than it treats others. For example, the use of racial profiling (e.g. targeting a person for questioning as a potential overseas visitor on the basis of their being a racial minority) is discriminatory and is prohibited by the Equality Act. See Chapter 11 for further information about how to avoid discrimination.

2.13. A relevant body must also take care that, when questioning or engaging with patients with a protected characteristic, the conduct of staff does not create an intimidating, hostile, degrading, humiliating or offensive environment for that patient.

2.14. Detailed guidance on the Equality Act 2010 is available at: [www.gov.uk/equality-act-2010-guidance](http://www.gov.uk/equality-act-2010-guidance)

## Overlap with other legal provisions

2.15. There are occasions where patients may be affected by other legal provisions:

- Injuries as a result of criminal actions: in these cases, the patient may be eligible to claim compensation from the Criminal Injuries Compensation Authority. It will be for the patient to pursue such a claim and, although the relevant body can advise the patient to contact the Authority, the possibility of compensation does not affect the patient's liability for charges as an overseas visitor. The recovery of NHS charges from the patient should not be suspended pending the outcome of a claim.
- Injuries as a result of a road traffic accident and personal injury: the requirement on insurers to pay a relevant body for services provided to an overseas visitor, where charges have been made and recovered for those services through the Charging Regulations, is zero. This provision was inserted with effect from 1 April 2009, and now appears in the [Personal Injuries \(NHS Charges\) \(Amounts\) Regulations 2015 \(SI 2015/295\)](#) made under the [Health and Social Healthcare \(Community Health and Standards\) Act 2003](#).

## Regulation 2 – Interpretation

2.16. This regulation provides definitions of the words and terms used in the Charging Regulations. The definitions which will be most useful on a daily basis are as follows:

- Child – for the purposes of the Charging Regulations, a child is someone under the age of 18.
- Overseas visitor – means any person of any nationality not ordinarily resident in the UK.
- Parental responsibility – has the meaning given in section 3 of the [Children Act 1989](#).
  - A person with parental responsibility has all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and their property. This does not include a person who is responsible for the child on a temporary basis, such as a teacher. This will be a matter of fact in each case.
- Relevant services – means accommodation, services or facilities provided under the 2006 Act, other than primary dental services, primary medical services or primary ophthalmic services, or equivalent services provided under that Act.
- Treatment the need for which arose during the visit – means treatment needed where the diagnosis of a condition is made when the first symptoms arise during a visit to the UK. It also applies where, in the opinion of a doctor or dentist employed by the relevant NHS body, treatment is needed quickly to prevent a pre-existing condition increasing in severity, e.g. dialysis. It does not include routine monitoring of an existing condition such as diabetes, nor does it cover treatment that the overseas visitor travelled to the UK for the purpose of seeking, or treatment that can await the overseas visitor's return home.

## Regulation 3 – The making and recovery of charges

- 2.17. This regulation states when and how a relevant body should make a charge for treatment and how it should recover the money; it places a legal obligation on a relevant body to determine whether the Charging Regulations apply to an overseas visitor. Whilst currently it is only NHS trusts, NHS foundation trusts and local authorities in the exercise of public health functions in England that have this legal obligation, from 23 October 2017 this will extend to any person providing NHS-funded chargeable community or secondary care services. Those organisations should ensure that they prepare to fulfil their legal obligations from that date.
- 2.18. Where a person is not ordinarily resident, the relevant body must make reasonable enquiries into the circumstances of that person to determine whether they meet one of the categories of exemption or are liable to pay charges. The enquiries must be reasonable with regard to all the circumstances of the individual case, including the person's illness or injury. If the patient is chargeable, this regulation requires the relevant body to make and recover a charge for any treatment provided. There is no option, nor is there the authority, to waive the charge on the part of the body. There are limited circumstances when persons granted asylum or temporary protection or humanitarian protection, or persons who are identified as victims of modern slavery, must be treated as exempt for services they received before acquiring that status. In such cases, any prior charges made must not be pursued, or if charges were recovered they must be repaid. More information can be found at Chapter 7.
- 2.19. Where a patient is claiming an exemption from charge, it is their responsibility to prove they are entitled to that treatment without charge. The relevant body should ask for documentary evidence to support a claim for free treatment. However, they must take into consideration the individual circumstances of each case, and that it will be easier to provide evidence in some circumstances than in others.
- 2.20. If, in the light of its enquiries, the relevant NHS body decides that the person is not eligible for treatment without charge, or that the person has not provided sufficient evidence to support their claim, then the relevant NHS body must levy a charge and take all reasonable measures to recover it from that person.
- 2.21. The relevant body must give the person paying the charge a receipt for the amount paid.
- 2.22. Certain categories of overseas visitors who are receiving a course of free treatment on the basis that they are exempt from charge cannot be charged for the remainder of that course of treatment if their exempt status changes to chargeable part-way through the course of treatment. It does not apply to those who are exempt under:
- regulation 10 or 11 (surcharge and transitional arrangements),
  - regulation 25(3) (children born to them in the UK) or
  - regulation 14 (reciprocal healthcare agreements).

It only applies if the overseas visitor has been properly assessed as exempt from charge to begin with, and where the overseas visitor did not provide fraudulent or misleading information to the relevant body. It applies only until the overseas visitor first leaves the UK. It is a clinical decision as to what constitutes a particular course of treatment. This provision (Regulation 3(5)) is sometimes referred to as the 'easement clause'.

## Regulation 3A - recording information

2.23. NHS trusts and foundation trusts are required to record on a patient's NHS Record when they are an overseas visitor, whether an exemption from charge category applies to that overseas visitor and on what date that assessment of their status in this regard took place. They therefore need to take steps to ensure they meet this obligation, such as OVMs having the correct accreditation and training to update patients' records accordingly.

## Regulation 4 – Liability for charges

2.24. The person liable to pay charges for treatment provided to an overseas visitor will, in most cases, be the overseas visitor themselves. There are only three exceptions:

- where the overseas visitor is present in the UK in the course of employment on board a ship, the liable person is the owner of that ship;
- for air crew present in the UK in the course of employment on an aircraft, the liable person is the employer of that person; and
- for a child to whom no exemption applies, the liable person is the person with parental responsibility for that child.

2.25. If, due to a change in circumstances, liability changes from one person above to another during the period in which relevant services are provided to an overseas visitor (eg a patient turns 18 during a course of treatment) each person is only liable to pay charges in respect of the relevant services provided during the period that they are liable for the charge.

## Regulation 5 – Repayments

2.26. There are certain circumstances where a relevant body must repay charges recovered under the Charging Regulations when it receives a claim for repayment:

- if the person was not a chargeable overseas visitor at the time the services were provided;
- if they did not receive the services; or
- in limited circumstances where charges have previously been recovered from:
  - an overseas visitor who goes on to acquire refugee status or be identified as a victim, or suspected victim, of modern slavery (see paragraph 2.28);
  - certain victims of female genital mutilation or failed asylum seekers supported under the [Care Act 2014](#), for which see paragraph 2.29.

2.27. The person making a claim for repayment must provide a receipt, a signed declaration in support of the claim, and such evidence in support of the claim that the relevant body requires. Where these conditions are met, any charges recovered must be repaid to the patient. The trust should alert the relevant commissioner to ensure any non-EEA incentive is repaid and costs for a charge-exempt overseas visitor are applied and paid by the relevant commissioner.

## Regulation 6 – Recovery of charges in respect of refugees and victims of trafficking

2.28. There are limited circumstances in which a relevant NHS body must cancel or repay charges made, or recovered, for treatment provided to an overseas visitor who goes on to:

- acquire refugee status (i.e. exempt under Regulation 15(a)); or
- be identified as a victim, or suspected victim, of modern slavery (i.e. exempt under regulation 16).

This provision is set out in more detail in Chapter 7 under the relevant sections for refugees and modern slavery victims.

## Regulation 6A – Recovery of charges in respect of victims of female genital mutilation and failed asylum seekers supported under the Care Act 2014

2.29. There are limited circumstances in which a relevant NHS body must not make charges or must cancel any charges made but not yet recovered. These are to:

- victims of female genital mutilation (FGM) for relevant services provided between 6 April 2015 and 31 January 2016 whose mutilation was performed outside the UK and before the [FGM Act 2003](#) came into force. Since 1 February 2016, following an amendment to the Charging Regulations, such people are also included in the exemption for FGM services; or
- failed asylum seekers, provided with relevant services between 6 April 2015 and 31 January 2016, who are receiving support under Part 1 of the [Care Act 2014](#) by the provision of accommodation.

2.30. Where charges have been made, and recovered, for relevant services provided as described above, please contact the Department of Health who will consider whether a refund of those charges can and should be made.

Situation before and after the 2017 Amendment Regulations coming into force.

Charging Regulations reference	Situation prior to 2017 Amendment Regulations coming into force	Situation subsequent to 2017 Amendment Regulations coming into force
Regulation 2: Expanding the bodies required to make and recover charges from overseas visitors to include non-NHS providers of NHS funded secondary.	Only NHS trusts, NHS foundation trusts and local authorities in limited circumstances were subject to the provisions within the Charging Regulations, meaning that when overseas visitors were provided with NHS-funded services by another organisation, no charge could be made to them.	From 23 October 2017 any organisation providing NHS-funded services that are not primary care services (as set out in the NHS Act 2006) will be subject to the Charging Regulations and required to make and recover charges to overseas visitors where no exemption applies.
Regulation 3(1A): The requirement to charge upfront for non-urgent/elective treatment.	Relevant NHS bodies were advised in guidance not to provide treatment to chargeable overseas visitors that clinicians had assessed as non-urgent until the person liable had paid in full.	From 23 October 2017, relevant bodies are required by law to withhold treatment from chargeable overseas visitors until the estimated full cost of the service has been paid, unless doing so would prevent or delay immediately necessary or urgent services (incl. maternity services).
Regulation 3(5)(iv): Addition of reciprocal healthcare agreements to the list of those exemption categories that, should they cease to apply to a person, they will also cease to apply in respect of any on-going course of treatment the person is having.	An overseas visitor who was exempt from charge under the terms of a reciprocal healthcare agreement and who was undergoing a particular course of treatment would be exempt from charge for the remainder of that course of treatment if their exemption ceased due to the reciprocal agreement coming to an end or their no longer being covered by its terms.	From 21 August 2017, an overseas visitor who is undergoing a course of treatment free of charge under the terms of a reciprocal healthcare agreement will, if that agreement terminates or ceases to apply on a date during that course of treatment, be liable for charges for the remainder of that course of treatment, as well as any new courses of treatment, where no other exemption applies. In the case of a child, their parent or person with parental responsibility will be liable for the charges.
Regulation 3A: A requirement on NHS trusts and foundation trusts to record when a person is an overseas visitor on that	Where the patient has an NHS record, OVMs at NHS trusts and foundation trusts are currently encouraged to undertake training to be able to update a patient's NHS Record when they have assessed that patient for charges, so that they are easily identified as chargeable	From 21 August 2017, where the patient has an NHS record, NHS trusts and foundation trusts will be required to record on a patient's NHS Record (their 'consistent identifier') when they are an overseas visitor and whether an exemption from charge category applies to that overseas visitor and on what



person's 'consistent identifier'.	by other NHS staff .	date that assessment of their status in this regard took place. They therefore need to take steps to ensure they meet this obligation, such as OVMs having the correct accreditation and training to update patients' records accordingly, and the pro-active use of the Summary Care Record application to enable the capture and use of a patient's chargeable status.
Regulations 8(1); semi colon here?9(g): exempting from charge palliative care services provided by a palliative care charity or community interest company (CIC).	Not chargeable, since such charities or CIC not within scope of the charging regulations.	No change. From 23 October, when non-NHS providers of NHS funded services come within scope of the Charging Regulations and have to make and recover charges from non-exempt overseas visitors, charges will still not apply to palliative care services provided by a palliative care charity or CIC.
Regulation 9: addition of services that are provided as part of the NHS111 telephone advice line to the list of services for which no charge is to be made.	Not chargeable, since provided outside a hospital by staff not employed or directed by a hospital, or provided by an organisation other than an NHS trust or NHS Foundation Trust.	No change. The exemption ensures that if the services become within scope of the Charging Regulations, either because of being provided outside a hospital and by staff not directed or employed by a hospital, or provided by an organisation that, from 23 October, would be a relevant body, the service will continue to be one for which no charge can be made.
Regulation 9: Removal of the exemption for relevant services provided outside a hospital or by its staff.	Currently any secondary care services that are provided outside a 'hospital' are exempt from charge, unless the staff providing those services are employed by, or under the Direction of, a hospital, in which case they are chargeable services to non-exempt overseas visitors.	From 21 August 2017, wherever community and secondary care services are provided by NHS trusts or foundation trusts, they are chargeable to non-exempt overseas visitors wherever provided unless the service itself is a free to all service, such as family planning services.
Regulations 9A, 10, 11: Removal of assisted conception services from the free services to which those covered by surcharge	A person who was exempt from charge because they had paid the immigration health charge ("the surcharge") this was abbreviated above, were exempt from paying it, or had had the requirement to pay it waived (Regulation 10), or were covered by transitional arrangements	From 21 August 2017 assisted conception services are no longer included within the scope of services that such people are entitled to without charge. However, there are important exceptions to consider in relation to current and seriously injured former armed forces members and their families and



<p>or transitional arrangements are entitled to without charge.</p>	<p>(Regulation 11) were exempt from charge for all NHS secondary care services upon the same basis as an ordinarily resident person for the duration of their visa.</p>	<p>those receiving courses of treatment that are underway on 21 August 2017. Also, other exemption categories might apply under the Charging Regulations. Please see paragraph 5.7 and 5.15-5.22 for more information.</p>
<p>Regulation 15(a), (b) and (d): Clarification that the exemptions in relation to refugees, asylum seekers and some supported failed asylum seekers also applies to their dependents.</p>	<p>The dependents of refugees, asylum seekers and supported failed asylum seekers are exempt from charge due to the fact that they are usually considered to be a refugee, asylum seeker or supported failed asylum seeker, respectively, in their own right .</p>	<p>The Department of Health has made amendments to this regulation to ensure that, in any rare cases whereby the dependents of those covered in this exemption category do not themselves meet the exemption criteria of refugee, asylum seeker or supported failed asylum seeker in their own right, they are ensured exemption status by this amendment which specifies that the exemption applies equally to the exempt person's dependent.</p>
<p>Regulation 23: Removal of exemption for workers on UK registered ships.</p>	<p>Overseas visitors working in any capacity on ships registered in the UK are exempt from charges. Unlike for overseas visitors working on ships registered outside the UK, the employer is not liable for the cost of treatment and the NHS absorbs the cost.</p>	<p>From 21 August 2017, the employer of an overseas visitor working, in any capacity, on a ship registered in the UK is liable for the cost of that ship worker's treatment. The employer is the owner of the ship on which they are employed or engaged. This brings the liability for charges into line with those who are employed on ships registered outside the UK. The ship worker himself or herself is not liable for the cost of their treatment.</p>

## 3. Ordinary residence

- 3.1. The UK's healthcare system is a residence-based one, which means entitlement to healthcare in the UK is based on living lawfully in the UK. This contrasts with many other countries which have insurance-based healthcare systems.
- 3.2. The test of residence that the UK uses to determine entitlement to free NHS healthcare is known as 'ordinary residence'. An overseas visitor is defined in the Charging Regulations as anyone who is not ordinarily resident in the UK.
- 3.3. The concept of ordinary residence should not be confused with permanent residence, usual residence, habitual residence or other phrases denoting residence in a place used in other domestic or European legislation. This chapter explains how the concept of ordinary residence should be applied to British citizens, EEA nationals and non-EEA nationals.
- 3.4. In practice, it may not be necessary to consider the question of ordinary residence, for instance where a patient presents a valid non-UK EHIC, PRC or S2 form. In this case it will already be clear that the patient is entitled to some free medically necessary care, although exact entitlement depends on rules relating to the use of these documents (see Chapter 9 for further details). But where that is not the case, the question of ordinary residence will be the most fundamental issue to resolve when operating the charging rules as a whole. This is because if a patient is classed as ordinarily resident in the UK, then the Charging Regulations do not apply to them, even if the patient has only been in the UK for a few days or weeks. The Secretary of State has no powers to charge someone who is ordinarily resident in Great Britain for NHS hospital treatment.

### Meaning of ordinary residence

- 3.5. A person is not ordinarily resident in the UK simply because they have British nationality; hold a British passport; are registered with a GP in the UK; have an NHS number; own property in the UK; or have paid (or are currently paying) National Insurance contributions and taxes in the UK.
- 3.6. 'Ordinarily resident' is not defined in the 2006 Act. The concept was considered by the House of Lords in 1982 in the case of *Shah v Barnet LBC*<sup>7</sup> and although the case was concerned with the meaning of ordinary residence in the context of the Education Acts, the decision is recognised as having a wider application and applies to the 2006 Act and the Charging Regulations.
- 3.7. When assessing the ordinary residence status of a person seeking free NHS services, a relevant NHS body will need to consider whether they are:  
*living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, whether of short or long duration.*
- 3.8. The concept of 'settled purpose' has been developed by the courts:  
*There must be an identifiable purpose for their residence here, there can be one purpose or several, and it may be for a limited period. The purpose for living in the UK must have a sufficient degree of continuity to be properly described as 'settled'.*
- 3.9. Ordinary residence can be of long or short duration. A person can be ordinarily resident in more than one country at once.
- 3.10. It is important to note that since 6 April 2015, non-EEA nationals who are subject to immigration control must have indefinite leave to remain (ILR) in the UK in order to be

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<sup>7</sup> *Shah v Barnet London Borough Council and other appeals* [1983] 1 All ER 226.

ordinarily resident in the UK. They must also still meet the other requirements of the test set out at paragraph 3.12; having ILR on its own is not sufficient since that person may no longer be, for example, residing in the UK on a properly settled basis, and may only be visiting.

## Determining ordinary residence

3.11. Whether a person is ordinarily resident in the UK is essentially a three-fold test (four-fold for non-EEA nationals) assessing whether that individual:

- is lawfully in the UK;
- is here voluntarily – it will be rare for a person not to be in the UK voluntarily; and
- is properly settled here for the time being; and
- in the case of non-EEA nationals subject to immigration control, has ILR in the UK.

## Being lawfully in the UK

3.12. British citizens have automatic right of abode in the UK, so are always here lawfully. EEA nationals are almost always here lawfully. It is important to note that a person does not need to meet the ‘right to reside test’ for certain benefits, for example, in order to be considered ordinarily resident in the UK. Non-EEA nationals usually need permission to be in the UK, except in some circumstances when they are not subject to immigration control, e.g. due to their relationship to an EEA national who is resident here, or when a diplomat.

## Being properly settled in the UK for the time being

3.13. While most non-EEA nationals must also have the immigration status of ILR (the right to live here on a permanent basis), there is no requirement for any person to actually be living here permanently or indefinitely in order to meet the ordinary residence test. There is no minimum period of residence that confers ordinarily resident status. In the past, the Department of Health has suggested that someone who has been here for less than six months is less likely to meet the ‘settled’ criterion of the ordinary residence description, but this is only a guideline.

3.14. For a British citizen, an EEA national and for a non-EEA national with ILR or a non-EEA national not subject to immigration control, it is perfectly possible to be ordinarily resident here from the day of arrival, when it is clear that that person has, upon arrival, taken up settled residence. In each case, it is for the relevant NHS body to decide whether the criteria within the ordinary residence description are met. A tool has also been developed to assist them in considering whether an individual is properly settled in the UK in order to establish ordinary residence. It can be found as part of the Overseas Visitor Manager (OVM) toolbox available via this link:

[www.gov.uk/dh/nhscostrecovery](http://www.gov.uk/dh/nhscostrecovery)

3.15. A person who is ordinarily resident will be so in their own right and it is not transferable to other family members (except in certain circumstances regarding children – see paragraph below). Therefore, if a spouse or civil partner of someone who is ordinarily resident here normally lives overseas and requires treatment during a visit to the UK, they will not be ordinarily resident or automatically entitled to free treatment. The relevant body must establish whether the ordinarily resident person’s spouse or civil partner meets one of the categories of exemption in their own right, or is liable to be charged.

3.16. Where a child who normally lives overseas is visiting an ordinarily resident parent, they may be ordinarily resident in line with their parent's ordinary residence if the parent can show that the child normally lives with both parents. If the child is subject to immigration control then they will also need to have Indefinite Leave to Remain (ILR) at the time of receiving treatment to be considered ordinarily resident. Additional rules apply to children of people exercising EU Treaty rights in the UK (see paragraph 9.25).

### Questions and answers

Q: Are those acting as missionaries or volunteers overseas ordinarily resident in the UK?

A: This will depend on their circumstances. A person can be absent from the UK for a temporary or finite period and still be ordinarily resident here. Staff, workers and volunteers for UK charity and missionary agencies, and their family members, may not intend to live overseas indefinitely, and may maintain a base in the UK to which they return regularly or periodically between assignments. This base may be their own home or the home of close friends or family. A letter from the UK-based organisation for which they have gone overseas, confirming that their assignment or series of assignments is temporary, may also be useful. Appearing settled in another country does not prevent them also being properly settled here, since a person can be ordinarily resident in more than one country at once. On the other hand, if there are no indicators that the person remains, or has ever been, properly settled here, then they will not pass the ordinary residence test and will be chargeable if no other exemption applies to them. See also the exemption for those in employment funded by the UK Government, as this may apply to some missionaries or volunteers overseas.

Q: What about someone who works overseas?

A: Again, this will depend on their circumstances. A person whose work takes them out of the UK for the majority of the time but whose home, which they return to between trips, remains here will still be ordinarily resident here. This would apply to, for example, a pilot or a member of cabin crew. However, if they are working and settled in one place overseas and only spend a few weeks of the year in the UK visiting family, then they are not likely to be properly settled here, in which case they would not be ordinarily resident here. If some people are posted overseas temporarily as part of their contract and maintain a base in the UK that they return to even if only on short stays, they may well still be ordinarily resident here. Assessing whether someone maintains ordinary residence in the UK will require consideration of their family and other relationships with people in the UK, financial, property and other connections to the UK, in addition to the time they actually spend in the UK in any given year.

It is important to note that some people may not be ordinarily resident in the UK but are still entitled to free NHS care because the UK is responsible for their healthcare costs via a registered S1 form or an EHIC and an A1. For further information, see Chapter 6, paragraphs 6.3-6.9 and Chapter 9, paragraphs 9.23 and 9.25.

Q: I have a patient who lives both here and in Spain, spending most of their time there. Where are they ordinarily resident?

A: A person can be ordinarily resident in more than one country at once. As long as they are properly settled here, despite spending more time in their other place of residence, they will meet the ordinary residence test. There is no requirement that the time be equally split between the UK and another country in order to maintain ordinary residence in the UK. Where a person has lived in more than one country for several years, consideration needs to be given to whether there is a pattern of regular trips to the UK over the years that demonstrates a sufficient degree of continuity to establish ordinary residence in the UK. The length and number of trips to the UK, family and other relationships with people in the UK, financial, property and other connections to the UK will all be relevant factors in determining

if the person is ordinarily resident in the UK despite spending time living in another country. If they live only in Spain, and are only here as a visitor, not as a resident, then they will not meet the ordinary residence test.

Although the patient may be deemed to be ordinarily resident they may still be insured in Spain, and may be entitled to a Spanish EHIC. Details of which can be processed and the cost of care reimbursed.

Q: Can a non-EEA national without ILR be ordinarily resident in the UK?

A: A non-EEA national without ILR can only pass the ordinary residence test if they are not subject to immigration control, e.g. they are diplomat posted to the UK, or have a right of residence here by virtue of their relationship with an EEA national who is resident here.

Q: Can someone studying overseas still be considered ordinarily resident here?

A: Yes, someone studying temporarily overseas can still be ordinarily resident here, if they, for example, regularly visit the UK (e.g. during school or university holidays) and plan to return to the UK after their studies have ceased. This will mean that they are entitled to free NHS healthcare when back in the UK. However, if it is not their intention to return to live in the UK and they have in fact moved their residence overseas and are simply visiting the UK, then they will not be ordinarily resident here. It is important to note that if a student takes up activity (for example work) that means that under EU rules they can be insured in the other EEA country, they may be entitled to an EHIC from that country. If the details of the EHIC are recorded, the UK can recover the cost of treatment from the other EEA country.

## 4. Detailed list of services which are exempt from charges

- 4.1. Some NHS services are free to everyone, even if the patient would be liable to pay for other services. Regulations 8 and 9 set out these services, including defining key terms.
- 4.2. Please note that despite these services being free to the patient, in the case of insured visitors from the EEA, the UK can still be reimbursed by the relevant EEA country for having provided these individuals with medically necessary treatment, if the patient has a non-UK EHIC, PRC or S2. Relevant NHS bodies are encouraged to record and report EHICs/PRCs whenever possible for such patients accessing 'exempt' services. More on this can be found at Chapter 9.
- 4.3. The current list of exempt services comprises:
- accident and emergency (A&E) services (whether provided at an A&E department or similar e.g. urgent care centre, walk-in centre or minor injuries unit) but not including services provided after the overseas visitor is accepted as an inpatient or at a follow-up outpatient appointment. So, where emergency treatment is given after admission to the NHS hospital, e.g. intensive care or coronary care, it is chargeable to a non-exempt overseas visitor. Note that some walk-in centres provide primary care services rather than A&E-type services and overseas visitors cannot be charged for such services either because primary care services are not within the scope of the regulations;
  - family planning services, which means services that supply contraceptive products and devices to prevent pregnancy (termination of an established pregnancy is not a method of contraception or family planning);
  - the diagnosis and treatment of the conditions specified in Schedule 1 to the Charging Regulations which is necessary to protect the wider public health. This exemption from charge will apply to the diagnosis of the condition, even if the outcome is a negative result. It will also apply to any treatment provided for a suspected specified condition, up to the point that it is negatively diagnosed. It does not apply to any secondary illness that may be present even if treatment is necessary in order to successfully treat the condition;

The conditions to which the exemption applies are:

- acute encephalitis
- acute poliomyelitis
- anthrax
- botulism
- brucellosis
- cholera
- diphtheria
- enteric fever (typhoid and paratyphoid fever)
- food poisoning
- haemolytic uraemic syndrome (HUS)
- human immunodeficiency virus (HIV)
- infectious bloody diarrhoea
- invasive group A streptococcal disease and scarlet fever
- invasive meningococcal disease (meningococcal meningitis, meningococcal septicaemia and other forms of invasive disease)
- Legionnaires' Disease

- leprosy
  - leptospirosis
  - malaria
  - measles
  - Middle East Respiratory Syndrome (MERS)
  - mumps
  - pandemic influenza (defined as the 'Pandemic Phase'), or influenza that might become pandemic (defined as the 'Alert Phase') in the World Health Organization's Pandemic Influenza Risk Management Interim Guidance
  - plague
  - rabies
  - rubella
  - severe acute respiratory syndrome (SARS)
  - smallpox
  - tetanus
  - tuberculosis
  - typhus
  - viral haemorrhagic fever (which includes Ebola)
  - viral hepatitis
  - whooping cough
  - yellow fever
- the diagnosis and treatment of sexually transmitted infections;
  - from 23 October 2017, palliative care services provided by a registered palliative care charity or a community interest company;
  - services provided as part of the "NHS 111" telephone advice line commissioned by a Clinical Commissioning Group or the NHS England;
  - services provided for treatment of a condition caused by
    - torture
    - female genital mutilation
    - domestic violence
    - sexual violence

including treatment of both physical and mental illness, or an acute or chronic condition. The exemption applies wherever the violence has been experienced (including violence that occurred abroad), provided that the overseas visitor has not travelled to the UK for the purpose of seeking treatment. Any other treatment that they need that is not caused by that violence is not free, unless covered by another exemption. More information on this exemption can be found in Chapter 7.

## Question and answers

Q: Is emergency treatment free to all?

A: No. Only A&E services that are provided prior to an overseas visitor being admitted as an inpatient are free to all. Emergency services provided after a patient has been admitted as an inpatient and at outpatient appointments are chargeable.

