EXPLANATORY MEMORANDUM TO

THE NATIONAL HEALTH SERVICE (CHARGES TO OVERSEAS VISITORS) REGULATIONS 2011

2011 No. 1556

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 This instrument consolidates the National Health Service (Charges to Overseas Visitors) Regulations 1989 (S.I. 1989/306) and subsequent amendments. It also introduces exemptions from NHS hospital charges to

- failed asylum seekers formally supported under section 4 or 95 of the Immigration and Asylum Act 1999;
- children in the care of a Local Authority; and
- certain members of the Olympic and Paralympic Games Family during Games Period in 2012.

It also extends the temporary absence allowed when calculating a period of residence in the UK from up to three months to up to 182 days, and amends the definition of pandemic influenza in the list of diseases for which treatment is free.

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None

4. Legislative Context

4.1 Section 175 of the National Health Service Act 2006 gives the Secretary of State for Health powers to make regulations governing charging persons who are not ordinarily resident in the United Kingdom for any NHS services they receive.

4.2 The National Health Service (Charges to Overseas Visitors) Regulations 2011 ("the charging regulations") provide for NHS bodies to charge overseas visitors for any NHS hospital treatment provided to the overseas visitor. Overseas visitors are defined in the charging regulations as anyone not ordinarily resident in the United Kingdom. The charging regulations place a duty on NHS bodies to make and recover charges to all overseas visitors for any treatment provided to them, unless the overseas visitor, or the treatment they receive, is covered by one of a number of exemption categories.

5. Territorial Extent and Application

5.1 This instrument applies to England.

6. European Convention on Human Rights

As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy background

7.1 In line with good legal practice, the Government has introduced this instrument to consolidate regulations made in 1989 and amended on several occasions. The charging regulations are therefore a tidied and updated reflection of S.I. 1989/306 and subsequent amendments.

7.2 The instrument also introduces three amendments to the charging regulations that were proposed in a consultation document in 2010 following a review of access to the NHS by foreign nationals. Consultation respondents supported these amendments.

7.3 The first amendment extends the exemption from charges for NHS hospital treatment currently available to those asylum seekers whose applications, including appeals, are under consideration to those who have failed in their application but who are supported by the UK Border Agency under section 4 or 95 of the Immigration and Asylum Act 1999 or other similar enactment.

7.4 The second amendment extends the exemption from charges to children under the care of a Local Authority, putting the entitlement to free NHS hospital treatment of such children beyond doubt.

7.5 The third amendment extends the temporary absence allowed when calculating a period of residence in the UK from up to three months to up to 182 days. In effect, this means that those UK residents that spend more than three months but less than six months each year outside the UK are now guaranteed free NHS hospital treatment, regardless of whether or not they can be considered ordinarily resident in the UK.

7.6 The instrument also introduces one further amendment necessary to fulfil a commitment made as part of the UK's bid to host the Olympic and Paralympic Games in 2012 that certain members of the Olympic and Paralympic Games Family will receive free NHS hospital treatment should they need it. This is limited to treatment when the need for it arises during the visit, not pre-planned treatment.

7.7 Finally, the instrument corrects the definition of pandemic influenza in the list of diseases for which no charge can be made, so that the exemption from charge takes effect if a 'phase 4, 5 or 6' pandemic has been declared by the World Health Organisation. Phase 4 is characterised by sustained human to human transmission of the virus so public health protection is required from that point. Charging those for pandemic influenza during a phase 4 or 5 situation, as the regulations require at present, might risk further spread.

8. Consultation outcome

8.1 A full public consultation exercise ran from 26 February 2010 to 30 June 2010. 166 responses were received from the public, healthcare professionals, the NHS, Royal Colleges, third sector organisations (particularly those concerned with migrant health) and others. A large majority of respondents were in favour of introducing the amendments outlined at 7.3 to 7.5 (85%, 94% and 77% respectively). The consultation document also included draft consolidated regulations for comment as to whether they were an accurate reflection of existing regulations or if they made material changes. Many respondents thought that some changes within the consolidation exercise would have a material effect. The consolidated regulations have therefore been modified to remove those material changes, eg extending charges to treatment provided by "NHS contractors".

9. Guidance

9.1 Guidance on how to implement the charging regulations has been updated. This was circulated for comment in draft form as part of the consultation and comments sought on its clarity and comprehensiveness. Modifications have been made based on some of those comments. The revised guidance has been issued to relevant NHS bodies who are expected to ensure that it is fulfilled and will also be available on the Department of Health website.

10. Impact

10.1 There is no impact on business, charities or voluntary bodies.

10.2 The impact on the public sector is that NHS bodies providing hospital services will see a small increase in the number of persons classified as overseas visitors who are exempt from paying charges for hospital treatment.

10.3 Impact Assessments for the amendments in relation to failed asylum seekers and extending the period of temporary absence are attached to this memorandum and will be published alongside the Explanatory Memorandum on www.legislation.gov.uk. There is no impact assessment for the amendment in relation to children as the numbers involved are considered too small. There is no impact assessment for the consolidated regulations as a whole as a consolidation exercise does not introduce material change.

