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RESEARCH ARTICLE

Charging 'overseas visitors' for NHS treatment, from Bevan to Windrush and beyond

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Abstract

This paper explores the development and operation of law and policy concerning the charging of overseas visitors for healthcare in England from the beginnings of the NHS to the present day. It highlights how this has been a highly contentious issue for decades, often linked with immigration policy, and is an area that still lacks comprehensive reliable empirical data to inform the debate. It explores and analyses the recent reforms to the NHS Overseas Charging Regulations introduced in 2015 and 2017. It demonstrates the problems in implementing the most recent regulations in an era of the 'hostile environment' and argues that the approach which has been taken can be seen as undermining the covenant of trust between patient and clinician and thus the fundamental principles of the NHS.

Keywords: health law; overseas visitors charging; NHS

Introduction

In October 2017 the UK Government introduced its strictest regulations yet for reclaiming charges from overseas visitors making use of the National Health Service. Anecdotes about overseas visitors flying to the UK specifically to give birth for free, or to get expensive HIV treatment at UK taxpayers' expense had been regularly appearing in the media and by the time of the 2015 general election were part of the political debate. A Nigerian woman who gave birth to quintuplets in London in 2011 was still making headlines in 2015 as an egregious example of health tourism and inadequate cost recovery.[1] The NHS Overseas Visitors Charging Regulations 2015, followed by even tougher 2017 revisions, are the Government's efforts to address these perceived abuses.[2] These new regulations have a dual purpose: to recover costs more effectively for the NHS and to stop 'health tourism', the alleged practice of citizens from other countries coming to the UK specifically to make use of the free health service. (This should be distinguished from the practice of travelling abroad for private care.[3]) Under the

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[1]L Osborne 'African mum of quintuplets let off £145,000 NHS bill: health tourist who came to UK to give birth says no one's asked her to pay' (*MailOnline*, 29 August 2015) https://www.dailymail.co.uk/news/article-3214709/African-mum-quintuplets-let-145-000-NHS-bill-Health-tourist-came-UK-birth-says-no-one-s-asked-pay.html; P Sawer 'Nigerian mother let off £145,000 NHS bill after birth of quins' (*The Telegraph*, 29 August 2015) https://www.telegraph.co.uk/news/health/news/11832487/Nigerian-mother-let-off-145000-NHS-bill-after-birth-of-quins.html.

[2]The NHS (Charges to Overseas Visitors) Regulations 2015, SI 2015/238, as amended by The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017, SI 2017/756.

[3]Figures are unreliable, but Government estimates for 2012/13 were that 'health tourism' (overseas visitors inappropriately accessing free NHS care) was costing about 0.3% of the total NHS budget, ie around £1.8 billion: 'Quantitative Assessment of

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Regulations, unless persons are 'ordinarily resident' or fall within one of a range of exceptions then they are liable to be charged for hospital care (excluding care in A&E),[4] and charges apply to secondary care delivered outside of the hospital setting.[5]

A recent example of the controversy surrounding these regulations arose concerning the 'Windrush generation' migrants from Commonwealth countries who arrived in the UK before 1971. In 2018 The Guardian reported on the case of Mr Albert Thompson, who moved to the UK from Jamaica 44 years ago. Despite decades of work and paying UK taxes, his lack of a British passport or other qualifying residence criteria meant that the Royal Marsden hospital in London asked him to pay £54,000 for radiotherapy for prostate cancer, money which he did not have: 'It's like I'm being left to die'.[6] Initially the Government refused to intervene but as the case gained publicity, sympathy and momentum, further examples came to light.[7] It was argued that the charging regulations would particularly hit those children of the Windrush generation who had never obtained British passports or naturalisation[8] and that an estimated 57,000 people were potentially at risk.[9] The embarrassing disclosure that the UK Border Agency had destroyed the original landing cards of migrants which might have proved their residency forced the Prime Minister to apologise and take urgent action to regularise the position of these citizens. This was followed by the resignation of the Home Secretary, Amber Rudd.[10] Mr Thompson was rapidly granted indefinite leave to remain in the UK and his cancer treatment was able to go ahead without charge. While the fallout from the debacle forced the Government to address the particular needs of the Windrush generation, this case highlights the challenges in proving 'ordinary residency' for others who do not have a publicity campaign on their side.[11]

At face value, it seems reasonable for the UK to charge non-residents for non-urgent medical care, reserving expensive resources for its own residents, something which has been the policy of most countries over a period of many years.[12] Yet there has long been a troubled relationship between the charging regulations and the ethos of the NHS, a system predicated on the principle that healthcare should be free at the point of use.[13] This is a sentiment which echoes through the decades. For some critics, the regulations threaten to undermine equality and human rights.[14] The progressive restriction of free healthcare to a country's own residents seems to run contrary to the expressed aim of universal health coverage (UHC). From a right to healthcare approach it could be argued that a basic package of

Visitor and Migrant Use of the NHS in England' (Prederi, 2013) p 11. With regard to paid care, the UK is a net exporter of patients but between 2010 and 2016 around 51,000–58,000 overseas residents travelled to the UK for medical treatment: https://www.ons.gov.uk/peoplepopulationandcommunity/leisureandtourism/adhocs/007642medicalvisitstoandfromtheuk2010to2016. Hanefeld found that overseas visitors paying for NHS facilities accounted for 25% of all revenue, while only representing 7% of patients: J Hanefeld et al 'Medical tourism: a cost or benefit to the NHS?' (2013) *Plops One* 8.10 e70406.

[4]See further discussion in Section 2 of this paper below.

[5]SI 2015/238, above n 2, reg 2(3).

[6]A Gentleman 'Londoner being denied NHS cancer care: "It's like I'm being left to die"' (*The Guardian*, 10 March 2018) https://www.theguardian.com/uk-news/2018/mar/10/denied-free-nhs-cancer-care-left-die-home-office-commonwealth; see also A Gentleman *The Windrush Betrayl Exposing the Hostile Environment* (Faber, 2019).

[7]A Gentleman, 'The children of Windrush: "I'm here legally, but they're asking me to prove I'm British"' (*The Guardian*, 15 April 2018) https://www.theguardian.com/uk-news/2018/apr/15/why-the-children-of-windrush-demand-an-immigration-amnesty.

[8]HC Home Affairs Committee 'The Windrush generation', 6th Report [Session 2017–19] (3 July 2018) HC 990, at 6–7.

[9]Ibid.

[10]BBC News 'Amber Rudd resigns as Home Secretary' 30 April 2018, https://www.bbc.co.uk/news/uk-politics-43944988.

[11]C Jayanetti 'NHS denied treatment for migrants who can't afford upfront charges' (*The Guardian*, 13 November 2018) https://www.theguardian.com/society/2018/nov/13/nhs-denied-treatment-for-migrants-who-cant-afford-upfront-charges.

[12]See UK government foreign travel advice on health costs abroad, for example in the USA: https://www.gov.uk/foreign-travel-advice/usa/health; Canada: https://www.gov.uk/foreign-travel-advice/canada/health; and Russia: https://www.gov.uk/foreign-travel-advice/russia/health.

[13]On the history of the NHS see T Delamothe (2008) 336 BMJ 1216; R Klein *The New Politics of the NHS: From Creation to Reinvention.* (Abingdon: Radcliffe, 2006); C Webster *The National Health Service: A Political History* (Oxford: Oxford University Press, 2nd edn, 2002). For further discussion of the founding principles see Section 2 of this paper below.

[14]J Smith and E Dexter 'Implications of upfront charging for NHS care: a threat to health and human rights' (2018) 41(2) Journal of Public Health 427, https://doi.org/10.1093/pubmed/fdy050.

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healthcare services should be provided free of charge for overseas visitors. The right to health is included in the 1948 Universal Declaration of Human Rights and UHC is a long-term objective of the World Health Organization (WHO):

> UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.[15]

There is also a binding right to health contained the International Covenant on Economic Social and Cultural Rights.[16] Rights to health are also recognised in Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women[17] and Article 24 of the Convention on the Rights of the Child.[18] Nonetheless, while a general right to health may be seen as an aspiration, translating this into specific rights to access health services in individual states is problematic in practice. The precise nature of access to health care services can be seen as something which is a matter of resource allocation, left to individual member states themselves to determine. For example, in the context of the jurisprudence of the European Convention on Human Rights, while a right to access emergency health care is in line with the approach taken by the European Court of Human Rights, there is no general right to demand access to specific health care services for nationals or for overseas visitors.[19] While the UK is a signatory to the Council of Europe's European Convention on Social and Medical Assistance, which provides that parties undertake to safeguard rights to medical assistance as their own nationals to nationals of other Treaty parties 'who are lawfully present in their territory and who are without sufficient resources', as we shall see below the issue will depend on whether they are 'ordinarily resident' or fall within one of the other exemptions under the Regulations.[20] Moreover while NHS treatment is free at the point of delivery (with the exception of certain charges, for example for prescriptions in England[21]) neither UK residents nor foreign visitors can demand the provision of specific treatments as this is ultimately subject to clinical discretion.[22]

The extent to which, and procedure by which, overseas visitors should be charged for healthcare has never been simply an assessment of cost-benefit, ie analysis of administrative cost against potential income. It needs to be seen in its political context. The impact upon the financial situation of the NHS

[15]WHO 'Universal health coverage (UHC) Fact sheet' (updated December 2017) and see also World Health Organisation *Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage* (2004). On the right to health see further P Hunt 'Interpreting the international right to health in a human rights-based approach to health' (2016) Health and Human Rights Journal https://www.hhrjournal.org/2016/12/interpreting-the-international-right-to-health-in-a-human-rights-based-approach-to-health/; TM Murphy *Health and Human Rights* (Oxford: Hart Publishing, 2013); J Tobin *The Right to Health in International Law* (Oxford: Oxford University Press, 2012).

[16]International Covenant on Economic, Social and Cultural Rights. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976, in accordance with Art 27.

[17]United Nations New York, 18 December 1979; see further MA Freeman and C Chinkin *The UN Convention on the Elimination of All Forms of Discrimination Against Women: A Commentary* (Oxford: Oxford University Press, 2013) pp 311–335.