Q: Do A&E services include minor eye services provided on a walk-in basis?

A: These are likely to be included within the A&E exemption where they are provided as a minor injuries service similar to those within an A&E unit.

Q: Can I ask European visitors and students from Europe for EHICs/PRC for A&E services?

A: Yes, even though you cannot charge any patient directly for A&E services, you should still seek to record and report EHICs wherever possible to allow the UK to be reimbursed by the relevant member state for providing this treatment. This is also true of the other exempt services, e.g. for infectious or sexually transmitted diseases. If they do not present an EHIC/PRC you cannot then charge the patient for these exempt services.

Q: Can I charge someone for A&E services while on an observation ward?

A: No, patients kept in observation wards or similar that are attached to A&E departments are usually still under the care of the A&E consultant and should not be charged unless and until they are formally admitted to NHS hospital as an inpatient.

Q: Can I charge for ambulance services?

A: No. Ambulance services are considered to be part of A&E care and should be provided free of charge where they are part of the patient's clinical need. However, whilst European visitors and students with valid EHICs cannot be charged directly for ambulance services, all A&E treatment costs (including ambulance services) should be recorded and reported via the Department of Work and Pensions OVT EHIC Portal (see para 9.14) portal.

Q: Is a termination of pregnancy considered to be a 'family planning service'?

A: No. A termination of pregnancy is not a method of contraception or family planning so does not fall under that exemption.

Q: I provide NHS community services, including to some overseas visitors. Should I be charging them?

A: As long as the services provided are not:

- primary medical services
- primary dental services
- primary ophthalmic services or
- equivalent services which are provided, or whose provision is arranged, under the 2006 Act

then you should charge overseas visitors for them unless an exemption category applies.

Q: Do I exempt from charge services that are provided by my organisation outside a hospital setting?

A: No. Whilst prior to 21 August 2017 there was an exemption for services that were provided otherwise than at, or by staff employed or directed by, an NHS hospital<sup>8</sup>, this is no longer the case. Whenever a relevant NHS body (or, from 23 October 2017, a relevant body)

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<sup>8</sup> "Hospital" was defined as follows:

(i) any institution for the reception and treatment of persons suffering from illness; (ii) any maternity home; and (iii) any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation, and includes clinics, dispensaries and outpatient departments maintained in connection with any such home or institution, and "hospital accommodation" must be construed accordingly



provides relevant services, these will be chargeable where no exemption applies regardless of whether or not they are provided at a 'hospital' and regardless of whether or not they are provided by staff employed or directed by a 'hospital'. Remember that relevant services does not include primary care services as these are not within scope of the Charging Regulations.

Q: Is palliative care chargeable?

A: Palliative care services, even if part-funded by the NHS, provided by an organisation that is a registered palliative care charity or a community interest company are free to overseas visitors who are otherwise chargeable for NHS services. However palliative care is not in and of itself an exempt service, therefore where it is provided by relevant bodies, it is subject to charge.

Q: Clinicians are treating a patient for TB. Do I charge for other conditions the patient has?

A: Yes, unless treatment of the other condition is also an exempt service, or the patient is exempt from charges under another exemption, then you must charge for the treatment of the other condition, even if the other condition impacts on the treatment of the TB.

Q: An overseas visitor says they have forgotten to bring their antiretroviral (ARV) therapy for their HIV. Do we provide it free of charge?

A: HIV is a disease for which treatment is free on public health grounds. Guidance to the NHS advises that in such circumstances the supply of free ARVs should be limited to an amount that will last until the overseas visitor returns home or has arranged for ARVs to be sent to them. Further guidance on this can be found at [HIV treatment for overseas visitors: Guidance for the NHS](#).

Q: Do I need to assess patients attending sexually transmitted diseases clinics for charges?

A: The diagnosis and treatment of sexually transmitted infections is free to all, so charging issues will arise less often in those settings. Regulations prevent the disclosure of any identifying disease other than to a medical practitioner (or to a person employed under the direction of a medical practitioner). This applies to information in connection with, and for the purpose of, the treatment of the patient and/or the prevention of the spread of the disease.

However, this does not mean that sexually transmitted diseases clinics do not have to apply the Charging Regulations or should not allow Overseas Visitor Managers (OVMs) access to do their job. Overseas visitors being provided with treatment for sexually transmitted diseases will still be liable for charges for other types of treatment unless another exemption applies, so it can still be helpful for awareness of charging issues to be raised in these settings.

Reimbursement claims can be made to other EEA countries for providing treatment for sexually transmitted infections whenever the patient has a valid EHIC/PRC/S2, so sexually transmitted diseases clinics can be encouraged to take down these details and provide OVMs with them. There would be no question of treatment being charged, or delayed, if no EHIC/ PRC/S2 was presented.

Q: Where can I go to find more information about HIV and sexual health treatment to pass on to patients?

A: Please use the Terrence Higgins Trust's helpline, THT Direct:

[www.tht.org.uk/our-charity/Get-help-now/THT-Direct](http://www.tht.org.uk/our-charity/Get-help-now/THT-Direct)

Q: What are the rules on organ donation?

A: There are clear Directions in the UK on the allocation of organs from deceased donors. The NHS Blood and Transplant Directions 2005 place patients into two categories – Group 1 and Group 2. The Directions make it clear that a person in Group 2 cannot receive an organ if there is a clinically suitable person in Group 1. Group 1 includes, amongst others, persons ordinarily resident in the UK, persons entitled under European legislation and certain people entitled under bilateral reciprocal health agreements.

Some overseas visitors come to the UK to donate live organs to residents of the UK. The cost of medical treatment specifically for the purposes of donating a kidney (donor assessment, donor surgery and out-patient follow-up appointments) will be covered by the NHS. Free treatment is not available to them after they have returned to their own country at the end of the 6 month period or for any treatment outside of the donor process (unless exempt).

## 5. The health surcharge: how to deal with and recognise someone who has paid or is exempt from paying

**This chapter is about non-EEA nationals applying to visit the UK for longer than six months, or to extend a period of leave to remain in the UK. It is not about those coming to the UK for six months or less, those on visitor visas, or those coming to the UK from the EEA who are not subject to immigration control.**

- 5.1. An immigration health charge (referred to in this guidance as the 'health surcharge') is payable by non-EEA nationals who apply for a visa to enter or remain in the UK for more than six months in a temporary capacity. People with indefinite leave to remain in the UK as well as those not subject to immigration control (e.g. diplomats posted to the UK) are not liable to pay the health surcharge, but may be ordinarily resident and entitled to free NHS healthcare on that basis (see Chapter 3 for information about ordinary residence).
- 5.2. Payment of the health surcharge entitles the payer to NHS-funded healthcare on a similar basis as someone who is ordinarily resident. They are entitled to NHS services free at the point of use, including NHS hospital care, with, from 21 August 2017, the exception of assisted conception services (e.g. IVF) (see paragraph 5.16). They must also pay for services for which a UK ordinary resident must also pay, such as dentistry and prescriptions in England, unless they also meet the particular exemption criteria of those services.
- 5.3. Payment of the health surcharge is mandatory when making an immigration application, subject to exemptions for certain categories of people and the discretion of the Home Secretary to reduce, waive or refund all or part of the health surcharge payment. Most of these groups also receive NHS-funded healthcare on a similar basis as an ordinarily resident person, again with the exception of assisted conception services from 21 August 2017.
- 5.4. The exemptions to paying the health surcharge are as follows<sup>9</sup>:
  - persons who apply for entry clearance where the leave to enter is for six months or less;
  - persons who apply for entry clearance or leave to remain under the Immigration Rules as visitors;
  - a child who applies for leave to remain and is looked after by a local authority (or equivalent in other devolved administrations);
  - a person, and their dependants, who makes an application for leave to remain which relates to a claim:
    - for asylum or humanitarian protection; or
    - that their removal from the UK would be contrary to Article 3 of the [European Convention on Human Rights](#);
  - victims of modern slavery (which includes victims of trafficking or slavery, servitude and forced or compulsory labour) with a positive conclusive grounds decision who apply for discretionary leave to remain (for personal circumstances, to help police with their enquiries or to pursue a compensation

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<sup>9</sup> Exemption categories for paying the health surcharge are subject to change, for instance those seeking entry clearance or leave to remain as Tier 2 intra-company migrant transfers are no longer exempt as of 27 April 2017.

claim against their trafficker) or under paragraph 159I of the Immigration Rules (a provision for victims who are overseas domestic workers) and their dependants;

- a person who applies for leave to remain under the Home Office “Destitution Domestic Violence Concession” policy and their dependants;
- a dependant of a member of HM forces, or of a member of a force who is exempt from immigration control under section 8(4)(b) and (c) of the [Immigration Act 1971](#), when applying for entry clearance or leave to remain as a dependant under the immigration rules;
- a person granted entry clearance or leave to remain pursuant to an EU obligation; or
- a British Overseas Territories citizen who is resident in the Falklands Islands.

5.5. The health surcharge is £200 per annum per applicant, with a discounted rate of £150 per annum for students and their dependents and Youth Mobility Scheme visa holders. The health surcharge is collected by the Home Office alongside the immigration application fee. The health surcharge must be paid for each applicant and for each dependant included in a visa application. This ensures that non-EEA migrants make a proportionate financial contribution to the NHS. Health surcharge income is delivered back to the NHS to be invested in frontline services.

5.6. The health surcharge must be paid in full for each year, or part of a year, that the applicant is applying to stay for. Failure to pay a health surcharge (except when an exemption from paying it applies, or when the Home Secretary waives, refunds or reduces the health surcharge) will result in an immigration application being refused or considered invalid, or, if leave has been granted, that leave will be cancelled.

### Exemption from NHS charges

5.7. The Charging Regulations provide for an exemption from NHS charges (except, from 21 August 2017, for assisted conception services), see paragraphs 5.23-5.30 for persons who:

- have paid the health surcharge;
- are exempt from paying the health surcharge (see paragraph 5.4 for a full list of exemptions), except where they are exempt by virtue of being a visitor to the UK or as a result of applying for leave to enter for six months or less; these persons are still liable for charges;
- the Home Secretary has exercised his or her discretion to:
  - waive the health surcharge;
  - reduce the health surcharge; or
  - refund part, but not all, of the health surcharge.

5.8. An individual who pays for the health surcharge is only entitled to free treatment once their application for a visa has been granted, and not from the date when the health surcharge is paid. The exemption from NHS charges applies to the period of leave to enter or remain in the UK granted to the person. Once that leave expires or is curtailed, the person becomes liable for charges from then on, including where the person is part-way through a course of treatment.

5.9. Individuals coming to the UK for six months or less as a visitor will be liable for charges under the Charging Regulations unless another exemption from charges applies.

5.10. Where a person is refunded part of the health surcharge, they will be exempt from NHS charges. However, where they receive a full refund, they are chargeable for NHS services at the point of delivery unless another exemption in the Charging Regulations applies. Where the health surcharge has been refunded because the person did not claim an exemption from paying the health surcharge, to which they were entitled, the person will be exempt from NHS charges in the same way as others are exempt from

paying it, as listed in section 5.4 of this guidance (except for visitors who are usually chargeable for NHS services).

- 5.11. Non-EEA migrants who applied for leave to enter or remain in the UK for more than six months prior to the implementation of the health surcharge (6 April 2015) will not be retrospectively required to pay the health surcharge. As these individuals will not have an opportunity to pay the health surcharge until they next make an immigration application, Regulation 11 operates as a transitional arrangement and exempts them from charges for NHS services until their existing leave (visa) expires. They will be liable to pay the health surcharge if they make a further application for leave to remain in the UK after 6 April 2015, subject to being eligible for exemption or waiver from paying the health surcharge.
- 5.12. Where a person who is exempt from charges under Regulation 10 or 11 makes an in-time application (before expiry of their existing leave) for further leave to remain in the UK, and their existing leave is extended pending the outcome of that application, they will continue to be exempt from NHS charges until any extended period of their existing leave expires.
- 5.13. Where a person who is exempt from charges under Regulation 10 or 11 stops being exempt from charges because their leave expires, they overstay their visa or have their visa curtailed or rescinded by the Home Office, they become chargeable for treatment from that point onwards, including for the continuation of courses of treatment that are already under way. The 'easement clause' under Regulation 3(5) does not apply to those under health surcharge or transitional arrangements.
- 5.14. A child born to a person who is exempt from charges under Regulation 10 or 11 will also be exempt from charges while they are aged three months or younger provided that the child has not left the UK since birth. Parents should ensure that they regularise their child's immigration status in the UK during this three-month period, which may include the parent paying the health surcharge on their child's behalf. If the parent does not regularise their child's status, they will be liable for any charges for treatment provided to the child after the three-month period.

### Assisted conception services

- 5.15. Since 21 August 2017, those exempt from charge under Regulation 10 (health surcharge arrangements) or 11 (transitional arrangements) are not exempt from charge in relation to assisted conception services.
- 5.16. Assisted conception services are defined in the Charging Regulations as any medical, surgical or obstetric services provided for the purpose of assisting a person to carry a child. Broadly speaking, this means any medicines, surgery or procedures that are required to diagnose and treat infertility so a person can have a child. It includes procedures such as intrauterine insemination (IUI), in vitro fertilisation (IVF) and egg and sperm donation.
- 5.17. However, it is important to understand a number of points in relation to this exclusion. Firstly, assisted conception services do not include services that are commissioned by NHS England as follows:
- services for serving members of the armed forces and their families;
  - infertility treatment for seriously injured serving members and veterans; and,
  - infertility treatment: further provisions.
- 5.18. Therefore, dependants of a member of HM forces, or of a member of a force who is exempt from immigration control, will still be able to receive assisted conception services free of charge due to the above exclusion within the definition.
- 5.19. Secondly, there are some groups who, whilst they may choose to make an application for leave to remain in the UK (under a category that means they are exempt from

paying the health surcharge, thereby entitling them to free NHS services except for assisted conception services), there are some overlapping exemptions within the Charging Regulations to consider. These groups are:

- people, and their dependants, who make an application for asylum, temporary protection or humanitarian protection;
- children who are looked after by a Local Authority;
- victims of modern slavery (which includes victims of trafficking or slavery, servitude and forced or compulsory labour) with a positive conclusive grounds decision; and,
- people who make applications for leave to remain under the Home Office Destitution Domestic Violence Concession (would only be entitled to free assisted conception services on the same basis as a resident, if the need to the services was as a result of domestic violence and the person had not travelled to the UK to receive treatment)

5.20. This means that when assessing if charges will apply for assisted conception services, relevant NHS bodies must consider whether Regulations 15(b), 16 or 9(f), or any other exemption, also apply to the patient. If they do, this will mean that no charge can be made to that person for assisted conception services, despite the exclusion of those services from the ones that those covered by health surcharge arrangements alone can receive without further charge.

5.21. Thirdly, those applying for leave to remain as either:

- a person granted entry clearance or leave to remain pursuant to an EU obligation; or
  - a British Overseas Territories citizen who is resident in the Falklands Islands,
- remain entitled to assisted conception services without further charge if they are covered for those services under the exemption for people with rights under EU law or under the terms of a reciprocal agreement.

5.22. Finally, a person who is exempt under Regulation 10 or 11 and who has begun a course of assisted conception treatment before 21 August 2017 will be entitled to the remainder of that course of treatment free of charge. New courses of assisted conception treatment begun on or after 21 August 2017 will not be free of charge and the overseas visitor will be required to pay for that service, unless exempt under another category, as described above. It is a clinical decision as to what constitutes a particular course of treatment.

5.23. Where two people are seeking assisted conception services with NHS funding, and one of the two people is covered by health surcharge arrangements and the other is ordinarily resident in the UK and therefore not subject to charge, the services required by the health surcharge payer will be chargeable. Any services required by the ordinarily resident person will continue to be freely available, subject to the established local or national commissioning arrangements.



## How to recognise someone who has paid the health surcharge

### Additional information contained in the Summary Care Record application on the Spine

- 5.24. Individuals living in England who have paid the health surcharge, or who are exempt or waived from payment of the health surcharge, will be pre-registered on the NHS Spine using information provided by the Home Office. NHS records for health surcharge payers, and those exempt or waived from paying the health surcharge, include basic demographic information visible to all NHS staff, including a 'green banner' indicating that they are 'Green: Paid or exempt from paying the surcharge' .
- 5.25. All smartcard-enabled staff will be able to view this banner when the record is viewed through the Summary care Record application (SCRa). The wording of the banner for all smartcard enabled staff will be 'Green: Free NHS (paid or exempt).' Upon seeing a record marked as 'green', NHS staff should still consider if any circumstances mean that the individual should be referred to the OVM, e.g. they are seeking assisted conception services.
- 5.26. Should an individual's 'green' status change for any reason (e.g. the period of granted leave expires), the individual may be chargeable for NHS services from that point onwards, including the remainder of courses of treatment already under way. These individuals will have a red banner, visible from all views, indicating that they are 'Red: Likely chargeable for NHS services'. This should act as a prompt to call the OVM, or relevant staff member, for further investigation to determine chargeability.
- 5.27. Where there is ambiguity about a person's chargeable status, the SCRa will show that individual with an Amber "decision pending" banner. This will mean that the OVM will need to investigate further on the chargeable status of the patient.
- 5.28. OVMs, or equivalents, are able to access additional information regarding a non-EEA individual's nationality, using the non-EEA nationals' UK issued Biometric Residence Permit (BRP) and their period of permitted stay in the UK via a 'Chargeable Status' tab within the SCRa.
- 5.29. Demographic information on health surcharge payers residing in England, and those exempt or waived from paying the health surcharge, will be visible on the local demographics system via the hospital IT system. However, the green/red banner will only be visible via the SCRa to NHS staff with smartcard access.
- 5.30. Only OVMs, or their equivalents, will have access to the additional immigration information regarding nationality and granted period of leave to remain in the UK via the 'Chargeable Status' tab within the SCRa. This tab will also contain details of previous periods of leave (after 6 April 2015) within the UK. To gain access to the additional immigration information contained in the tab, you will need to apply for access via your local registration authority. You should complete an RA02 form and request access to the B0259 activity code, which is called 'Entitlement Administration'.
- 5.31. The following screenshot provides an example of what the NHS record of a health surcharge payer will look like when viewed through the Chargeable Status tab on the SCRa, visible only to OVMs; The example screen is for a person who has paid the health surcharge (Green Status);

# Summary Care Record application: Example showing a person who has paid the health surcharge

NHS Spine II Windows 7 - IE11 (Linked Base for NHS Spine II Windows 7 - IE11 and NHS Spine II Windows 7 - IE11 Clone) [Running] - Oracle VM VirtualBox

Machine View Devices Help

https://nww.int.spine2.ncrs.nhs.uk/summarycarerecord/immigrationstatus

NHS Summary Care Record... x Check an address W Postal addresses in the Republ...

Find a patient Change role Help Print Exit Summary Care Record NHS

**Indiana MUNCEY** DoB 25-Mar-2012 Not specified NHS 945 222 9276 GP Practice C81604 Address 6 ADAMS COURT, ILKESTON, DERBYSHIRE, UNITED KINGDOM, DE7 8YF

Patient Details Chargeable Status

Green: Free NHS (Paid or exempt)

Home Office Status Overseas Visitor Manager Status

### Current Status

Paid or exempt from the health surcharge	Green
Immigration status valid from	14-Sep-2016
Home Office Reference Number	REF01
Biometric Residency Permit	
Country of Nationality	England
Spine System Effective From date	14-Sep-2016

### Home Office Chargeable Status

The Home Office Chargeable Status may take one of the following values:

- 01 Green: Paid or exempt from the health surcharge
- 02 Red: Likely chargeable for NHS service
- 03 Update: Patient is now a British Citizen

Any valid 'Green' or 'Update' current status takes priority over any 'Red' status.

**Use of the NHS Summary Care Record is subject to confidentiality regulations. Some actions will raise a privacy alert.**

[More about privacy alerts](#)

### Current Status

Paid or exempt from the health surcharge	Green
Immigration status valid from	13-Sep-2016
Home Office Reference Number	REF068768
Biometric Residency Permit	
Country of Nationality	India
Spine System Effective From date	14-Sep-2016

### Historical Status

This information is held by Spine, though there may be other historic statuses that have not been recorded.

Immigration Status From	Immigration Status To	Status	HO Reference	BRP Number	Country of Nationality	System Effective From	System Effective To
14-Sep-2016		Green	REF009	None	United Kingdom	14-Sep-2016	31-Jan-2017

https://nww.int.spine2.ncrs.nhs.uk/summarycarerecord/patientsearch/ue - Demographic Administrator - NHS CONNECTING FOR HEALTH (X09) Version: r.17-02.1.4.20170302141335





their previous leave expired), then they are likely to be chargeable for NHS services. A person whose leave has been curtailed is likely to be chargeable for NHS care. However, they may be in possession of a BRP that has not yet expired. This reinforces the importance of checking the Spine for updates on a patient's immigration status.

5.39. Certain categories of migrants will not be issued with a BRP. This includes asylum seekers, and those applying for leave as victims of domestic violence. These groups will be exempt from paying the health surcharge and will have an NHS record created on the Spine demonstrating their 'green' status. See Chapter 7 for more information about what other evidence you can accept to establish entitlement to free NHS services for these groups.

5.40. Some non-EEA nationals have a right to live in the UK as family members of an EEA national who is exercising EU Treaty rights, typically by working in the UK. These individuals are exempt from paying the health surcharge and will have an NHS record created on the Spine demonstrating their 'Green: Free NHS (paid or exempt)' status during the time granted to remain in the UK. They will be issued with a Biometric Residence Card (BRC) instead of a BRP from April 2015. Some may continue to rely on valid non-biometric residence cards until they expire. The BRC will be almost identical in style and substance to the BRP and should be handled in the same way to verify eligibility for free NHS services.

5.41. OVMs should be aware that since April 2015, short stay permits are issued to persons who have extended their stay in the UK for a cumulative period of six months or less. BRPs will be issued to migrants who apply for leave to remain in the UK for a total period of more than six months. Individuals who carry a short stay permit will not have a banner describing their access to NHS services on the Spine and will be subject to the charges (unless another exemption from charges in the Charging Regulations applies).

### No NHS record visible on the Spine and no BRP

5.42. There is a transitional period in which some people who have paid the health surcharge, or who are exempt or waived from paying the health surcharge, do not have an NHS record or a BRP. These individuals are likely to be:

- nationals of a country where, at the time of the immigration application process, the BRP was not issued (this can be verified using the timetable in the toolbox outlining when migrants of certain countries were issued with a BRP as part of the immigration application process);
- people who applied for leave to enter or remain in the UK prior to the implementation of the health surcharge or who will be exempt from charges until their existing visa expires; or
- those who are exempt from paying the health surcharge and who are not issued with a BRP.

5.43. Asylum seekers and those applying for leave to remain as victims of domestic violence are not issued with a BRP. These groups should have an NHS record visible on the Spine, but if one is not available you should continue to use good judgement and other available documentation such as the Application Registration Card (ARC) or evidence of exemption from paying the health surcharge from the Home Office to ascertain eligibility for free NHS services.

5.44. You will need to continue to exercise good judgement and make enquiries of the Evidence and Enquiry team at the Home Office, where individuals are not recorded on the Spine and where you cannot verify that the health surcharge has been paid.

The table below outlines different categories of non-EEA migrants who may apply for leave to enter and remain in the UK for a period of more than six months, and who will therefore be in scope of paying the immigration health surcharge, and the documentation that NHS staff should request to verify their status.

	Exempt from paying surcharge	Exempt from NHS charges	Issued a BRP	Status on SCRa	Documentation to verify status
Health surcharge payees (whose visas remain valid)	N	Y (except assisted conception services)	Y	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• BRP</li> <li>• Visa stamp/vignette in passport to show that leave to enter or remain in the UK for more than 6 months was granted after April 2015 (during the transition period as the BRP is rolled out overseas)</li> </ul>
British Overseas Territories citizens who are resident in the Falklands Islands	Y	Y (check against Regulation 14 for assisted conception services)	Y	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• BRP</li> <li>• Visa stamp/vignette in passport to show that leave to enter or remain in the UK for more than 6 months was granted after April 2015</li> </ul>

	Exempt from paying surcharge	Exempt from NHS charges	Issued a BRP	Status on SCRa	Documentation to verify status
Dependants of military personnel	Y	Y	Y	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• BRP</li> </ul>
Intra-company transfers	N	Y (except assisted conception services)	Y	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• BRP</li> <li>• Visa stamp/vignette in passport</li> </ul>
Non-EEA nationals exercising an EU right	Y	Y (check against Regulation 12 for assisted conception services)	N (issued with BRC)	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• BRC from April 2015</li> <li>• Permanent and temporary residence cards (during the transition period as the BRP is rolled out overseas)</li> <li>• Visa stamp/vignette in passport</li> </ul>

	Exempt from paying surcharge	Exempt from NHS charges	Issued a BRP	Status on SCRa	Documentation to verify status
Children who are looked after by a Local Authority and make an application for leave to remain	Y	Y	Y	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• Confirmation from the Local Authority that the child is looked after</li> <li>• Confirmation from the Home Office that they have made an application for leave to remain</li> <li>• Visa stamp/vignette in passport (during the transition period as the BRP is rolled out overseas)</li> <li>• BRP if granted leave to remain by the Home Office</li> </ul>
People, and their dependants, who make an application for asylum, temporary protection or humanitarian protection	Y	Y (check against Regulation 15 for assisted conception services)	N (issued with ARC)	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• ARC</li> <li>• Confirmation from Home Office that asylum application or application for temporary protection or humanitarian protection is still under consideration</li> <li>• BRP if granted refugee status (including temporary protection or humanitarian protection)</li> </ul>

	Exempt from paying surcharge	Exempt from NHS charges	Issued a BRP	Status on SCRa	Documentation to verify status
People, and their dependants, whose removal from the UK would be contrary to Article 3 of the European Convention on Human Rights	Y	Y (except assisted conception services)	Y	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• BRP</li> <li>• From April 2015, could be issued with a 'short stay permit' for periods of 6 months or less, in which case a BRP will not be issued</li> </ul>
Victims of modern slavery and their dependants who make applications for leave to remain	Y	Y (check against Regulation 16 for assisted conception services)	N	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• Confirmation from the UK Human Trafficking Centre or Home Office that they are a victim of human trafficking</li> </ul>
People who make applications for leave to remain under the Home Office Destitution Domestic Violence Concession	Y	Y (check against Regulation 9(f)(iii))	N	Green	<ul style="list-style-type: none"> <li>• Additional information on the SCRa</li> <li>• Confirmation from the Home Office of Destitution Domestic Violence Concession having been granted</li> <li>• From April 2015, could be issued with a 'short stay permit' for periods of 6 months or less, in which case a BRP will not be issued</li> </ul>

	Exempt from paying surcharge	Exempt from NHS charges	Issued a BRP	Status on SCRa	Documentation to verify status
People who applied for leave to enter or remain in the UK prior to the implementation of the health surcharge	N/A	Y (except assisted conception services)	Y (in country applicant)  N (out of country applicant)	Green  none	<ul style="list-style-type: none"> <li>Migrants who applied for further leave to remain in the UK prior to the implementation of the health surcharge and still have leave to remain will have a BRP</li> <li>Migrants who applied for leave to enter the UK from abroad will have a stamp/vignette in passport demonstrating that leave was granted for more than 6 months prior to April 2015</li> </ul>
Special long-stayer visitors (e.g. private medical or academic visitors)	Out of scope	N	Y	none	<ul style="list-style-type: none"> <li>BRP marked to clearly state visitor category</li> <li>Visa stamp/vignette in passport (during the transition period as the BRP is rolled out overseas)</li> </ul>
Short-term students or Parents of Tier 4 child visitors	N	Y (except assisted conception services)	Y	Green	<ul style="list-style-type: none"> <li>Additional information on the SCRa</li> <li>BRP</li> <li>Visa stamp/vignette in passport to show that leave to enter or remain in the UK for more than 6 months was granted after April 2015</li> </ul>



## When could a status on the SCRa change for health surcharge payers?

5.45. A status can change on the SCRa when a person:

- applies for further leave to remain and application is granted → status remains green;
- applies for further leave to remain and application is refused → status changes green to red;
- has their period of leave granted is curtailed → status changes green to red
- has their period of leave granted expire and no in-time application for an extension of leave is made → status changes green to red;
- is granted UK citizenship → green banner with an update that patient has ILR;
- is granted indefinite leave to remain → green banner remains with an update that patient has ILR;
- is an asylum seeker and is granted refugee status or humanitarian protection → status remains green;
- is a failed asylum seeker with no recourse to further appeal (leave is curtailed or expires) → status changes to red; and,
- is a failed asylum seeker and may be exempt from NHS charges if they are supported by the Home Office or a Local Authority → status remains green (see Chapter 7 for more information)

NB: A migrant whose leave has been curtailed is likely to be chargeable for NHS care. However, they may be in possession of a BRP that has not yet expired. This reinforces the importance of checking the Spine for updates on a patient's immigration status.