10.4 There is also no impact assessment for the amendment in relation to the Games family since the UK is committed to ensuring that certain Games Family members will not be charged for NHS hospital treatment during Games Period. In any event, the numbers accessing NHS hospital treatment are expected to be small: the London Organising Committee for the Olympic Games has estimated that 95% of medical incidents will be treated in local polyclinics, whilst many Games Family members will also have their own medical teams. Further, many Games Family members would have been exempt under another category anyway, eg those visiting from a country with which the UK has a bilateral healthcare agreement.

10.5 The change to the definition of pandemic influenza is necessary on public health grounds and it will only impact on the NHS. Prompt detection and treatment of early cases will help to contain further spread and the resulting cost of treating new cases.

11. Regulating small business

11.1 The legislation does not apply to small business.

12. Monitoring & review

12.1 The consolidated regulations, including the new additions, will continue to be monitored by the Department of Health policy team on an ongoing basis. Any issues arising will initially form part of a further wholesale review of charges for healthcare for overseas visitors, expected to conclude in 2012. The Department of Health policy team will carry out this review and will assess if the policy is working as intended.

13. Contact

Craig Keenan at the Department of Health (Tel: 0113 254 6438 or email: craig.keenan@dh.gsi.gov.uk) can answer any queries regarding the instrument.

Title:	Impact Assessment (IA)
Impact assessment of extending the 'period of absence' for UK residents	**IA No:** 6041
Lead department or agency: Department of Health	**Date:** 18/03/2011
Other departments or agencies:	**Stage:** Final
	Source of intervention: Domestic
	Type of measure: Secondary legislation
	Contact for enquiries: David Pennington

Summary: Intervention and Options

What is the problem under consideration? Why is government intervention necessary?

People living in the UK for part of the year, while also spending significant periods of time abroad risk being judged as not ordinarily resident and so not entitled to free NHS treatment, although some exemptions do protect this group.
The current regulations allow current residents a regular absence from the UK of up to three months per year before they risk being chargeable for hospital treatment.
With people having increasingly mobile lifestyles, the time is right to review this regulation.

What are the policy objectives and the intended effects?

Policy objective:
- to better reflect current practice in the NHS and so improve equity,

Intended effects:
- to protect the health and well-being of relevant individuals, without exposing NHS resources to abuse.
- relevant individuals will have enhanced freedom of movement.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

1) Do nothing
2) Extend the absence period from 3 months p/a to 6 months p/a

Option 2 is the preferred option. This option allows for an increased freedom of movement, without encouraging the use of NHS Resources by individuals who spend very little time in England.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 5/2014	
What is the basis for this review? Please select. **If applicable, set sunset clause date:** Month/Year	
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	No

Ministerial Sign-off For final proposal stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister: ***Anne Milton*** Date: ***17th March 2011***

Summary: Analysis and Evidence

Policy Option 2

Description:

Impact assessment of extending the 'period of absence' for UK residents

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: -64	**High:** -32	**Best Estimate: -48**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	nil		4-7	**53-81**

Description and scale of key monetised costs by 'main affected groups'

Exchequer costs

Other key non-monetised costs by 'main affected groups'

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	nil		4	**19**

Description and scale of key monetised benefits by 'main affected groups'

Other key non-monetised benefits by 'main affected groups'

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5

Data has been largely unavailable and many estimates, ranges and assumptions have been used. The consultation document asked for any additional available data in respect of IAs and related equality impact assessments, which might inform future versions, but no appropriate new data were received. Please see the main body of the IA.

Direct impact on business (Equivalent Annual) £m:			In scope of OIOO?	Measure qualifies as
Costs: 0	**Benefits:** 0	**Net:** 0	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			03/05/2011		
Which organisation(s) will enforce the policy?			DH		
What is the annual change in enforcement cost (£m)?			£nil		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** nil	**Non-traded:** nil	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** n/a	**Benefits:** n/a	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro**	**< 20**	**Small**	**Medium**	**Large**
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on…?	**Impact**	**Page ref within IA**
Statutory equality duties[1] Statutory Equality Duties Impact Test guidance	Yes	11
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	No	
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	
Sustainable development Sustainable Development Impact Test guidance	No	

[1] Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessments of earlier stages (e.g. Consultation, Final, Enactment) and those of the matching IN or OUTs measures.

No.	Legislation or publication
1	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_113266.pdf
2	
3	
4	

+ Add another row

Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y_0	Y_1	Y_2	Y_3	Y_4	Y_5	Y_6	Y_7	Y_8	Y_9
Transition costs										
Annual recurring cost										
Total annual costs										
Transition benefits										
Annual recurring benefits										
Total annual benefits										

* For non-monetised benefits please see summary pages and main evidence base section

Microsoft Office
Excel Worksheet

Evidence Base (for summary sheets)

The problem to be addressed and the reason for intervention

1. People living in the UK for part of the year, while also spending significant periods of time abroad risk being judged as not ordinarily resident and so not entitled to free NHS treatment, although some exemptions do protect this group.
2. The current regulations include a specific disregard of any period of temporary absence of not more than three months for the purposes of calculating a period of residence - in effect, this allows current UK residents a regular period of absence from the UK of up to three months per year before they risk being chargeable for hospital treatment.