[18]United Nations, adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49. See also W Barthe Eide *A Commentary on the United Nations Convention on the Rights of the Child: The Right to Health Article 24* (Martinus Nijhoff, 2006).

[19]See on the right to emergency healthcare *Mehmet Senturk and Bekir Senturk v Turkey* (App No 13423/09) (2013) 60 EHRR 4; *Asiye Genc¸ Turquie* (App Bo 24109/07), judgment of 27 January 2015 and A Nissen 'A right to access to emergency health care: the European Court of Human Rights pushes the envelope' (2018) 26(4) Medical Law Review 693 and on rights to access health care in general *Scialaqua v Italy* (1998) 26 EHRR 164.

[20]Council of Europe, Paris, 11/12/1953.

[21]National Health Service Act 2006, s 1(4).

[22]*Re J* [1992] 2 FLR 165: *R (on the application of Burke) v GMC* [2005] QB 424*; In the Matter of Charlie Gard*, 8 June 2017 https://www.supremecourt.uk/news/permission-to-appeal-hearing-in-the-matter-of-charlie-gard.html.

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is multifactorial, including the pressures of an aging population, increasingly sophisticated (and expensive) medical treatments and (some would argue) chronic underfunding.[23] However, over many years – as we shall see below – politicians have claimed that the cost of overseas visitors using free NHS services has had a significant adverse impact, resulting in fewer resources for the NHS despite a dearth of detailed empirical evidence to that effect. The other major political issue is that of the link between NHS overseas visitor charging regulations and immigration controls.[24]

Charging patients directly is alien to many, particularly NHS staff who are often uncomfortable with the change in dynamics and their role in this process.[25] The enforcement of charges for healthcare can be seen as contrary to the founding principles of the NHS, namely that they should meet the needs of everyone, that they should be free at the point of delivery and based on clinical need and not the ability to pay.[26] They can be viewed as a distortion of the NHS as a public service providing healthcare to patients in need, and of the principles of solidarity which underpin it.[27] There remains also a difficult relationship between the aims of the Home Office concerning immigration policy and charging patients for treatment. Notably, recently stricter overseas charging regulations can be seen as very uncomfortably intertwined with the Conservative-Liberal coalition and subsequent Conservative Governments' efforts to create a 'hostile environment' for potential migrants to the UK.[28]

This paper focuses upon the position in English law. The situation in the other devolved jurisdictions is different and goes beyond the scope of this present paper.[29] The charging system is rooted in primary legislation in the form of the National Health Service Act 2006,[30] secondary legislation – the NHS Overseas Visitors Charging Regulations[31] – and related Guidance.[32] Section 1 of this paper examines the backdrop to the current NHS Overseas Charging Regulations from Bevan and the early days of the NHS to the Conservative Government of David Cameron of 2015–17, with a detailed examination of the parliamentary debates and policy issues which arose as charging regimes were considered, introduced and implemented. It demonstrates that fundamental themes of access to health care which is free at the point of delivery, citizenship, discrimination and cost have been repeated time and time again over the decades. Section 2 of the paper examines the wide-ranging changes to the regulations introduced in 2015 and 2017 under the Cameron Government and further implemented under the Government of Theresa May. It critically explores their rationale, how this can be seen as integrally linked to NHS budgetary constraints and to the recent Home Office hostile environment agenda and the fallout from the implementation, leading to calls for abolition. The final section of the paper discusses the lessons to be learnt and issues which remain to be resolved.

[23]See for example concerns expressed in relation to the new NHS long-term plan with its required changes for healthcare delivery and accompanying 'efficiency savings': R Hurley 'Doctors spurn NHS long term plan' (2019) 365 BMJ l4392.

[24]See discussion in Section 1 of this paper.

[25]See eg Z Kmietowicz 'NHS staff march against passport checks' (2017) BMJ 359; H Burn 'Returning our ebola medals: our opposition to the hostile environment within the NHS' (2018) 68 British Journal of General Practice 580.

[26]See A Pollard and J Savulescu 'Eligibility of overseas visitors and people of uncertain residential status for NHS treatment' (2004) 329 BMJ 346.

[27]On the role of social solidarity and the NHS see further C Newdick 'Citizenship, free movement and health care: cementing individual rights by corroding social solidarity' (2006) 43 Common Market Law Review 1645.

[28]J Kirkup and R Winnett 'Theresa May interview: "We're going to give illegal migrants a really hostile reception"' (*Daily Telegraph*, 25 May 2012) https://www.telegraph.co.uk/news/uknews/immigration/9291483/Theresa-May-interview-Were-going-to-give-illegal-migrants-a-really-hostile-reception.html.

[29]The regulations currently in force across the UK are: England: The NHS (Charges to Overseas Visitors) Regulations 2015, as amended 2017; Scotland: The NHS (Charges to Overseas Visitors) (Scotland) Regulations 1989; Wales: The NHS (Charges to Overseas Visitors) (Wales) Regulations 1989, as amended 2007; Northern Ireland: The Health and Personal Social Services Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2015.

[30]National Health Service Act 2006, s 175.

[31]See above n 2.

[32]Department of Health & Social Care 'Guidance on implementing the overseas visitor charging regulations' (February 2020).

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1. Charging overseas visitors for treatment: back to the future

In this section we explore the charging of overseas visitors for treatment from the late 1940s until the present. We chart how the emerging themes prove enduring and equally problematic across the successive decades.

(a) From 1948–1979: from free healthcare for all to charging overseas visitors

A fundamental principle of the National Health Service since its founding in 1948 is that healthcare should be free at the point of delivery. The 'father of the NHS', Aneurin Bevan, memorably stated that:

> No country can legitimately call itself civilised if a sick person is denied medical aid because of a lack of means.[33]

An NHS publication in 1949 provided that:

> The National Health Service will provide you with all medical, dental and nursing care. Everyone, including all visitors to this country, whether of British nationality or not, can use it or any complete part of it. There are no charges except for a few special items, and no insurance qualifications are necessary.[34]

During Parliamentary debate in April 1949 on the National Health Service Leaflet (No 2) and foreign visitors,[35] this apparent extravagance drew criticism from Conservative MP, Sir Waldron Smithers:

> The Minister of Health cares so little for the taxpayers of this country and for the contributors to this scheme that he offers free health services to anyone who likes to come to these shores…[36]

The then Parliamentary Secretary to the Minister of Health (Mr Blenkinsop) responded by stating that:

> He asked… about the number of foreigners who have been treated. We cannot give him those figures because we do not – and do not intend to – discriminate between … one section of the people who are here in our land and another. If we were to discriminate – to try to get the sort of statistics the hon. Member wishes – it would inevitably mean that we should have to require the completion of some difficult forms; that we should have to require people of all nationalities inside this country to submit themselves to an examination about their nationality, and all kinds of provisions… Certainly, the Government have no intention of introducing any regulations of that kind, which… would in all probability cost a great deal more than the cost of the minor provisions now being made.[37]

Mr Blenkinsop assessed the cost of treating foreign visitors at around £200,000 per year and said that:

> for the very small expenditure which may be involved, we are doing good service to our friends throughout the world.[38]

[33] A Bevan *In Place of Fear* (1951, reprinted by Quartet Publishing: London 1978) p 100.
[34] NHS Leaflet No 2 (1949) quoted by Sir Waldron Smithers MP in *Hansard* HC Deb, vol 463, col 2439, 8 April 1949.
[35] *Hansard* HC Deb, vol 463, cols 2439–48, 8 April 1949.
[36] Ibid, col 2240.
[37] Ibid, col 2446.
[38] Ibid, col 2448.

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In the early years of the NHS, save for a few individual MPs, the Labour and Conservative parliamentary parties were in agreement that the ideal situation was one of reciprocal healthcare access with other countries. It was argued that overseas visitors should be encouraged as they contributed to the British economy and Labour Ministers argued that free NHS care could be part of the attraction.[39] Nevertheless, the Government subsequently agreed[40] to include an opposition amendment[41] which gave the power to make regulations to charge non-resident patients for services.[42] This provision remained moribund. This was questioned in Parliament in 1957 as part of a debate on the rising costs of running the NHS.[43]

The Parliamentary Secretary to the Ministry of Health, JK Vaughan-Morgan, while recognising the resentment caused by those benefiting from the NHS without contributing to it, stated that the powers under the 1949 Act had not been used for administrative reasons relating to the problems of defining 'non residence' which could result in extended controls at ports. Moreover, he stated that:

> if we exclude non-residents from entitlement to the Health Service we impose upon doctors, dentists and hospitals the responsibility of discovering whether a patient is entitled to receive such treatment. Either the patient must produce something such as an identity card, or a very unwelcome burden is placed upon the practitioner to decide.[44]

He gave Parliament an 'outside estimate' of the cost of non-residents using the NHS as around £150,000 a year, the great majority being visitors from Canada and Australia (to put this in perspective, the total NHS budget for 1950 was £460 million).[45] While reciprocal arrangements were to be preferred, it was noted that only slow progress had been made on this. Not until 1963 was NHS guidance introduced for the charging procedure to be followed.[46] This stated that temporary visitors should be regarded as private patients, except in the case of emergency treatment or treatment arising for an accident or illness contracted in the UK, which would be free.

In 1977 the legal regulation of the NHS was consolidated in the NHS Act passed that year. Section 121 of the Act confirmed the power of the Government to make regulations to charge non-resident patients.[47] In the House of Lords, Lord Wells-Pestell, speaking for the Labour Government, explained:

> It was simply thought desirable for the Secretary of State to be able, if he chose, to charge a higher rate to individuals, particularly wealthy foreign patients, who might come to this country for highly specialised treatment requiring expensive equipment and skills because such treatment costs less here than in other countries in the world.[48]

As before, it was stated that there were no reliable figures as to the number of foreign visitors to the UK and 'there was no intention at that time to enact regulations'.[49] It was also stressed that this provision would not apply to citizens of EEC countries with which the UK had reciprocal agreements.