## Question and answers

Q: I heard Home Office changed the visitor rules for extended visitor categories, how does that affect me?

A: The Home Office introduced changes on 24 April 2015 to simplify the visitor rules. From this date, those who apply as an extended student visitor (issued with 11 month visas) or a Parent of a Tier 4 child (issued with 12 month visas) will fall within health surcharge scope. However the requirement to pay the health surcharge was waived between 24 April 2015 to October 2015 as Home Office made updates to the name of these visas.

When considering the chargeable status of someone on one of these types of visas, OVMs need to take account of the following:

- Before 6 April 2015 – consider those on student visitor visas of 11 months exempt from charge (under previous Regulations). Also, those on 'Parents of child' visitor visas may have been ordinarily resident here and thus are also entitled to free NHS hospital treatment.
- Between 6-23 April 2015 – consider those on student visitor visas and those on Parents of child visit visas chargeable.
- From 24 April 2015-October 2015 – do not charge those on short term students (11 months) and Parents of Tier 4 child visas whilst the visa is valid; they come under health surcharge arrangements due to the health surcharge being waived. Visas or BRPs will still be marked 'visitor'. Where a BRP forms part of the immigration application, the individual will be pre-registered on the Spine



- with a green banner on the Summary Care Record application. They will be entitled to free NHS hospital care.
- From October 2015 – short term students (11 months) and parents of Tier 4 child will be required to pay the health surcharge. Visas or BRPs will be marked as short-term student or Parent of Tier 4 (Child) student. Individuals will be pre-registered on the Spine with a green banner on the Summary Care Record application. They will be entitled to free NHS hospital care.
- Those on student visitor visas of up to 6 months remain directly chargeable since they are not subject to health surcharge arrangements.

## 6. Former UK residents, armed forces members and war pensioners

### Former UK residents

- 6.1. Former UK ordinary residents who have emigrated and no longer reside in the UK are usually chargeable on visits to the UK. However, there are two important things to consider before charging: whether the patient is still ordinarily resident in the UK, and, if not, whether they are exempt from charge under the Charging Regulations.
- 6.2. British citizens, European Economic Area (EEA) nationals and non-EEA nationals with indefinite leave to remain who are returning to resume properly settled residence in the UK will meet the ordinary residence test (assuming their residence is lawful and voluntarily adopted), most likely from the date of their arrival. See Chapter 3 more information on ordinary residence.
- 6.3. The following exemption categories may apply to those who are not ordinarily resident in the UK:
  - Regulation 12 – EU rights: Former residents now residing in other EEA countries (and in limited circumstances residing outside the EEA) may have a right under EU law to free NHS hospital care. See Chapter 9 for more information on persons with EU rights.
  - Regulation 13 – UK pensioners resident in the EEA: UK pensioners who are resident in another EEA member state are exempt from charge for all NHS hospital treatment, including elective treatment, provided that they have registered an S1 document in that member state. See Chapter 9 for more about this exemption.
  - Regulation 14 – reciprocal healthcare agreements: Former residents residing in countries with which the UK has a reciprocal healthcare agreement may be covered by the terms of that agreement and be entitled to free NHS hospital healthcare (usually only for medically necessary healthcare but will depend on the terms of the relevant agreement). See Chapter 10 for more information on reciprocal healthcare agreements.
  - Regulation 20 – armed forces, Crown servants and UK Government funded employment: former residents may be working abroad as part of an armed service or as a Crown servant. They may also be in UK Government funded employment abroad or be employed by the British Council or Commonwealth War Graves Commission. Such individuals may be exempt from charges (see paragraphs 6.4 to 6.7).
  - Regulation 22 – war pensioners and armed forces compensation recipients: Such individuals are exempt from charges while visiting or living in the UK (see paragraphs 6.8 and 6.9).

## Armed forces members, Crown servants and UK Government funded employment (Regulation 20)

### Armed forces members

- 6.4. Members of the regular and reserve forces (collectively referred to as UK forces) are exempt from charge for all treatment. The armed forces member does not have to have been a former UK resident, but the exemption will also cover those who are serving overseas and who might not be considered ordinarily resident in the UK.
- 6.5. The spouse/civil partner and children under 18 of the armed forces member are also exempt from charge, even if the armed forces member is not in the UK with them at the time of treatment. The spouse/civil partner or child must be in the UK lawfully. Note that those dependants of armed forces members who apply to reside in the UK for six months or more will be entitled to free NHS healthcare by virtue of the health surcharge arrangements (they are exempt from having to pay the health surcharge – see Chapter 5 for more details).

*Examples of evidence include proof that they are a serving member of the UK forces, e.g. valid UK forces ID card or confirmation from the Ministry of Defence.*

### Crown servants, British Council staff, Commonwealth War Graves Commission staff, and those in employment (paid or unpaid) financed in part by the UK Government (in arrangements with the government or public body of another country or territory)

- 6.6. A person from any of the above groups (called a ‘qualifying employee’ in the regulation) is exempt from charge for all treatment, provided that they are either:
- visiting the UK in the course of the qualifying employment; or
  - if visiting for leisure/other purposes, they were ordinarily resident in the UK immediately prior to being posted overseas as a qualifying employee. A qualifying employee who was not ordinarily resident in the UK immediately prior to their current post will still be exempt if they had previously held another post as a qualifying employee, and were ordinarily resident in the UK immediately prior to taking up that earlier post.
- 6.7. The spouse/civil partner or children under 18 of the qualifying employee are also exempt from charge, even if the qualifying employee is not in the UK with them at the time of treatment. The spouse/civil partner or child must be in the UK lawfully. However, if the qualifying employee was not previously ordinarily resident as described in the paragraph above, and is only exempt because they are visiting the UK as a requirement of their employment, their spouse/civil partner or child will only be exempt when visiting the UK with that qualifying employee.

*Examples of evidence include proof of such employment, and of being ordinarily resident in the UK prior to taking up such a post. For more information about evidence of ordinary residence, see Chapter 3.*

## War pensioners and armed forces compensation scheme payment recipients (Regulation 22)

6.8. People who receive UK war pensions or war widows' pensions are exempt from charges for all NHS hospital treatment, as are recipients of armed forces compensation scheme payments. This exemption extends to their spouse/civil partner and/or dependent children if they are lawfully present and visiting the UK with the exempt overseas visitor.

6.9. Examples of evidence include proof of appropriate pension/compensation scheme payment – pension book/slip, letter from the Ministry of Defence or the Department for Work and Pensions. The relevant NHS body should contact the Departments for confirmation if necessary.

### Question and answers

Q: Will the NHS pay for repatriating someone to the UK if they become seriously ill while abroad?

A: No. The NHS is not responsible for funding repatriation back to the UK. However, if the patient's family make their own arrangements to repatriate the patient who on arrival will be resuming their ordinary residence, then they will become entitled to access full NHS treatment free of charge from the date of their arrival. In cases where relevant NHS bodies are advised in advance that a patient is arriving, they must make adequate arrangements to ensure that the patient receives the appropriate healthcare on their arrival back in the UK.

## 7. Vulnerable patients and those detained

- 7.1. When operating the charging rules it is very important to consider the position of vulnerable overseas visitors, including those unlawfully resident in our communities, both those who are exempt from charge and those who are chargeable.
- 7.2. Not all people who are in vulnerable positions are exempt from charge, but the NHS must always provide immediately necessary or urgent care, including maternity care, to any chargeable patient, regardless of whether or not they have yet paid for that care. Chapter 8 discusses in detail what should happen when a chargeable patient cannot pay for treatment.
- 7.3. OVMs and other frontline staff are strongly encouraged to speak to their safeguarding leads if, in the course of their work, they are concerned about the welfare of any patient. It can also be helpful for OVMs to build constructive relationships with local agencies which support people in various types of need, or to seek advice and information from relevant national agencies and organisations. This can help in understanding the needs and circumstances of patients, some of whom can be very afraid of disclosing personal information. This can have a negative impact on their care. Working together with organisations and agencies supporting these patients helps to ensure that they receive the support they need, and are fully informed about how to access support services, including any entitlement to free NHS hospital services. It can also improve a person's understanding of the charges they face and the choices they have (including the consequences of incurring NHS debts), and facilitate discussions about the possibility of payment plans being agreed for those having difficulty paying for the cost of their treatment.

### Treatment of conditions caused by specified types of violence (Regulation 9(f))

- 7.4. An overseas visitor who has been subjected to certain types of violence will not be charged for treatment or services needed to treat conditions caused by that violence. The types of violence are:

#### Torture

- 7.5. The term 'torture' means

*Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions<sup>10</sup>.*

- 7.6. Services provided for the treatment of a condition directly attributable to torture are free to all overseas visitors, provided that the overseas visitor has not travelled to the UK for the specific purpose of seeking that treatment. Coming to the UK to escape torture does not mean coming here for the specific purpose of seeking treatment. Provision of treatment should be holistic, include medical and psychological care, and may include measures such as medical, physical and psychological rehabilitative services. Many

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<sup>10</sup> Article 1(1) of the [UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment](#).

survivors of torture suffer mental health difficulties and mental health services play a key role in their treatment.

7.7. There are significant complexities in identifying this group of vulnerable people. Survivors of torture may not disclose humiliating and degrading experiences of torture and ill-treatment, or may disclose this sensitive information over a period of time as a relationship of trust develops. When identifying a survivor of torture (and other cruel, inhuman or degrading treatment or punishment) to establish if an exemption applies, an OVM should accept:

- confirmation from a medical professional, including a referring GP, who could most appropriately identify signs and symptoms of torture and that the treatment accessed is attributable to this torture; and/or
- confirmation from an appropriate non-governmental organisation or charity, such as the [Helen Bamber Foundation](#) or [Freedom from Torture Foundation](#), confirming that the patient is a client of theirs and is accessing their services as a survivor of torture.

7.8. Both Foundations provide training, capacity-building and supervision to NHS clinicians on the identification of victims of torture, and the assessment of their health needs, and are keen to continue to offer training and/or contribute to training packages to build capacity to support the identification of survivors of torture.

### Female genital mutilation

7.9. Female genital mutilation (FGM) means the excision, infibulation or other mutilation (collectively referred to as mutilation) of the whole or any part of a female's labia majora, labia minora or clitoris, where that mutilation constituted an offence under the [Female Genital Mutilation Act 2003](#) (or would have done so if performed before the Act came into force).

7.10. Services provided to a girl, woman or transgender man for the treatment of any condition, including a chronic condition or a mental health condition, that is caused by the FGM are covered by the exemption and are free of charge. This includes any maternity services (antenatal, perinatal and postpartum treatment) the need for which is caused by the mutilation.

7.11. The exemption applies wherever and whenever the FGM was performed, provided that the overseas visitor has not travelled to the UK for the specific purpose of seeking that treatment. Any other treatment that a person who is a victim of FGM needs that is not directly attributable to the FGM may be chargeable unless covered by another exemption.

7.12. Where FGM is identified in NHS patients, it is now mandatory to record this in the patient's health record. Since September 2014, all acute trusts are required to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM.

7.13. Health professionals in acute trusts should always update a patient's record with whatever discussions or actions have been taken. If the patient has undergone FGM, referral to a specialist FGM clinic should always be considered. If a relevant NHS body refers a patient to social services or the police, then this should also be recorded in the patient's health record. If a patient is identified as being at risk of FGM, then this information must be shared with the GP and health visitor, as part of safeguarding actions.

7.14. In order to establish if an exemption should apply, OVMs should therefore obtain confirmation from a medical professional (which might be a referring GP) who is aware of the patient's health record that FGM is, or will be, recorded there, and that the treatment being accessed is directly attributable to the FGM. A referral from an FGM

clinic will also be evidence that a charge is not to be applied for treatment attributable to the FGM.

7.15. You can access training resources on FGM using the link below:

<https://www.gov.uk/government/collections/female-genital-mutilation-fgm-guidance-for-healthcare-staff>

## Domestic violence

7.16. The Home Office has developed a non-statutory cross-government definition of domestic violence and abuse which is:

*any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members<sup>11</sup> regardless of gender or sexuality. The abuse can encompass, but is not limited to:*

- psychological
- physical
- sexual
- financial
- emotional

7.17. Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

7.18. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

7.19. The Home Office website on domestic violence and abuse provides other useful resources at [www.gov.uk/domestic-violence-and-abuse](http://www.gov.uk/domestic-violence-and-abuse).

7.20. Services provided for the treatment of a condition that is directly attributable to domestic violence are free to all overseas visitors provided that the overseas visitor has not travelled to the UK for the specific purpose of seeking that treatment. This will include any mental health services that are needed as a consequence of the violence.

7.21. It is often difficult to identify victims of domestic violence, particularly as victims are often in powerless and dangerous situations and may be unwilling to disclose that they are suffering in this way. However, where a person has disclosed previously to a medical professional that they are a victim, this may be recorded in their health record. In such cases, OVMs may be able to obtain confirmation from a medical professional (including a referring GP) who is aware of the patient's health record that the person has experienced domestic violence, and that the treatment being accessed is directly attributable to domestic violence. Otherwise, an OVM should accept confirmation from a medical professional who could most appropriately identify signs and symptoms of domestic violence that the services being provided are directly attributable to that violence.

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<sup>11</sup> Family members are: mother, father, son, daughter, brother, sister and grandparents; in-laws or step-family.



7.22. A number of training tools and sources of information exist to support clinicians to recognise domestic violence. The Department of Health has provided the following resources:

- April 2014, a toolkit for health visitors, to help increase knowledge about identifying people affected by domestic violence and providing support through partnership working: <https://www.gov.uk/government/publications/guidance-for-health-professionals-on-domestic-violence>.
- Responding to Domestic Abuse: a handbook for health professionals which gives practical guidance to healthcare professionals working with patients who may have experienced or are experiencing domestic abuse. The 2009 edition is available at: <https://www.gov.uk/government/publications/guidance-for-health-professionals-on-domestic-violence>
- Improving safety, reducing harm: children, young people and domestic violence. A practical toolkit for front-line practitioners, 2009. This toolkit for health professionals was developed to improve responses to a range of key issues affecting children and young people, including domestic violence, bullying, sexual violence and gangs as well as child protection and risk assessments.

7.23. In the absence of confirmation from a medical professional, it is crucial that, in trying to establish if charges apply, people who may be victims of domestic violence are treated sensitively and discreetly, especially if accompanied by others who may be violent towards them. In no circumstances should documentation regarding charging (or exemption from charging) be sent to the patient that mentions domestic violence, due to the danger this might place the person in. For this reason, organisations supporting victims of domestic violence may also be reluctant to provide documentation specifying that a person is considered by them to be a victim of domestic violence. OVMs must bear this in mind when trying to establish if charges apply to the person. If a victim has made steps to claim legal aid because they have separated from the abusive partner/family member, they would have needed to provide documentation from a domestic violence refuge or specialist support service; this could count as evidence of entitlement to free treatment, where necessary.

7.24. Frontline staff and OVMs should be aware that some non-EEA nationals and their dependants are able to make applications to the Home Office for leave to remain under the Destitution Domestic Violence Concession policy, following the breakdown of their relationship due to domestic violence. These individuals are exempt from paying the health surcharge and are entitled to healthcare on the same basis as an ordinary resident. They will have a 'Green: Paid or exempt from the health surcharge' banner on their record when viewed through the SCRa.

## Sexual violence

7.25. Sexual violence is rape or sexual assault. Sexual violence may be included in domestic violence too. When it is not, a separate exemption means that services provided for the treatment of a condition directly attributable to sexual violence are free of charge, provided that the overseas visitor has not travelled to the UK for the specific purpose of seeking that treatment. Treatment will include mental health services and maternity services needed as a consequence of sexual violence.

7.26. Anyone can be a victim of rape or sexual assault, no matter what age they are, their sexuality and regardless of whether they are male or female.



7.27. If a person is a victim of rape or sexual assault it may be recorded in their health record, in which case OVMs may be able to obtain confirmation from a medical professional who is aware of the patient's health record that the patient is a victim of sexual violence, and that the treatment being accessed is directly attributable to that violence. Otherwise an OVM should accept confirmation from a medical professional, including a referring GP, who could most appropriately identify signs and symptoms of sexual violence, that the services being provided are directly attributable to that violence.

7.28. One source of referral is from a Sexual Assault Referral Centre (SARC), which provides specialist medical and forensic services. Therefore, this will be an obvious indicator that the services being accessed are as a result of sexual violence, so that treatment will be exempt from charges.

### Refugees (Regulation 15(a))

7.29. Anyone granted asylum, temporary protection or humanitarian protection under the Immigration Rules made under section 3(2) of the [Immigration Act 1971](#) is recognised as a refugee and is exempt from charges. A person who has leave to enter or remain in the UK as the dependant of such a person is also exempt from charges.

7.30. It may be that NHS treatment is provided to a person before they are recognised as a refugee. Whilst in most cases it is likely that the person would have been exempt because of being an asylum seeker (see below), there may be occasions when a person who has been recognised as a refugee was not exempt. However, charges incurred prior to a person being recognised as a refugee must be refunded or, if not yet paid, cancelled as long as they were in the UK for the purpose of making an application to be granted temporary protection, asylum or humanitarian protection under the immigration rules at the time of being provided the services.

7.31. Refugees are also exempt from paying the health surcharge, and are entitled to their NHS healthcare free of charge on the same basis as an ordinary resident. They will have a green banner on their record when viewed through the SCRa. See Chapter 5 for more information.

7.32. The following should be provided as evidence of being granted asylum, temporary protection or humanitarian protection:

- a 'Green: Paid or exempt from the health surcharge' banner on the patient's record, when the record is viewed through the Summary Care Record application; or
- confirmation from the Home Office of asylum, temporary protection or humanitarian protection having been granted.

7.33. OVMs should also contact the Evidence and Enquiry team at the Home Office if they need confirmation that a person has been granted asylum, temporary protection or humanitarian protection.

### Asylum seekers and others seeking refuge (Regulation 15(b))

7.34. Anyone who has made a formal application with the Home Office to be granted asylum, temporary protection or humanitarian protection which has not yet been determined is also exempt from charges, as are their dependants as part of the application. Formal applications are those made under the 1951 UN Convention and its 1967 Protocol and also any other request for humanitarian protection, such as some claims made on protection from serious harm grounds under Article 3 of the European Convention on Human Rights. Relevant NHS bodies should seek their own legal advice if it is not clear under what circumstances a person is making such a claim.

7.35. A person, and their dependants, who makes an application for leave to remain which relates to a claim for asylum or humanitarian protection, or on the basis that their

removal from the UK would be contrary to Article 3 of the European Convention on Human Rights, will be exempt from paying the health surcharge and will be entitled to their NHS healthcare on the same basis as an ordinary resident.

7.36. Other than the Patient Record, the following should be provided as evidence having made an application for asylum, temporary protection or humanitarian protection:

- Application Registration Card (ARC) issued by the Home Office; or

Confirmation from the Home Office that the person has made such an application and that it is still under consideration. OVMs should be aware that ARCs have been upgraded and new cards rolled out that have a two year validity period which is printed on the front of the card. Since ARCs are only taken from applicants upon their removal from the UK, there may still be occasions where those who have failed to be granted asylum here (they are 'Appeal Rights Exhausted') and are not in an exemption from charge category may still have an 'in-date' ARC, so it is still important to check their Patient Record to see if they have a green or red banner (for which further investigation of their chargeable status would be necessary). The previous version of the ARC will continue to be valid until 2019, so OVMs may continue to see them until then.

### **Asylum seekers supported by the Home Office under section 95 (Regulation 15(c); and failed asylum seekers supported by:**

**- the Home Office under section 4(2) of the Immigration and Asylum Act 1999 or**

**- a local authority under section 21 or Part 1 (care and support) of the Care Act 2014 (Regulation 15(d))**

7.37. A person who has had their asylum/humanitarian protection application and all appeals rejected becomes a 'failed asylum seeker'. They will become liable for charges for their NHS community or secondary care at that point, unless one of the following situations applies to them.

7.38. Persons who are being supported by the Home Office under section 95 of the [Immigration and Asylum Act 1999](#) are exempt from charges. Section 95 support is provided to asylum seekers where they would otherwise be destitute and this normally continues for those failed asylum seekers who have children under the age of 18.

7.39. Some failed asylum seekers are supported under other provisions of the 1999 Act because, whilst making reasonable efforts to leave the UK, there are genuine recognised barriers to their return home. Any failed asylum seeker receiving support from the Home Office under s4(2) of the 1999 Act, and anyone treated as their dependent in the provision of the support, is exempt from charges.

7.40. Failed asylum seekers being supported by a local authority under section 21 of the [National Assistance Act 1948](#) or Part 1 (care and support) of the [Care Act 2014](#) by the provision of accommodation are also exempt from charges. Such failed asylum seekers receive this support due to a need for care and attention (usually because of a disability), and are in an analogous situation to those receiving section 4(2) support, who are usually able bodied.

7.41. Failed asylum seekers in England now receive support from the Local Authority under Part 1 of the Care Act 2014 and not section 21 of the National Assistance Act 1948 Act.

7.42. An OVM might come across a failed asylum seeker who was provided with relevant services between 6 April 2015 and 31 January 2016 and who was, at that time, supported under Part 1 of the Care Act 2014 by the provision of accommodation. In this circumstance, any outstanding charges already made to such a person should be cancelled and any charges for such services not yet made, should not be made. In the event that the Department of Health becomes aware that charges have been made and recovered prior to 1 February 2016, the Department will look at the particular facts of the case and consider whether a refund of those charges can and should be made. Consideration will be undertaken on a case by case basis. Failed asylum seekers who were supported by section 21 before it was repealed will continue to be exempt from charge even though they are now supported by the provision of accommodation under the Care Act 2014.

7.43. Relevant NHS bodies in England should note that section 21 of the National Assistance Act 1948 continues to apply in Wales and therefore eligible failed asylum seekers in Wales may receive support under the 1948 Act and then receive relevant NHS services in England.

7.44. The following should be provided as evidence of being supported by the Home Office or a local authority:

- confirmation from the Home Office that the person is being supported under section 95 of the 1999 Act, or is a failed asylum seeker supported under s4(2) of the 1999 Act; or
- Confirmation by a local authority that the person is being supported under section 21 of the NAA Act or Part 1 of the Care Act.

7.45. A failed asylum seeker who makes a fresh application for asylum, temporary protection or humanitarian protection will become an asylum seeker again and will therefore be exempt from charges again under Regulation 15(b), until that new application, including any appeals, is determined. A person does not become an asylum seeker again at the point they make a fresh claim for asylum or the claim is received by the Home Office, but only when that claim has been 'recorded' by the Home Office. Charges will still apply during any period between the first application, including appeals, being 'rejected' and the second, fresh, application being 'recorded' by the Home Office.

### **Children looked after by a local authority (Regulation 15(e))**

7.46. Children who are looked after by a local authority within the meaning of section 22(1) of the [Children Act 1989](#) are exempt from charges. This will include the following children who are accommodated by a local authority:

- children in the care of the local authority by virtue of a care order (by a court);
- children who are unaccompanied by a parent or guardian in the UK or abandoned or for whom there is no one with parental responsibility; and
- children who are voluntarily accommodated by a local authority (without the need for intervention by a court).

7.47. There may be occasions when a relevant NHS body treats an overseas visitor child who is unaccompanied or abandoned, or for whom there is no one with parental responsibility, and whom the relevant NHS body believes should be in the care of or looked after by the local authority. Where that child is subsequently taken into the care of the local authority, there will be no charge for the treatment prior to the child being taken into the care of, or becoming looked after by, the local authority.

7.48. OVMs and frontline staff should be aware that some of these children will make applications to the Home Office for leave to remain in the UK. They are exempt from paying the health surcharge, and are entitled to all their NHS healthcare free of charge on the same basis as an ordinary resident. They will have a 'Green: Paid or exempt from the health surcharge' banner on their record when viewed through the Summary Care Record application.

7.49. Confirmation from the local authority should be obtained to confirm that the child is looked after by that local authority.

## **Victims, and suspected victims, of modern slavery (Regulation 16)**

7.50. A "victim of modern slavery" means a victim of:

- trafficking in human beings;
- slavery;
- servitude; or
- forced or compulsory labour.

7.51. A person who is thought to be a victim of modern slavery can be referred to the 'competent authorities' (CA) of the UK to be identified as such. The CA are currently the UK Human Trafficking Centre (UKHTC) and, where cases are linked to asylum and immigration issues, the Home Office. The CA will then consider if there are reasonable grounds to consider the person to be such a victim and if so, will issue a 'reasonable grounds' decision. Individuals given a reasonable grounds decision are suspected victims of modern slavery and are exempt from charge until a final determination is given by one of the CAs (unless a final determination is not required, which would be highly unusual). They will continue to be exempt from charge if the CA confirms them as being a victim of modern slavery with a 'conclusive grounds' decision.

7.52. Those whom the CA confirm not to be victims of modern slavery are no longer exempt from charge, other than for courses of treatment already under way, which remain free of charge until complete or until the person leaves the country.

7.53. It may be that NHS treatment is provided prior to a person being referred to the CA for identification. Charges incurred prior to a referral to the CA for assessment as a victim of modern slavery must be refunded or, if not yet paid, cancelled, when the CA provide a reasonable grounds decision. If the CA does not provide a reasonable grounds decision, these charges are not cancelled or refunded. If the CA goes on to establish that the person is not, in fact, a victim of modern slavery, no treatment provided during the time that the person was suspected as being a victim of modern slavery, or provided prior to being referred to the CA for such an assessment, will become chargeable.

7.54. The spouse/civil partner and dependent children of those exempt under this regulation are also exempt from charges in their own right, as long as they are here lawfully. They do not have to have been here with the victim of modern slavery during the entire period of their stay.

7.55. Victims of modern slavery are often in powerless situations and frontline staff may come across them before they have had a chance to escape their oppressors and seek help. They may be unwilling to disclose their situation, although frontline staff are often trusted individuals who might be best placed to identify signs of trafficking and/or slavery. A leaflet and e-learning resources are available for health professionals, to raise awareness about the issue of modern slavery and enable health professionals to identify and respond to victims more effectively. A copy of the leaflet is available at: <https://www.gov.uk/government/publications/identifying-and-supporting-victims-of-human-trafficking-guidance-for-health-staff>

The e-learning resources can be accessed at: <http://www.e-lfh.org.uk/programmes/modern-slavery/>

7.56. Consequently, it may be that NHS staff are concerned that a person they are treating or assessing for charges is a victim of modern slavery. OVMs should speak to their safeguarding lead for advice. If the patient appears to be in danger, the relevant NHS body should contact the police.

7.57. There are also charitable 'First Responder' organisations that are trained to identify and provide support to victims, and suspected victims, that can be contacted for advice. OVMs are encouraged to engage with these organisations to ensure that victims of modern slavery who are not exempt from charges (because they are unwilling to be referred to the CA) still receive the support they need. The current list of First Responder organisations can be found here:

<http://www.nationalcrimeagency.gov.uk/about-us/what-we-do/specialist-capabilities/uk-human-trafficking-centre/national-referral-mechanism>

Some victims of modern slavery go on to make applications to the Home Office for leave to remain as victims of modern slavery. They are likely to be exempt from paying the health surcharge. In the circumstance, while their visa is valid, they are entitled to all their NHS healthcare free of charge on the same basis as an ordinary resident. They will have a 'Green: Paid or exempt from the health surcharge' banner on their record when viewed through the Summary Care Record application. Victims of modern slavery may make applications for a period of discretionary leave, and may not be required to pay the health surcharge.