3. A survey to ascertain the number of residents who are currently identified and charged for absences of 3-6 months was conducted by DH among a sample of trusts. This showed that most trusts take a lenient approach and do not apply charges creating inconsistency and perceived unfairness.

4. With people having increasingly mobile lifestyles, the time is right to review this regulation. Increasing the permitted period of absence from three to six months would be consistent with current exemptions for state pensioners. At the same time, six months is a short enough disregard to distinguish between genuine residents who spend the majority (at least half) of the year in the UK, and citizens who now choose to reside in another country for most or all of the year, returning only for short visits, including specifically to access NHS healthcare.

What are the policy objectives and the intended effects?

5. Policy objective:
    - To better reflect current practice in the NHS and so improve equity.

6. Intended effects:
    - To protect the health and well-being of relevant individuals, without exposing NHS resources to abuse.
    - Relevant individuals will have enhanced freedom of movement.

Identification of Options to consider

7. Option 1 - 'do nothing' is included for comparison.
8. Option 2 - to increase the absence exemption from 3 months to 6 months.
9. It is assumed that any absence exemption beyond 6 months would allow NHS resources to be exploited by people who live in England for a short period of time each year purely to access free health care.

10. Option 2 is the preferred option. This option would be implemented by amendments to existing regulations and so would be mandatory for all providers of NHS secondary care.

11. For both options, costs fall on the NHS budget, and benefits fall on relevant individuals. The costs and benefits are highlighted separately for each option.

Do Nothing (option 1)

12. The do nothing option would maintain the current policy: individuals who live outside of England for more than 3 months per annum do not have a specific exemption from charges for NHS secondary care, although there is some protection for particular groups, such as UK pensioners.

Benefits

13. There are no assumed incremental benefits.

Risks

14. No risks envisaged.

Costs

15. The incremental costs are £nil.

Extending the absence exemption from 3 to 6 months (Option 2)

16. The costs and benefits have been assessed over a 10 year period to be in line with the default period. The policy itself has no specified time limit.

Benefits

Table 1: Total undiscounted benefits

2010/11 £m	2011/12 £m	2012/13 & thereafter £m
0	3	4

The policy is assumed to start in mid 2011 and is then pro rata'd.

16. We have identified only one quantifiable benefit to individuals: the cost that they currently pay for NHS or alternative treatment, which will no longer be payable under the new policy.

17. Please see a summary calculation below::

	Description	**Value p/a**
	Estimated number of individuals out of the country between 3 and 6 months who are charged for NHS treatment	378
Multiplied by	DH estimated average cost per patient per annum	£10,000
Total	Total annual current cost of treating all individuals who travel outside of the UK between 3 and 6 months p/a	**£3,780,000**

18. We assume that none of the people affected currently forego treatment completely and rather obtain treatment privately. Therefore, additional QALYs are not included as a benefit. We also assume that the cost of alternative provision is the same as NHS treatment costs.

19. There is assumed to be no write off of charges, as these individuals are likely to have insurance, and / or are likely to be easily chased up.

20. The total number of patients affected is based on a sample of NHS acute hospitals. An estimate has been derived from this data, which suggests that across the NHS approximately 378 people per annum would be affected by the change, before considering any increased uptake. This number is particularly small as the survey also confirmed that many hospital Trusts may prefer to consider identified people as still ordinarily resident and so do not impose charges. A minority however do determine that charges should be applied.

Costs

Table 2: Costs to the NHS

	2010/11 £000	2011/12 £000	2012/13 & thereafter £000
Direct costs on NHS budget	0	3 - 5	4 - 6
Total undiscounted costs including opportunity costs	0	8 -12	10- 16

Notes
1. Undiscounted **opportunity costs** to the NHS budget are calculated in line with the Exchequer approach:
2. All costs are current 10/11 costs.
3. The cost is assumed to start in mid 2011 and is pro rata'd.

21. The costs are estimates of the total cost of providing free NHS secondary care to those who previously did not receive it, and would be eligible under the new policy. This includes both those who currently use the NHS, and those who currently have healthcare arrangements outside of the NHS.

22. The costs consist of two components: loss of charging revenue to the NHS; increase in uptake of individuals who currently have alternative healthcare arrangements.

28. 23. All costs impact on the NHS budget, and as such opportunity costs are applied to all costs (i.e by multiplying costs by 2.4) This process of applying opportunity costs takes into account that the next best alternative use of NHS resources gives a benefit of £2.40 for every £1 spent.

Loss of charging revenue to the NHS

24. This is the cost that individuals currently pay for NHS or alternative treatment, which will no longer be payable under the new policy. The methodology and value is exactly the same as that highlighted for the corresponding benefit in the benefits section: the cost to the NHS is a benefit to relevant individuals in society. This cost is multiplied by 2.4 to account for opportunity costs, but the corresponding benefit is not.