[39]*Hansard* HC Deb, vol 465, cols 1066–180, 24 May 1949.
[40]*Hansard* HC Deb, vol 20, cols 441–442, 17 March 1982.
[41]National Health Services (Amendment) Act 1949, s 17.
[42]*Hansard* HC Deb, vol 468, cols 629–45, 19 October 1949.
[43]Mr Gerald Nabarro, Conservative MP: *Hansard* HC Deb, vol 567, cols 159–80, 18 March 1957.
[44]*Hansard* HC Deb, vol 567, cols 176–178, 18 March 1957.
[45]J Appleby '70 years of NHS spending' (*Nuffield Trust*, 21 March 2018) https://www.nuffieldtrust.org.uk/news-item/70-years-of-nhs-spending.
[46]*Hansard* HC Deb, vol 20, col 418, 17 March 1982.
[47]In Scotland, these powers were established by the National Health Service (Scotland) Act 1978, s 98.
[48]*Hansard* HL Deb, vol 377, col 563, 10 November 1976.
[49]Ibid.

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(b) The Conservative Government of Margaret Thatcher: the first NHS overseas visitors charging regulations

For some Government members it was initially a source of pride that the UK could offer foreign visitors a level of healthcare which they might not get in their own countries. However, as decades passed, the numbers of visitors increased, as did the financial stress on the NHS generally, and critically, the political environment also changed. By the early 1980s the arguments on each side were established and they remained largely along the same party lines for two decades. For proponents of ever tighter regulation (principally the Conservatives), overseas visitor charges were necessary to provide more money for the NHS and to stop health tourism. They also brought the UK into line with most other countries in the world in terms of charging visitors who are patients. Opposing this view (principally the Labour and Liberal position) was the argument that there was insufficient data to justify the charges, and what information there was, suggested that this was a minor issue which did not justify the administrative burden on NHS staff of implementing these regulations. Furthermore, the process of identifying chargeable patients, it was argued, would lead to discrimination and hurt those in society who may be particularly vulnerable such as failed asylum seekers, children and pregnant women.[50] Both sides claimed to have public and NHS support.

A working party was established in July 1981 by the Conservative Government to look at overseas visitors' use of the NHS and its report led to the National Health Service (Charges to Overseas Visitors) Regulations 1982, applicable to England and Wales, with comparable regulations for Scotland introduced shortly after.[51] The working party report surveyed 8,152 patients and found that only 22 patients were potentially chargeable (before taking into account patients with communicable diseases who would be exempt from charging). The report also found, on the basis of a study of four hospitals, that:

> the checks made on patients to establish overseas visitors were infrequent and irregular, the registration of patients was largely carried out by clerical officers, many of whom were not aware of any restrictions on NHS treatment of overseas visitors… and that patients were often questioned about eligibility only if they had given a foreign place of birth or address or were of foreign appearance.[52]

Despite this evidence of the limited utility of the charging process, the charging regulations were taken forward. The Conservative MP Sir William van Straubenzee, had no doubt that the Government had the public behind it:

> Few matters arouse more passionate hostility and anger among perfectly decent people who do not have an ounce of prejudice in their veins than the feeling of misuse of the NHS, as they believe, with the occasional actual example, by those who come from abroad.[53]

When introducing the reforms in Parliament the Secretary of State for Health and Social Services, Norman Fowler argued that the measure would:

[50] We are using the term 'vulnerable' here in a descriptive manner, reflecting the approach taken by the debates. It is of course possible to view the nature of vulnerability as a 'universal, inevitable, enduring aspect of the human condition' as highlighted in the work of Martha Fineman but such an analysis goes beyond the scope of this current paper. See further MA Fineman 'The vulnerable subject: anchoring equality in the human condition' (2008) 20(1) Yale Journal of Law and Feminism 1.

[51] The National Health Service (Charges to Overseas Visitors) Regulations 1982, SI 1982/795 and the National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1982, SI 1989/364 and see further H Carty 'Overseas visitors and the NHS' (1983) 5 Journal of Social Welfare and Family Law 258.

[52] *Hansard* HC Deb, vol 20, col 418, 17 March 1982.

[53] *Hansard* HC Deb, vol 20, cols 411–52, 17 March 1982.

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raise extra income for the National Health Service… which lifts the burden from the British taxpayer and avoids the possibility of racial discrimination in the present hospital admission procedures…[54]

He added that '… the provision merely rectifies an anomaly that leaves us out of line with almost every country in the free world'.[55] The question of whether this would in fact reduce racial discrimination was raised during the debates.[56] The regulations came into force two months before a landmark House of Lords case in 1982, *R v Barnet London Borough Council, ex p Nilish Shah*, which established the meaning of 'ordinary residence' as the requirement of entitlement to public services, including the NHS.[57]

In the debates on the charging regulations, questions were raised about the absence of effective data demonstrating the need for such regulations. The Conservative Government estimate in 1982 of recoverable costs of £6 million (to put this in context the total health budget for 1982–83 was £10 billion)[58] was disputed by the Labour opposition, who argued that the regulations were unjustifiable:

to winkle out a minuscule number of foreign tourists, a fraction of whom might be abusing the NHS… the administrative costs of the Government's scheme would most certainly exceed the net savings in preventing abuse.[59]

Kenneth Clarke, Minister of State for Health, downplayed the administrative cost:

The only increase in cost would be for hospitals with a large number of overseas visitors – such as some of the London hospitals – where additional costs might be involved. We are talking about perhaps half a staff post. The £6 million that we hope to gain vastly outweighs any administrative costs.[60]

As the 1982 regulations came into force, the Labour MP Alf Dubs asked a series of questions:

how many overseas visitors had been charged, what the income had been for each regional health authority… extra staff appointed to administer the new procedures… whether the new procedures had been introduced in all hospitals, from which countries the overseas visitors came who had been charged.[61]

But this was rejected and in Parliament when discussing the criticisms made of the scheme Kenneth Clarke stated that

The answer to his inquiry is, first, that we are not collecting centrally the information he wants and, secondly, that it is far too early in the lifetime of the scheme to check any sensible statistics because the information is not readily to hand'.

He went onto say:

I have no intention of organising a massive statistical collecting operation, which would merely impose a high administrative cost.[62]

[54]*Hansard* HC Deb, vol 20, col 416, 17 March 1982.
[55]Ibid.
[56]*Hansard* HC Deb, vol 20, cols 411–52, 17 March 1982.
[57]*R v Barnet London Borough Council, ex p Shah* [1983] 2 AC 309.
[58]*Hansard* HC Deb, vol 29, col 373, 20 Oct 1982.
[59]*Hansard* HC Deb, vol 20, col 438, 17 March 1982: Mr Michael Meacher, Labour MP.
[60]*Hansard* HC Deb, vol 20, col 446, 17 March 1982.
[61]*Hansard* HC Deb, vol 36, col 718, 7 February 1983.
[62]*Hansard* HC Deb, vol 36, col 721, 7 February 1983.

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There was a notable tightening of policy later in the 1980s when the Health and Medicines Act 1988 introduced powers enabling the Secretary of State to charge for healthcare at commercial rates.[63] This was followed by the enactment of new charging regulations in 1989 across the UK.[64] There are now different charging regulations operational across the devolved jurisdictions.[65] The focus of this paper is upon the regulations which operate in England. The revised primary consolidating legislation for the NHS in force today is the National Health Service Act 2006. As with its predecessor, the National Health Service Act 1977, section 175 of the 2006 Act allows the Secretary of State for Health to make regulations for the making and recovery of charges from any person who is not ordinarily resident in Great Britain.

(c) Labour Governments of Tony Blair and Gordon Brown (1997–2010)

While the Labour Party had previously been seen as opposed to extending charges to overseas visitors, the mid-2000s saw a shift in approach by the Blair and the Brown Governments. Charging was introduced for maternity care of women not ordinarily resident and this included such persons as refused asylum seekers, trafficked women, and undocumented migrants.[66] Long before the era of an explicit Government policy of hostile environment, the development of NHS overseas visitor charging regulations often proceeded in tandem with immigration controls.[67] For example, the 1963 Ministry of Health guidance came one year after the first Commonwealth Immigration Act 1962 and the 1982 NHS (Overseas Visitors) Charging Regulations followed the 1981 Nationality Act. By the mid-2000s there were links in media coverage between migration and health tourism. As Baroness Howells commented in a 2004 House of Lords debate on the case for introducing tighter regulations for charging overseas visitors using the NHS:

> The press have mounted a sustained attack on immigration, with campaigns against ‘benefit tourists’ and asylum seekers… we as decision-makers have to be very careful not to breathe oxygen into the fire of intolerance, however good our intentions. The brunt of this hysteria will be borne not only by visitors coming into this country, but also by ethnic minorities who live here legally and those currently seeking asylum.[68]

The link between the restriction of healthcare for overseas visitors and immigration controls became explicit by 2007 when the Home Office produced a strategy document ‘Enforcing the Rules: A strategy to ensure and enforce compliance with immigration laws’[69] including a planned ‘review of access rules for NHS care for foreign nationals to simplify the process of applying controls’.[70] In March 2007 the Department of Health (DoH) ‘agreed to a joint review with the Home Office of the rules governing NHS access for foreign nationals’.[71] (It is of note that the term ‘foreign nationals’ is used here rather than the much broader term ‘overseas visitors’. This terminology is important since, as we explore in this paper, it is not nationality but residence which is the basis for access for NHS services.) The DoH and the Home Office proposed the sharing of information

[63]Health and Medicines Act 1988, s 7.

[64]The National Health Service (Charges to Overseas Visitors) Regulations 1989, SI 1989/306.

[65]See n 29 above.

[66]R Bragg ‘Maternal deaths and vulnerable migrants’ (2008) The Lancet 880 and see R Ashcroft ‘Standing up for the medical rights of asylum seekers’ (2005) 25 Journal of Medical Ethics 125.

[67]R Bragg and R Feldman ‘“An increasingly uncomfortable environment’: access to health care for documented and undocumented migrants in the UK’ in *Migration and Social Protection* (London: Palgrave Macmillan, 2011) p 146.

[68]*Hansard* HL Deb, vol 658, cols 950–68, 5 March 2004.

[69]Home Office ‘Enforcing the rules: a strategy to ensure and enforce compliance with our immigration laws’ (Home Office, 2007).

[70]Ibid at p 14 as quoted in Bragg and Feldman, above n 67.