7.58. The following should be provided as evidence:

- a letter from the CA confirming their status as a victim (a 'conclusive grounds' decision), or suspected victim (a 'reasonable grounds' decision) for whom the recovery and reflection period has not elapsed;
- those who make an immigration application for leave to remain as a victim of modern slavery will have a 'Green: Paid or exempt from the health surcharge' banner on their NHS record, when it is viewed through the Summary Care Record application, indicating their access to NHS services on the same basis as a person who is ordinarily resident. Note that not all victims will make such an application to the Home Office, so they will not all have a green banner indicating their status.

7.59. Prior to 1 February 2016 only victims, or suspected victims, of human trafficking were exempt from charge for NHS hospital treatment. The competent authority of the UK will now also consider suspected victims of modern slavery, as well as victims of human trafficking, within this formal process.

### **Exceptional humanitarian reasons (Regulation 13)**

7.60. This regulation allows the Secretary of State for Health to designate an individual as exempt from charges on exceptional humanitarian grounds, as long as certain specified criteria are met. This designation can only be made by the Secretary of State. It is envisaged that the powers will only be used very rarely, where there is a clear humanitarian imperative to do so (e.g. the UK is responsible for causing the injury needing treatment or there are humanitarian reasons for treating the person in the UK). As far as relevant NHS bodies are concerned, their role in the context of the Charging Regulations is to establish whether such a determination has been made, not to make the determination themselves.



7.61. The following should be noted with regard to evidence:

- The relevant NHS body will be advised that the appropriate determination has been made and supporting documentation will be provided (although in an emergency this may arrive after the patient).

7.62. Where such a determination is made, the person will be allowed to be accompanied by an authorised companion (which need not be their spouse/civil partner) and any authorised children, who will be exempt from charges for treatment the need for which arises while they are here, but not for other treatment.

### **Persons detained in an NHS hospital or subject to court ordered treatment (Regulation 18)**

7.63. People who are detained in an NHS hospital or deprived of their liberty or subject to court ordered treatment are exempt from charges for the treatment specified in the court order and any treatment provided during their detention. This exemption applies to the following people:

- overseas visitors liable to be detained in an NHS hospital under the [Mental Health Act 1983](#) (the 1983 Act) or any other legislation authorising their detention;
- overseas visitors received into guardianship under the 1983 Act or subject to a community treatment order under that Act;
- overseas visitors deprived of their liberty under section 4A, 4B, 16 or Schedule A1 of the [Mental Capacity Act 2005](#);
- and overseas visitors required to submit to treatment imposed by a court order, other than those set out above. The following should be provided as evidence:
  - a court order; or
  - evidence that the detention is authorised, in the form of a referral.

### **Prisoners and detainees (Regulation 19)**

7.64. Anyone who is in prison or in a young offender institution and anyone who has been detained under immigration legislation is exempt from charges. They will have been referred for treatment by the appropriate authorities.

### **Operation of the easement clause in respect of vulnerable individuals**

7.65. Under the easement clause, any particular course of treatment under way when either:

- an asylum seeker's application, including all appeals, is rejected; or
- a person stops receiving section 95 support from the Home Office; or
- a failed asylum seeker stops receiving support from the Home Office under section 4(2) of the 1999 Act, or section 21 or Part 1 support from a local authority; or
- a person ceases to be a child looked after by a local authority; or
- a prisoner is released from prison or immigration detention; or
- a person is no longer detained in a hospital or liable to court ordered treatment; or
- a person suspected of being a victim of modern slavery by a competent authority (having issued a 'reasonable grounds' decision), who is then found by

the competent authority not to be a victim of modern slavery, will continue free of charge until that course of treatment concludes or the person leaves the country.

7.66. However, they must be charged for any new courses of treatment, although relevant NHS bodies are reminded that, regardless of the lack of advance payment, they must not withhold treatment that is medically considered immediately necessary or urgent in that it cannot wait until the patient can reasonably be expected to return home. They are also reminded that they have the option to write off debts and not pursue them when the person is genuinely without funds. See Chapter 8 for more details.

### **Links and contacts for relevant support groups**

7.67. We have provided a small number of suggested links to national organisations who support vulnerable individuals who might be exempt from charges under the Charging Regulations but this is by no means intended to be an exhaustive list. OVMs are encouraged to build constructive relationships with those local agencies which support people in various types of need in their own local areas. This can also be found in the OVM toolbox: <https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants>

## 8. When to provide NHS treatment to those not entitled to it free of charge

**This chapter gives important advice on the safeguards that relevant NHS bodies must employ to protect the lives of overseas visitors who are not exempt from charges under the Charging Regulations, and guidelines on how relevant NHS bodies should handle such people without the resources to pay, including when to withhold treatment.**

### What are the relevant NHS bodies' responsibilities?

- 8.1. Chapter 2 sets out the legal obligations under the Charging Regulations of all relevant NHS bodies.
- 8.2. Relevant NHS bodies must also ensure that treatment which is immediately necessary is provided to any person, even if they have not paid in advance. Failure to provide immediately necessary treatment may be unlawful under the [Human Rights Act 1998](#). Urgent treatment should also always be provided to any person, even if deposits have not been secured. Non-urgent treatment should not be provided unless the estimated full charge is received in advance of treatment. See paragraph 8.3 for more important information on non-urgent treatment.

### What is immediately necessary, urgent and non-urgent treatment?

- 8.3. Only clinicians can make an assessment as to whether a patient's need for treatment is immediately necessary, urgent or non-urgent. In order to do this they may first need to make initial assessments based on the patient's symptoms and other factors, and conduct further investigations to make a diagnosis. These assessments and investigations will be included in any charges.

### Immediately necessary treatment

- 8.4. Immediately necessary treatment is that which a patient needs promptly:
  - to save their life; or
  - to prevent a condition from becoming immediately life-threatening; or
  - to prevent permanent serious damage from occurring.
- 8.5. Relevant NHS bodies must always provide treatment which is classed as immediately necessary by the treating clinician irrespective of whether or not the patient has been informed of, or agreed to pay, charges, and it must not be delayed or withheld to establish the patient's chargeable status or seek payment. It must be provided even when the patient has indicated that they cannot afford to pay.

### Maternity treatment

- 8.6. Due to the severe health risks associated with conditions such as eclampsia and pre-eclampsia, and in order to protect the lives of both mother and unborn baby, all maternity services must be treated as being immediately necessary. Maternity services include all antenatal, intrapartum and postnatal services provided to a pregnant person, a person who has recently given birth or a baby. No one must ever be denied, or have delayed, maternity services due to charging issues. Although a person must be informed if charges apply to their treatment, in doing so they should not be discouraged from receiving the remainder of their maternity treatment. OVMs and clinicians should be especially careful to inform pregnant patients that further maternity healthcare will not be withheld, regardless of their ability to pay.



## Urgent treatment

- 8.7. Urgent treatment is that which clinicians do not consider immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to leave the UK. Clinicians may base their decision on a range of factors, including the pain or disability a particular condition is causing, the risk that delay might mean a more involved or expensive medical intervention being required, or the likelihood of a substantial and potentially life-threatening deterioration occurring in the patient's condition if treatment is delayed until they return to their own country.
- 8.8. For urgent treatment, relevant NHS bodies are strongly advised to make every effort, taking account of the individual's circumstances, to secure payment in the time before treatment is scheduled. However, if that proves unsuccessful, the treatment should not be delayed or withheld for the purposes of securing payment.
- 8.9. Treatment is not made free of charge by virtue of being provided on an immediately necessary or urgent basis. Charges found to apply cannot be waived and if payment is not obtained before treatment then every effort must be made to recover it after treatment has been provided.

## Non-urgent treatment

- 8.10. Non-urgent treatment is routine elective treatment that could wait until the patient leaves the UK. Relevant NHS bodies do not have to provide non-urgent treatment if the patient does not pay in advance and should not do so until the estimated full cost of treatment has been received (see paragraph 8.19).

## Clinician and OVM collaboration

- 8.11. The decision on whether a patient's need for treatment is immediately necessary, urgent or non-urgent is only for clinicians to make, and they should be asked to complete an Advice from Doctors or Dentists Form (<https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme>), which should then be documented in the patient's notes and a copy sent to the relevant service/delivery manager.
- 8.12. However, in determining whether or not a required course of treatment should proceed even if payment is not obtained in advance, or if it can safely wait until the patient can return home (i.e. whether it is urgent or non-urgent), clinicians will need to know the patient's estimated return date.
- 8.13. It is the responsibility of OVMs to gather the information on when the patient can return home in such cases, based on the patient's ability to do so. It is also the OVM's responsibility to establish whether or not the patient is entitled to free NHS treatment in the first place.

## Future changes

- 8.14. It is very important to note that **the law will change on 23 October 2017** so that it will be a legal requirement to recover in advance the estimated full cost of a course of treatment unless doing so would prevent or delay the provision of immediately necessary or urgent treatment. In practice this will mean that where a clinician has determined a patient's need for care to be non-urgent/elective, payment from the person liable will be required upfront and in full, where no exemption category applies, before the treatment can be provided. Where services are immediately necessary or urgent, full upfront payment should be secured wherever possible, unless doing so would prevent or delay the treatment. Providers of NHS-funded community and secondary care will therefore need to prepare for how they will ensure that they meet this legal requirement.

## How to determine when an overseas visitor patient can reasonably be expected to return home

- 8.15. The general principle is that overseas visitors should either return home for treatment that is not immediately necessary or urgent, or pay in advance of receiving it. However, in some cases it may not be possible or reasonable to expect a person to return home quickly enough for treatment. Clinicians will need to know when a patient can reasonably be expected to return home in order to decide if their need for NHS-funded community or secondary care is urgent or if it can safely await their return.
- 8.16. As a condition of their entry to the UK, general visitors are required to have sufficient funds available to finance their stay, and that of any dependants, as well as the onward or return journey. Many documented migrants have return journeys booked when they enter the UK. If they need treatment before that return date but claim that they cannot pay for it in advance, they should arrange an earlier journey home before the treatment would be necessary in the opinion of a clinician. If an earlier journey home would not be reasonable, and treatment is urgent, care should be provided and debts recovered when clinically appropriate.
- 8.17. Those without return journeys booked are expected to return home for the treatment needed, again, unless it would not be reasonable to do so. As a final resort, the date at which their visa requires them to leave the UK should be used as the date of return.
- 8.18. For undocumented migrant patients, including failed asylum seekers, the likely date of return may be unclear, and will have to be assessed on a case-by-case basis, including their ability to return home. Some may be prevented by travel or entry clearance restrictions in their country of origin, or by other conditions beyond their control.
- 8.19. For some cases relating to undocumented migrants, it will be particularly difficult to estimate their return date. Relevant NHS bodies may wish to estimate that such patients will remain in the UK initially for six months, and the clinician can then consider if treatment can or cannot wait for six months, bearing in mind the definitions of urgent and non-urgent treatment given above. However, there may be circumstances when the patient is likely to remain in the UK longer than six months, in which case a longer estimate of return can be used.
- 8.20. Where a clinician has decided that the need for treatment is non-urgent and can wait until the patient returns home, this should be reassessed if the patient informs the relevant NHS body that their return date has been postponed for valid reasons. It should also be reassessed if the patient's medical condition unexpectedly changes. On being told that their need for treatment has been found to be non-urgent, and will therefore not proceed without advance payment, patients should be informed that they should present again for a reassessment of the urgency of their treatment if their condition changes. Alternatively, patients' circumstances may require regular follow-up by clinicians.

## NHS Screening

- 8.21. If a chargeable patient presents in relation to a standard invitation to take part in screening for a non-exempt condition, this is likely to be considered non-urgent and therefore require full upfront payment before going ahead.

## What limits should be placed on treatment?

8.22. While urgency of treatment is a matter of clinical judgement, this does not mean that treatment should be unlimited; there may be some room for discretion about the extent of treatment and the time at which it is given. In many cases, a patient undergoing immediately necessary treatment may be able to be stabilised, allowing them to be safely discharged and giving them time to return home for further treatment rather than incurring further avoidable NHS charges. This should be done wherever possible, unless ceasing or limiting treatment would precipitate deterioration in the patient's condition.

## Recommended timeline for establishing a patient's entitlement to free treatment and applying relevant charges

8.23. When a patient is in need of immediately necessary treatment, it may not be appropriate, or possible, to inform them ahead of treatment commencing that charges might apply, nor to secure from them an agreement to pay those charges. Patients who, after baseline questioning (see Chapter 11), appear not to be ordinarily resident here or not covered by health surcharge arrangements, or who do not provide a valid EHIC, PRC or S2 form, or evidence of a registered S1 form should be notified that charges might apply at the earliest appropriate opportunity. They should subsequently be interviewed by an OVM to establish this definitively, when it is medically appropriate to do so. Patients should not be told by anyone that charges will not apply until their status as chargeable or exempt from charges is formally established.

8.24. In circumstances where it is possible and appropriate to assess charges and request payment before or during a course of immediately necessary treatment, relevant NHS bodies should make clear to the patient that treatment will not be withheld or delayed if they do not pay in advance or provide an appropriate EEA healthcare form.

8.25. If and when it is established that charges apply, the patient should be informed and presented with an invoice for the treatment they have received and/or an estimation of the charges they are liable for in respect of any future treatment. However, patients who may be in need of further immediately necessary or urgent treatment should not be discouraged from receiving it, even if they indicate that they are unable to pay. In some cases it may be appropriate not to present an invoice until all immediately necessary or urgent treatment has been completed, but patients should nevertheless be fully informed about the charges they might face.

8.26. An overseas visitor whose need for treatment after admission from A&E or from a GP referral is not considered immediately necessary should be interviewed by the OVM at the earliest appropriate opportunity and before a course of treatment commences, to establish if they are entitled to free treatment or have to pay.

8.27. However, if it is established that the patient is a chargeable overseas visitor who claims they cannot pay, and this has been done before the patient has seen the clinician or had the necessary diagnostic tests, the patient must not then be prevented from going on to see the clinician, since it will be necessary for the clinician to determine what treatment is needed (potentially taking into account the results of necessary diagnostic tests) and the consequent level of urgency,. Only when a clinician confirms that the need for treatment is non-urgent should treatment be withheld, pending payment. It should be remembered that diagnostic tests for STIs or the infectious diseases listed at paragraph 4.3 are exempt from charge, even if the diagnosis is negative.

8.28. When, after this initial assessment, clinicians consider the need for treatment to be urgent, relevant NHS bodies should obtain the full estimated cost of treatment during

the period before treatment is to commence, as long as this does not delay or impede treatment.

8.29. However, where a clinician considers that a chargeable patient's need for treatment is non-urgent, further treatment processes (e.g. putting the patient on a waiting list or booking outpatient clinics) should not be initiated until the estimated full cost of treatment has been obtained. Any surplus which is paid can be returned to the patient on completion of treatment. This is not refusing to provide treatment, it is requiring payment conditions to be met in accordance with the Charging Regulations before treatment can commence.

8.30. When providing treatment to a chargeable overseas visitor, clinicians should be asked to complete an Advice from Doctors or Dentists Form (template available in the OVM toolbox at <https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme>), which should then be documented in the patient's notes and a copy sent to the relevant service/delivery manager.

## 9. How to deal with those with EU rights and exemptions

**The current rules under EU Regulations continue to apply, at least until the UK leaves the EU. The NHS should still maximise the identification of these patients and collect the necessary information to enable cost recovery.**

- 9.1. OVMs need to be aware of the entitlements the EU Regulations (Regulations (EC) 883/2004 and 987/2009 – the ‘EU Regulations’)<sup>12</sup> provide to certain visitors from Europe over and above the entitlements provided elsewhere under the Charging Regulations. The UK can claim reimbursement for the cost of providing healthcare to visitors from other EEA states or Switzerland under the EU Regulations, if certain data are captured. A person’s eligibility under the EU Regulations will normally be established by production of the relevant EEA healthcare document (EHIC, PRC, S2 or S1) confirming that the holder is covered for their health costs by the country of issue. See the introduction and footnote on page 6 for an explanation of the main EEA forms of interest to OVMs.
- 9.2. Regulation 13 of the Charging Regulations concerns extended rights to free treatment for overseas visitors who are treated as if entitled under EU Regulations, namely UK pensioners for whose healthcare costs the UK is responsible for in their EEA country of residence because of a registered UK-issued S1 form. These rights mean they should not be charged for healthcare in secondary healthcare settings.
- 9.3. OVMs also need to know of rights granted to visitors from the EEA under Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare – also known as the Cross-border Healthcare Directive or ‘the Directive’.<sup>13</sup> If a patient is exercising rights under the Directive, the health provider should recover the full cost of treatment directly from the patient. However, the charge recovered from the patient should be equal to the NHS tariff for that service, or the equivalent NHS cost if no national tariff exists. Regulation 13(1) of the [National Health Service \(Cross-Border Healthcare\) Regulations 2013](#) (see paragraph above) applies here. Regulation 7(2) of the Charging Regulations confirms this and applies the same principles to all visiting patients who reside in EEA countries (and who are not otherwise exempt from charging).
- 9.4. It is important to remember that this guidance seeks to provide as much help and advice as possible. However, it cannot cover everything and is not intended to be a substitute for the Charging Regulations themselves, which contain the legal provisions.

### Who is covered for healthcare under the EU Regulations?

- 9.5. The EU Regulations apply to all countries within the EEA, which is made up of the 28 member states of the EU:
  - Austria
  - Belgium

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<sup>12</sup> Regulation 12 of the Charging Regulations principally concerns those overseas visitors who are entitled to access NHS healthcare by virtue of EU rights arising under the EU Social Security Regulations (EC) [883/2004 and 987/2009](#)

<sup>13</sup> The Directive was implemented in England through Regulation 13(1) of the [National Health Service \(Cross-Border Healthcare\) Regulations 2013](#)

- Bulgaria
- Croatia
- Cyprus (Southern)
- Czech Republic
- Denmark
- Estonia
- Finland
- France
- Germany
- Greece
- Hungary
- Ireland
- Italy
- Latvia
- Lithuania
- Luxembourg
- Malta
- Netherlands
- Poland
- Portugal
- Romania
- Slovakia
- Slovenia
- Spain
- Sweden
- UK

plus

- Iceland
- Liechtenstein and
- Norway.

9.6. Switzerland has a separate agreement with the EU which, in effect, applies the EU Regulations to Switzerland.

9.7. The UK also has reciprocal healthcare agreements with some other European countries, but these are outside of the EU Regulations (see Chapter 10).

9.8. Only residents 'insured' under any public healthcare system of an EEA country or Switzerland are covered by the EU Regulations when they are visiting the UK. In detail, this covers: below should be bullet points

- EEA nationals, stateless persons or refugees, plus their family members and survivors (irrespective of nationality) of these groups of people, insured in each case under any public healthcare system in an EEA country (N.B. they may be 'insured' by the UK even if they are living abroad. See paragraph 9.55 onwards);
- Swiss or EU nationals, stateless persons or refugees, plus their family members and survivors (irrespective of nationality) of these groups of people, insured in each case in Switzerland;
- non-EEA nationals legally resident and insured in any EU country (except Denmark).



## European Health Insurance Card (EHIC)

- 9.9. A valid EHIC or Provisional Replacement Certificate (PRC) for the EHIC can demonstrate that a visitor (including a student) is exempt from charge under the EU Regulations, and therefore entitled to free NHS treatment that is medically necessary during their visit until their planned date of return. This is because the other country is responsible for the healthcare costs of the visitor. The UK can reclaim back the cost of providing treatment to the patient, if the details of the EHIC or PRC are recorded on the OVM portal.
- 9.10. However, an arrangement between the UK and the Republic of Ireland means that visitors from the Republic of Ireland do not have to present an EHIC to obtain free NHS treatment under the EU Regulations. They only need to present evidence that they are resident in the Republic of Ireland, although a valid EHIC can be used as evidence of this. Visitors from the Republic of Ireland do need to be referred with an S2 for pre-planned treatment.
- 9.11. Visitors who are resident in Switzerland or the EEA (except Ireland) who do not provide an EHIC/PRC must be charged for their NHS hospital treatment at 100% of the NHS tariff or equivalent, unless they are ordinarily resident in the UK or a different exemption applies to them under the Charging Regulations.
- 9.12. A person who has been charged because they did not provide an EHIC/PRC may be entitled to a reimbursement from their home state on their return. Alternatively, if they provide a valid EHIC/PRC covering the period of treatment within a reasonable timescale after treatment, they should be reimbursed by the relevant NHS body.
- 9.13. Visitors from the EEA/Switzerland may be exempt under a different exemption category within the Charging Regulations and it is very important that this is considered before the patient is charged. EEA and Swiss nationals as well as some non-EEA nationals not subject to immigration control, who are ordinarily resident in the UK are entitled to free treatment on that basis.
- 9.14. However, if the visitor is able to show a valid EHIC or PRC from another EEA member state or Switzerland, the UK can claim back the cost of their treatment from that country. It is possible to be ordinarily resident in the UK and still be insured by another country. This is often the case with EEA students coming to study in the UK. Consequently, if a patient from another EEA country or Switzerland presents for treatment and the treating NHS provider suspects they are ordinarily resident in the UK, the provider should still ask the patient if they have an EHIC/ PRC and report their details via the OVT web portal.
- 9.15. In order for the UK to make a claim to the relevant EEA state or Switzerland for treating its residents, it is imperative that the data from the EHIC/PRC is recorded and reported to the Overseas Healthcare Team at the Department for Work and Pensions (DWP) via the OVT web portal (see paragraphs 9.49-9.54 below).

## What treatment is free under the EHIC?

9.16. A person with a valid EHIC/PRC is entitled to free treatment for 'all treatment that is medically necessary before their planned date of return', except where charges also apply to residents in England, such as prescription and dental fees. In other words, this means treatment that it is medically necessary to provide a visitor during their temporary stay in the UK, with a view to preventing them from being forced to return home for treatment before the end of their planned duration of stay. The patient does not need to have a specific leaving date or duration of stay, as long as the stay is temporary. This means the following is covered:

- diagnosis of symptoms or signs occurring for the first time after the visitor's arrival in the UK;

- any other treatment which, in the opinion of a registered medical or dental practitioner, is required promptly for a condition which:
    - arose after the visitor's arrival; or
    - became acutely exacerbated after their arrival; or
    - would be likely to become acutely exacerbated without treatment; plus
  - the treatment of chronic or pre-existing conditions, including routine monitoring.
- 9.17. It should be noted that the above definition of 'medically necessary treatment' is different from the entitlement to free treatment that applies to visitors from reciprocal agreement countries which are not covered by EU regulations (see regulation 14 and Chapter 10).
- 9.18. A temporary stay is a period during which someone is staying in a place other than the one where they usually live and they do not move their 'centre of interest' there. For the purpose of the EU Regulations, a temporary stay is not limited to a defined period of time and will depend on the individual circumstances of the case.
- 9.19. In the case of maternity services, the EHIC covers all maternity care, including antenatal and postnatal care, provided the reason for the woman's visit was not specifically to give birth or receive maternity treatment. In this case, the patient should present an S2 form to the relevant NHS body. However, given that not all EEA countries automatically issue an S2 for maternity care, discretion can be applied if a valid EHIC is presented instead. If no valid entitlement document is presented, then payment will be required from the patient (unless a different exemption applies).
- 9.20. Patients with valid EHICs are eligible for free dialysis treatment, but this is dependent on the patient making an advance booking and the facilities being available at the time requested. Home oxygen services are also covered under the EHIC. Again, patients should make advance arrangements for provision, usually with a GP practice, and should ensure they have enough oxygen to travel to their destination in the UK and for their return home. Oxygen for travel must be arranged privately and is not covered by the state-funded arrangements described above. The treatments that require advance booking may be subject to change in the future.

### **What about workers from the EEA/Switzerland posted to the UK?**

- 9.21. 'Posted workers' are those sent to the UK on a time-limited posting by their employer from another EEA country or Switzerland, or the other way around, rather than those who have chosen to move to another country to take up employment or to seek work. Posted workers here for less than two years should show an EHIC and an A1 document. The details of the EHIC should be recorded on the portal. Posted workers who are in the UK for more than two years should be covered by an S1 document, but may also be classed as ordinarily resident in the UK.

### **What about workers from the UK posted elsewhere in the EEA/Switzerland?**

- 9.22. Workers from the UK who are sent to work in another EEA country or Switzerland on a time-limited posting by their employer may be issued with an A1 (to be used alongside an EHIC) or S1 form by Her Majesty's Revenue and Customs (HMRC) for use abroad. This gives them the right to receive NHS services for free when visiting England, just like someone who is ordinarily resident here. The family members of UK posted workers, even if living elsewhere in the EEA/Switzerland, may also have a UK-issued S1 form registered abroad and are therefore entitled to come to the UK for healthcare as though they were ordinarily resident. For further information, see paragraphs 9.56-9.58.



## What about family members living outside of the EEA/Switzerland?

9.23. EU Regulations require that direct family members of an EEA/Swiss national who is exercising their treaty rights in the UK, for example by moving from abroad to work in England, should be treated as though ordinarily resident in the UK. Direct family members include a spouse/civil partner and children. A parent or grandparent of the EEA national or the spouse/ civil partner would also qualify if they are dependent on either of them.

## What about family members who are living elsewhere in the EEA/Switzerland?

9.24. EU Regulations require that direct family members of an EEA/Swiss national who is exercising their treaty rights in the UK, for example by moving from abroad to work in the UK, may be eligible for a UK-issued S1 form to be registered in their country of residence. Direct family members include a spouse/civil partner and children. A parent or grandparent of the EEA national or the spouse/civil partner would also qualify if they are dependent on either of them. If they have a registered S1 form abroad, they will be eligible to return to the UK to access treatment as though they were ordinarily resident in the UK, except if they are family members of frontier workers, who would only be entitled to unplanned healthcare on the same basis as with an EHIC. For further information, see section 'Persons resident in another EEA country but whose healthcare costs the UK remains responsible for' para 9.63.

## What about students from the EEA?

9.25. Students from the EEA/Switzerland who are temporarily studying in the UK may remain insured in their home state. Therefore, students should be asked to show a valid EHIC/PRC, and any NHS-funded treatment costs should be reported via the OVT portal. If they cannot provide a valid EHIC/PRC, OVMs will need to consider whether they are ordinarily resident and therefore should not be charged.

9.26. Students may be here for several years before returning home, so they are likely to require a greater range of treatments than a general holiday-maker would need. Their EHIC will still cover them for all treatment that it is medically necessary to provide to them during their temporary (albeit lengthy) stay in the UK.

## What about coming to England for pre-planned treatment?

9.27. There are currently three potential ways for people from another EEA country or Switzerland to receive planned healthcare in England:

- [The Directive route](#)<sup>14</sup> (the Directive does not apply to Switzerland);
- The S2 route<sup>15</sup>;
- Holders of a UK-issued S1 form<sup>16</sup> registered with the relevant authorities in another EEA country or Switzerland may also be able to return to England and obtain planned healthcare (see also 9.57).

9.28. The key difference between the routes is that the S2 route and S1 only relate to state-provided treatment, and costs are dealt with directly between states. The S2 form acts as a form of payment guarantee. This means that in the majority of cases, the patient is not required to pay anything themselves (other than any applicable statutory charge

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<sup>14</sup> Directive 2011/24/EU.

<sup>15</sup> Articles 22(1)(c) and 55(1)(c) of Regulation (EEC) 1408/71 and Articles 20 and 27(3) of Regulation (EC)

<sup>16</sup> Article 18 of Regulation 883/2004 and regulation 13 of the Charging Regulations.

that would also be payable by those ordinarily resident, for example prescription and dental charges).

