HOUSE OF LORDS

Select Committee on the European Union

Home Affairs Sub-Committee

Corrected oral evidence: Brexit: Reciprocal Healthcare

Wednesday 11 October 2017

11.35 am

Watch the meeting

Members present: Lord Jay of Ewelme (The Chairman); Lord Condon; Lord Crisp; Lord Kirkhope of Harrogate; Lord O'Neill of Clackmannan; Baroness Pinnock; Lord Ribeiro; Lord Soley; Lord Watts.

Evidence Session No. 4 Heard in Public Questions 26 - 35

Witnesses

I: Laura Brackwell, Director, National Audit Office; David Raraty, Audit Manager, National Audit Office; Bob Alexander, Deputy Chief Executive, NHS Improvement.

Examination of witnesses

Laura Brackwell, David Raraty and Bob Alexander.

Q26 **The Chairman:** Welcome. Thank you very much indeed for coming to give evidence to us. We are very grateful to all of you. In earlier discussions, we found there was quite a lot on facts and figures that we did not entirely understand, which is why we thought it would be good to have this session, so we are very grateful to you for coming. It is a public session, as you know, so there will be a transcript taken in public and we will send it to you afterwards to have a look at.

Before we get into the questions, perhaps I could ask you all to introduce yourselves. That would be very helpful. If Bob Alexander could also say a little bit about the organisation to which he belongs, that would be very helpful.

Bob Alexander: I am Bob Alexander. I am the deputy chief executive and finance director of NHS Improvement, an umbrella organisation that sits over the two previous statutory bodies: Monitor, which was the regulator of the foundation trust group; and the NHS Trust Development Authority, which was the overseer and performance manager of NHS trusts on their journey towards foundation trust status. Those two organisations have been brought together under a single umbrella management team, in an attempt to streamline and smooth the whole piece of provider regulation.

The Chairman: That was very helpful, thank you.

Laura Brackwell: I am Laura Brackwell, Director at the National Audit Office, and I led the piece of work that led to the report we published last year on recovering the cost of treating overseas visitors.

David Raraty: I am David Raraty. I also work for the National Audit Office, as you can see. I am a manager at the office, working on value-for-money reports and I was one of the authors of the report that we published in October last year, *Recovering the cost of NHS treatment for overseas visitors*.

The Chairman: Thank you very much. As a former public servant, may I say it is good to have the NAO in this position, rather than the one in which I am used to having it? Perhaps I could start by asking whether you could give a brief overview of the research methodology and key findings of the NAO report, *Recovering the Cost of NHS Treatment for Overseas Visitors*, which you have just referred to and mention what areas of NHS treatment it covers.

Laura Brackwell: Thank you very much for the chance to come and talk to you about the work we did. The report looked at the progress the Department of Health and the NHS were making in increasing the amount that was charged and recovered for treating overseas visitors who access NHS care, and at some of the barriers to successful cost recovery. In terms of your inquiry on reciprocal healthcare, we were looking at

overseas visitors who come and access the NHS here, rather than UK residents who go overseas. Therefore, our work essentially covered those types of NHS treatment that are chargeable, which is mainly non-emergency hospital treatment, with some slight complexity around the edges. In the main, it is non-emergency hospital treatment that is chargeable at the moment, but there are discussions about whether that should be extended.

In terms of collecting evidence, we used the usual NAO range of methods: interviews, document review, quite a lot of data analysis where data were available and financial analysis. We also carried out an online consultation with acute and specialist trusts to try to get some views from hospital trusts about what it was like for them, in terms of trying to identify and recover money.

In terms of the findings, we found that the amount being charged had increased since the Department of Health had launched its cost recovery programme. The amount had increased from £97 million in 2013-14 to £289 million in 2015-16. However, most of that increase was due to a change in the regulations that led to the introduction of the immigration health surcharge, which brought into the charging regime a group of people, students and temporary migrants from outside the EEA, who had not previously been charged. That generated £164 million in 2015-16, so a big chunk of the increase was down to that change in the rules. The other key finding was that the department was not on track to meet its ambition, which was to recover up to £500 million by 2017-18. It was somewhat behind the curve on that.

In terms of trying to improve cost recovery, we identified a range of barriers. A key challenge for trusts is identifying chargeable patients, and we will probably come on to that. There are some issues around the extent to which NHS staff are bought into the programme, the extent to which they see it as their role to try to identify chargeable patients and some concerns about the unintended consequences of the programme. When it comes to patients from outside the EEA, patients who are charged personally, there are some issues around getting money back and debt recovery.

Finally I should say, as David mentioned, we published our report last October and we have not done work since then to update it. The position we have is then, but I am sure Bob Alexander will be able to give a more up-to-date position.

David Raraty: That was a very comprehensive summary. The other point of context is that this is essentially a bit of a programme management report. The regulations that allow the NHS to collect money from overseas visitors are quite old, but the department launched a new programme to increase the amount that is being collected, so there is an audit context there. One of the audit questions for us was to see how well the department was doing to implement that programme and meet the target that it had set for that programme.

The Chairman: Thank you. Mr Alexander, do you have any comments on that? Is there anything you want to say about the report, at this stage?

Bob Alexander: I do not think so, Chairman. I will wait to see where the Committee goes with questions and do my best to answer them.

Q27 **Lord O'Neill of Clackmannan:** We have a general picture that there is a difference between what is potentially chargeable and what is actually charged. The difference is much greater for EEA nationals than non-EEA nationals. Can you explain in a wee bit more detail why this is the case?

Laura Brackwell: The first thing to say is it is very difficult to know. The data that we present in our report in one of the graphs—figure 4, I think it is—present a figure for potentially chargeable and what was actually charged. They indeed show that the gap is greater for EEA visitors than for non-EEA. The figures for potentially chargeable were based on research that the Department of Health commissioned in 2013. There were a lot of assumptions made in that, so the figures are subject to a fair degree of uncertainty. As you say, taking all that into account, it shows a bigger gap for EEA than for non-EEA.