[71]Department of Health ‘Review of access to the NHS by foreign nationals. Consultation on proposals’ (February 2010) Foreword, p 1.

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on overseas visitors who had unpaid NHS bills so that they could be refused any future UK visa until the debt was settled. A 2009 impact assessment prepared by the newly-created UK Border Agency, said there were 'outstanding debts of over £5m owed by non-resident patients to a small sample of hospitals', and that 'there is a relatively small number of non-resident patients who appear determined to access NHS services and are not paying charges they owe'.[72]

It was estimated that the cost of implementation of this data sharing was £2.76 million, allowing for a potential net benefit of just over £6 million. The Border Agency stated that 'one of the main aims is deterrence' and as repeat offenders were stopped, both the implementation costs and the sums recovered would fall.[73] Also in 2009 there were reports of care being refused for failed asylum seekers,[74] which led ultimately to a judicial challenge which confirmed that care could be refused to such patients.[75]

Apart from this data sharing, the finding of the joint 'review of access' was that 'the current policy remains substantially sound' but the review proposed some further protections for 'vulnerable groups'.[76] In February 2010 the Government began a consultation both on these proposed changes, and on other ideas to improve overseas visitors charging. Strongly promoted was the idea of a health insurance requirement for visitors on the grounds that this could simplify the process and facilitate access to NHS resources.[77] The Government proposed to undertake a comprehensive comparative study to ascertain the approach taken in countries requiring migrants and visitors to have health insurance.[78] Other suggestions included the introduction of a health insurance fee for temporary migrants and students.

(d) 2010–2020: from Conservative/Liberal coalition 2010 to Cameron and May Conservative Governments

The new Conservative-Liberal Coalition Government, with Andrew Lansley as Secretary of State for Health, published a response to the Labour Government's consultation in March 2011. This document stated that the previous review:

> failed to address fundamental issues in the current charging regime. Current rules and practices around charging non-residents are complex and difficult to apply.[79]

The Government indicated that it intended to carry out a further review which would include looking at qualifying residency criteria, exemptions, how to establish more effective and efficient processes, and whether to introduce a requirement for health insurance tied to visas. There was no mention of the previously proposed comprehensive comparative study of systems in other countries. In the meantime, consolidated Overseas Visitors Charging Regulations were introduced for England in 2011.[80] These incorporated the 1989 Regulations, subsequent amendments and further exemptions for certain failed asylum seekers, children in the care of a local authority, and participants in the 2012 Olympic and Paralympic Games – the enhanced exemptions which had been proposed by the previous Labour Government.

[72]UK Border Agency 'Impact assessment of proposed amendments to the immigration rules; refusing entry or extensions of stay to NHS debtors' (7 December 2009) p 1, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/257679/ria.pdf.

[73]Ibid, p 5.

[74]See discussion in C Newdick 'Treating failed asylum seekers' (2009) 338 BMJ, including the case of Ama Sumane, a Ghanaian patient with multiple myeloma, who was refused treatment by University Hospital Cardiff. Her condition was stabilised and she was then removed to Ghana where there was limited treatment available for her condition.

[75]*R (on the application of YA) v Secretary of State for Health* [2009] EWCA Civ 225.

[76]Department of Health, above n 71, Foreword, p 1.

[77]Ibid, Chapter 5 'Health insurance for overseas visitors'.

[78]Ibid, p 29.

[79]Department of Health 'Access to the NHS by foreign nationals – Government response to the consultation' (18 March 2011) p 5.

[80]National Health Service (Charges to Overseas Visitors) Regulations 2011, SI 2011/1556.

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While there had been amendments to the charging regulations over time, a new and more rigorous policy was pursued following Jeremy Hunt taking office as Secretary of State for Health in September 2012. The notable and rapid change in emphasis on reclaiming costs became linked to concerns of the NHS 'deficit'.[81] This can in turn be seen as Government concern regarding costs of services in an era of austerity.[82] There have been numerous attempts to estimate the cost of treatment of overseas visitors to the NHS. In 1949 the estimate had been £200,000 per year, by 1957 the calculation had gone down to £150,000. In 1982, recoverable costs were estimated at £6 million. This grew to £367 million in 2012/13 and the target for 2017/18 was £500 million. (The DHSC budget for that year was £130 billion).[83] However, while substantial sums have been cited, every one of these estimates has been prefaced with an admission that it was based on incomplete and doubtful data. In 2015, Meirion Thomas, a former consultant at the Royal Marsden Hospital and vocal campaigner, claimed that the annual loss to the NHS stood at £3 billion 'based on anecdotal reports he received after going public with his concerns'.[84] Nonetheless it was these fiscal concerns which lay directly behind the response of tightening the regulations for charging overseas visitors and to the reforms of 2015 and 2017 which are explored in the next section.

2. The current regulations in England: application and controversy

The National Health Service (Charges to Overseas Visitors) Regulations 2015, as amended in 2017, are the current regulations in force in England.[85] They replaced the 2011 Regulations and are the latest and toughest application of the rules for overseas visitors using the NHS. In this section we consider the scope of the regulations, their implementation and the ongoing controversy which surrounds them. The regulations can be seen as leading to tensions with the fundamental principle of the NHS that treatment should be free at the point of use.[86]

(a) The test of 'ordinary residence'

The regulations apply to 'overseas visitors', who are defined under the regulations as 'a person not ordinarily resident in the United Kingdom'.[87] These may be tourists, students, temporary workers, former UK residents who are now living overseas, short-term migrants who are staying in the UK for less than six months, and people living in the UK illegally. The test for 'ordinary residence' was established

[81] National Audit Office 'Department of Health. Recovering the cost of NHS treatment for overseas visitors' (28 October 2016) p 7.

[82] For a very helpful background to the debates concerning austerity see further M Blyth *Austerity: The History of a Dangerous Idea* (Oxford: Oxford University Press, 2013).

[83] The King's Fund 'The NHS budget and how it has changed', 5 September 2019, https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget (last accessed 11 June 2020).

[84] R Clark 'Cost of treating health tourists is killing the NHS' (*Daily Express*, 31 October 2016) https://www.express.co.uk/comment/expresscomment/727339/NHS-cost-treatment-foreign-tourists-Bimbo-Ayelabola, a figure which he subsequently revised down to two billion: J Meirion Thomas 'Health tourism is a gaping wound in our NHS' (*MailOnline*, 24 October 2017) https://www.dailymail.co.uk/debate/article-5010685/J-MEIRION-THOMAS-Health-tourism-gaping-wound-NHS.html.

[85] The 2015 Regulations were introduced during David Cameron's Government, and the 2017 Regulations under the Government of Theresa May. See further S Steele and C Devlin 'Access and entitlements for migrants and visitors to the UK in the English National Health Service' in K Kuehlmeyer et al (eds) *Ethical, Legal and Social Aspects of Health Care for Migrants: Perspectives from the UK and Germany* (London: Routledge, 2018).

[86] The provision of NHS prescriptions in England is an exception, though some groups are exempt – for example retired persons and children.

[87] Above n 2, reg 2(b) and see K Syrett ' The organisation of the NHS' in JM Laing and JV McHale *Principles of Medical Law* (Oxford: Oxford University Press, 2017); L Hiam and M McKee 'Upfront charging of overseas visitors using the NHS' (2017) 359 BMJ j4713.

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in the 1982 House of Lords case of *Shah*[88] and confirmed in subsequent cases.[89] Government guidance states that:

> Ordinary residence is established if there is a regular habitual mode of life in a particular place 'for the time being', 'whether of short or long duration', the continuity of which has persisted apart from temporary or occasional absences. The only provisos are that the residence must be voluntary and adopted 'for a settled purpose'… Ordinary residence is proven more by evidence of matters capable of objective proof than by evidence as to state of mind.[90]

In terms of what constitutes proof, DoH guidance advises that:

> 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.[91]

For people from outside the EEA the residence test is even tougher. Section 39 of the Immigration Act 2014 changed the meaning of 'ordinary residence' for non-EEA nationals, who also need to have indefinite leave to remain in the UK in order to receive free secondary NHS healthcare:

> 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 ordinarily resident in the UK.[92]

The regulations impose an obligation to charge for secondary healthcare[93]

> having made such enquiries as it is satisfied are reasonable in all the circumstances, including in relation to the state of health of that overseas visitor, determines that the case is not one in which these Regulations provide for no charge to be made.[94]

The regulations as amended in 2017 also now provide that:

> (1A) Where the condition specified in paragraph (2) is met, before providing a relevant service in respect of an overseas visitor, a relevant body must secure payment for the estimated amount of charges to be made under paragraph (1) for that relevant service unless doing so would prevent or delay the provision of:
> (a) an immediately necessary service; or
> (b) an urgent service.[95]

Thus, the charges must be paid upfront unless clinical discretion is used to enable treatment without upfront charge.[96] Critically in such a situation, even if the person is treated they will still remain

[88] *R v Barnet London Borough Council, ex p Shah*, above n 57.
[89] *R v Hammersmith Hospitals NHS Trust, ex p Reffell* [2000] 55 BMLR 130; *R (on the application of YA) v Secretary of State for Health* [2009] EWCA Civ 225.
[90] UK Visas and Immigration 'Guidance. Ordinary Residence' (October 2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/258236/ordinaryresidence.pdf.
[91] Above n 32, p 26, para 3.5.
[92] Ibid, para 3.10.
[93] Above n 2, reg 3(1).
[94] Ibid, reg 3(2).
[95] Above n 2, reg 3(1A).
[96] Above n 32, p 68, para 8.17.