9.29. The Directive operates on a principle of purchase and reimbursement. Patients are able to purchase state or private healthcare in England and seek reimbursement for this treatment from their home country up to the cost of the treatment in that country.

### The Directive route

9.30. The EU Directive grants a fundamental right to purchase healthcare services across the EEA for EEA residents and to apply for reimbursement from their home system on their return. The patient will also bear the financial risk of any additional costs which may arise, for example travel and accommodation costs.

9.31. A patient may obtain healthcare in another EEA country under the Directive without authorisation from their state of residence, except where the legislation in the state of residence requires the seeking of prior authorisation. This is different from the S2 route, where all healthcare must be authorised in advance before an S2 form is issued.

### Who can seek reimbursement under the EU Directive?

9.32. People residing in countries within the EEA can seek reimbursement under the EU Directive when they return to their state of residence.

9.33. Visitors residing in Switzerland are not covered by the Directive.

9.34. Non-EEA nationals who are legally resident and insured in the EEA (but not in Switzerland) are also covered by the Directive.

### Obligations on NHS providers under the Directive

9.35. OVMs should be aware that healthcare providers in England who are providing treatment to visiting patients under the provisions of the Directive need to observe some key requirements. They must:

- provide patients with relevant information on treatment options, quality and safety;
- provide clear invoices and price information;
- apply fees in a non-discriminatory manner;
- ensure transparent complaints procedures and procedures to obtain redress are in place;
- apply adequate systems of professional liability insurance or similar;
- respect privacy in the processing of personal information; and,
- supply patients with a copy of the record of their medical treatment.

### Charging under the Directive route

9.36. The Directive requires healthcare providers to provide visiting patients with clear information on prices and clear invoices. Pricing must be non-discriminatory: providers cannot make up a price or seek to charge more simply because the person is a visiting patient seeking treatment under the Directive. Healthcare providers must therefore apply the same fees for healthcare to visiting patients as it would cost the NHS to provide that treatment to domestic patients. If there is no comparable price for domestic patients, the price must be based on objective, non-discriminatory criteria. The NHS (Cross-Border Healthcare) Regulations 2013 provide that, where a visiting patient receives an NHS service for which a charge can be made, the visiting patient must not be charged more than the amount that an NHS commissioner would have been charged if that service had been provided to an NHS patient.

9.37. If providers (including providers from the independent sector contracted to deliver NHS services) accept a visiting patient for treatment, they must not assume that such patients wish to be considered as private patients even though the patient is not coming

through a usual NHS route and is not referred formally by their state health system. This is because they are exercising their rights under the Directive and may themselves receive reimbursement from their state system for eligible costs under the provisions of the Directive. At the same time, patients who specify from the outset that they do wish to be treated privately may be charged in the same way as at the equivalent cost to private patients resident in England.

9.38. In terms of how these requirements are met, for secondary healthcare provided by the NHS, relevant NHS bodies should recover the full cost of the treatment given to a visiting patient under the Directive. EEA countries must have a transparent mechanism for the calculation of costs for cross-border healthcare and this must be based on objective, non-discriminatory criteria known in advance. To calculate the NHS cost, trusts should use the latest mandatory tariff (or equivalent) or the published national average reference costs at: <https://improvement.nhs.uk/resources/national-tariff-1719/>

9.39. Providers will need to ensure systems are in place for dealing with requests for treatment from visiting patients. This includes processes for seeking more information about the patients' conditions and diagnoses where this is not initially available, systems for dealing with payment direct from the patients, clear information about the services provided and the terms of treatment.

### Non-discrimination under the Directive

9.40. Patients from other EEA countries who wish to access treatment from NHS providers (including those contracted to the NHS in the independent sector) raises particular issues for providers in relation to non-discrimination. While there is no specific requirement on the provider to accept any patient, there are a number of factors that need to be considered.

9.41. The Directive does not require providers to accept visiting patients for planned healthcare if this would be to the detriment of ensuring sufficient access for their own patients with similar health needs. It also does not require providers to prioritise visitors to the detriment of other patients, for instance by increasing waiting times. However, acute trusts or other providers would need to be able to explain and evidence the lack of capacity, demonstrate that refusal is necessary and show they were not discriminating against nationals of other states on grounds of nationality if rejecting a request for treatment.

9.42. In principle, the strongest ground for refusing a visiting patient is a lack of service capacity. However, the provider would need to consider whether the patient could be offered the option of joining the waiting list, to be treated alongside domestic patients on the basis of clinical priority. The patient may also consider the option of approaching a different provider.

### The S2 route

9.43. The S2 (formerly E112) route is a separate arrangement<sup>17</sup> from the Directive for people from another EEA country or Switzerland who want to come to the UK expressly to seek treatment. These patients will need to obtain prior authorisation from their social security institution, which bears the cost, meaning that the patient should not be charged for that treatment.

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<sup>17</sup> under Articles 22(1)(c) and 55(1)(c) of Regulation (EEC) 1408/71 and Articles 20, 27(3) and 36 of Regulation (EEC) 883/2004.

- 9.44. A person who has obtained permission from their social security institution to seek treatment in the UK under EU Regulations will be issued with an S2. They must make advance arrangements with the treating provider for their treatment and be given the same clinical priority as NHS patients. This means that if there is an NHS waiting list, they are subject to it.
- 9.45. Patients referred under scheduled treatment arrangements will continue to be covered for all medically necessary treatment for any other conditions if they show a valid EHIC/PRC.
- 9.46. To avoid the complications that may occur if a patient authorised to seek NHS treatment in the UK is inadvertently treated privately, NHS hospitals and consultants are advised to establish when accepting such referrals whether the treatment should be at the cost of the patient's relevant foreign authority or at the patient's own cost, and if they wish to be a chargeable NHS or private patient.
- 9.47. Where an NHS hospital has agreed to accept a patient under these arrangements, but on arrival the patient cannot produce the appropriate form, only treatment under the 'all medically necessary treatment' definition should be provided without charge (assuming they can show their EHIC or PRC). The patient can pay in advance for the planned treatment and should be charged the tariff cost or equivalent (if no national tariff exists) for the treatment. The patient may be able to claim reimbursement for this cost from their state of residence. If the relevant form is subsequently received, the charge should be refunded. If the form has not been received by the time the patient is discharged from NHS hospital they should be told to take the matter up with their social security institution.
- 9.48. The number of referred patients from Malta who are treated free under these arrangements is governed by a strict quota and is monitored by the Department of Health. Arrangements exist by which NHS hospitals are notified in advance of patients authorised to come under these arrangements. The Maltese High Commission in London allocates quota numbers to patients referred to the UK. When the quota is exhausted, further patients may be referred to the UK by the health authorities of Malta, but these patients should be charged for their treatment.  
Reclaiming the costs of treating EEA/Swiss residents under the EHIC and S2 routes
- 9.49. In order for the UK to make a claim to the relevant EEA country or Switzerland for the cost of treating their residents, it is imperative that the data from a valid EHIC/PRC/S2 /or Maltese quota number is recorded and reported to the Overseas Healthcare Team at DWP. Without this data, the UK cannot make a claim for reimbursement and is in effect subsidising the healthcare costs of other countries.
- 9.50. All treatment carried out whenever a valid EHIC/PRC/S2 is presented, including 'exempt' services such as treatment in A&E, and including when the person with an EHIC might be exempt in another way or if they are ordinarily resident, should be reported using the OVT portal, which NHS trusts and foundation trusts can access at: [www.ovt.dh.nhs.uk/](http://www.ovt.dh.nhs.uk/)
- 9.51. The full cost of treatment should be recovered. To calculate the cost, relevant NHS bodies should use the latest national tariff guidance at: <https://www.england.nhs.uk/nhs-standard-contract><sup>18</sup> supplementing this with local tariffs calculated in accordance with the rules set out in the national tariff document where the treatment does not have a national tariff price.

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<sup>18</sup> This is the web link for the national tariff payment system for 2014/15. For guidance for subsequent years, search for 'NHS tariff' at [www.gov.uk/government/publications](http://www.gov.uk/government/publications)

9.52. Relevant NHS bodies should note that recording and reporting this data so that the UK can claim reimbursement from the appropriate country does not mean that relevant NHS bodies do not have to invoice the appropriate commissioner. If this commissioner is not invoiced, then the relevant NHS body will not be paid for treating the patient.

9.53. Full instructions on how to submit this data can be found in the Department of Health Finance Manual, which can be accessed via the internet at:  
<http://www.info.doh.gov.uk/doh/finman.nsf>

9.54. For advice on how to operate the web portal/submit data contact DWP Overseas Healthcare Team. Email: [OHT.Overseasvisitorsteam@DWP.gsi.gov.uk](mailto:OHT.Overseasvisitorsteam@DWP.gsi.gov.uk)

### **People resident in another EEA country for whom payment of healthcare costs remains the responsibility of the UK**

9.55. Under the EU Regulations, some people who are resident in other EEA member countries or Switzerland (for example frontier and posted workers, and pensioners) may have their healthcare costs paid for by the UK by virtue of the UK being the 'competent country' for them and therefore responsible for their healthcare costs. These persons should have a valid UK-issued S1 registered in their EEA country of residence or Switzerland (except some posted workers, who will have a UK A1 and UK EHIC). OVMs need to be aware that there will be times when visitors from the EEA or Switzerland fall within this category.

9.56. Except for family members of frontier workers (see paragraph below), people in this category are entitled to not be charged for planned and unplanned NHS treatment, except where charges would also apply to UK residents, for example prescription and dental charges. They will need to show evidence of their entitlement and may have to make arrangements before accessing care.

#### **Family members of frontier workers**

9.57. As set out above, there is one group of persons within this category who are not entitled to all NHS treatment on the same basis as people ordinarily resident in the UK. These are family members of 'frontier workers'. 'Frontier workers' are people who are resident in one EEA country but work in the UK, with a valid UK S1 registered in their country of residence. While 'frontier workers' are entitled to full NHS treatment, as explained in the paragraph above, their family members, also resident in the other EEA country with a UK S1, are only entitled, free of charge, to treatment which becomes medically necessary during a temporary visit to England. However, they will still need to pay any charges which also apply to residents in England, such as prescription and dental charges. They do not need to show an EHIC for this, but may be asked to show a copy of their S1, failing this, OVMs should contact DWP OHT (see para 9.54 for details) to verify the status of their S1.

#### **UK pensioners living in another EEA country**

9.58. In April 2015, there was a change in law which meant that all UK state pensioners who are living in the EEA or Switzerland and have registered an S1 form from the UK with the local authorities in their EEA country of residence are entitled to not be charged for NHS secondary healthcare, just like someone who is ordinarily resident in England. This rule also applies to any of their family members who also possess a UK-issued S1. However, they will need to pay any charges which also apply to UK residents, such as prescription and dental charges. Individuals who have registered a UK S1 in another EEA country should be asked to provide some evidence confirming this. If they present a UK-issued EHIC, their EHIC information should not be entered into the portal for reimbursement. Regulation 13 of the Charging Regulations concerns this category of patient.



## Obligations on OVMs to confirm S1 or A1 entitlement

- 9.59. To confirm entitlement to treatment, OVMs should, in the first instance, ask the patient to present a copy of their UK-issued EU healthcare form (S1 or A1). OVMs will need to check whether there is an 'end date' on the form as some S1s are time-limited and entitlement to free NHS treatment is directly linked with the S1 form's validity. If OVMs have any questions about an S1 form, they can contact the DWP Overseas Healthcare Team (details below) to make further enquiries about the form's registration status. If OVMs are unable to confirm the patient's status, and the patient is neither ordinarily resident here, nor exempt under another category under the Charging Regulations, then the patient may be liable for their healthcare costs. However, if the patient is able to present their valid form within a reasonable period of time, the Trust should consider reimbursing the patient for costs incurred.
- 9.60. OVMs can check whether a patient has a registered S1 form in another EEA country by contacting the Overseas Healthcare Team at [Overseasvisitorsteam@DWP.gsi.gov.uk](mailto:Overseasvisitorsteam@DWP.gsi.gov.uk)
- 9.61. Because there is no prior authorisation process (unlike with an S2) and the patient does not pay (unlike with the Directive) when returning to England with an S1 form, trusts can ask the patient to obtain a GP referral in order to establish entitlement under local commissioning rules, if it is unclear whether a patient would be entitled to the treatment they are seeking if they were living locally. However, if it is clear that the patient would be entitled to the treatment locally, a GP referral should not be used to question the medical assessment of a clinician abroad. EU rules on mutual recognition of professional qualifications means that a clinician's assessment abroad should be respected. An S2 form issued by the relevant institution can also be accepted instead of a copy of an S1 form.
- 9.62. On a procedural level, it is down to an individual trust how to accept patients, and processes may vary between trusts.

## When are S2s issued by the UK for persons resident in another EEA country or Switzerland

- 9.63. The UK (DWP Overseas Healthcare Team) is also responsible for issuing the S2 for pre-planned treatment in either the UK or another member state for the holders of a UK S1 form (formerly E106/E121/E109) when that person lives in:

Austria	Denmark	Hungary	Slovakia
Belgium	Estonia	Latvia	Slovenia
Bulgaria	France	Lithuania	
Croatia	Germany	Poland	
Czech Republic	Greece	Romania	

- 9.64. All remaining EEA countries/Switzerland will continue to issue the S2 to those living there who have registered S1s in that country.

## Patients' rights and information

- 9.65. If visitors from the EEA ask for information on accessing healthcare in the UK, they can be directed to the following website:  
<http://www.nhs.uk/nhsengland/Healthcareabroad/pages/Healthcareabroad.aspx>

9.66. Patients can also contact National Contact Points for issues related to the Directive. A list of National Contact Points for European member states can be accessed at the following website: [http://ec.europa.eu/health/cross\\_border\\_care/docs/cbhc\\_ncp\\_en.pdf](http://ec.europa.eu/health/cross_border_care/docs/cbhc_ncp_en.pdf)

## Other European issues

9.67. It should be noted that:

- a) for the purposes of the relevant EU Regulations:
  - France includes the overseas departments of Guadeloupe, Martinique, Guyane (French Guiana) and Réunion;
  - Spain includes the Balearic Islands, the Canary Islands, Ceuta and Melilla;
  - Portugal includes the Azores and Madeira.
- b) the territory of Denmark excludes the Faroe Islands and Greenland. However, a separate reciprocal healthcare agreement between the EU and Greenland allows Greenland nationals visiting EEA countries to receive immediately necessary treatment under state healthcare;
- c) Andorra, Monaco, San Marino and Vatican City are not part of the EEA;
- d) EU law is suspended in the north Cyprus. It only applies in the rest of Cyprus. Therefore, visitors from north Cyprus are not covered by the EU Regulations. Visitors who are ordinarily resident in north Cyprus and chargeable directly at the point of use for NHS services should be counted as ordinarily resident in the EEA and should therefore be charged on that basis (i.e. at 100% of tariff);
- e) the UK sovereign bases in Cyprus do not count as part of the UK in this context, nor as part of the EU;
- f) for the purposes of healthcare, relations between the UK and Gibraltar are governed by a bilateral healthcare agreement (Chapter 10). The EU Regulations do not apply;
- g) though not covered under the EU Regulations, Bosnia and Herzegovina, Kosovo, Macedonia, Montenegro and Serbia have reciprocal agreements with the UK (see Regulation 14 and Chapter 10).

## Questions and answers

Q: Can temporary visitors from the EEA/Switzerland who have a valid EHIC (or PRC) receive free dialysis?

A: Yes, those with valid EHICs are entitled to free dialysis; they do not need an S2 (formerly E112). This is subject to the patient making an advance booking and facilities being available at the time of treatment.

Q: Can temporary visitors from the EEA/Switzerland use an EHIC (or PRC) for maternity care?

A: Yes, those with valid EHICs (or PRCs) are covered for all maternity care, including antenatal and postnatal care, providing the reason for their visit was not specifically to give birth or receive maternity treatment, in which case they should have been referred here using an S2. However, for pragmatic reasons, a valid EHIC can be accepted instead of an S2 at the discretion of the relevant NHS body.

Q: Can temporary visitors from the EEA/Switzerland use an EHIC (or PRC) for a termination of pregnancy?

A: An EHIC (or PRC) can be used, as long as the termination of the pregnancy is deemed immediately necessary before the planned date of return of the patient to their home country. Women from an EEA country or Switzerland who come to the UK specifically to seek terminations will be liable for charges unless they have obtained an authorised S2 (formerly E112) from their own health institutions.

Q: A husband and wife are here from an EEA country. He needs treatment but does not have an EHIC with him. His wife does have her EHIC. Does he need to show his EHIC to get free treatment?

A: The spouse/civil partner and children under 18 of those with EHICs are exempt from charge under the Charging Regulations, but only in certain circumstances. If the family member is entitled to hold an EHIC from another EEA member country then the family member exemption does not apply. Therefore the husband would need either to present his EHIC (or PRC) or demonstrate that he is not entitled to an EHIC from the other EEA member country in order for the family member exemption in the Charging Regulations to apply.



# 10. How to deal with those under reciprocal healthcare agreements and other international obligations

## Reciprocal healthcare agreements (non-EEA) (Regulation 14)

10.1. The UK has reciprocal healthcare agreements with some non-EEA countries.

Overseas visitors who can present evidence that they are nationals, citizens or lawful residents (as appropriate) of one of these countries should be treated as exempt from charges in respect of treatment that the relevant agreement entitles them to.

*Evidence required:*

- *Proof that the person is a national/citizen/resident (as appropriate) of the country and that they are resident in that country, e.g. passport, residence permit, identity card, social security card, utility bill etc. For referrals for elective treatment (see below), confirmation from the relevant country/ DWP that the referral has been agreed*

10.2. Within the reciprocal agreements there are a number of variations in the level of free treatment afforded to visitors travelling to the UK. Generally, only immediate medical treatment is to be provided free of charge, to allow the overseas visitor to return home for other needs. Also, the agreements do not usually apply when the person has travelled to the UK for the purpose of obtaining healthcare. However, this is not always the case. See the table below for the level of free treatment by country, and other conditions that apply.

Country	Level of cover provided (see key)	Further information
Anguilla	1*	Applies to all residents of that country. Can also refer four patients to the UK for free NHS hospital treatment.
Australia	1*	Applies to all residents of that country.
Bosnia and Herzegovina	3	Applies to all insured persons of that country.
British Virgin Islands	1*	Applies to all residents of that country. Can also refer four patients to the UK for free NHS hospital treatment.
Falkland Islands	4	Applies to all residents of that country. Can refer an unlimited number of patients to the UK for free elective treatment.

Country	Level of cover provided (see key)	Further information
Gibraltar	3	Applies only to citizens resident in that country when that citizen is not expected to stay in the UK for more than 30 days. Can also refer an unlimited number of patients to the UK for free elective treatment (see 10.4).
Isle of Man	2	Applies to all residents of the Isle of Man for a period of stay in the UK that has not exceeded, nor is expected to exceed, three months.
Jersey <sup>19</sup>	2	Applies to all residents of Jersey for a period of stay in the UK that has not exceeded, nor is expected to exceed, three months.
Kosovo	3	Applies to all insured persons of that country
Macedonia	3	Applies to all insured persons of that country.
Montenegro	3	Applies to all insured persons of that country.
Montserrat	1*	Applies to all residents of that country. Can also refer four patients per year for free NHS hospital treatment.
New Zealand	2	Applies only to citizens resident in that country.
Serbia	3	Applies to all insured persons of that country.
St Helena	1*	Applies to all residents of that country. Does not include Ascension Island or Tristan da Cunha. Can also refer four patients per year for free NHS hospital treatment.
Turks and Caicos Islands	1*	Applies to all residents of that country. Can also refer four patients per year for free NHS hospital treatment.

Key:

1. Immediate medical treatment only.
2. Only treatment required promptly for a condition which arose after arrival into the UK or became (or but for treatment would have become) acutely exacerbated after such arrival. Services such as the routine monitoring of chronic/pre-existing conditions are not included and free treatment should be limited to that which is urgent in that it cannot wait until the patient can reasonably return home.
3. All treatment on the same basis as for a person insured in the other country, including services such as routine monitoring of pre-existing conditions, but not

<sup>19</sup> The UK has a reciprocal agreement with Jersey, but not with the other Channel Islands.

including circumstances where a person has travelled to the other country for the purpose of obtaining healthcare.

4. All treatment free on the same terms as for an eligible UK resident (an ordinary resident), including elective treatment.

For all levels of coverage, it will be for a doctor or dentist employed by the relevant NHS body to provide clinical input into whether required treatment meets a specific level of coverage.

\*For these countries, the agreement will also apply to those persons requiring treatment if they are a member of the crew, or a passenger, on any ship, vessel or aircraft travelling to, leaving from or diverted to the UK and the need for urgent treatment has arisen during the voyage or flight.

### Referrals for elective healthcare under the agreements

- 10.3. Depending on the terms of the particular country's reciprocal healthcare agreement, the exemption also applies to those who have been referred to the UK specifically for NHS treatment. Normally the referrals can be made only when the countries do not have adequate facilities to provide the treatment needed.
- 10.4. Referrals from Gibraltar are commissioned by Gibraltar itself. Trusts should not bill back the Clinical Commissioning Group for treatment provided to someone referred from Gibraltar under the terms of the reciprocal healthcare agreement.
- 10.5. The British Overseas Territories of Anguilla, the British Virgin Islands, Montserrat, St Helena and the Turks and Caicos Islands can refer up to four patients each per year. In respect of the Falkland Islands, there is no limit on the number of referrals that can be made. Referral arrangements are made by the relevant British Overseas Territory through the DWP Overseas Healthcare Team (see Chapter 9 for their contact details). Persons hoping to be referred should contact the relevant British Overseas Territory in the first instance.
- 10.6. For all people who are referred for NHS treatment as per paragraphs 10.3 to 10.4 above, advance arrangements for their acceptance should be made and the patients must be given the same priority as patients living in the UK.
- 10.7. A number of reciprocal healthcare agreements ended on 31 December 2015 and the agreement with Barbados ended on 30 September 2016. If the overseas visitor began an ongoing course of treatment which was exempt under the reciprocal agreement on or before 31 December 2015 or 30 September 2016 respectively, there should be no charge for the remainder of that course of treatment provided after the date of termination, under the easement clause.
- 10.8. However, it should be noted that a change to the easement clause now means that, from 21 August 2017, should any reciprocal healthcare agreements be terminated in the future or cease to apply in respect of an overseas visitor for some other reason, charges will apply to overseas visitors that cease to be covered by the agreement for the remaining part of a course of treatment that is already underway, as well as any new courses of treatment. The overseas visitor will remain exempt from charge if another exemption applies.

## The UK's obligations under the European Convention on Social and Medical Assistance 1954 and the European Social Charter 1961 (Regulation 24(a))

10.9. Nationals of countries that are contracting parties to the European Convention on Social and Medical Assistance or the European Social Charter are exempt from charges for treatment the need for which arises during the visit' here when they are lawfully present in the UK and without sufficient resources to pay. Other reciprocal arrangements have generally superseded these arrangements, although not in the case of Turkey. The regulation will apply when lawfully present nationals from Turkey are genuinely without the resources to pay a charge for their treatment. However, since visitors from Turkey are required to have sufficient funds available to finance their stay, as well as their onward or return journey, they are unlikely to be genuinely without resources to pay, at least by instalments, or other assets, so this exemption is unlikely to apply.

*Examples of evidence:*

- *Proof of nationality and lawful presence in the UK, e.g. passport.*
- *Evidence of inability to pay, e.g. they are destitute.*

## North Atlantic Treaty Organisation (NATO) (Regulation 21)

10.10. The eligibility of NATO personnel and attached civilians stationed in the UK is governed by the Agreement Regarding the Status of Forces of Parties to the North Atlantic Treaty. This regulation provides for free treatment to be given to a person, or the spouse/civil partner and/ or dependent children of a person, who is serving with the armed forces of a country which is part of NATO.<sup>20</sup> The only NATO country to have bases in the UK and maintain substantial numbers of service personnel here is the USA, but members of the armed forces of the other countries may spend time on duty in the UK.

10.11. NATO personnel and their exempt family members are expected to use their own or UK armed forces hospitals, but if the services they require cannot readily be provided by the medical services of their own or the UK armed forces (e.g. because NHS services are significantly more accessible to the patient) then NHS hospital services may be provided free of charge.

*Example of evidence:*

- *Will be in receipt of appropriate documentation confirming NATO status.*

## Questions and answers

Q: Is dialysis (either haemodialysis or peritoneal dialysis) included under the terms of the reciprocal agreements?

A: Temporary visitors from all non-EEA countries with which the UK has a reciprocal agreement should be provided with free dialysis, if clinicians consider this to be immediate medical treatment. In considering this, clinicians should assess if the dialysis can safely wait until the patient can return home, but this may be unlikely. This is subject to the patient making an advance booking and facilities being available at the time of treatment.

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<sup>20</sup> The NATO countries are Albania, Belgium, Bulgaria, Canada, Croatia, Czech Republic, Denmark, Estonia, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Lithuania, Luxembourg, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Turkey, the UK and the USA.

Q: Are maternity services included under the terms of the reciprocal agreements?

A: Women from non-EEA countries with which we have reciprocal healthcare agreements are eligible to receive immediately necessary medical treatment in connection with their pregnancy, if an unexpected emergency arises, or would arise without treatment, during their visit. This applies irrespective of whether the pregnancy was first confirmed in the UK or elsewhere.

Those from Bosnia and Herzegovina, Gibraltar, Kosovo, Macedonia, Montenegro and Serbia may also be entitled to routine maternity healthcare free of charge, as long as they did not travel to the UK specifically for that treatment. However, if they come to the UK or remain in the UK to obtain routine antenatal healthcare or deliver their baby then charges will apply, unless they are specifically referred to the UK under the agreement because of complications. Those from the Falkland Islands can receive all treatment free of charge, but referrals should still be pre-arranged with the DWP Overseas Healthcare Team.

# 11. Collaborative working and separation of duties: the role of staff in Cost Recovery

**This chapter explains how to operate the charging rules to optimum effect. For the time being the guidance only addresses NHS bodies - trusts and foundation trusts. More detailed guidance for non-NHS bodies providing NHS funded community and secondary care will be available shortly.**

- 11.1. NHS senior managers must set the correct tone within their organisation for the implementation of the charging rules. This is not only because relevant NHS bodies have a legal obligation to make and recover charges from chargeable overseas visitors for the services they receive, but also because it ensures that the services provided to overseas visitors are funded through the collection of charges rather than placing additional financial burden on the NHS and ensures that NHS funds remain solely for patients who are ordinarily resident. The recovery of charges from chargeable non-EEA overseas visitors also enables the collection of additional revenue, including a profit-making element following the introduction of commercial charging, that will support better health service delivery to all ordinarily resident patients.
- 11.2. Senior managers must ensure the compliance of their relevant NHS body with its statutory duties and that legislation, guidance and advice provided by the Department of Health, NHS Improvement or NHS England is followed. More information about the statutory duties of relevant NHS bodies in implementing the charging rules for overseas visitors can be found in Chapter 2.