Increase in uptake of individuals who currently have alternative healthcare arrangements.

25. We have also assumed an increased demand due to the change in policy of up to 5% per annum, although this is speculative. The higher figure in Table 2 is based on this assumption, and the lower figure based on the assumption of increased demand being 1%.

The summary calculation is below:

	Description	Value p/a
	Number of individuals who travel between 3 and 6 moths and seek NHS treatment	5,716
Multiplied by	Percentage assumed uptake	1% 5%
Multiplied by	DH Estimated cost per person for treatment	£10,000
Total		**£571,582** **£2,857,909**

Risks

26. The analysis is based on the number of patients who are currently being charged for NHS services and would otherwise be exempt. However, some people in this group will have health insurance or otherwise pay for healthcare without using the NHS. If this group choose to use NHS services and not private healthcare, there would be an increase in the benefits to individuals. An estimate of the additional cost to the NHS is included below.

27. There is a significant uncertainty around the data we have drawn from our sample of NHS acute hospitals. However there are very few alternative data sources, and those that are available are of poor quality. Thus, our estimates are the best approach available to us now.

Summary Measure of Net Benefit and Equality Impacts

28. The net benefit (PV) is calculated by subtracting the total present value of opportunity costs from the total present value of benefits.

29. The net benefit value is located on the 'Analysis: Summary and Evidence' sheet.

30. The net benefit shows whether the benefits provided by the policy give an overall social cost or overall social benefit.

An Equality Impact Assessment Screening is discussed in a later section.

Net Benefit Range

32. Given the lack of robustness and certainty around the data, it is prudent to take the best and worst case net benefit scenarios as the Net Benefit Range.

The preferred option

33. The preferred option is option 2. To 'do nothing' would not reduce inequalities or address the changing travel trends.

34. There is a negative net benefit for option 2 However that does not take into account the reduction in inequalities which is likely to result from the policy.

Specific Impact Tests

Specific Impact Test	Significant Impact?
Competition	No
Small firms	No
Legal Aid	No
Sustainable Development	No
Health	Discussed above. Health Impact Assessment not required
Carbon and Greenhouse gas	No
Other Environment	No
Race	See 'Equality Screening' below
Disability	See 'Equality Screening' below
Gender	See 'Equality Screening' below
Age	See 'Equality Screening' below
Religion	See 'Equality Screening' below
Sexual Orientation	See 'Equality Screening' below
Human Rights	No
Rural Proofing	No

Equality Screening

35. There is no foreseeable differential impact due to disability, gender, sexual orientation, or religion or belief. The proposal improves equality between those of different ages by bringing the general exemption in line with that available to UK state pensioners who can reside for up to six months of the year in EEA countries without losing any entitlement to continued free NHS healthcare. There may also be a positive impact on minority ethnic groups who may be more likely to have family overseas and so spend extended periods outside the UK, although there is no evidence available to support this conjecture.

36. A full EqIA was not completed. The screening assessment is based on limited but robust data. The department will undertake an equality assessment of current regulations and guidance and conduct a full equality assessment as part of its intended wider review of charges to overseas visitors.

Conclusion

37. The preferred option is option 2. Option 1 does not address the problem. The consultation ran from 26 February to 30 June 2010 and the majority agreed with the question of whether option 2 should be implemented. We will therefore amend the charging regulations to bring option 2 into force.

Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

Annex 1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. If the policy is subject to a sunset clause, the review should be carried out sufficiently early that any renewal or amendment to legislation can be enacted before the expiry date. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

Basis of the review: [The basis of the review could be statutory (forming part of the legislation), i.e. a sunset clause or a duty to review , or there could be a political commitment to review (PIR)]; We will review for good policy practice reasons.
Review objective: [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?] This will be reviewed initially as part of a further review on the charging regime for overseas visitors to check that the policy intent is working.
Review approach and rationale: [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach] This will be reviewed initially as part of a further review on the charging regime for overseas visitors to check that the policy intent is working.
Baseline: [The current (baseline) position against which the change introduced by the legislation can be measured] supported failed asylum seekers are charged for NHS hospital treatment
Success criteria: [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives] supported failed asylum seekers are not charged for NHS hospital treatment.
Monitoring information arrangements: [Provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review]
Reasons for not planning a review: [If there is no plan to do a PIR please provide reasons here]

Add annexes here.

Title:	Impact Assessment (IA)
Impact assessment of Exemptions for Failed Asylum Seekers **Lead department or agency:** Department of Health **Other departments or agencies:**	**IA No:** 6040 **Date: 18**/03/2011 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Secondary legislation **Contact for enquiries:** David Pennington

Summary: Intervention and Options

What is the problem under consideration? Why is government intervention necessary?