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liable to subsequently pay for the cost of the treatment. It is unclear to what extent this exception is currently being used in practice and the exercise of clinical discretion may be all that is between an individual getting into thousands of pounds of debt or forgoing treatment. The level of cost may also prove a major shock to potential patients, given that the 2015 Regulations also provided for the introduction of commercial charging. This means that medical treatment for non-residents is charged at 150% of the standard NHS tariff.[97] In itself this is symbolically important. This is not simply reimbursing costs: this is also healthcare charging explicitly as a means of income generation. This is nothing new in the NHS in general but it is striking to see the use of commercial tariffs being charged directly to patients.[98]

Uncertainties remain regarding the precise impact of the regulations. In the past the question of proving ordinary residence was rarely an issue. Although the regulations and their predecessors are predicated upon the assumption that potential patients need to prove their entitlement to care, this was not something which was routinely pursued in detail. The guidance for the regulations now emphasises that evidence should be sought regarding entitlement to care.[99] The prospect of this was criticised from the outset and it was suggested it could have the potential to cause chaos.[100] Pilots introduced to tighten up the screening procedures to verify ordinary residence have proved particularly controversial. In 2016 a pilot scheme in 18 NHS trusts required patients to bring to appointments two forms of identification proving their permanent residency in the UK. The scheme was run by NHS Improvement working with the DoH and also, notably, the Home Office, and a spokesman said that the hospitals chosen were those:

> with the biggest funding gap attributed to overseas visitors and migrants in an attempt to meet the Government's target of recovering up to £500 m a year in this way.[101]

NHS Improvement offered intensive support to 50 acute trusts which it had identified with the biggest potential for recovering such income. The cost of implementing the pilot scheme and providing 'intensive support' is unclear, as its overall effectiveness.

In a letter of 5 September 2017, Jeremy Hunt stated that Ipsos Mori would formally evaluate the pilots and that these findings would be used in analysis of any proposals later that year.[102] This formal evaluation has never been published, although the Evening Standard on 29 May 2018 reported that the pilot schemes had found 'only a tiny number' of patients to be ineligible for free care and that out of 8,894 people in London Hospitals asked for two forms of ID before treatment only 50 (1/180) were charged for treatment.[103] What is striking is that these figures are consistent with those of the 1982/3 study discussed above and that 27 years on there did not appear to a radical change in demand. At St George's Hospital in Tooting – claimed to be a particular target of 'health tourists' – some 1660 maternity patients were screened over five months with 18 persons found liable to pay, and who were charged £45,000 in total.[104] Two participating Trusts had either shelved plans to extend checks or

[97] Above n 2, reg 7(3).

[98] See eg P Hunt 'Income generation in the NHS' (1989) 4(1) Journal of Management in Medicine 56; MJ Roddis 'Income generation in the NHS: opportunity or myth?' (1996) 6(55) British Journal of Hospital Medicine 67.

[99] Above n 32.

[100] J Wise 'News charging overseas patients upfront could cause "chaos", BMA warns' (2017) 365 BMJ j655.

[101] K Forster 'Patients at 20 NHS hospitals having to show passports and ID in "health tourism" crackdown' (*The Independent*, 17 January 2017) http://www.independent.co.uk/news/uk/politics/nhs-hospitals-20-forced-show-passports-id-health-tourism-crackdown-healthcare-jeremy-hunt-government-a7530931.html.

[102] Letter from Jeremy Hunt to Sarah Wollaston MP, 5 September 2017. HC Health Committee: Correspondence with the Secretary of State relating to pilots of checking for eligibility for NHS treatment: https://www.parliament.uk/documents/commons-committees/Health/Correspondence/2017-19/Correspondence-SoS-pilots-nhs-eligability-210717.pdf.

[103] R Lydall '8,900 Checks on NHS "health tourists" find just 50 liable to pay' (*Evening Standard*, 29 May 2018) https://www.standard.co.uk/news/health/8900-checks-on-nhs-health-tourists-find-just-50-liable-to-pay-a3850121.html.

[104] Ibid.

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ended them completely.[105] The DoH was reported to be 'considering the findings of the evaluation before deciding on next steps'.[106]

Other problematic aspects of the implementation of the revised regulations have come to light. Allegations have been made of discriminatory practice in the implementation process, with claims that individuals have been targeted due to having non-traditional English surnames.[107] In addition, proving ordinary residence can be very difficult for some individuals, particularly those who may be elderly or not in a settled situation, such as the homeless and others who may never have obtained a British passport. People who are in a care home and immobile may not have utility bills (although these alone will not be sufficient to prove ordinary residence) or a driving licence – documents which are required under the pilot scheme.[108] It may also be difficult for those whose work takes them between countries on a regular basis. Rather than undertaking a detailed investigation of each patient, requiring the provision of documentation, an alternative option could be the use of an electronic plastic card with a bar code identifier. Showing such a card before providing treatment is an approach adopted in certain other European countries, eg the carte vitale in France.[109] Nonetheless in a country which has only required the presentation of identity cards during the First and Second World Wars, although there was provision for use of identity cards (though not compulsorily required) from 2006–2010,[110] it is likely that a specific health identity card may meet resistance.

(b) Other persons exempt from charges under the Regulations

In addition to those 'ordinarily resident' a number of other groups of persons are exempt from charges. As we saw in Section 1 above, the 2010 reform proposals had raised the prospect of a 'health insurance' for temporary migrants and students. This now takes the form of the immigration health charge[111] (referred to by the Home Office as the 'health surcharge'),[112] which is payable at the time of making their visa application by temporary migrants and students from outside the EEA who come to the UK for six months or more.[113] This payment exempts them from charges for NHS treatment during the period of their visa. This can effectively be seen as a 'health insurance' paid in advance. Also exempt during the current period of transition following the UK's exit from the EU on 31 January 2020 are visitors with rights to healthcare under EU law,[114] or from other states which have reciprocal healthcare agreements with the UK. This includes those who receive treatment under the European Health Insurance Card (EHIC) card, what is known as the 'S1' or' S2' scheme under EU Regulation

[105]Ibid.

[106]Ibid.

[107]L Pasha-Robinson 'Pregnant British woman ordered by NHS to prove she is from UK to receive free treatment' (*The Independent* 2017) https://www.independent.co.uk/news/uk/home-news/pregnant-british-woman-emma-szewczak-harris-nhs-treatment-addenbrookes-hospital-polish-uk-a8012846.html.

[108]For example, list of 'Acceptable identification documents' at https://www.guysandstthomas.nhs.uk/patients-and-visitors/patients/nhs-entitlement.aspx#na.

[109]See P Mitchell 'France gets smart with health à la carte' (1998) 351 (9104) The Lancet 736.

[110]Provision was made for identity cards in the Identity Cards Act 2006 but these were not compulsory and this was repealed by the Identity Documents Act 2010. In consideration of identity cards before the 2006 Act was eventually introduced there was support given to identity cards to crack down on 'health tourism': see S Goodchild 'Ministers say ID cards "good for NHS" (*The Independent*, 25 April 2004) and the Select Committee stated that 'it would be sensible for the identity card to be the mechanism that enables individuals to access their NHS records', House of Commons Home Affairs Committee 'Identity Cards' Fourth Report of Session 2003–04 para 176, HC 130-1.

[111]Above n 2, reg 10, power to impose this charge had been granted by the Immigration Act 2014, s 38.

[112]'Pay for UK healthcare as part of your immigration application' https://www.gov.uk/healthcare-immigration-application.

[113]The charge is currently £400 per year (£300 for certain visa categories) and is due to increase in October 2020 to £624 per year (£420 for certain visa categories): Immigration (Health Charge) Order 2015, SI 2015/792 (as amended, most recently by the Immigration (Health Charge) Amendment Order 2018, SI 2018/1389); see also M Gower 'The Immigration Health Surcharge' House of Commons Library Briefing Paper, Number CBP 7274, 27 April 2020.

[114]Above n 2, reg 12.

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883/2004, or under the Patients' Rights Directive. EHIC provides limited free healthcare to citizens from EEA countries, the cost being subsequently reimbursed by their home country. The S1 form is for people who live in one EEA country and have their healthcare costs covered by another EEA country up to the limits as stated in the country in which they are resident, so for example some EU citizens resident in this country. The S2 form is for those people who choose to have their healthcare in a different EEA country to the one where they live.[115] The Patients' Rights Directive provides EU citizens with the right to travel to another EU country to receive medical care and reimbursement. The right is not unlimited. In some situations, such as those requiring hospital care, prior authorisation from the member state may be required and treatment can be refused in certain circumstances, such as risk to public health.[116] Under the Withdrawal Agreement the costs of the treatment of those who are currently being treated at the end of transition will be covered by home member states.[117]

Post transition EEA residents who are lawfully in the UK under the settled status scheme and who are ordinarily resident will also be exempt from charging for treatment. The Home Office is operating the settled status scheme which has the effect of implementing the relevant provisions of the EU Withdrawal Agreement and granting immigration status to EU citizens. The scheme applies to those EU citizens who are resident in the UK at the end of the transition period; they must apply for settled status by 30 June 2021. If an EU citizen has five years' continuous residence they have a right to reside permanently in the UK under Article 15 of the Withdrawal Agreement and may apply for settled status. If they have not been resident for five years but are resident at the end of the transition period then they are deemed to have 'pre-settled status' and are able to reside for a further five years from the date on which pre-settled status is given.

Considerable uncertainties remain as to the position of those EEA citizens who are not covered by the Withdrawal Agreement.[118] For those coming to the UK from another EEA member state for a period of time, perhaps to study or work, the Government may decide that (as with non-EU citizens at present) they may be subject to the Immigration Health surcharge (discussed below). In the case of EEA visitors who are in the UK on a more temporary basis, they will almost certainly be subject to the charging regulations. Charges under the Overseas Visitors Regulations also do not apply if the individual is covered by a reciprocal healthcare agreement between their country and the UK.[119] It may of course be possible for negotiations to enable continued recognition of reciprocal health rights for future new residents. The Healthcare (European Economic Area and Switzerland Arrangements) Act 2019 would enable the implementation of such agreements but at the time of writing the position is extremely fluid.

The regulations also exclude from charge refugees, asylum seekers, failed asylum seekers who are destitute or likely to become destitute without support, and their dependants.[120] Prisoners and immigration detainees are also excluded,[121] as are children who are looked after by a local authority. The regulations also exclude victims and suspected victims of human trafficking[122] or where the Secretary

[115] 'Resources for NHS trusts to help manage overseas visitors and migrant charging' (*GOV.UK*, 2018) https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants and see further discussion of the impact of EU law on patient's rights to claim treatment in other EU member states in TK Hervey and JV McHale *European Health Law: Themes and Implications* (Cambridge: Cambridge University Press, 2015).