## What a relevant NHS body needs to do

- 11.3. In order to enforce their legal responsibilities, all relevant NHS bodies (note that from 23 October 2017 the term will be 'relevant body' and will include any provider of NHS-funded secondary care, where no exemption applies) will need to have systems in place to support charging of overseas visitors, with staff who have the appropriate skills to:
  - identify, without discrimination, all patients who may be liable to charges. This will involve all staff inpatient administration, including A&E, outpatient clinics and wards. At least one person must be responsible for organising the training of these staff and the configuration of the Patient Administration System. Procedures must be in place to enable identification of chargeable patients out of normal hours (especially during weekends);
  - interview people to establish if they are, in fact, ordinarily resident or, if not, whether they are exempt from charges or liable for charges and record an overseas visitor's chargeable status on their Patient Record, via the Summary Care Record application. These in-depth interviews need to be handled sensitively and by staff who have been adequately trained to perform this task, including training on appropriate interview techniques and how to identify patients in a non-discriminatory manner (e.g. to avoid racial discrimination and harassment). The relevant NHS body must ensure that they have an adequate number of these staff to provide cover at all sites and that appropriate back-up services, for example interpreters, are available;

- make and recover charges from people who are not covered by an exemption category, providing them with a written statement of why charges apply, what the charge is estimated to be and how they can pay. Relevant NHS bodies are obliged to provide this statement under Regulation 19 of the Care Quality Commission (Registration) Regulations 2009 (SI 2009/3112). Where reasonably practicable, this statement should be given to the patient before treatment is provided. Where a person is in need of immediately necessary or urgent treatment it may not be possible or appropriate to provide them with this statement ahead of treatment. In such cases the statement should be given to the patient as soon as possible after treatment is provided.
- 11.4. It should be noted that, from 23 October 2017, providers of NHS-funded community and secondary care services will be obliged to recover in advance the estimated full cost of treatment from the person liable, unless doing so would prevent or delay the provision of immediately necessary or urgent treatment. In practice this will always apply where a clinician has assessed the patient's need as non-urgent. Whilst this has been recommended best practice for several years, it will become a legal requirement from that date. Therefore, those providers should prepare to ensure they can fulfil this obligation from 23 October 2017.
- 11.5. The Department of Health strongly recommends that each relevant NHS body has a designated person to oversee the implementation of the Charging Regulations. Tools to help staff assigned to this role are available on: [www.gov.uk/dh/nhscostrecovery](http://www.gov.uk/dh/nhscostrecovery) The role of OVMs
- 11.6. The OVM's role is to see that the Charging Regulations are properly implemented and applied to all affected patients concerned. This will mean that OVMs have the same responsibilities as those described above for relevant NHS bodies. OVMs must fully understand the Charging Regulations, be able to communicate information about the Regulations to other NHS staff and patients, and identify, make and recover charges from chargeable overseas visitors in accordance with the Regulations. They must be given the authority to ensure that the charging rules can be properly implemented in all departments.
- 11.7. Staff assigned to a cost recovery role must be of sufficient seniority and skill to be able to resolve complex and sensitive situations and to deal effectively with administrative staff, clinicians, senior trust managers, finance colleagues and members of the public, ensuring that all groups understand their responsibilities.
- 11.8. We advise that the OVM is best placed within the finance department, to give them access to the full process (identification through to cost recovery) and to ensure that the finance department can more easily keep track of its responsibilities. However, we also advise that OVMs be visible to patients and frontline staff rather than be situated in a back office away from patient-accessible areas.
- 11.9. OVMs should be ready to provide more formal briefing events for all members of staff – both administrative and clinical – who come into contact with patients, for example at staff induction courses. These training sessions need to be repeated at regular intervals to ensure that new and existing members of staff understand the work of the OVM and the role they themselves may have to play.

### Developing and maintaining good relationships

- 11.10. Regular contact with local community relations organisations is valuable. These organisations can be of significant assistance in communicating information about overseas visitors' liability for charges to members of their community, in particular to members of the overseas visitor community who may have language barriers to obtaining information, or who are vulnerable and receiving support through those



voluntary sector organisations.

- 11.11. The Department of Health also recommends building strong relationships between relevant NHS bodies and both their commissioners and referring GP surgeries. Whilst GPs are not able to make a decision on whether a patient is or is not subject to the Charging Regulations, they are sometimes willing and able to indicate on a referral letter where they know a patient is only in the country for a short time.
- 11.12. The success of the charging rules depends on all NHS trust staff being aware and supportive of the role of the OVM and his/her team.

### Identifying patients who may be liable for charges

- 11.13. Administrative staff have an essential role to play in identifying people who may be liable for Trust charges. The vast majority of people will not be liable for charges – nonetheless, **the same questions must be asked of every single patient, in every single department**, whose chargeable status is not known, in order to identify potentially chargeable patients. We call these the ‘baseline questions’.
- 11.14. The Department of Health suggests that administrative staff use the following baseline questions. Please note that you do not have to use the exact wording suggested below: if you are more comfortable covering this ground in a different way, please continue to do so, as long as the meaning of the questions remains the same and the same questions are asked of all people whose chargeable status is not known. We will keep these questions under review, including what documentation is appropriate, as learning from pilot work becomes clearer
- 11.15. The baseline questions are:

"Where have you lived in the last 6 months?"

- If the UK only, no further action
- If outside the UK, or UK plus other country, then ask:
  - "Do you have a EHIC or other document to show that you're entitled to free NHS care?"
- If a non-UK issued EHIC is provided, take details from the card

Regardless of the answer or documents provided in answer to the second question,

- inform the OVM that the patient may be an overseas visitor
- Inform the patient they may be interviewed to check entitlement

- 11.16. Administrative staff must avoid discrimination when asking these questions. More information is provided at paragraph 11.17 onwards.

- 11.17. These questions need to be asked every time a patient begins a new course of treatment at the NHS hospital and is entered onto the relevant NHS body's records for inpatient or outpatient care, either on paper or computer, and by either administration or ward staff, in order to comply with the Charging Regulations. As set out above, in cases where there is doubt about whether the patient is ordinarily resident, they should be referred for interview by the OVM. The questioner should inform the patient that he or she will be further interviewed.

- 11.18. This does mean that booking-in staff, ward clerks etc. will need to be prepared to ask for basic supporting evidence such as documents that demonstrate both lawful ability to reside in the UK and the fact of doing so. Being unable to provide evidence does not mean that someone should be refused treatment, only that they should be

referred to the OVM for further investigation.

- 11.19. Where an OVM determines that a patient is subject to the Charging Regulations, or conversely receives evidence to indicate that the patient is no longer chargeable, they should update the patient's record via the SCRa. The 'flagging' of patients' records with their chargeable status is, from 21 August 2017, a statutory obligation on NHS trusts and foundation trusts.
- 11.20. The Department of Health has published a toolbox at: [www.gov.uk/dh/nhscostrecovery](http://www.gov.uk/dh/nhscostrecovery) to help trusts with their responsibilities here, including standardised best practice pre-attendance forms for all patients to fill in when being admitted. This form will explain that people should be prepared to provide certain pieces of evidence and should have a declaration for the person to sign, in which it is clear why the questions are being asked and what use may be made of the data. Checking will then be a quick and simple matter that need not add more than a few seconds to the booking-in process. Relevant NHS bodies should place this form on their intranet to be used by admissions staff, and it should be made available in multiple languages as appropriate to the local demographic of the organisation.
- 11.21. In some departments that cater for the very elderly or those with mental health problems, or when direct admission from critical healthcare is needed, the baseline questioning may be inappropriate or unworkable. In these cases admissions staff should still be aware of the possibility of people being liable for charges, and should notify the OVM of any patient whose chargeable status is unknown based on any non-discriminatory information they have (i.e. not purely on the basis of appearance, language, accent etc.).
- 11.22. Where it is established that a person may not be ordinarily resident here:
- the person should be told immediately, where possible and appropriate, that they will need to be interviewed to establish their eligibility for free NHS treatment;
  - the person who identifies that person as potentially liable for charges should contact the OVM as soon as possible and arrange for an interview to take place. Wherever possible, that interview should take place before treatment begins but if, in the opinion of medical staff, the treatment is immediately necessary or needed urgently it should always go ahead without delay;
  - where it is not possible for a person to be referred for immediate interview by the OVM, a note should be placed inside the medical records to alert other members of staff to the person's potential liability for charges. This does not mean that treatment should be withheld or altered in any way. A suggested form of words is as follows:
- This patient may not be ordinarily resident in the United Kingdom and has been referred for further interview by the Overseas Visitors Team. The patient may be liable to pay for any treatment received. The patient has been informed.*
- 11.23. In undertaking this role, administrative staff should also fully understand the financial implications for the trust, and why the procedures to determine chargeable status are important.
- 11.24. The following are details of some websites which may assist OVMs in carrying out their duties in relation to the Equalities Act 2010. NB: this is a small sample and is not intended to serve as a complete list, see NHS BME Network [www.nhsbmenetwork.org.uk/about/priorities/](http://www.nhsbmenetwork.org.uk/about/priorities/) and Equality and diversity in the NHS [www.nhs.uk/NHSEngland/thenhs/equality-and-diversity/Pages/equality-and-diversity-in-theNHS.aspx](http://www.nhs.uk/NHSEngland/thenhs/equality-and-diversity/Pages/equality-and-diversity-in-theNHS.aspx)

## Avoiding discrimination in establishing if charges apply

- 11.25. In any dealings with patients, including overseas visitors, administrative staff must comply with their legal duties in respect of avoiding discrimination. This includes compliance with the Human Rights Act 1998 and the Equality Act 2010. Further information about the obligations of relevant NHS bodies under these pieces of legislation is set out in Chapter 2. In particular, relevant NHS bodies (and staff) must not discriminate against persons based on their having any of the protected characteristics (age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, nationality, religion and belief, sex, sexual orientation) in comparison to persons without those characteristics. They must also, when exercising their functions, have due regard to the need to:
- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
  - advance equality of opportunity between people who share a protected characteristic and those who do not;
  - foster good relations between people who share a protected characteristic and those who do not.
- 11.26. It is therefore important that no person is discriminated against in the application of the Charging Regulations when establishing entitlement to free treatment. Ordinary residence or exemption from charges cannot be judged from a patient's external appearance, or name, accent or language. It is not discriminatory to ask someone if they are ordinarily resident in the UK as long as all patients are asked the same baseline questions. This is regardless of any external factor or characteristic such as appearance, accent, race, first language or name.
- 11.27. Relevant NHS bodies need to ensure that all staff involved with the identification and interviewing of potentially chargeable people should be properly advised of their role and provided with adequate training on how to exercise the general equality duty and how to avoid discrimination.

**Relevant NHS bodies, ideally through an OVM, must ensure that all staff involved with the identification and interviewing of potentially chargeable patients should be properly advised of their role and provided with adequate training on how to exercise the general equality duty. E-learning is available via the Department of Health.**

## What about A&E?

- 11.28. Whenever possible, A&E staff must ask all patients whose chargeable status is not known the baseline questions at the most appropriate point of 'booking in'. A&E is a vital point at which to flag up a potentially chargeable overseas visitor as it can be the first point of contact many people have with the relevant NHS body. A&E treatment is free to all until the patient is admitted as an inpatient or provided with an outpatient appointment. However, for visitors from the EEA who have an EHIC card, charges can be billed to the respective member state for all A&E treatment. Questions to establish chargeable status should however be asked when appropriate to the patient's situation: if the patient has been deemed by a triage clinician to be able to wait before receiving care, there may be time for further administrative or demographic information to be taken. However, if for example a patient arrives by ambulance and is transferred directly to 'majors' the time to establish a patient's chargeable status is likely to be later.

11.29. It is also important that visitors from the EEA are identified and asked to present their EHIC or Provisional Replacement Certificate (PRC). Even when the treatment provided is not directly chargeable to patients (e.g. A&E services), the UK is still able to recover the cost of such treatment provided to persons insured by another EEA member state from the relevant member state. EHIC or PRC information should be collected by A&E departments and reported through the Overseas Healthcare Team web portal. Information on EEA visitors and the reporting process can be found in Chapter 9.

**OVMs should request a daily printout of those patients who have been admitted from A&E who answer positively to the baseline questions.**

### Use of the Summary Care Record application to establish if charges apply

11.30. Chapter 5 discusses how NHS staff can see a green banner on a patient's record if a patient is covered by health surcharge arrangements and is therefore entitled to free treatment, or a red banner if their visa has ended or been curtailed so that further investigations by the overseas team on their chargeable status will be necessary.

11.31. OVMs who have completed the relevant cost recovery training, are entitled to apply for RBAC0266, which will enable them to edit a patient's chargeable status. Whilst a 'Green in date' Home Office status, where present, will always display as such, an OVM can capture information pertaining to chargeable status, and update the chargeable status for a patient where the patient does not have this information recorded against their NHS record. For example, the OVM could capture EHIC information, and indicate that the patient is within Category C "Charge exempt (EHIC/PRC/S2)" (see Chapter 13), which will generate an amber banner for that patient on the OVM view to indicate that the evidence needs to be checked to ensure exemption remains valid for the course of treatment.

11.32. This also means that when an OVM in one hospital has determined the chargeable status of a patient, other NHS bodies may be able to benefit from the investigations that have been done already. This reduces duplication of effort in the system. OVMs should satisfy themselves that the information recorded is accurate and up to date.

### Interviewing patients who may be liable to charges

11.33. Where it is not possible to determine chargeable status from a person's record, it is likely that the patient will need to be interviewed to establish if charges apply.

11.34. A relevant NHS body should ensure that all staff involved with the identification and interviewing of a person who may have to pay a charge for treatment are properly advised of their role and provided with adequate training. Staff involved in interviewing people should have a thorough understanding of the Charging Regulations and guidance, together with training and techniques for handling difficult situations. Staff can sometimes be confronted with distressed, angry or abusive patients and/or relatives. They should be fully trained on the relevant NHS body's policy for dealing with violence or potentially violent situations. As already mentioned, they should also be trained on how to exercise their organisation's general equality duty and to avoid discrimination when identifying chargeable people.

## Timeliness of interview

- 11.35. It is important that a person is aware as soon as possible that there may be a charge for treatment. While it may not always be practicable for interviews to happen immediately, OVMs should ensure that a member of their team sees potentially liable patients as soon as they possibly can. Failure to do so, resulting in a bill being presented to a person who was not aware that they were liable, could result in accusations of maladministration, which the relevant NHS body would then have to defend. However, the fact that a person was not informed that charges would apply does not alter the fact that, under the Charging Regulations, they are still liable for that charge.

## The main interview

- 11.36. This should be undertaken discreetly and sensitively in private and, wherever possible, before treatment has started. The interviewer should begin by explaining that a person not ordinarily resident in the UK can, in some circumstances, be liable for the cost of their treatment. The interviewer should explain that the interview is taking place because the patient indicated during the process of administration (or because admissions staff have indicated) that he or she may not normally live in the UK, or has been unable to show that he or she has the right to live here. Some people will be clear that they are not normally resident here, but others may dispute the assessment. The first issue to explore during the interview, therefore, is whether the person may be ordinarily resident. A person cannot be charged if they are ordinarily resident in the UK. Chapter 3 discusses ordinary residence in detail.
- 11.37. If, after questioning, the interviewer decides that the person is not ordinarily resident here, then that person is an overseas visitor for the purpose of the Charging Regulations. The next stage of the interview therefore needs to establish if the person is exempt from charges by virtue of any of the exemptions listed in the Charging Regulations, described in Chapter 1.

## Overseas visitors claiming exemption – supporting documentary evidence

- 11.38. Where a person claims to be covered by any of the exemptions, or indeed claims to be ordinarily resident, the relevant NHS body is required, by provision of the Charging Regulations, to make “such enquiries as it is satisfied are reasonable in all the circumstances” to confirm that is the case. It is for the person to satisfy the relevant NHS body of the validity of their claim to free treatment, and the relevant NHS body is entitled to ask for supporting documentary evidence, as long as it does not behave unreasonably. Some trusts routinely ask for two forms of ID (one to prove identity, the other to prove UK residence) from all patients whose residence status is unknown that demonstrates lawful, settled residence in the UK, which is best practice when booking a patient in for planned care.
- 11.39. Where the person cannot support their claim, the relevant NHS body may decide to charge for treatment. However, in making this decision it should take account of the individual circumstances and judge each case on its own merits. For example, in some cases it will be easier for the person to provide evidence than in others. Also, just because one of the exemption categories is found not to apply does not mean that others will not apply. Each should be considered. If charged, the person can claim reimbursement at a later date providing that sufficient evidence can be produced to show that he or she was entitled to free treatment at the time it was given.



- 11.40. The onus is on the individual patient within this guidance to provide whatever evidence he or she thinks is appropriate to support their claim. Examples of types of acceptable evidence are listed with each exemption from charge category in earlier Chapters. These examples are only a guide and should not be taken as comprehensive lists. People may provide other evidence that is equally valid, and interviewers should be prepared to be flexible. Certainly, it would not be reasonable to reject evidence out of hand simply because it is not listed in this guidance.
- 11.41. In general, people will be able to provide satisfactory documentary evidence to support their claim. Where, however, the person does not have the evidence to hand, an interviewer may be asked to either accept confirmation from a reputable third party or, in some cases, accept the word of the person without supporting evidence.
- 11.42. What level of evidence is acceptable is entirely a matter for the relevant NHS body in the light of the individual person's circumstances. Providing the relevant NHS body can demonstrate, if need be, that it has acted reasonably in all cases, it is unlikely to encounter criticism.

### **Duty to record information on the summary care record application**

- 11.43. From 21 August 2017, there is a legal obligation on NHS trusts and foundation trusts to record "information against an overseas visitor's 'consistent identifier'. The consistent identifier is, in this context, a patient's NHS record which is identified using the patient's NHS number. NHS trusts and foundation trusts must record where they have determined that a patient is subject to the Charging Regulations the date of that decision and whether an exemption from charge applies. In practice, this will include marking a patient's record with the correct 'banner' and ensuring that the decision to charge or exempt from charge is noted for audit purposes. Where charging information already exists on a patient's record, it will be for each NHS foundation trust or trust to determine if they agree or if they wish to assure themselves that the information held on the patient is still correct.

### **The role of clinicians**

- 11.44. The success of the charging rules depends on all NHS staff, including clinicians, being aware and supportive of the role of the OVM.
- 11.45. It is the clinician's role to provide appropriate healthcare for their patients and to make decisions on their treatment based on their clinical needs. As part of their normal practice, for ordinarily resident people and chargeable overseas visitors alike, clinicians have an obligation to consider the costs associated with different treatment options and to balance these against the potential for a successful outcome. It is right that clinicians are aware of the cost implications of providing non-urgent treatment to chargeable overseas visitors who cannot or will not pay when that treatment could wait until they return home.
- 11.46. Clinicians are not expected to make judgements regarding the eligibility of patients for free NHS hospital treatment (with the exception of confirming when a patient is receiving particular treatment that is exempt from charges), but if it is the clinician who first becomes aware that a person may not be ordinarily resident in the UK, they should notify the OVM and can, if appropriate, inform the patient that charges might apply. Clinicians and other staff should not indicate to patients that treatment will be free unless and until this is established, as a charge may have to be levied if the OVM subsequently assesses the patient as chargeable.
- 11.47. Ultimately, it is always a clinician's decision on what treatment is needed. Whether the relevant NHS body then withholds or limits that treatment will depend on information received from OVMs on when the patient can return home (so that the

clinician can decide if the treatment is urgent or non-urgent) and on the patient's intentions on paying (so that non-urgent treatment does not commence without prior payment).

- 11.48. Clinicians have four key responsibilities under the Charging Regulations:
- **To take the final decision as to whether treatment is immediately necessary, urgent or non-urgent.** More information on when treatment is immediately necessary, urgent or non-urgent can be found in Chapter 8.
  - **To confirm that a patient is receiving exempt services.** For example, confirmation that a patient is undergoing diagnosis and/or treatment for a condition affecting public health and listed in Schedule 1 to the Charging Regulations or undergoing diagnosis or receiving treatment for a sexually transmitted infection. Information on services that are exempt from charges is in Chapter 4.
  - **To confirm that a patient is a victim of specified types of violence** (torture, female genital mutilation, sexual or domestic violence). It is not expected that the clinician will be able to provide confirmation in all cases, in particular in respect of victims of torture, domestic or sexual violence where the cause of physical injuries and symptoms may not be immediately apparent. The Department of Health strongly recommends that clinicians are advised of this important role and its implications. Further information on exemption from charges for victims of specified types of violence can be found in Chapter 7.
  - **To confirm the patient is fit to travel to return home for further treatment.**

**OVMs must ensure that clinicians are aware of the important role these decisions play in the implementation of the charging rules and ensure effective management and prioritisation of NHS resources.**

### The role of finance staff

- 11.49. Finance staff need to be aware of their role in implementing the charging rules for overseas visitors. In particular, finance staff must understand the distinction between chargeable overseas visitors and private patients. Chargeable overseas visitors are chargeable for NHS services. They should not be confused with private patients, and the cost of any services they are provided with will be different from the rates charged to private patients. See Chapter 13 on the calculation of charges for chargeable overseas visitors. The treatment of chargeable overseas visitors is subject to the same clinical priority as other NHS patients. The beds they occupy are not pay beds and consultants cannot charge them for their services.
- 11.50. It is important that overseas visitors who are liable to charges are identified as early as possible in their dealings with the relevant NHS body in order to reduce the incidence of failure to pay, and to protect NHS resources. In the context of charging overseas visitors, the point at which to charge can be considered in terms of the urgency of the treatment needed. See Chapter 4 for more details.
- 11.51. Finance departments need to ensure that they are able to issue invoices promptly, perhaps at very short notice, in order to ensure that the invoice can be presented, wherever possible, before the patient leaves the relevant NHS body. Some relevant NHS bodies have had success with the installation of a portable credit card machine, to take to the patient before they are discharged.



## The role of GPs and primary care

- 11.52. A patient does not need to be ordinarily resident in the UK to be eligible for NHS primary medical care. Therefore, anybody in England, including overseas visitors, may fully register as an NHS patient or as a temporary resident if they are to be in an area for between 24 hours and three months, and consult with a GP without charge. This applies even if they may be chargeable for NHS secondary care services.
- 11.53. No registration application can be refused on the grounds of race, gender, class, age, religion, sexual orientation, appearance, diversity or medical condition. In reality, this means that the practice's discretion to refuse a patient is limited. There is no minimum period that a person needs to have been in the UK before a GP can register them, although practices may wish to consider the length of time the patient anticipates spending in the practice area when deciding whether to register the patient as a full or temporary patient.
- 11.54. Furthermore, GPs have a duty to provide free of charge treatment which they consider to be immediately necessary or an emergency, regardless of whether that person is an overseas visitor or registered with that practice. For further information on patient registration, please refer to Patient Registration: Standard Operating Principles for Primary Medical Care (General Practice) (2015) published by NHS England at: <https://www.england.nhs.uk/?s=Standard+Operating+Principles+for+Primary+Medical+Care>

**Being registered with a GP, or having an NHS number, does not give a person automatic entitlement to access free NHS hospital treatment. OVMs should ensure that local GPs understand this so that they do not unintentionally misinform their patients regarding hospital charges and so that where possible they identify in the referral letter any patient that may be an overseas visitor or is an EHIC holder.**

- 11.55. OVMs should consider establishing formal contacts with local GPs to aid this process, which can be used by them as a useful tool in identifying potential chargeable overseas visitors who have to pay for treatment. GP surgeries could also be encouraged to display posters regarding entitlement to NHS hospital treatment.
- 11.56. However, GPs should not be discouraged from referring their patients to the relevant NHS body. It is the relevant NHS body's duty, not the GP's, to establish entitlement for free NHS hospital treatment. Furthermore, neither relevant NHS bodies nor anyone acting on their behalf should imply that a particular patient should not be registered with a GP practice as that is exclusively a matter for that GP.
- 11.57. Changes to the GP contract have been agreed for 2017-18 that help to identify patients with a non-UK issued EHIC or S1 form or who may be subject to the Charging Regulations. From a date in 2017 (yet to be decided), practices will be required to provide all new patients with a revised GMS1 form (used to register patients permanently with a GP practice), which includes supplementary questions to determine a patient's eligibility to free hospital healthcare. For those patients who self-declare that they hold either a non-UK issued EHIC or a S1 form, the practice will be required to manually record that the patient holds either of these forms in the patient's medical record and then send the form and supplementary questions to NHS Digital (for non-UK issued EHICs) or the Overseas Healthcare Team (for S1 forms) via email or post. More information will be provided to affected parties in due course.

## Other issues within the charging rules

### Referrals by one NHS body to another

- 11.58. It is the duty of the relevant NHS body providing treatment to establish whether that treatment will be free to the person and to make and recover charges where that person is liable. This is equally the case where a person is referred from one relevant NHS body to another. The relevant NHS body receiving the person should assure itself as to the eligibility of the patient and make and recover charges as appropriate. The referring body should pass on the necessary information it has obtained regarding a patient's chargeable status, so as to minimise duplication of administration.
- 11.59. A relevant NHS body should not refuse to accept and treat a person on the grounds that they are currently a chargeable overseas visitor at another relevant NHS body and that they have not paid for their treatment. If clinicians refer a person to a relevant body then that body should treat the patient and apply the charging rules in the usual manner. If the treatment the patient needs at the second body is considered by its clinicians to be non-urgent, then it can be withheld until payment is received.

### Other statutory NHS charges

- 11.60. An overseas visitor exempt from charges under the Charging Regulations is normally liable for other statutory NHS charges, such as those for prescriptions, on the same basis as someone ordinarily resident in the UK. However, some charge-exempt patients will also be exempt from statutory prescription charges, for example asylum seekers, and will be issued with an HC2 certificate for full help with health costs. However, having an HC2 does not in itself mean the patient is exempt from charges under the Charging Regulations. Information on other statutory charges can be found at: <http://www.nhs.uk/NHSEngland/Healthcosts/Pages/help-with-health-costs.aspx>

### Fraud – NHS Protect

- 11.61. NHS Protect has national responsibility to lead work on protecting NHS staff and resources from crime. It has responsibility for tackling fraud, bribery, corruption, criminal damage, theft and other unlawful actions such as market-fixing.
- 11.62. When there is a suspicion that:
- an overseas visitor is attempting to access, or has accessed, free NHS treatment by fraud or deception; or
  - an NHS employee is attempting by fraud and deception to facilitate a chargeable patient receiving NHS care without identification or correct charge (or has already done so),

this should be reported to the relevant NHS body's Local Counter Fraud Specialist (LCFS), the NHS Fraud and Corruption Reporting Line on 0800 028 40 60 or online at <http://www.nhsbsa.nhs.uk/fraud>. The LCFS and/or NHS Protect will undertake an investigation and seek to apply criminal and civil sanctions, where appropriate.

### Patient confidentiality and data sharing

- 11.63. Relevant NHS bodies have legal obligations under the Data Protection Act 1998 (DPA) in relation to the sharing and storing of a patient's data. The sharing of data in the two main examples discussed in the next chapter (paragraphs 12.2-12.11) has been found by the High Court to be compliant with the DPA. The principles of patient confidentiality are also very important to the NHS and are the basis of the doctor/patient relationship. However, non-clinical data about a patient is not confidential information, so can be shared by NHS staff without the patient's consent for the purposes of the two main examples.

11.64. There may be circumstances other than when fulfilling their statutory function of making and recovering charges where relevant NHS bodies feel they should share data – which might include confidential data – about a patient without their consent. For instance, an NHS hospital may become aware that a patient may be here without proper authorisation and may consider informing the Home Office of this, or the Home Office may request details of a patient’s medical condition to assess if they have any particular requirements whilst the Home Office are investigating them in their care. More information on working with the Home Office is available in Chapter 12. A decision would need to be taken in the full light of the patient’s circumstances before data is shared without a patient’s consent. Generally, the NHS should not share patient data with third party agencies without the patient’s consent except where:

- they are required to do so by law (e.g. where a court order has been made);
- they have special permission for health or research purposes; or
- there is an overriding public interest to do so (e.g. where the police are investigating a serious crime).

11.65. It is important that each case should be judged on its own merits. Relevant NHS bodies are encouraged to seek legal advice as to whether the sharing of that information is lawful and each case should be discussed with the relevant NHS body’s Caldicott Guardian before a decision is taken.

11.66. In the context of this document, trusts are allowed to share non-clinical data with third parties without the patient’s consent when it is to determine if they are chargeable and to report chargeable non-EEA patients with a debt of £500 or more (see Chapter 12).

### Complaints and appeals

11.67. If a patient considers that they have been charged incorrectly, they should collaborate with the OVM to discuss on what basis they have been found to be chargeable and whether the provision of further documentary evidence is required. Where there continues to be a disagreement about how the Charging Regulations have been applied to a particular patient, the patient may want to seek the services of the relevant NHS body’s Patient Advice and Liaison Service (PALS).