Regulations governing free access to NHS secondary care services in England do not differentiate between those who have exhausted the asylum process and been directed to leave the UK, and those who have exhausted the asylum process but are destitute, face recognised barriers to return and on that basis qualify for support from the UK Border Agency. The Government believes that this position is anomalous and potentially leaves NHS staff in a difficult position in relation to charging people who are destitute and cannot leave the country. It proposes to amend the charging regulations.

What are the policy objectives and the intended effects?

To provide a fair level of free access to NHS treatment for failed asylum seekers who are cooperating with UKBA, face recognised barriers to return, but cannot make alternative healthcare arrangements.

To prevent health conditions in this group deterioriating to the extent they need more expensive medical intervention.

To protect NHS resources from those who have been directed to leave the country.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

1) Do Nothing

2) Exemptions for those supported by the United Kingdom Border Agency because they would otherwise be destitute or have children, (Section 95 where appeals rights Exhausted), and/or would otherwise be destitute and cannot return home through no fault of their own (Section 4). The second option is the preferred option. This option supports those groups whom have been identified as vulnerable and unable to return home, whilst excluding groups whom it has been decided could feasibly return home but choose not to do so.

Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** 5/2014 **What is the basis for this review?** Please select. **If applicable, set sunset clause date:** Month/Year	
Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	No

Ministerial Sign-off For final proposal stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister: ***Anne Milton*** Date: ***17th March 2011***

Summary: Analysis and Evidence

Policy Option 2

Description:

Impact assessment of Exemptions for Failed Asylum Seekers

Price Base Year 2010	PV Base Year 2010	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	**High:** Optional	**Best Estimate: £650k**

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£12m (1yr)		£15m	**£126m**

Description and scale of key monetised costs by 'main affected groups'

Total costs including opportunity costs
All costs are exclusive to DH

Other key non-monetised costs by 'main affected groups'

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate	£12m		£14m	**£126m**

Description and scale of key monetised benefits by 'main affected groups'

Other key non-monetised benefits by 'main affected groups'

Key assumptions/sensitivities/risks **Discount rate (%)** 3.5%

Data has been largely unavailable and estimates, ranges and assumptions have been used. The consultation document asked for any additional available data in respect of IAs and related equality impact assessments, which might inform future version. Please see the main body of the IA. Data has been updated in relation to number of s4/s95 supported failed asylum seekers.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs:	**Benefits:**	**Net:**	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?			England		
From what date will the policy be implemented?			03/05/2010		
Which organisation(s) will enforce the policy?			DH		
What is the annual change in enforcement cost (£m)?			£nil		
Does enforcement comply with Hampton principles?			Yes		
Does implementation go beyond minimum EU requirements?			N/A		
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)			**Traded:** nil	**Non-traded:** nil	
Does the proposal have an impact on competition?			No		
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?			**Costs:** n/a	**Benefits:** n/a	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	**Micro**	**< 20**	**Small**	**Medium**	**Large**
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on…?	**Impact**	**Page ref within IA**
Statutory equality duties[1] Statutory Equality Duties Impact Test guidance	Yes	13
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	No	
Human rights Human Rights Impact Test guidance	No	
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	
Sustainable development Sustainable Development Impact Test guidance	No	

[1] Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessments of earlier stages (e.g. Consultation, Final, Enactment) and those of the matching IN or OUTs measures.

No.	Legislation or publication
1	http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_113270.pdf
2	
3	
4	

+ Add another row

Evidence Base

Ensure that the information in this section provides clear evidence of the information provided in the summary pages of this form (recommended maximum of 30 pages). Complete the **Annual profile of monetised costs and benefits** (transition and recurring) below over the life of the preferred policy (use the spreadsheet attached if the period is longer than 10 years).

The spreadsheet also contains an emission changes table that you will need to fill in if your measure has an impact on greenhouse gas emissions.

Annual profile of monetised costs and benefits* - (£m) constant prices

	Y_0	Y_1	Y_2	Y_3	Y_4	Y_5	Y_6	Y_7	Y_8	Y_9
Transition costs										
Annual recurring cost										
Total annual costs										
Transition benefits										
Annual recurring benefits										
Total annual benefits										

* For non-monetised benefits please see summary pages and main evidence base section

Microsoft Office
Excel Worksheet

Evidence Base (for summary sheets)

Introduction

1. Unsuccessful asylum applicants qualify for section 4 support from the UK Border Agency if they face recognised barriers to returning home and have no means of support and/or a special need.

2. Those with children who have exhausted asylum appeal rights, are destitute, and were previously in receipt of section 95 support continue to qualify while they remain in the UK. The proposal to adjust the NHS charging regulations in England affects both groups. Sections 4 and 95 relate to the Immigration and Asylum Act 1999.

3. The analysis presented here differs from that in the Impact Assessment alongside the consultation document in two ways.

    - We have uprated the cost estimate to reflect the estimated costs for 2010/11, by assuming that the estimate for 2009/10 has grown by 5.5%, in line with the average growth in PCT allocations.
    - The number of failed asylum seekers being supported by the UKBA has fallen from 17,163 to 10,297.

    The net effect of these two changes is to reduce both the costs and benefits by approximately a third.