[116] Directive 2011/24/EU of 9 March 2011, Art 8 on the application of patients' rights in cross-border healthcare.

[117] HM Government *Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community* (19 October 2019).

[118] Guidance had been issued in relation to a No-Deal Brexit scenario in 2019 but as the UK did leave with a withdrawal agreement and went into Transition this is no longer valid: 'Guidance Overseas visitor charging: no-deal Brexit guidance for NHS service providers', last updated 3 October 2019: https://www.gov.uk/guidance/overseas-visitor-charging-guidance-for-nhs-service-providers-on-updates-to-regulations.

[119] Above n 2, reg 14.

[120] This refers to those who are receiving support under s 95 of the Immigration and Asylum Act 1999 from the Home Office: ibid, reg 15.

[121] Ibid, reg 19.

[122] Ibid, reg 16.

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of State for Health determines there to be exceptional humanitarian reasons to provide a free course of treatment.[123]

While the charging regulations provide exemptions for patients who undergo compulsory treatment for mental illness under court order,[124] or those deprived of their liberty under the Mental Health Act 1983 or the Mental Capacity Act 2005[125] curiously there is no provision for other patients with mental disability within the terms of the Mental Capacity Act 2005. It remains entirely unclear why, for example, there is no provision for patients who lack decision making capacity due, for example, to advanced dementia. Such failure to effectively engage with this group of people is a fundamental flaw in the legislation, short sighted and frankly perplexing.[126] We would argue that those lacking mental capacity should today be included in the group who are automatically recognised as exempt from charges. A third exempt category is UK government employees, members of the regular and reserved armed forces,[127] NATO employees[128] and war pensioners.[129] There are also exemptions for family members of persons who are exempt under the other provisions under the regulations.[130]

(c) Specific types of healthcare services excluded from charging

Some healthcare services are also excluded from charge.[131] This has always been the case for emergency treatment, although only if it is provided at an A&E department, walk-in centre, minor injuries unit or urgent care centre.[132] However, following emergency treatment after leaving A&E care then care becomes chargeable. Services provided outside hospital such as by GPs are excluded from the charging arrangements.[133] This was not extended under the 2017 review although it remains possible such services may be chargeable in future (see discussion below). Controversially the revision to the 2015 regulations in 2017 also extended charges to non-NHS providers of NHS-funded care and to secondary care delivered outside of the hospital setting.[134] It remains unclear how this change has operated in practice.

Some services are also exempt on public health grounds. For example, no charge will be made to overseas visitors for the diagnosis and treatment of a large number of specified infectious diseases, which includes TB, pandemic flu, HIV/AIDS[135] and in 2020 the Coronavirus (COVID-19).[136] However, on 21 July 2017 the Chair of the Health Committee, Sarah Wollaston MP, wrote to the Secretary of State for Health, Jeremy Hunt, about an NHS Trust instructing patients at its Infectious Diseases Department to bring identification proving permanent residence to their appointments, failing which they might be charged for treatment.[137] The Trust in question was one of those taking part in the pilot scheme of the 2015 Charging Regulations. As a result of Dr Wollaston's letter, the pilot in the Infectious Diseases Unit was cancelled as 'there was too great a risk of confusing

[123]Ibid, reg 17.
[124]Ibid, reg 18(c) and (d).
[125]Ibid.
[126]Some concerns regarding these provisions were raised before the House of Lords European Union Select Committee hearing in 2017: House of Lords European Union Committee *Brexit reciprocal healthcare 13th Report of Session 2017–19*, HL Paper 107.
[127]Ibid, reg 20.
[128]Ibid, reg 21.
[129]Ibid, reg 22.
[130]Ibid, reg 25.
[131]Above n 32, p 12, para 1.1.
[132]Above n 2, reg 9.
[133]Ibid, reg 9(b).
[134]Above n 2, reg 9.
[135]Above n 2, Sch 1.
[136]Ibid, reg 9, Sch 1.
[137]Letter from Dr Sarah Wollaston MP, Chair of Health Committee to Jeremy Hunt (21 July 2017) https://www.parliament.uk/documents/commons-committees/Health/Correspondence/2017-19/Correspondence-SoS-pilots-nhs-eligability-210717.pdf.

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patients',[138] although it appears that it was in fact the implementing staff who were confused and unaware that infectious diseases were exempt from overseas charging. Diagnosis and treatment of sexually transmitted infections and services that are provided as part of the NHS111 telephone advice line are also exempt.[139] Other forms of care are exempted on humanitarian grounds, namely palliative care, treatment required for a physical or mental condition caused by: torture, female genital mutilation, domestic violence, or sexual violence as long as the person has not travelled to the UK for the purpose of seeking that treatment.[140]

Family planning services (but not termination of pregnancy services) are exempt from charging.[141] 'Immediately necessary or urgent care, including maternity care' is exempt from charging.[142] Any maternity services consequent upon female genital mutilation[143] or sexual violence are also exempt from charge.[144] However, as we saw earlier, other aspects of pregnancy care – including childbirth itself – are chargeable. The Department of Health and Social Care guidance on the regulations notes that:

> 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.[145]

This guidance does not mean that women will be exempted from charge. Thus, while women are to be informed that care will not be withheld on the basis of their ability to pay, they will still be liable for the cost of non-exempt services. It has been persuasively argued that including this within the category of charging can be seen as sex discrimination, as to deprive women of care during pregnancy can be seen as a barrier to good health.[146]

Visitors from outside the EEA who do not fall into the category of exempt services or individuals and cannot meet the residency requirement are to be charged directly for secondary care in advance of treatment. The 2017 revisions to the Charging Regulations further tightened the rules by requiring upfront charging for non-exempt patients, unless doing so would prevent or delay the provision of immediately necessary or urgent services. There was an attempt to bring judicial review to challenge the revised legislation in 2017 on the basis of failure to undertake adequate consultation but this was not successful.[147]

(d) Implementation and impact of the reforms to the Charging Regulations in 2015 and 2017

The implementation of the charging regulations raises several issues regarding the provision of NHS care. First, concerns have been raised about the administrative burden on NHS staff, and also that the regulations have been poorly understood and implemented. In England the 2017 amendments to the 2015 Charging Regulations placed obligations upon NHS senior managers to ensure compliance with

[138] See above, n 102.
[139] Above n 32, p 12, para 1.1.
[140] Above n 2, reg 9(f).
[141] Ibid, reg 9(c).
[142] Above n 32, para 7.2.
[143] Ibid, para 7.11.
[144] Ibid, para 7.26.
[145] Above n 32, para 8.6.
[146] A Shahvisi and F Finnerty 'Why is it unethical to charge migrant women for pregnancy care in the National Health Service' (2019) 45 Journal of Medical Ethics 1.
[147] *R (on the application of MP) v Secretary of State for Health and Social Care v Equality and Human Rights Commission* [2018] EWHC 3392 (Admin).

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systems to support charging covering 'all staff inpatient administration including A&E, outpatient clinics and wards'.[148] NHS service providers are to appoint an Overseas Visitors Manager (OVM) to oversee implementation of the charging regulations.[149] All staff are expected to understand their obligations under the regulations. Meirion Thomas has argued that trusts are at fault for failing to appoint sufficient OVMs to implement the regulations.[150] In 2017 Ipsos Mori found a lack of senior level buy-in, ie support and awareness. While many staff groups felt that the principle of charging overseas visitors and migrants was fair 'there was also evidence that a significant minority of frontline clinicians are resistant to those principles, and levels of support may be declining over time amongst a number of staff groups'.[151] Although awareness of charging had increased, 'one in five Trust Chairs and board members were unaware that some patients could be charged'.[152]

Secondly, it has been suggested that the charging obligations can effectively result in hospital administrative or clinical staff becoming a 'border guard'[153] or a 'debt collector'.[154] The obligation to ascertain chargeable status is placed on A&E staff to direct 'baseline questions' to patients when they are booked in.[155] Obligations are also placed upon finance staff, including ensuring that charges can be implemented rapidly and if needed at very short notice. There is a requirement to record against a person's NHS 'consistent identifier' the fact that they are considered an overseas visitor, the date on which this was decided and whether they are exempt from charges.[156] A consistent identifier is a patient's unique NHS number which confirms a person's identity and allows for all data sharing associated with or facilitating care for that individual. This enables easier tracking of individuals' status within the NHS. The computerised recording of such information makes it easier to transfer such information. This in turn given rise to concerns regarding the privacy and confidentiality of patient information, something which has been a fundamental principle of health care provision since the days of the Hippocratic Oath, and which today is safeguarded through the law concerning breach of confidence and also provisions of data protection law,[157] and the legitimacy of the use of such information by other agencies. Concerns were expressed when reports in September 2019 revealed that NHS Trusts had been passing information to the credit reference agency Experian to ascertain whether a person has a 'credit footprint' in the UK and thus whether they are resident and consequently able to obtain free treatment.[158]

Thirdly, and particularly controversial, is the major responsibility placed on doctors themselves to decide clinical need for treatment, and whether it is considered emergency care (and therefore exempt from charging). This inevitably impacts on the role of the doctor and the commitment to healthcare free at the point of delivery pledged by Bevan at the founding of the NHS. There is concern that the

[148] Above n 32, para 11.3.

[149] Above n 33, paras 11.6–11.9.

[150] Meirion Thomas, above n 84.

[151] Ipsos MORI 'Overseas visitor and migrant NHS cost recovery programme. Formative evaluation – final report' (January 2017) at iv.

[152] Ibid.

[153] Doctors of the World: quoted in A Gentleman 'Crackdown on migrants forces NHS doctors to "act as border guards"' (*The Guardian*, 20 April 2017) https://www.theguardian.com/uk-news/2017/apr/20/crackdown-migrants-nhs-doctors-border-guards-immigration-undocumented-migrants.

[154] J Meirion Thomas and K Chand 'Is Jeremy Hunt right to act on health tourism?' (*The Guardian*, 23 October 2013) https://www.theguardian.com/commentisfree/2013/oct/23/jeremy-hunt-health-tourism-nhs-visitors.

[155] Above n 32, at 90, para 11.28.

[156] Above n 2, reg 3A.