11.68. Where an NHS patient is unhappy with the healthcare they have received, it is right that they, or someone on their behalf and with their consent, can use the NHS complaints procedure. OVMs need to ensure that they and patients charged for NHS services are aware of the complaints procedure and that there are effective operational links with the organisation’s complaints manager that reflect the extant guidance on managing complaints.

## 12. Working with the Home Office

**This chapter advises on when it is appropriate for NHS staff to seek information from or provide information to, the Home Office. It should be read in conjunction with the Patient confidentiality and data sharing section in Chapter 11.**

**More detailed guidance for non-NHS bodies providing NHS funded community and secondary care will be available shortly.**

### Using the Home Office for advice

- 12.1. There may be occasions where patients produce entry clearance documents that are not familiar to Overseas Visitor Managers (OVMs). Useful information can be found on the [UK Immigration and Visas pages of GOV.UK](#).

### Sharing data to determine a patient's immigration status

- 12.2. When other avenues of establishing entitlement have been exhausted, it may be necessary to establish the immigration status of a person. This might include (but is not limited to) establishing whether a failed asylum seeker has exhausted all their appeal processes and whether or not they are receiving support that would qualify them for an exemption, or cases where an NHS hospital comes across a person who appears to be in the country without the proper authority. Enquiries about a patient's immigration status should be sent securely via email to the Home Office's Evidence and Enquiry (EE) Unit. Evidence and Enquiry should respond to your request within five working days.
- 12.3. There is also an enhanced checking and advice service which the Home Office offers. This enables OVMs to get real time access on a patient's immigration status which can be provided over the telephone. Further information on this can be obtained by emailing [IEChecking&AdviceService@homeoffice.gsi.gov.uk](mailto:IEChecking&AdviceService@homeoffice.gsi.gov.uk) or by speaking to your Local Partnership Manager. Please note that the Home Office cannot advise on how this information affects the patient's liability for NHS charges.
- 12.4. The NHS is not required to obtain consent from a patient before sharing non-clinical data with the Home Office for the purposes of determining the patient's immigration status. However, the NHS should notify the patient that their data is being shared, and how this data may or will be used. You are not required to keep a signed record of the patient's consent for your records, although you are encouraged to provide the patient with the information leaflet known as "Information for patients: why your data has been shared with the Home Office", which is part of the OVM toolbox. It is also best practice to keep a note recording that this has been done. For further information on patient confidentiality, see Chapter 11. It still remains the case that under no circumstances should any clinical data be divulged when seeking immigration status information from the Home Office.
- 12.5. NHS staff using this service must ensure that the data they send outside of the NHS to government departments and agencies is via a secure route. For email, this means being sent from an email account which ends nhs.net as these have inbuilt encryption technology. The Home Office will not accept emails which do not come from these accounts, nor will they accept emails from unrecognised persons or from non-relevant NHS body staff. It is therefore important that you inform the Department of Health Overseas Visitors Policy Team of any changes to personnel, so that the Home Office can be kept updated of their nhs.net email accounts. You can send this information to the Visitor & Migrant NHS Cost Recovery Programme via email: [nhscostrecovery@dh.gsi.gov.uk](mailto:nhscostrecovery@dh.gsi.gov.uk)

- 12.6. An EE pro forma, developed by the Home Office and tested by OVMs, is available in the OVM toolbox available at: [www.gov.uk/dh/nhscostrrecovery](http://www.gov.uk/dh/nhscostrrecovery).
- 12.7. The EE pro forma has been designed to be used by all government departments and agencies – including NHS providers – who require information on an individual's immigration status. By having a single form, the EE Unit is now able to process information requests much quicker than previously – now within five working days. Should the information not be received after five days, please send another email marked 'second request', which will be dealt with as a priority.
- 12.8. To establish a patient's immigration status, you should send the completed EE form via secure email to the Home Office's EE Unit: [evidenceand enquiryunit@homeoffice.gsi.gov.uk](mailto:evidenceand enquiryunit@homeoffice.gsi.gov.uk)
- 12.9. Once an immigration status is established, for any follow up action or more detailed enquiries you should contact the Home Office Interventions and Sanctions Unit: [I&SDReferrals@homeoffice.gsi.gov.uk](mailto:I&SDReferrals@homeoffice.gsi.gov.uk)
- 12.10. The EE Unit now manages all initial status check enquiries. You should be aware that in some cases the data you share could be used to update Home Office records and, if applicable, may be used for the enforcement of immigration control. Before sharing any data other than the non-clinical data already provided to the Home Office, you should ensure that your trust seeks its own legal advice. You do not require a patient's express permission to share their non-clinical data with the Home Office for the purpose of establishing if they are chargeable. However, it remains best practice to inform the patient that you have done so and why, and to keep a record of having done so.

### Sharing data on those with debts to the NHS

- 12.11. NHS bodies (or debt collection agencies working on their behalf) can share non-clinical data with the Home Office, via the Department of Health, on chargeable non-EEA patients, providing they meet set criteria, with a view to better collect debts owed. The Home Office can then use that data to deny any future immigration application to enter or remain in the UK that the person with the debt might make. Patients do not have to provide their consent to this data being shared but NHS bodies should ensure that patients are aware of the potential immigration consequences of not paying a debt for which they are liable. More specific guidance on sharing data with the Home Office for this purpose is provided in the OVM toolbox. NHS bodies must ensure that they pay due regard to the most recent version of the guidance when sharing patient data.

# 13. Financial and miscellaneous matters

## Introduction

13.1. The Secretary of State for Health has since April 2015 exercised the power under section 175(4) of the National Health Service Act 2006 to calculate charges for overseas visitors on a commercial basis, which may include a reasonable profit element. Commercial charging only applies to overseas visitors who ordinarily reside outside the EEA or Switzerland. Charges for overseas visitors who ordinarily reside within EEA states must not exceed the cost of providing that service to an ordinarily resident patient.

13.2. Several categories of charging rules operate in parallel and relevant NHS bodies and their commissioners may require additional support to embed these. This chapter has been designed to help relevant NHS bodies understand which charging categories should be applied to which cohort of chargeable patient. Towards the end of the chapter, cross-cutting topics such as Value-Added Tax (VAT), translation and interpretation costs and calculating the length of stay are covered.

## Determining the correct charging category

13.3. The charging categories<sup>21</sup> and the involvement of commissioners in each case will depend on the patient's residency status. It will be necessary to interview the patient to determine whether they are ordinarily resident in the EEA or not. Where another person is liable for the charges accrued by an overseas visitor (e.g. the owner of a ship on which an overseas visitor works or an air crew member's employer) then charges must still be calculated on the basis of the overseas visitor patient's residency.

13.4. Relevant NHS bodies should refer to other sections of this guidance when determining a patient's residency. This chapter outlines the six charging categories for the following types of patient:

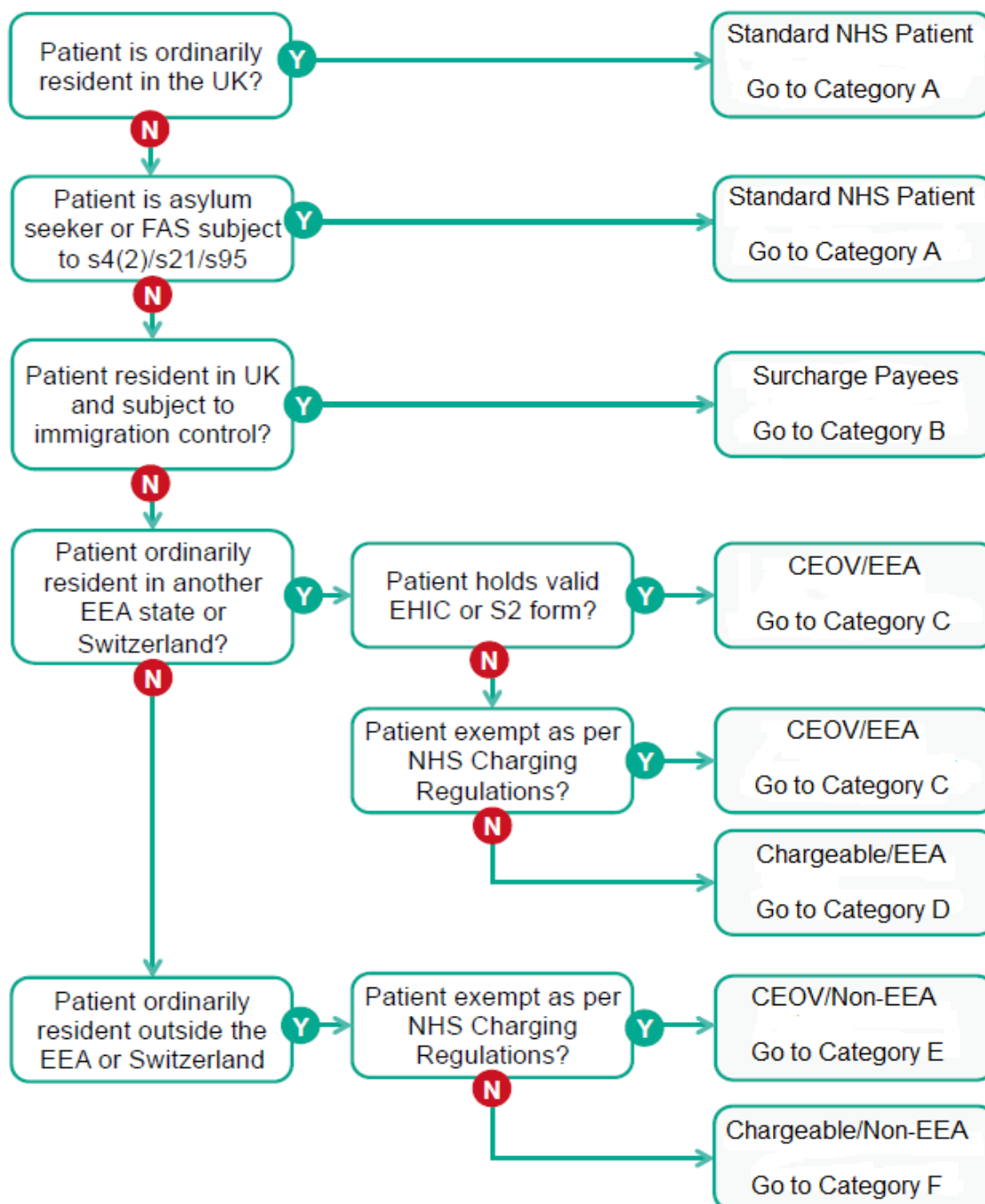
- patient ordinarily resident in the UK (category A);
- patient an asylum seeker or failed asylum seeker supported by certain conditions (category A);
- patient subject to immigration control, resident in the UK and a surcharge payee (or exempt or waived from paying the surcharge) (category B);
- patient ordinarily resident in another EEA State or Switzerland (categories C & D); and
- patient ordinarily resident outside the EEA or Switzerland (categories E & F).

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<sup>21</sup> [www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf)



13.5. The flow diagram below sets out the six charging categories that have applied from April 2015 onwards. This chapter should be cross-referenced with the NHS England document entitled [Who Pays? Determining responsibility for payments to providers](#) (published August 2013) and the updated guidance Improving systems for Cost Recovery for Overseas Visitors and any subsequent guidance issued by NHS England on the subject of determining the correct commissioner. These two documents are referred to as 'Who Pays?' for the purposes of this chapter.





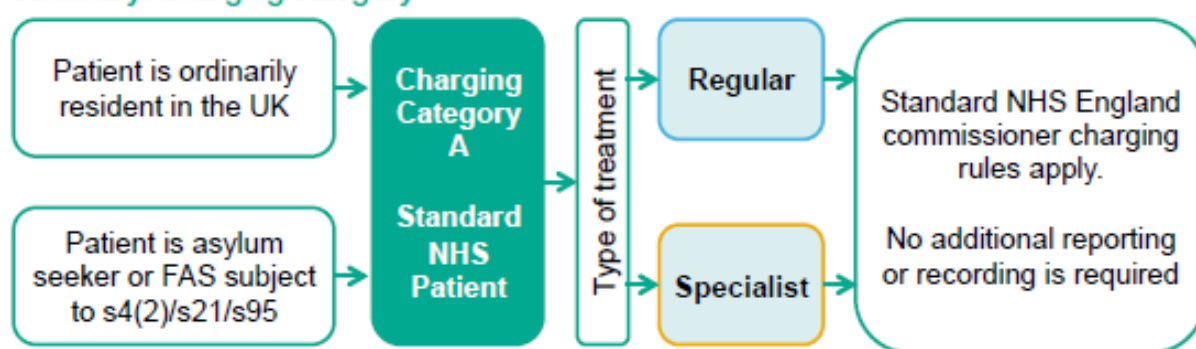
## Applying the correct charging rules

### Charging category A: Standard NHS Patient

13.6. Patients in this category are deemed to be ordinarily resident in the UK (according to the Charging Regulations). This charging category follows the “baseline” rules as set out in NHS England’s guidance on responsible commissioner, known as [Who Pays? Determining responsibility for payments to providers](#) It follows all the standard rules that NHS providers and commissioners abide by when determining the responsible commissioner, as described in Section A: General Rules, in Who Pays? Any patient falling into this category will be known in this chapter as a “Standard NHS Patient”.

13.7. Interim guidance [Improving Systems for Cost Recovery for Overseas Visitors](#) was published by NHS England in May 2015 to reflect these changes and should be read in conjunction with the existing ["Who pays?"](#) guidance (see 13.6)

#### Summary: Charging category A



### Charging category B: Surcharge payee

13.8. Patients in this category are deemed to be:

- resident in the UK but subject to Immigration Rules (i.e. they need a visa to live, work or study in the UK and are not considered to be ordinarily resident);
- in possession of a valid visa issued on or after 6 April 2015 permitting medium to long- term residence in the UK (typically from six months’ to five years’ duration although not always); and
- EITHER a health surcharge payee;
- OR exempt or waived from paying the health surcharge.

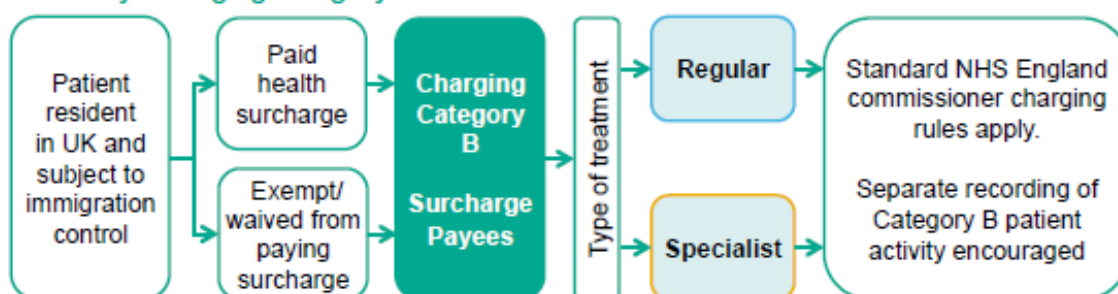
13.9. For simplicity, the payment arrangements for patients who are subject to immigration control and have paid the surcharge, or who are exempt or waived from paying it, should be managed as per a Standard NHS Patient. This category of patient is in general able to access NHS healthcare free at the point of use, except where normal charges such as prescription, optical or dental charges apply. From 21 August 2017, there is one exception to this general rule, when NHS-funded assisted conception services will be removed from what is covered by the surcharge.

13.10. If a patient has paid the surcharge (or is exempt/had the surcharge waived) and is referred to begin a course of assisted conception treatment on or after 21 August 2017, they will have to pay upfront and in full before their treatment commences. There are exceptions to this (including where assisted conception services are commissioned by NHS England on behalf of serving members and veterans of the UK armed forces). Please see Chapter 5 for details.

13.11. Apart from assisted conception services, in general relevant NHS bodies should follow the same rules for determining the responsible commissioner as laid out in paragraph 1 of Who Pays? However, where possible, they should note in their billing

- 13.12. where a patient has been treated under Charging category B. This will be important for future policy making and national/local decisions on funding allocations.
- 13.13. In the case of patients who would normally fall into this category but who had their visa issued before 6 April 2015, they will remain subject to Charging category A until they next extend or apply for a new visa. Until such time, they are subject to the 2011 Charging Regulations and will be for the most part deemed ordinarily resident when in the UK.

#### Summary: Charging category B



#### Charging category C: Charge-exempt overseas visitor/EEA

- 13.14. For the purposes of this section, any reference to an “EEA country” should be taken to mean any one of the 31 member states of the European Economic Area plus Switzerland
- 13.15. Patients in this category are:
- not ordinarily resident in the UK;
  - ordinarily resident in another EEA country; and
  - EITHER insured by another EEA country, and in possession of a European Health Insurance Card/Provisional Replacement Certificate (EHIC/PRC) or an S2 form;
  - OR not insured by another EEA country but exempt from domestic Charging Regulations.
- 13.16. The vast majority of patients in this category will be insured by another EEA country and therefore possess or have the right to possess an EHIC/PRC or an S2 form. See Chapter 9 for more information on the EHIC/PRC and the S2 route.
- 13.17. Typically, this category of patient will use NHS services in the UK either on a ‘needs arising’ basis if on a short-term visit or when studying here (through the EHIC/PRC mechanism) or on an elective basis (through the S2 route).
- 13.18. In NHS billing terms, this category is known as charge-exempt overseas visitors (CEOV) as set out in Who Pays? CEOV/EEA is a new sub-category to distinguish the costs related to patients insured by other EEA member countries from those related to patients from outside the EEA who are exempt or waived from charges (CEOV/non-EEA, see Charging category E).
- 13.19. Individuals who are either in receipt of a state pension from another EEA country or who are classed as ‘posted workers’ and who have been provided with an S1 form to cover the costs of their healthcare when living in the UK, should also be classed as an EEA/CEOV. See Chapter 9 for more information on the S1 route.
- 13.20. While providers should invoice their commissioner(s) for the costs of healthcare provided to CEOV/EEA patients (as per the Who Pays?), they must also report this

activity (EHIC/PRC or S2) and its value via the Overseas Healthcare portal. These reports are essential for the Overseas Healthcare Team to be able to reclaim the costs of NHS healthcare provided to such visitors from the relevant EEA member country. The income from these claims is a key income stream into the NHS and the relevant NHS bodies are expected to do all they can to properly identify and record the details of patients in possession of a non-UK EHIC/ PRC or an S2 form.

13.21. The EHIC incentive scheme was launched on 1 October 2014 to encourage relevant NHS bodies to report their EHIC activity. The scheme allows NHS providers to claim an incentive from the Department of Health worth 25% of the standard tariff for every valid EHIC activity report they make on the portal in addition to the cost of healthcare that is charged to their commissioner. For more details, see the EHIC incentive guide in the toolbox or contact the Overseas Healthcare Team ([oh.t.overseasvisitorsteam@dwp.gsi.gov.uk](mailto:oh.t.overseasvisitorsteam@dwp.gsi.gov.uk)).

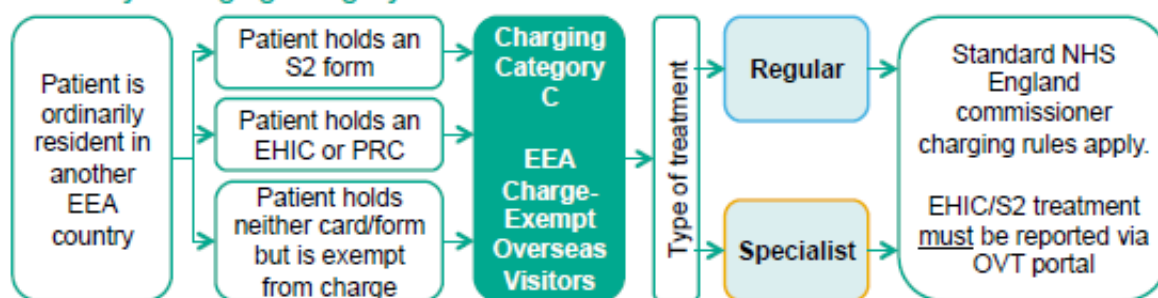
13.22. If the patient falls into one of the categories of persons exempt from charge or who requires treatment that itself is exempt from charge under the Regulations, the patient should also be classed as CEOV/EEA and charged to the relevant commissioner (as per Who Pays?).

13.23. The majority of healthcare provided to CEOV/EEA patients will be of a “needs arising” nature. However, as students are eligible to hold an EHIC/PRC if they remain insured by their EEA home state, they could seek access to more specialist, elective or long-term NHS healthcare while in the UK. As such, there is no clear rule of thumb as to when specialist or elective treatment should be provided to EEA visitors and when this is no longer appropriate.

13.24. Generally speaking, if CEOV/EEA patients wish to access specialist or elective treatment in the UK, they should be encouraged to obtain either an S2 form from the EEA country which insures them or access NHS healthcare via the EU Directive on cross-border healthcare (see Chapter 9). Relevant NHS bodies should use their own discretion as to if and when to have this conversation with patients.

13.25. While it is good practice to assist patients to obtain a PRC (if, for example, they have forgotten to bring their EHIC), it is the patient’s responsibility to ensure that the correct paperwork is provided if they wish to benefit from healthcare free at the point of delivery. If the provider is unable to obtain an EHIC/PRC or an S2 form and the patient is not exempt from charges, then the relevant NHS body should apply charges (as per Charging category D). The patient should then be provided with invoices and receipts to facilitate reimbursement from their home country on return.

#### Summary: Charging category C



## Charging category D: Chargeable EEA patient

13.26. Patients in this category are:

- not ordinarily resident in the UK according to the Charging Regulations;
- ordinarily resident in another EEA country (including Northern Cyprus) not insured by another EEA country, and so do not possess an EHIC/PRC or an S2 certificate; and
- not covered by any other exemption in the Charging Regulations.

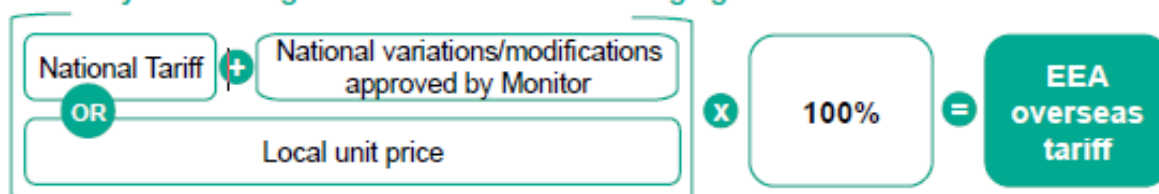
They are deemed chargeable at the point of delivery for NHS-funded community and secondary care.

13.27. If patients fall into this category, they should be asked if they have private health/travel insurance. If they do not possess this, or if the relevant NHS body deems the insurance to be insufficient to cover the costs of healthcare, the relevant NHS body should charge the patient directly and provide the necessary paperwork for the patient to then manage any future reimbursement from their insurer.

13.28. Relevant NHS bodies are reminded that healthcare that is immediately necessary or urgent must never be refused, regardless of the patient's ability to pay, although charges should still be recovered in parallel or immediately after treatment is provided. For more information about when healthcare must be provided and when payment should be requested before treatment proceeds, see Chapter 8.

13.29. Because of European law considerations, the Charging Regulations state that a patient legally resident in the EEA or Switzerland can only be charged the same rate by the NHS that would be charged to the commissioner if the individual had been a Standard NHS Patient (i.e. equivalent to the levels of charging as set out under Charging category A). Charges for patients in Charging category D should therefore be calculated as follows:

### Summary: calculating the level of EEA direct charging



13.30. Under Charging category D, from 6 April 2015, the provider is able to access the chargeable patient risk-sharing mechanism from its commissioner. This mechanism is proportionate to the charge being invoiced to the patient. The responsible commissioner will pay the costs of healthcare provided to this category of patients at 50% of tariff (or whatever the cost of the treatment determined in accordance with the national tariff and rules). No further administration charges should be added. To determine the responsible commissioner in this regime, please refer to the new NHS England “Who Pays?” supplement entitled “Improving Systems for Cost Recovery from Overseas Visitors”.

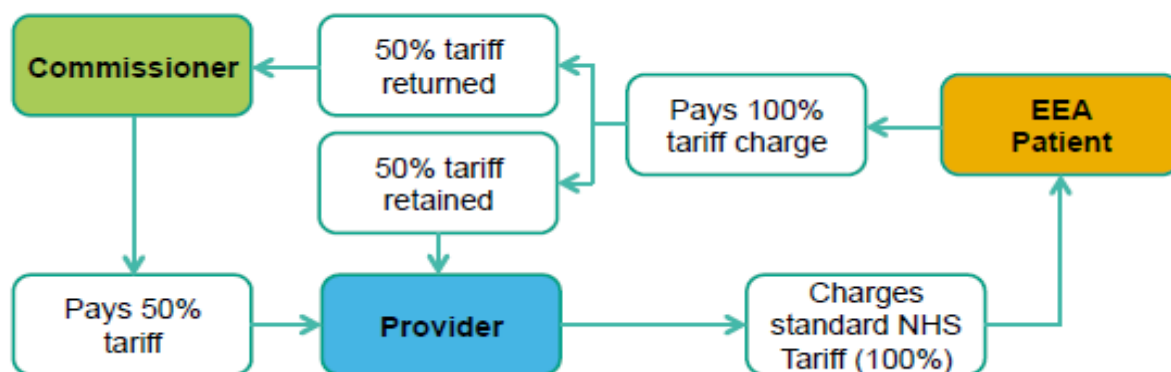
13.31. The exact nature of the payment flows should be decided between the provider and the responsible commissioner (please refer to the new NHS England guidance for further details). However, the basic principle remains that whatever payment the provider receives from the patient, this is divided equally between the provider and the commissioner, until such time as the commissioner has fully recouped the amount it paid the provider for the EEA chargeable patient.

13.32. It is strongly recommended that relevant NHS bodies agree a sensible protocol for managing the risk-share agreements with their commissioners (including CCGs and NHS England). Some relevant NHS bodies have agreed to invoice their commissioner once or twice a year for patients in Charging category D and F, to allow sufficient time to obtain payment directly from patients before commissioners pay any risk share on the identified income and is deemed unrecoverable. Commissioners should ensure that the management information and reporting requirements they are placing on their providers in relation to the risk-share rules are proportionate and pragmatic.

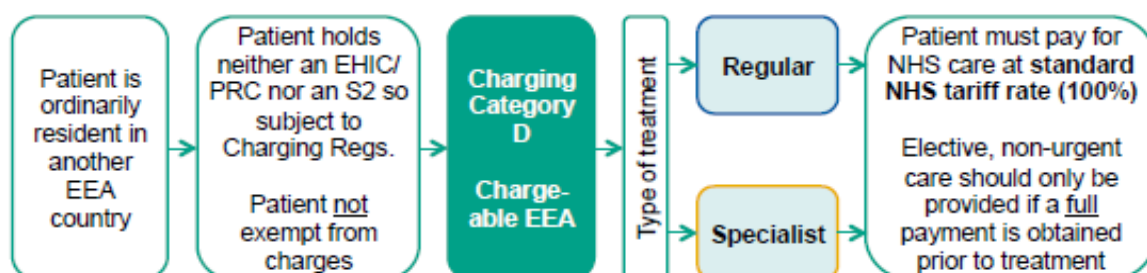
13.33. From 6 April 2015 relevant NHS bodies should only be using the risk-share agreement with commissioners in the case of treatment deemed by clinicians to be immediately necessary or urgent. If the care required is non-urgent, relevant NHS bodies must seek the full estimated costs upfront from the patient and not begin treatment until this is received. In these circumstances, the risk of non-payment is removed and therefore sharing this with commissioners is no longer necessary. Relevant NHS bodies and their commissioners should review their invoicing and payment flows for Charging category D and F patients to reflect the new legal obligation.