The problem to be addressed and the reason for intervention

3. Currently people seeking asylum are exempt from NHS charges while their claim is still outstanding, and any appeal is ongoing.

4. Those whose claims have been refused (failed asylum seekers, FAS) are chargeable for treatment that begins after they have been directed to leave the country and their full appeals process has been exhausted. Immediately necessary or urgent treatment may still be provided in advance of payment although a charge must be levied. Charges may be written off after reasonable efforts have been made to seek recovery, taking into account the person's ability to pay.

5. We are not proposing any change to these arrangements for the vast majority of failed asylum seekers. Some failed asylum seekers have limited resources, meaning that debts to the NHS are often written off and the cost of administering charges is likely to outweigh the income recovered. Untreated non-urgent conditions may also lead to more costly, urgent provision for which costs would be unlikely to be recoverable. However, automatic entitlement to full, free secondary care, including both urgent and non-urgent treatment, would not be consistent with the denial of leave to remain and may act both as a deterrent to leaving the UK on a voluntary basis and an incentive to others to travel here illegally and to misuse the UK's asylum system.

6. Similarly, we are proposing no change to the current position for other people who are here in breach of the UK's immigration laws and have not claimed asylum, such as illegal entrants and overstayers, who have no lawful basis of stay in the UK, are required and expected to leave the UK, and are subject to charges.

7. We are proposing a specific exception for those FASs who are cooperating with UKBA and are supported under sections 4 or 95 of the Immigration and Asylum Act 1999. Section 4 and Section 95 provides basic welfare support but does not currently include free access to secondary healthcare. The extension of free healthcare to these groups therefore is wholly consistent with this element of the government's migration and asylum policy.

Policy objectives

8. Policy objective:

- To provide a fair level of free access to NHS treatment for FAS who are unable to make alternative health arrangements and the fact that they receive support from the UK Border Agency recognises that there are barriers to their leaving the UK.

9. Intended effects:

- An improvement in their general health of these individuals and the promotion of wider public health, without exposing NHS resources to abuse.

Identification of Options to consider

10. We considered two options:

- **option 1 -** no change
- **option 2 -** extend free NHS secondary care to failed asylum seekers supported under Section 95 or Section 4. This aims to promote fair access and reduce inequalities.

11. The second option is the preferred option. This option supports those groups that have been identified as vulnerable and unable to return home, while excluding groups that could feasibly return home. It would be implemented by amending existing regulations and so would be mandatory for all providers of NHS secondary care.

12. For both options, costs fall on the NHS budget, and benefits fall on the NHS and on relevant groups of asylum seekers. Therefore the costs and benefits are highlighted separately for each option.

Do Nothing (option 1)

13. The do nothing option maintains current policy: FASs are not eligible for most free secondary care, meaning that many have only limited access to free healthcare. They may receive urgent treatment but will subsequently be charged for this, even though it is unlikely that they will have the means to pay, resulting in the NHS having to write off charges. In practice therefore the NHS is incurring some costs for the treatment of FASs with urgent healthcare needs but this is at a rate lower than would be expected for the population as a whole.

Benefits

14. There are no incremental benefits.

Costs

15. The incremental costs are £nil.

Risks

16. There is a continuing risk that, by doing nothing, FASs in need of healthcare present late with urgent or immediately necessary needs, which the NHS must provide irrespective of whether or not the costs can be recovered. This is likely to be more expensive than earlier, but non-urgent, intervention.

Exempt supported FASs from charges for NHS secondary care (Option 2)

17. The costs and benefits have been assessed over a 10 year period to be in line with the default period. The policy itself has no specified time limit.

Benefits

Table 1: Total undiscounted benefits

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 & thereafter £m
Benefits to individuals	0	19	16	13

The policy is assumed to start in mid- 2011 and is then pro rata'd.

Cost of self-funding healthcare

18. The first benefit is the cost which relevant individuals currently have to pay for NHS secondary care, which will not be payable under the new policy.

19. No robust data are available on the number of section 4 or section 95 FASs currently seeking NHS secondary care. A sample of NHS Trusts suggests that each year about 7% of asylum seekers whose claims are in process access NHS secondary care, similar to the general population. We suspect that some of the section 4 and section 95 group considered here will be deterred from seeking care by the possibility of charges. The same survey suggests that the intervention rate (the percentage of the population seeking NHS secondary care) for these groups may be as low as 1.3%. However, this is based on a very small sample and many trusts will have no means of recording that people are from these specific groups. We have therefore assumed a current presentation rate of 3.5% pa or 600 patients.

20. The same sample suggests that about 75% of all charges are written-off and never recovered. However, the vast majority of FASs claim to lack adequate funds and so we believe this estimate is also low. Therefore, taking 75% as a starting point, we have assumed that 90% of charges are currently written-off or the individuals are not recognised as chargeable.

21. Based on the cost per head of population of Hospital and Community Health Services, estimated to support resource allocations, we estimate that the cost for each person who seeks secondary healthcare is approximately £15,462. This will be an overestimate for this group if they tend to be younger than the population in general. On this basis, we estimate that the benefit those people who are currently paying for healthcare (i.e., taking in to account that many have charges written off) is £1.0m.