[157] In relation to the impact of the regulations on privacy and confidentiality see eg JMK Reynolds and C Mitchell '"Inglan is a bitch": hostile NHS charging regulations contravene the ethical principles of the medical profession' (2019) Journal of Medical Ethics 497 and see further in relation to the nature of the concepts in health care generally G Laurie et al *Mason and McCall Smith's Law and Medical Ethics* (Oxford: Oxford University Press, 11th edn, 2019) ch 6; JV McHale 'From X v Y to care.data and beyond: health care confidentiality and privacy in the C21st: a critical turning point?' (2015) 3 Journal of Law Medicine and Ethics 103; C Stanton 'To share or not to share' (2018) 26(2) Medical Law Review 328.

[158] S Lintern 'Revealed: mass use of credit check firm to find NHS patients to charge' Health Service Journal, 30 September 2019.

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very implementation of the regulations might effectively change the nature of the therapeutic relationship. Doctors are imbued in their training and professional ethics with the ethical principles of beneficence and non-maleficence – 'do no harm'.[159] Yet here doctors are asked to make a decision which has a notable fiscal dimension, knowing that if they do not exercise clinical discretion this could deprive patients of much needed treatment in a situation where if ordinarily resident they would have immediately gone ahead with treatment. While doctors can effectively override administrators by saying treatment should go ahead even if patients do not pay upfront, in practice this may not be easy to do. Moreover, in this situation, while patients may be treated, they will still be subsequently liable for the costs of that treatment. Clinicians today are engaged in rationing decisions but these do not normally have such immediacy. Generally, a decision whether to fund a treatment on financial grounds will be subject to oversight through a local Clinical Commissioning Group or in the case of treatments not generally available in the NHS via NHS England through its individual funding request procedures.[160] The situation for overseas visitors is very different. Furthermore there is the question of the immediate impact on patient health and possible impact on the cost of future treatment. If a doctor misjudges the need of a particular patient for treatment and it is withheld this could lead to the death of the patient or to a more serious medical condition requiring emergency care in A&E which may be far more extensive than the original treatment which has been denied. Finally, where obligations are placed on doctors to undertake assessments or other administration as part of the charging process this would inevitably detract from the time available to treat other patients.

(e) Charging overseas visitors and primary care

There has been a discussion going back to the mid-2000s as to whether primary care should be included in the charging arrangements.[161] While the Regulations currently do not extend to primary care there are signs of an incremental impact on primary care practice as the DoH has suggested that OVMs should consider establishing formal contacts with GPs to help with the process of identifying chargeable patients.[162] In 2019, guidance on the charging system issued to Primary Care providers and headed 'How you can help get money back into the NHS' indicates that primary care providers should encourage patients to provide information as to their exempt status and where available upload applicable documentation.[163] Patients are also to be made aware of the prospect of being charged for secondary care. In 2019 there were reports that some NHS hospitals had asked some London GP practice managers to assist in the identification of patients who were entitled to free NHS treatment.[164]

(f) The Regulations and the 'hostile environment'

Further aspects of the regulations can be seen as linked to the Conservative-Liberal Government and post 2015 Conservative efforts to create a 'hostile environment' for potential migrants to the UK.[165] A

[159]See Reynolds and Mitchell, above n 157, and for further discussion of beneficence and non-maleficence see also T Beauchamp and J Childress *Principles of Biomedical Ethics* (Oxford: Oxford University Press, 2019).

[160]NHS England 'Individual funding requests for specialised services a guide for patients' (2017) https://www.england.nhs.uk/wp-content/uploads/2017/11/ifr-patient-guide.pdf.

[161]Department of Health 'Proposals to exclude overseas visitors from eligibility to free NHS primary medical services: a consultation' (London: Department of Health, 2004) discussed in S Hull and K Boomla 'Primary care for refugees and asylum seekers' (2006) 332 BMJ 62.

[162]Above n 32, para 11.57.

[163]Department of Health and Social Care 'Guidance Providing healthcare for overseas visitors from the EEA and Switzerland: information for primary care staff' (updated 22 October 2019).

[164]E Mahmase 'Migrant health: trusts asked GPs to identify whether patients they refer are eligible for free NHS care' (2019) 367 BMJ 16002.

[165]See discussion in A Shaves 'Austerity or xenophobia? The causes and costs of the "hostile environment" in the NHS' (2019) Healthcare Analysis 202.

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2017 Freedom of Information request found that under the pilot scheme, one trust alone – St George's University Hospitals NHS Foundation Trust – had reported 153 patients to the Home Office 'to follow up possible immigration sanctions'.[166] While it may be valid to chase debt recovery, there are considerable concerns that undocumented migrants would be deterred from seeking medical treatment. So for example, a study by Maternity Action supported by the Royal College of Midwives reported adverse effect on pregnancy care due to the charging regulations, with women not coming forward sufficiently early in their pregnancy, not attending for tests or in some situations avoiding care entirely because they were concerned by the prospect of Home Office action.[167]

This is not only in relation to an individual's own treatment; it has also been argued that there is evidence that undocumented migrants are not seeking treatment for their children, due to concerns of the prospect of charging and of Home Office action, or not taking children for vaccinations with consequent public health problems that this may present.[168] These factors mean that many doctors are resistant to their role in implementing the regulations.[169] The legitimacy of data-sharing regarding immigration status with the Home Office was unsuccessfully challenged by the BMA through judicial review in 2015.[170] In 2017 there were reports that GP practices had been asked to inform patients of the identification requirement when referring them, but according to GP Online:

> practices in some areas were registering undocumented migrants as 'no fixed abode' to prevent the Home Office using GP data to check on patients' immigration status.[171]

The controversy this generated and the intervention of the Chair of the Health Select Committee led to the Government agreeing to remove data-sharing arrangements between the NHS and the Home Office for identification of illegal migrants.[172] However, it has subsequently been reported that the Home Office immigration officers have been contracted to work within public service organisations to facilitate checks on immigration status, and reports indicate that this service has been offered to NHS trusts.[173] This remains a matter of grave concern and also raises the prospect, as noted above, of patients deferring treatment until their condition deteriorates such that they are treated as an emergency in a situation where they may have a much worse prognosis of recovery and potentially greater treatment cost than if they had simply received routine secondary care. There have been strong calls from some, such as the campaigning organisation 'Docs Not Cops', for the 2015 and 2017 Regulations themselves to be totally repealed.[174]

[166] J Hambly Freedom of Information request to the Department of Health and Social Care: 13 February 2017, reported at https://www.whatdotheyknow.com/request/nhs_charges_for_overseas_patient.

[167] J Wise 'Don't charge migrants for maternity care, say midwives (2019) BMJ 15487 and see also ER Turnbull et al 'The exclusion of pregnant women from NHS health care: a cross-sectional, humanitarian, health service evaluation' (2019) The Lancet special edition 394 S2 1 November.

[168] NJ Russell et al 'Charging undocumented migrant children for NHS healthcare: implications for child health' (2019) 104(8) Archives of Disease in Childhood 722.

[169] M Weaver 'Doctors threaten to boycott plan for patients to show ID at hospitals' (*The Guardian*, 22 November 2016) https://www.theguardian.com/society/2016/nov/22/doctors-threaten-to-boycott-plan-for-patients-to-show-id-for-nhs-care.

[170] *R (W and others) v Secretary of State for Health (British Medical Association intervening)* [2015] EWCA Civ 1034.

[171] N Roberts 'GPs urge boycott of ID-on-referral hospital charging scheme' (*GP Online*, 24 April 2017) https://www.gponline.com/gps-urge-boycott-id-on-referral-hospital-charging-scheme/article/1431277.

[172] D Campbell 'NHS will no longer have to share immigrants' data with Home Office' (*The Guardian*, 9 May 2018) https://www.theguardian.com/society/2018/may/09/government-to-stop-forcing-nhs-to-share-patients-data-with-home-office. For further background on data sharing see L Hiam et al 'Creating a "hostile environment for migrants": the British government's use of health service data to restrict immigration is a very bad idea' (2018) Health Economics Policy and Law 107.

[173] M Savage and C Cadwalladr 'Revealed: how Home Office hires out staff to hunt immigrants' (*The Guardian*, 16 February 2019) https://www.theguardian.com/uk-news/2019/feb/16/home-office-hires-out-staff-hunt-migrants-hostile-environment.

[174] See http://www.docsnotcops.co.uk/.

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(g) The effectiveness of the Regulations in cost recovery

A key motivation for the new regulations was, of course, that of recovery of costs. But how effective has it been? As we saw above, historically the introduction of charging regulations was based on inadequate evidence.[175] Have the 2015–17 changes really made a difference? The Government's 'Visitor & Migrant NHS Cost Recovery Programme Implementation Programme 2014–16' stated in 2014 that it would be introducing the collection of key metrics: (a) invoiced income; (b) actual cash recovered: (c) bad debt provision: (d) written-off debt; and that 'for the first time, the NHS will be able to measure how well it is recovering the amounts that it is owed'.[176] Yet when in 2016 the National Audit Office (NAO) made an effort to estimate figures they noted the incompleteness and unreliability of available data,[177] including with regard to the sums chargeable.[178]

The NAO's calculation for potential recovery was based on DoH figures from 2013. For 2012–13 the NAO estimated potential chargeable income of £367 million, representing 0.3% of the total NHS budget. Of this sum, £73 million was recovered. For 2013–14 and 2014–15, £97 million was recovered each year, followed in 2015–16 by a dramatic jump to £289 million recovered. This included £164 million from the new health surcharge, introduced in the 2015 Charging Regulations. Another contributory factor was the ability to charge non-EEA visitors 150% of the NHS national tariff from 2015. Although the NAO estimated that the target of £500 million for 2017/18 was unlikely to be met, they advised that £346 million was likely to be recovered for that year – a considerable increase on the 2012/13 figure of £73 million – and there has been an upward trend in recent years. However, this is largely due to income from the health surcharge. The absence of conclusive data means it is unclear whether the target of £500 million cost recovery for 2017/18 was either realistic or achievable. The estimates of potential income carried heavy caveats from the NAO about the limited and uncertain data on indicators such as numbers of patients and charges applicable. An Ipsos Mori report of January 2017 also found it impossible to make a comprehensive cost-benefit analysis due to unavailable data.