### Summary: EEA direct charging finance flows

Summary: EEA direct charging finance flows



Summary: Charging category D





## Charging category E: Charge-exempt overseas visitor/non-EEA

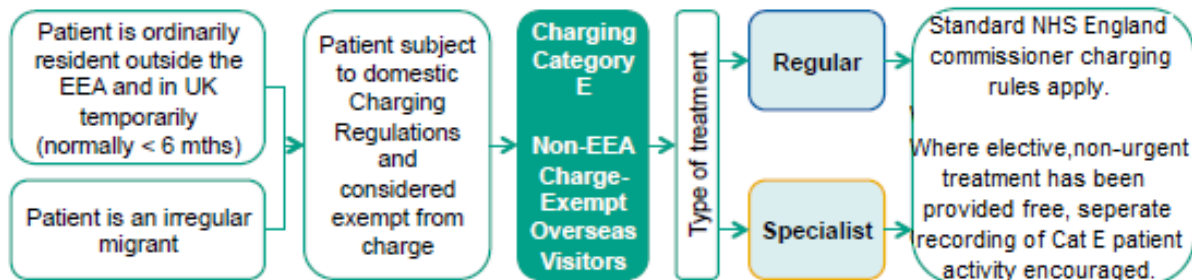
13.34. The category of patients considered to be charge-exempt overseas visitors from outside the EEA has existed for some time and falls into the baseline allocations inherited by Clinical Commissioning Groups in 2013. These are patients who:

- are not ordinarily resident in the UK;
- ordinarily resident outside the EEA or Switzerland, or living in the UK without immigration permission;
- have not paid the health surcharge (or have not been exempt or waived from paying it);
- are therefore subject to the Charging Regulations; BUT
- are exempt from charging, either because of their personal status or because the treatment they are seeking is exempt from charge.

13.35. This charging category would be applied to individuals such as a qualifying UK crown servant visiting the UK or a non-EEA visitor who attends A&E (but is not admitted to hospital) or needs treatment for an infectious disease while on holiday in the UK. For some exemption categories, eg under reciprocal healthcare agreements, entitlement may be limited to exclude some services (see Chapter 10).

13.36. The relevant NHS body should refer to the [Who Pays?](#) guidance to determine who the responsible commissioner is and invoice them the standard NHS tariff/costs for the treatment (as per the charging rules applied to a Standard NHS Patient under Charging category A).

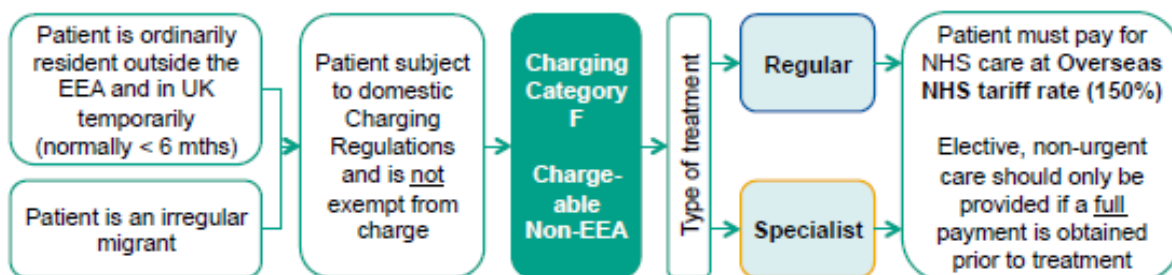
### Summary: Charging category E



## Charging category F: Chargeable non-EEA patient

- 13.37. The final category comprises patients who are:
- not ordinarily resident in the UK;
  - ordinarily resident outside the EEA or Switzerland or living in the UK without immigration permission;
  - not subject to the health surcharge (or exempt or waived from paying it); and
  - not otherwise exempt from charging under the Regulations.
- 13.38. This charging category therefore includes patients who are ordinarily resident in a non-EEA country (which could include UK or EEA passport holders as well as non-EEA citizens) or patients who are in the UK on an irregular basis (which could include illegal migrants, visa over stayers and failed asylum seekers not otherwise exempt from charges).
- 13.39. This is the only charging category whereby a relevant NHS body can charge a higher rate than the standard NHS tariff or local tariff negotiations, and is designed to include a reasonable profit element.
- 13.40. If patients fall into this category, they should be asked if they have private health/travel insurance. If they do not possess this, or if the provider deems the insurance to be insufficient to cover the costs of healthcare, the provider should charge the patient directly and provide the necessary paperwork for the patient to then manage any future reimbursement from their insurer. There is no requirement on the relevant NHS body to accept insurance details if they are not assured that they will receive payment from the insurer.
- 13.41. For more information about when healthcare must be provided and when payment should be requested before treatment proceeds, see Chapter 8.
- 13.42. Under Charging category F, from 6 April 2015, the provider is able to access the new chargeable patient risk-sharing mechanism from its commissioner. This is proportionate to the charge being invoiced to the patient. Unlike Charging category D, patients in this category are not subject to European law but instead fall under the new Charging Regulation 7 that sets out the levels of charging to apply.

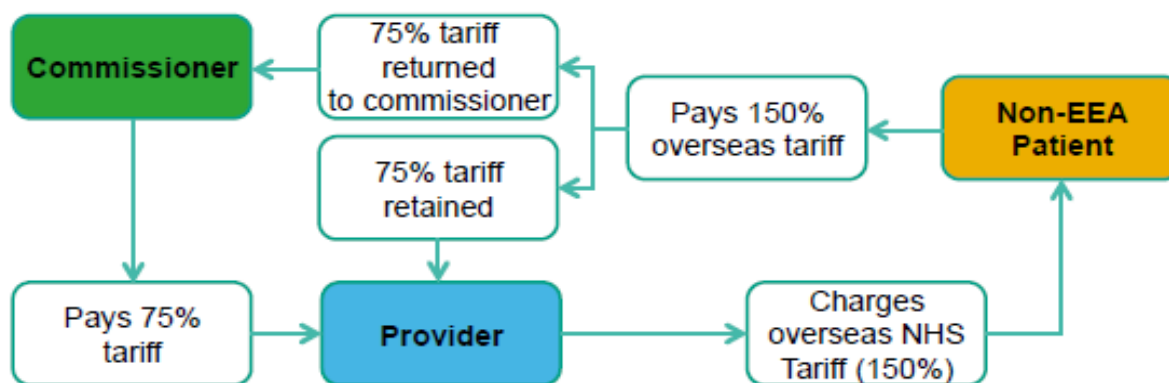
### Summary: Charging category F





13.43. If treatment has begun on or after 6 April 2015, commissioners pay the costs of healthcare provided to this category of patients at 75% of tariff (or whatever the cost of the treatment determined in accordance with the national tariff and rules). This can be based on the costs that are charged to the commissioner for any Standard NHS Patient. The relevant NHS body will charge the patient 150% of tariff (or whatever the cost of the treatment determined in accordance with the national tariff and rules). This is explained in more detail in the section below.

**Summary: Non-EEA finance flows**



13.44. The payment flows should be decided between the provider and the relevant commissioner (see [Who Pays?](#) for further details). However, the basic principle remains that whatever payment the provider receives from the patient, this is divided equally between the provider and the commissioner, until such time as the commissioner has fully recouped the amount it paid the provider for the non-EEA patient.

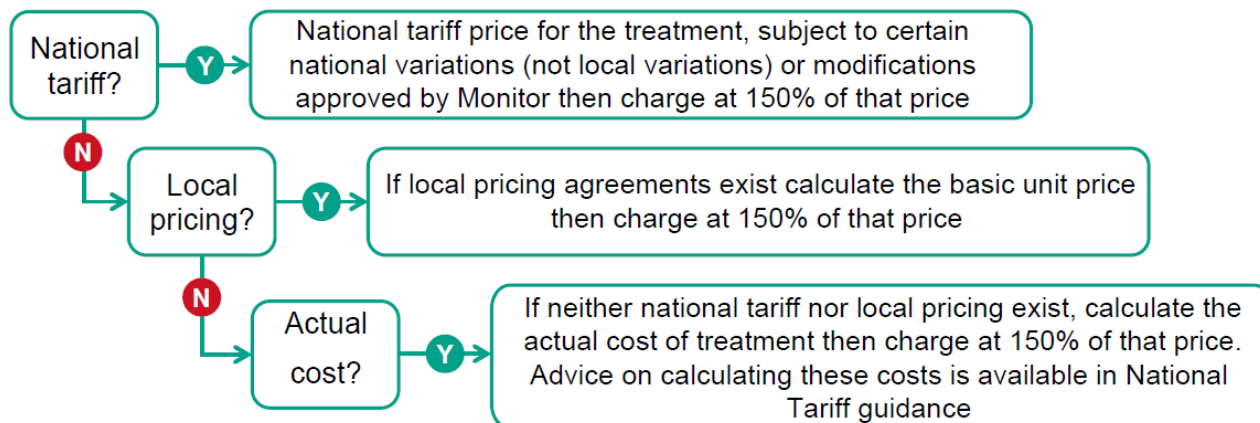
13.45. It is strongly recommended that relevant NHS bodies agree a sensible protocol for managing the risk-share agreements with their commissioners (including CCGs and NHS England). Some relevant NHS bodies have agreed to invoice their commissioner once or twice a year for patients in Charging category D and F, to allow sufficient time to obtain payment directly from patients before commissioners pay any risk share on the identified income and is deemed unrecoverable. Commissioners should ensure that the management information and reporting requirements they are placing on their providers in relation to the risk-share rules are proportionate and pragmatic.

13.46. From 6 April 2015, relevant NHS bodies should only be using the risk-share agreement with commissioners in the case of treatment deemed by clinicians to be immediately necessary or urgent. If the care required is non-urgent, relevant NHS bodies must seek the full estimated costs upfront from the patient and not begin treatment until this is received. In these circumstances, the risk of non-payment is removed and therefore sharing this with commissioners is no longer necessary. Relevant NHS bodies and their commissioners should review their invoicing and payment flows for Charging category D and F patients to reflect the new legal obligation.

## Calculating the correct level of charges for Charging category F

13.47. Regulation 7 sets out how charges are to be calculated for chargeable non-EEA patients (i.e. those who fall into Charging category F as set out above). How the tariff is calculated depends on whether the relevant service has a national price or is a pathway payment service (e.g. maternity services or cystic fibrosis) or the price is determined by the rules set out in the national tariff (e.g. locally agreed prices).

### Summary: Which NHS charging rules to apply



## National price

13.48. Where a service has a national price in the national tariff, the overseas tariff will be the national price subject to any relevant:

- national variation for market forces factor;
- national variation for top-up payments;
- national modification; and
- agreed local modification.

13.49. Local variations to the national price for a service are not to be applied to the calculation of the overseas tariff. The marginal rate emergency rule, the 30-day readmission rule and variations to support transition to new payment approaches should not be applied. No other additions or inclusions (e.g. translation services, administrative costs) may be made to the price. The 150% tariff includes these costs in addition to a profit element.

## Pathway payment services

13.50. Currently, two pathway payment mechanisms exist – the maternity pathway payment and the cystic fibrosis pathway payment. Where the relevant NHS body cannot identify the component price for a relevant service that is provided as part of a bundle of services, the relevant NHS body may set the overseas tariff on a reasonable basis having regard to the matters set out below:

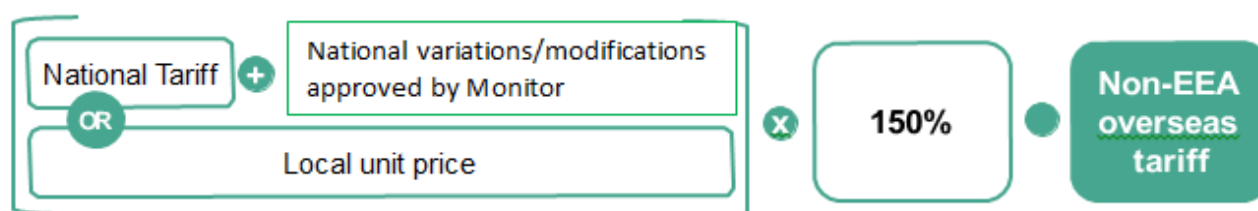
- the price of the full pathway payment;
- the proportion of the bundle of services that the overseas visitor receives; and
- the complexity of the service provided to the overseas visitor.

- 13.51. For example, where a patient with cystic fibrosis receives one week of NHS hospital treatment while in England, the relevant NHS body will need to take the following into account when determining the price that should be charged for the services provided:
- the price of the cystic fibrosis pathway for the relevant band of patient complexity;
  - the services provided during the one-week NHS hospital stay as a proportion of the yearly pathway payment; and
  - the complexity of the services provided to the patient during their stay.
- 13.52. Calculation of charges must be reasonable and will vary on a case-by-case basis taking into account all of the relevant factors. However, the principle remains that non-EEA chargeable patients should be charged using the same methodology whichever relevant NHS body is providing the treatment.
- 13.53. If it is possible to identify the component prices for a service (e.g. for maternity services it may be possible to identify the price for providing the antenatal component of the pathway), then the relevant NHS body should calculate the price using the relevant national price as set out in paragraphs 13.47 and 13.48.

### Price determined in accordance with the rules (locally agreed prices)

- 13.54. Where the relevant services do not have a national price and the price is locally agreed between commissioners and providers, the overseas tariff will be the locally agreed price subject to any applicable:
- national variation for Market Forces Factor;
  - national variation for top-up payments;
  - national modification; and
  - agreed local modification.
- 13.55. The marginal rate emergency rule, the 30-day readmission rule and variations to support transition to new payment approaches should not be applied. No other additions or inclusions (e.g. translation services, administrative costs) may be made to the price. The 150% tariff includes these costs in addition to a profit element.

### Summary: Calculating the level of non-EEA charges



### Collaborative working between provider and commissioner

- 13.56. For the two processes involving payment of chargeable EEA (Charging category D) and non-EEA (Charging category F) patient costs by the commissioner, it is vital that a successful working relationship is established between the provider and the commissioner in the area of overseas visitor management. Commissioners have the power to audit providers' procedures and systems to ensure that providers are doing all they can to identify chargeable patients and recover the costs of healthcare from them. Failure to demonstrate this could result in the commissioner refusing to pay the provider for the chargeable EEA or non-EEA patient's healthcare costs.

- 13.57. This is covered in more detail in the NHS England supplement to the Who Pays? guidance. It is strongly advised that providers and commissioners begin discussions as soon as possible to ensure that they both agree the easiest and least burdensome approach to demonstrating due diligence and invoicing the commissioner for the amounts to be paid. According to the chargeable overseas visitor numbers for a particular provider, this could be on a per-patient basis, it could be monthly, quarterly or even annually. The best organisations to decide are those managing the payment flows themselves, i.e. the provider and the responsible commissioner.
- 13.58. Providers and commissioners are also encouraged to agree early on the appetite for risk of chargeable patient debt. The organisation holding the debt is the only one legally allowed to decide when and if to write off any outstanding debt. However, providers will wish to discuss decisions involving large amounts of debt and where they have established that the cost of pursuing debt is not worth the investment.

### Further information on NHS chargeable patients

- 13.59. Patients treated under Charging category D (EEA chargeable patients) or Charging category F (non-EEA chargeable patients) are classed together in this section as NHS chargeable patients.

### Emergency Care Data Set: NHS Data Dictionary charging categories

- 13.60. From October 2017, the NHS data dictionary will include the A-F charging categories in the Emergency Care Data set as a drop down menu. Alongside the charging categories, there will also be a “decision pending” text field that will allow OVMs to indicate on the system that they are investigating a patient’s status and documentation.
- 13.61. This will be developed as an NHS Digital Information Standards Notice, which will put a legal obligation on trusts to use these categories. Following this notification, relevant NHS bodies will need to ensure that their Patient Administration System (PAS) suppliers introduce these changes and ensure that they reference the Spine content. Whilst awaiting the Information Standards Notice, relevant NHS bodies can also work with their PAS suppliers to negotiate necessary changes, potentially on a faster timeline.

### The difference between NHS Chargeable patients and private patients

- 13.62. NHS chargeable patients should not be confused with private patients, and the cost of any services they are provided with will be different from the rates charged to private patients. See the section on the calculation of charges for NHS chargeable patients.
- 13.63. The treatment of NHS chargeable patients is subject to the same clinical priority as Standard NHS Patients. The beds they occupy are not pay beds and consultants cannot charge them for their services. NHS chargeable patients are not eligible to be “fast tracked” for services or provided with any supplementary service that they would not have access to as a Standard NHS Patient.

### When charges should be administered to NHS chargeable patients

- 13.64. It is important that NHS chargeable patients who are liable for charges are identified as early as possible in their dealings with the relevant NHS body in order to provide the patient with more choice in what treatment to accept and what to postpone until they return home. In the context of charging NHS chargeable patients, at what point to charge can be considered in terms of the urgency of the treatment needed. See Chapter 8 for more details. Relevant bodies should note that from 23 October 2017 they will be required to obtain upfront payment for the full estimated cost of care unless doing so would prevent or delay the provision of immediately necessary or urgent

treatment. In practice, this requirement will always apply to elective, non-urgent care.

13.65. Presenting an invoice to a person who was not aware that they were liable for charge could result in accusations of maladministration, which the relevant NHS body would then have to defend. However, the fact that a patient was not informed that charges will apply does not alter the fact that, under the Charging Regulations, they are still liable for that charge. Relevant NHS bodies do not have discretion to waive charges and where a patient who has received services is identified as chargeable the relevant NHS body must recover those charges from the patient.

### Who to charge when a patient is exempt from charges (CEOV EEA or non-EEA)?

13.66. Where an overseas visitor is exempt from charge (i.e. they fall under Charging category C or Charging category E), then the relevant NHS body should invoice the appropriate commissioner as set out in [www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf). Further information can also be obtained by contacting [England.responsiblecommissioner@nhs.net](mailto:England.responsiblecommissioner@nhs.net)

13.67. Where a patient is insured by another EEA country or Switzerland (i.e. they fall under Charging category C), then the relevant NHS body must take appropriate steps to ensure that the UK can recover the cost of treating that patient. Relevant NHS bodies will need to:

- invoice the responsible commissioner as per Who Pays?; and
- record and report any EHC or PRC details to the DWP Overseas Healthcare Team via the Overseas Visitors Treatment web portal.

13.68. Without this information, the UK is unable to make a claim for reimbursement for treating these visitors. See Chapter 9 for more details.

### Methods of payment and dealing with third parties

13.69. Relevant NHS bodies can accept payment by any method acceptable to them. Where a relevant NHS body provides treatment in advance of payment, it will be helpful, particularly if debt recovery action becomes necessary, to ask the patient, or someone on their behalf, to sign an undertaking to pay form. However, the overseas visitor will be liable to pay the debt whether or not they sign an undertaking to pay form.

13.70. NHS chargeable patients are liable to pay for their treatment even where an undertaking to pay by a third party or sponsor has been received (e.g. the patient has travel insurance or the patient is sponsored by an employer or government). The relevant NHS body must decide whether or not to accept the risk of seeking payment from this third party rather than directly from the patient.

13.71. Relevant bodies should be wary of dealing directly with third parties unless agreements have been reached on billing and currency. Some overseas insurers demand itemised billing or pay in local currencies which, with fluctuating exchange rates, can leave trusts with a shortfall on income. The problems will be minimised if the NHS chargeable patient pays the trust directly and then recovers the cost themselves. If the relevant NHS body has no experience of dealing with such matters it may be advisable to take specialist advice either from its own legal advisers or from a company specialising in debt collection.

### Pursuing overseas debt

13.72. Relevant NHS bodies are recommended to consider employing the services of a debt recovery agency that specialises in the recovery of overseas debt, except in relation to persons whom it is clear to the relevant NHS body will be unable to pay (e.g. destitute illegal migrants for whom such action may not be appropriate or cost-effective). There is some evidence that those who do so are significantly more



successful in recovering debt from NHS chargeable patients residing overseas.

### Recording NHS income and debt in the accounts

13.73. Where any charge has been made in respect of NHS services, relevant NHS bodies must invoice for that treatment. It is extremely important that all invoices, together with recognised cash receipts, provisions made and amounts written off, are accurately recorded in the accounts of relevant NHS bodies. Not only does this provide important financial information for the relevant NHS body itself, but it also provides the Department of Health with emerging patterns or problems with the level of charges being recovered from overseas visitors and the amount of debt being recorded. Relevant NHS bodies are required to separately identify income payable by chargeable overseas visitors in their accounts.

### Accounting procedures

13.74. Relevant NHS bodies should also recognise any written off debt within the appropriate part of their accounts and ensure that these are shown as losses and special payments overseas visitors' bad debt. It is extremely important that overseas visitor bad debt is properly and accurately reported in the accounts, no matter what the level of debt. It is only through accurate recording that the scale of unrecovered debt can be known. More detailed accounting requirements have been in place since the financial year 2014/15, and the Department of Health, along with NHS Improvement and NHS England continue to keep these under review.

13.75. Relevant NHS bodies are now required to show separately within their accounts cash receipts relating to previous years' income. This is where an invoice has been raised and the chargeable NHS patient (EEA or non-EEA) has made a cash payment in relation to that invoice.

13.76. Also new is a requirement for relevant NHS bodies to record the increase in provision for impairment relating to this category of debt in the current financial year.

### When to write off debt

13.77. The relevant NHS body may want to write off a debt for accounting purposes where:

- the NHS chargeable patient has subsequently died and recovery from their estate is impossible; or
- given the NHS chargeable patient's financial circumstances, it would not be cost effective to pursue it (e.g. they are a destitute illegal migrant or are genuinely without access to any funds or other resources to pay their debt); or
- all reasonable steps have failed to recover the debt (e.g. the NHS chargeable patient is untraceable or there are no further practical means of pursuing debt recovery).

13.78. However, writing off the debt for accounting purposes may not necessarily mean that the debt is extinguished and relevant NHS bodies are still able to recover it. Debts can be cancelled entirely if the charges they relate to are found not to have applied in the first place.

## Further information on how to record financial information

13.79. Full instructions on how to recognise and record financial information within the accounts should first be directed to your accounts team within the relevant NHS body itself. However, further information on the accounting process itself can be found at

- [NHS Trusts – Department of Health group accounting guidance - Accounting guidance for the Department of Health group bodies.](#)
- [NHS Foundation Trusts – the FT Annual Reporting Manual \(ARM\)](#)

## Terms and conditions for financial support to trusts

13.80. Any financial assistance provided by the Secretary of State for Health to NHS Foundation Trusts or NHS Trusts under Section 40 or Schedule 5 of the NHS Act 2006 comes with terms and conditions. Currently, recipients of such financial support are required to fulfil conditions around better chargeable patient identification and cost recovery.

## Further Question and Answers for NHS Chargeable Patients

Q: How do I work out how long a patient has been an inpatient?

A: For inpatients the day of admission and the day of discharge count together as a single day. Thus, someone admitted on a Monday and discharged on the Friday of that same week should be treated as having been an inpatient for four days.

Q: If a patient does not have sufficient funds to pay for their NHS treatment straight away, can I accept payment instalments?

A: Yes, although the relevant NHS body must ensure that, wherever possible, the patient adheres to a sensible, agreed payment plan. Failure to do so may result in the patient's non-clinical details and information about debt being reported to the Home Office and may affect future immigration decisions. See Chapter 8 for more details.

Q: Should I add VAT to a patient's invoice?

A: No. All charges to NHS chargeable patients are exempt from VAT.

Q: Where a patient dies without making or completing payment, can I obtain payment from the patient's family or the patient's estate?

A: Apart from in the case of children aged 18 or under or where a shipowner/airline is liable, it is the patient who is solely liable for their debt; therefore no one else becomes liable after they die. Relevant NHS bodies should seek repayment from the patient's estate if possible but otherwise the debt will need to be written off (see paragraph 13.76). An offer from relatives or another person to meet the debt can be accepted but should not be actively sought, nor is it acceptable to pursue relatives of a deceased patient for recovery of a debt for which they have no legal liability.

Q: What is the difference between a NHS chargeable patient and a private patient?

A: Overseas visitors who are liable for charges are NHS chargeable patients. They should not be confused with private patients. They must receive the same priority (but no additional services) as NHS patients.



Q: What if I was not aware that someone was chargeable at the time, but I have since found out they should have been charged, can I present them with a bill now?

A: The fact that a patient was not informed that charges apply to them at the time does not alter the fact that, under the Charging Regulations, they are still liable for that charge.

However, it is important that a patient is aware as soon as possible that there may be a charge for treatment. Failure to do so, resulting in a bill being presented to a person who was not aware that they were liable, could result in accusations of maladministration, which the relevant NHS body would then have to defend.

Q: What happens if I have already invoiced my commissioner for the cost of treatment provided to a chargeable patient who I thought wasn't chargeable?

A: If you have deemed the patient chargeable, you should charge them and reimburse any earlier payment you have received from your commissioner. Note that the commissioner may be required to pay part of the cost of the patient's treatment under the risk-share agreement until such time as you are able to recoup the full costs from the patient directly.

Q: What about dental services?

A: NHS dental services not provided by a relevant NHS body do not come under the Charging Regulations. Broadly speaking, this means any primary dental services provided under a general dental services contract. NHS dental services do have their own charging rules which are separate to the NHS (Charges to Overseas Visitors) Regulations. Information on general dentistry costs can be found at:-

<http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Dentalcosts.aspx>

Q: What about eye care services?

A: NHS-funded eye care services not provided by a "relevant NHS body" do not come under the Charging Regulations. Broadly speaking, this means any primary ophthalmic services provided under a general ophthalmic services contract. Information on general eye care costs can be found at:-

<http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Eyecarecosts.aspx>

Q: What about prescription charges?

A: Charges for prescriptions in England are set out separately to the NHS (Charges to Overseas Visitors Regulations). Information on statutory prescription charges can be found here:-<http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Prescriptioncosts.aspx>

Q: What about IVF or other assisted conception services?

A: In the majority of circumstances, it is not the OVM's job to decide if a person is an eligible candidate for a course of NHS-funded in vitro fertilisation (IVF) treatment, only if the patient is entitled to free NHS hospital treatment generally. However, if the patient is chargeable for pre-planned NHS hospital treatment, or if they are exempt from charge under surcharge or transitional arrangements only, then they will not be able to receive NHS IVF or assisted conception treatment free of charge. More information on IVF can be found on the Human Fertilisation and Embryology Authority's (HFEA) website - <http://www.hfea.gov.uk/>

Q: What about UK residents seeking dialysis overseas?

A: UK residents who enquire about the provision of haemodialysis or peritoneal dialysis whilst abroad should be directed to the NHS unit where they normally dialyse for information. For EEA countries an EHIC will cover the cost of treatment (in Spain visitors will be issued with a P10 form before their visit).

Q: What about Prosthetic services?

A: Charges will apply for prosthetic services when the patient is neither ordinarily resident in the UK nor exempt from charge under the Charging Regulations.

Q: What about Wheelchairs?

A: Generally, if an individual is assessed as needing a wheelchair for their medical needs, when they will be provided with one, free of charge, by the NHS. Therefore, if an individual is eligible to access free NHS hospital treatment for free, they could receive a wheelchair for free. If not, they would have to pay for it.

Currently, each CCG sets medical eligibility criteria for the provision of different types of wheelchair (e.g. manual/powered), based on assessment of local need and resources.

A short summary of state-funded wheelchair provision is provided here:

<http://www.nhs.uk/NHSEngland/AboutNHSservices/social-care-services/Pages/nhs-wheelchair-services.aspx>

Q: What about transplants?

A: There are clear Directions in the UK on the allocation of organs from deceased donors. The NHS Blood and Transplant Directions 2005 place patients into two categories – Group 1 and Group 2. The Directions make it clear that a person in Group 2 cannot receive an organ if there is a clinically suitable person in Group 1. Group 1 includes, amongst others, persons ordinarily resident in the UK, persons entitled under European legislation or reciprocal health agreements, and certain people entitled under bilateral reciprocal health agreements.

Some overseas visitors come to the UK to donate live organs to residents of the UK. The cost of medical treatment specifically for the purposes of donating a kidney (donor assessment, donor surgery and out-patient follow-up appointments) will be covered by the NHS. Free treatment is not available to them after they have returned to their own country at the end of the 6 month period or for any treatment outside of the donor process (unless they are otherwise exempt).