Greater Quality Adjusted Life Expectancy

22. Some section 4 and section 95 FASs will currently not be seeking secondary healthcare to avoid charges. This group will benefit from additional Quality Adjusted Life Years (QALYs). There is no information available to estimate the value of NHS intervention for this particular group and so we have used a standard assumption that every £25,000 of NHS spend delivers £60,000 worth of QALYs. Based on the additional spend for this group (see below) we estimate that the benefit of these additional QALYs has a value of £13m.

23. A discount rate of 1.5% has been used for QALY's.

24. This is based on the annual benefits that will accrue after 1 full year of the policy being in place. In the first full year of the policy, it is assumed that the intervention rate will be higher, and thus costs and benefits are higher. This is explained in more detail in the cost section below when discussing the cost of an 'increase in the uptake of FAS'.

Benefits to the NHS

25. There are additional benefits to the NHS that people in this group in need of healthcare will come forward earlier and not wait until their condition is serious to avoid charges. However, we have not been able to estimate the possible size of this benefit.

Risks and Sensitivity

26. There is a significant uncertainty around the data we have drawn from our sample of NHS acute hospitals. However there are very few alternative data sources, and those that are available are of poor quality. Thus, our estimates are the best approach available to us now.

Costs

Table 2: Total costs to the NHS budget

	2010/11 £m	2011/12 £m	2012/13 £m	2013/14 & thereafter £m
Total undiscounted costs	0	8	8	6
Total undiscounted costs including opportunity costs	0	20	18	15

Notes
1. Undiscounted opportunity costs to the NHS budget are calculated in line with the Exchequer approach:
2. All costs are current 10/11 costs.
3. The policy is assumed to start in mid 2011 and is then pro rata'd.

27. Table 2 summarises the total cost to the NHS of providing free secondary care to supported FASs. Costs are built up from three components: loss of charging revenue to the NHS; increase in uptake of NHS services by supported FASs; and increase in the number of supported FASs, incentivised by the availability of free NHS secondary care.

28. All costs impact on the NHS budget, and as such opportunity costs are applied to all costs (i.e by multiplying costs by 2.4). This process of applying opportunity costs takes into account that the next best alternative use of NHS resources gives a benefit of £2.40 for every £1 spent.

Loss of charging revenue to the NHS

29. This is the cost which relevant individuals currently have to pay for NHS secondary care, which will no longer be payable under the new policy. This is based on our assumed presentation rate and write-off rate, described above.

30. This is also the same methodology as estimating the benefit to individuals in no longer having to pay NHS charges: the cost to the NHS is a benefit to relevant individuals in society. This cost is multiplied by 2.4 to account for opportunity costs, but the corresponding benefit is not.

Increase in uptake of current relevant FAS

31. As we discussed above, our assumption is that about 3.5% of section 4 and section 95 FASs access secondary care each year, compared to about 7% per year for asylum

seekers whose claim is in process. This is similar to the rate of access to secondary care in the general population.

33. We have assumed that in the second year onwards the rate at which supported FASs access secondary care grows to 7% per year. Additionally, during the first year there will be some additional demand that was previously unmet, which we take to mean that 10% of the supported FAS population accesses secondary care

34. Please see a summary of the calculation below:

Costs after the first full year of the policy

	Description	**Value (£ = p/a)**
	Total population of relevant Section 4 and Section 95 individuals	10,297
Multiplied by	Increase in the intervention rate (7%-3.5%) – difference due to rounding	3.4%
Multiplied by	Estimated cost per relevant patient	£15,462
Total		**£5,385,288**

Costs in the first full year of the policy:

	Description	**Value (£ = p/a)**
	Cost per annum as above	**£5,131,036**
Plus:		
	Total population of relevant Section 4 and Section 95 individuals	10,297
Multiplied by	Increase in the intervention rate (10%-7%) – difference due to rounding	3.1%
Multiplied by	Estimated cost per relevant patient	£15,462
Total		**£10,355,506**

Increase in requests for section 4 status

35. There is also a risk that the availability of free NHS secondary care could create an additional demand to be supported through section 4. However, the administrative hurdles to achieve section 4 are significant and difficult to manipulate so we do not believe this will be significant. In the analysis it is assumed to be zero. However, a sensitivity analysis is performed in the net benefit range section below which factors in the possibility of a 5% increase in applications.

Summary Measure of Net Benefit and Equality Impacts

36. The net benefit (PV) is calculated by subtracting the total present value of opportunity costs from the total present value of benefits.

37. The net benefit value is located on the 'Analysis: Summary and Evidence' sheet.

38. The net benefit shows whether the benefits provided by the policy give an overall social cost or overall social benefit. In this case, the preferred option gives an overall social cost.

39. An Equality Impact Assessment Screening is discussed in a later section.

Risks, Sensitivities and Assumptions; Net Benefit Range

40. Underlying the net benefit range are the estimated costs of the policy, and as such the issues related to these costs are included in this discussion.