Moreover it cannot be assumed the health of migrants is necessarily the same as that of the home population.[179] Research shows that migrants are in fact less likely to use health services and they tend to be younger, fitter and not likely to suffer from chronic conditions or to require expensive surgery.[180] The health profile for tourists may differ again, with elderly travellers more prone to strokes or heart attacks for example, than young migrant workers. It is also likely that not all parts of England will be receiving the same proportions of overseas visitors.[181] The NAO noted 'a significant variation in the amounts charged and a relatively small number of trusts are responsible for a large proportion of the charges'.[182] This variation may have many causes, including poor implementation of the regulations. However, a disparity in overseas visitor numbers across trusts is likely to be a factor. More would be expected to travel to large cities, particularly London, whether as tourists, students or temporary migrant workers. In a report of February 2017, the Government announced a programme targeting

[175]It is recognised that unlike the drive to evidence-based medicine, evidence-based health law can be seen as problematic given the impact of politics on the development of legislation, but at the same time we would argue that as far as possible legislation should be evidence based and that aspects of such an evidence-based rationale can be seen, eg in relation to the development of impact assessments in relation to proposed legislation. On evidence-based law see also JJ Rachlinsk 'Evidenced-based law' (2011) 96 Cornell Law Review 901.

[176]Department of Health 'Visitor & Migrant NHS Cost Recovery Programme. Implementation Plan 2014–16' (14 July 2014) at 14.

[177]National Audit Office 'Department of Health. Recovering the cost of NHS treatment for overseas visitors' (28 October 2016) Summary at 6, para 7.

[178]Ibid, Summary at 9.

[179]*Hansard* HC Deb, vol 20, cols 414–415, 17 March 1982.

[180]S Poduval et al 'Experiences among undocumented migrants accessing primary care in the United Kingdom' (2015) 45 (2) International Journal of Health Services 320.

[181]G Iacobucci, 'New law will force hospitals to charge foreign patients for non-urgent care' (2017) BMJ 358.

[182]Above n 177.

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support for a specific group of trusts which due to factors such as size, location and overall expenditure were likely to have the greatest chance of recovering costs.[183]

Some high-profile pregnancy cases alleged to be cases of health tourism appear also to be cases in which individuals had complex emergency health needs where, according to the DoH's own guidance,[184] it might have been unlawful under the Human Rights Act 1998 not to provide care.[185] In these reported cases the patients denied that they had come to the UK specifically to exploit the NHS, and they were subsequently billed for their treatment. Although these debts were enforceable under the legislation it is unclear whether enforcement would have been cost effective, as these individuals then subsequently left the UK.

It remains to be seen to what extent the operation of the revised regulations will be sustainable. However, it does seem likely that with increased scrutiny more patients will fail to meet the residency criteria. In the US, it was estimated that nearly half of all bankruptcies were due to an inability to pay medical fees.[186] It is possible that non-eligible overseas visitors in the UK may be forced to a similar strategy of declaring bankruptcy in order to be relieved of healthcare costs. There are also concerns regarding the impact of the extension of charging regulations outside the hospital setting, with community services having to check migration status.[187] Meirion Thomas has claimed that 'maternity, renal dialysis, cancer and HIV are the services most commonly targeted by overseas visitors'.[188] If so, the latest charging regulations are unlikely to greatly impact on these alleged abuses. As an infectious disease, HIV care remains free to overseas visitors, although Government guidance is that this should be limited if possible: 'to an amount that will last until the overseas visitor returns home or has arranged for [antiretroviral drugs] to be sent to them'.[189]

During the Cameron Government the DoH indicated that there was an intention to eventually extend charges to services such as primary care, GP care, A&E and ambulance services.[190] However, a 2017 consultation on possible changes was met with considerable opposition due to practical challenges and concerns that persons with infectious diseases could be deterred from receiving treatment.[191] Such an extension could have further adverse impact on the care of persons with irregular immigration status, children and those in need of maternity care.[192] Similarly, there was opposition to charging at emergency care settings such as A&E, with a fear that it would lead to problems of delay in treatment. It remains to be seen whether this will be taken forward in the future.

As we have seen, the implementation of the 2015 Regulations and their 2017 amendment has not only proved controversial but, as with every previous iteration of the charging regulations, their efficacy remains unproven. Is it possible to reconcile concerns of cost with respect for the principle of non-maleficence – 'do no harm'? We return to these issues in the final section of this paper.

[183]Department of Health 'Making a fair contribution. Government response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England' (February 2017) p 12.

[184]Ibid, p 5.

[185]Osborne, above n 1; *Hospital, BBC 2 Series 1, Episode 4* (first shown 1 February 2017) https://www.youtube.com/watch?v=PCaojtogBfU.

[186]DU Himmelstein et al 'Medical bankruptcy in the United States, 2007: results of a national study' (2009) 122(8) The American Journal of Medicine 741.

[187]L Hiam and M McKee 'Upfront charging of overseas visitors using the NHS' (2017) 359 BMJ 4713.

[188]Meirion Thomas and Chand, above n 154.

[189]Above n 32, p 32.

[190]Department of Health 'Making a fair contribution. Government response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England' (February 2017) p 5.

[191]Ibid, p 44.

[192]T Powell and A Bate 'Briefing Paper Number CBP03051, NHS charges for overseas visitors' (House of Commons Library 23 October 2017) p 18 and see RA Feldman et al 'Hostile environment prevents women from accessing maternal care' (2020) 368 BMJ m968.

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Conclusions

Arguments about whether and to what extent overseas visitors should be charged for use of NHS services have raged for decades. Repeated attempts to improve the process have often resulted in greater complexity and administrative burdens, although there has been some success in increasing costs recovery. Initially the regulations were regarded as a provision for infrequent cases, as the use of the NHS by overseas visitors was not seen as a major problem. The events of the last decade have led to a heightened attempt to implement charging in an era of austerity and of the hostile environment. Yet the justification for the practical efficacy of this policy remains unproven. Quite simply, is the gain worth the cost of consequent harms? The lack of accurate data has been a long-term impediment to developing appropriate, evidence-based policy in this area.

In 2019 the Academy of Medical Royal Colleges called for a suspension of charges until the Government's review of the scheme was published.[193] But despite calls also by the Health and Social Care Committee for its publication, the details of the full review are still not in the public domain.[194] A summary report suggested that there was no evidence that individuals had been deterred from treatment or that there had been an impact on public health.[195] Subsequently in 2019 a Department of Health spokesperson stated that there had not been an intention to publish a formal review document on the impact of the regulations.[196] This is not a satisfactory response. The changes of the last few years have been introduced at a rapid pace without proper opportunity for comprehensive evaluation. It is clear that this area needs to be revisited by the Government. At the very least the Government should provide very clear information as to the precise impact of the charging regulations and not attempt to extend this further without a demonstrably clear evidence base.

Furthermore, as we have seen, the implementation of the latest Charging Regulations has far deeper implications than that of simply the reimbursement of costs to the NHS. Leaving the charging of overseas visitors as something to be implemented by individual NHS trusts affects the dynamics and role of NHS staff, as well as putting pressure upon those on the front line. The relationship with the Home Office and recently the question of the hostile environment has proved fundamentally problematic in developing law and policy in this area. It was said by Michael Meacher MP during the debates on the charging regulations in 1982:

> The Government should not expect NHS staff to do their dirty work in cracking down on immigration – that is what it is about – or in reducing eligibility for NHS treatment.[197]

Yet we do not seem to have learned from the past. As events over the last few years have demonstrated, not least the Windrush cases highlighted above, the operation of the charging process has had a serious adverse impact upon clinician–patient relationships, and unless reformed is likely to increase the prospect of patients being deterred from seeking care now and in the future.[198] The campaigning

[193]Academy of Medical Royal Colleges 'NHS Charges to overseas visitors regulations: a statement from the Academy of Medical Royal Colleges' (2019) https://www.aomrc.org.uk/wp-content/uploads/2019/03/2019-03-14_NHS_charges_overseas_visitors_regulations.pdf.

[194]Health and Social Care Committee called the Secretary of State to give evidence to them. Correspondence with the Secretary of State relating to overseas visitors charging: https://www.parliament.uk/documents/commons-committees/Health/Correspondence/2017-19/Correspondence-with-Secretary-of-State-relating-to-Overseas-visitor-charging.pdf; Evidence of the Secretary of State, 19 July 2019 http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/work-of-the-secretary-of-state/oral/103780.pdf.

[195]I Torjesen 'Migrant charging in the NHS: how can doctors support patients when hospital care is denied' (2019) 365 BMJ I2881

[196]Ibid.

[197]*Hansard* HC Deb, vol 20, cols 411–52, 17 March 1982.

[198]While at the end of 2018 the Health Minister Stephen Hammond stated that there was no evidence of patients being deterred from seeking, this was disputed by the Royal Colleges, which called for charges to overseas patients to be ended: Review of amendments made to the NHS Overseas Visitor Charging Regulations in 2017: written statement HCWS1174, December 2018, https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/

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organisation 'Docs Not Cops' is now calling for the Government to commission a full and independent inquiry into the impact of NHS charging on individual and public health, and provide compensation to the families and communities already impacted.[199] Such an inquiry may indeed provide an important opportunity for a comprehensive reconsideration of the area – though, as with any inquiry, the issues are unlikely to be rapidly resolved.

When Sir Waldron Smithers spoke in 1949 of the need to charge overseas visitors for NHS care, it is unlikely that he could have imagined the complexity, practical difficulties and political quagmire that such a proposal would still be creating for policy makers 70 years later. Not simply knee-jerk responses to financial constraints, but also a worrying interface between health care delivery, migration and identity in an era of the hostile environment has inevitably adversely impacted on patients and prospective patients' relationship with the NHS. What is clear is that urgent action is needed at national Government level to reconsider the nature and scope of the regulations, to stop the covenant of trust between patient and clinician and the fundamental principles of the NHS from being further eroded.

Commons/2018-12-12/HCWS1174; A Rimmer 'Royal Colleges call for end to charges for overseas patients' (2018) 363 BMJ, 21 December 2018.

[199]Above n 174.

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