41. The data required were largely unavailable. Assumptions have therefore been made throughout (highlighted in the costs and benefits sections above for option 2) based on expertise of the Overseas Visitors team and others from DH. The assumptions made may be either under or over optimistic.

42. Data for this policy come from DH and NHS acute hospitals.

43. Relevance of the data from NHS acute hospitals is quite high, but lacks robustness and is based largely on estimates.

44. The data from DH is robust, but lacks a small amount of relevance.

Net benefit range

45. If the policy is to proceed, there may be an increase in applications for support under Section 4, despite our assumption that this won't occur. If applications increase by 5%, annual total costs (undiscounted) from year 2 inclusive increase by £750k (inc. opportunity costs).

46. The two estimated costs discussed in the costs section above are subject to a number of assumptions. To indicate the possible range in net benefit 20% is added (subtracted) on to (from) the net benefit. This, along with the £750k cost increase specified in the paragraph above will determine the net benefit range.

Specific Impact Tests

47. Please see the table below for the test and results:

Specific Impact Test	Significant Impact?
Competition	No
Small firms	No
Legal Aid	No
Sustainable Development	No
Health	Health Impact Assessment not required
Carbon and Greenhouse gas	No

Other Environment	No
Race	See 'Equality Screening' below
Disability	See 'Equality Screening' below
Gender	See 'Equality Screening' below
Age	See 'Equality Screening' below
Religion	See 'Equality Screening' below
Sexual Orientation	See 'Equality Screening' below
Human Rights	No
Rural Proofing	No

Equality Screening

49. According to the Home Office, as at June 2009, the top 5 countries which Section 4 individuals originate from are Iraq (23%), Iran (13%), Zimbabwe (9%), Eritrea (8%), Sudan (6%).

    According to the Home Office, as at June 2009, the top 5 countries which Section 95 (ARE) individuals originate from are Pakistan (16%), Zimbabwe (8%), Iran (7%), China (7%), Afghanistan (6%).

50. There is no foreseeable differential impact on disability, gender, sexual orientation, or religion or belief. This policy increases equality by bringing more of the FAS population into line with the general population in terms of eligibility for free NHS hospital treatment, which in turn is likely to lead to them accessing secondary care more.

50. The initial screening suggests that there should be some positive impact on ethnicity and religious belief. However the numbers affected are small so the overall impact on equality at a national level will be minimal. The relevant Section 4 and Section 95 individuals cannot be compared against the general FAS population for equality implications as their circumstances are markedly different.

51. The UK Border Agency receives applications from adherents to a wide range of world religions and from different racial groups, some times on the basis of religious or racial persecution in their home countries. No particular racial or religious group is liable to be affected by this proposal.

52. A full EqIA was not completed. The screening assessment is based on limited but robust data. The department will undertake an equality assessment of current regulations and guidance and conduct a full equality assessment as part of its intended wider review of charges to overseas visitors.

Sources of Evidence

Control of Immigration: Quarterly Statistical Summary (April - June 2009), Home Office

Departmental Report 2008, Department of Health

Conclusion

53. The preferred option is option 2. Option 1 does not address the problem. The consultation ran from 26 February until 30 June 2010 and the majority agreed with the

question of whether option 2 should be implemented. Therefore we will amend the charging regulations to bring option 2 into force.

Annexes

Annex 1 should be used to set out the Post Implementation Review Plan as detailed below. Further annexes may be added where the Specific Impact Tests yield information relevant to an overall understanding of policy options.

Annex 1: Post Implementation Review (PIR) Plan

A PIR should be undertaken, usually three to five years after implementation of the policy, but exceptionally a longer period may be more appropriate. If the policy is subject to a sunset clause, the review should be carried out sufficiently early that any renewal or amendment to legislation can be enacted before the expiry date. A PIR should examine the extent to which the implemented regulations have achieved their objectives, assess their costs and benefits and identify whether they are having any unintended consequences. Please set out the PIR Plan as detailed below. If there is no plan to do a PIR please provide reasons below.

Basis of the review: [The basis of the review could be statutory (forming part of the legislation), i.e. a sunset clause or a duty to review , or there could be a political commitment to review (PIR)]; We will review for good policy practice reasons.
Review objective: [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?] This will be reviewed initially as part of a further review on the charging regime for overseas visitors to check that the policy intent is working.
Review approach and rationale: [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach] This will be reviewed initially as part of a further review on the charging regime for overseas visitors to check that the policy intent is working.
Baseline: [The current (baseline) position against which the change introduced by the legislation can be measured] supported failed asylum seekers are charged for NHS hospital treatment
Success criteria: [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives] supported failed asylum seekers are not charged for NHS hospital treatment.
Monitoring information arrangements: [Provide further details of the planned/existing arrangements in place that will allow a systematic collection systematic collection of monitoring information for future policy review]
Reasons for not planning a review: [If there is no plan to do a PIR please provide reasons here]

Add annexes here.