In terms of the reasons, to be blunt, we do not know. It is quite hard to speculate. In the work we did, we did not see why that would be the case. The systems were not different or worse for EEA patients, so it seems an interesting difference.

David Raraty: That is true. There are a lot of caveats associated with the numbers. One of them is that there is a difference between the cost of treatment and the amount that is invoiceable, because some treatments are exempt. The consultants excluded a large number, which they thought could be around £300 million, for people who had no means to pay, so there would be no point in including them in the numbers. If they had no means to pay, they were unlikely to be credible payers at all. There is a lot of uncertainty about that in the first place.

Bob Alexander: I am sorry, Chairman: neither of my organisations was involved in the piece of work that gave rise to the analysis. I just make the observation that we know the identification of overseas visitors who could be charged, from either an EEA perspective or a non-EEA perspective, is challenging. Therefore, I assume that anything purporting to be a cost of treatment, by definition, must be subject to a set of assumptions, which may or may not be valid, at any one particular time, in any one particular organisation. Of course, the way in which charges are made to individuals is based on the national tariff. The national tariff, at least in the way it is currently calculated, is an amalgamation of average costs and not the relevant cost of treatment in any one particular organisation pertaining to where the event happened.

Lord O'Neill of Clackmannan: Do I take it that you did not really identify differing levels of collection between different health trusts or the bodies that were responsible for claiming the money? There obviously will be some where there are a lot of tourists or immigrant workers on a

short-term basis, but again the immigrant workers may be of a certain age that would not necessarily feature in the health stats. We are really fumbling in the dark here, are we not?

Laura Brackwell: Interestingly, from looking at the data that are available, we found quite a lot of variation between trusts in the amounts they were charging for both EEA and non-EEA visitors. For example in 2015-16, 22 acute and specialist trusts did not report any cases under the EHIC scheme, and eight trusts did not charge any visitors from outside the EEA.

When we delved beneath that and did some further analysis—you are right—some of the variation could be explained simply by the size of the trust or its location. Trusts in London for example, where there are a lot of visitors, charged a higher amount. We found from the analysis we did that about half of the variation could be explained by factors such as location and trust size, but about half could not. Some of that may be down to very local circumstances or one or two high-value cases that can skew the number in any particular year, but it suggests that there may be differing processes; some trusts are simply giving it a higher priority or are better at it. We felt that the data suggested there was room for improvement and that it was certainly worth probing further behind the numbers to find out what those that seemed to be doing well were doing.

Lord O'Neill of Clackmannan: Could you perhaps give us a ballpark figure, as to how much the NHS loses each year as a result of this shortfall?

Bob Alexander: I would be surprised if the NAO could do that. In fact, as one of the key recommendations that came out of its report, following the PAC report and hearing, which I am sure you are cognisant of, NHSI undertook to do two things, one in explicit conjunction with the department. I know you have received evidence from the department, so they may have told you this. That was to co-sponsor and support an intensive cost recovery team, who would go into 20 of the larger trusts in the country where statistics and evidence suggest that they would have—I use the word "significant" as a pejorative term—a worthwhile amount of overseas visitor engagement.

That was to try to get under the skin of what their processes and shortfalls were, and what good practice could look like, so that we would have some way of sharing that more widely across the acute trust sector. Those projects are under way. They were delayed somewhat because of the timing of the general election. The department did not feel that it could continue them through that period, so we have picked them up again and they are due to finalise towards the end of the autumn. That would be very good learning.

By the same token, we also said that we would try, through a process of collecting regular, consistent information from the entirety of the trust sector, and triangulating that against other evidence, to come up with an indication of opportunity—I would not want to say it was as robust as

income lost—based on what one might expect that organisation would see, given the population that it served.

Lord O'Neill of Clackmannan: That is why it is useful to have a ballpark figure.

Bob Alexander: That piece of work is to finish shortly, by the end of autumn. I am hoping that it will coincide with the project work that we have done in the 20 specific organisations and we will be able to come up with a more comprehensive approach for trusts to follow.

Lord O'Neill of Clackmannan: I have one last point. Is similar work being conducted by your comparators in Wales, Northern Ireland and Scotland? I am a Scot, but I am conscious that a lot of the negotiations will be conducted on behalf of the UK. The information should be more broadly based than just England, but can you tell us if similar work is being done?

Laura Brackwell: I do not know; that is the short answer. You are right. In terms of the two streams, for the non-EEA visitors it is essentially a devolved issue, so responsibility will rest with the health departments in the devolved nations. The EEA scheme—EHIC and schemes for pensioners and other treatment—is a UK-wide scheme and the Department of Health negotiates on behalf of the UK as a whole, as I understand it.

The Chairman: It would be very helpful, Mr Alexander, if you were able to keep in touch with us, so that we have sight of the report as soon as it is possible to do so, in case it fits in with our own timing.

Q28 **Lord Soley:** I understand the complexity of trying to get the figures, but I am not quite sure if there is a nice, simple list for people like me of why there is this difference between continental Europe and the UK. It seems to me that some of the differences can be listed. For example, British people are more likely to retire to France and Spain and, because of their age, they are more likely to use health services. You have to have an ID card in continental Europe. You do not here, so you can identify people in a way that you cannot in the UK, unless we insist on everybody taking their passport when they go to their GP, which would not be wildly popular. Then there are things like the difficulty hospitals might have in working out how much the cost is.

Is there a list of why it is so difficult to get figures that make sense of the differences between the UK and European countries, because they seem to be much more successful at it? It is not just about competence; I suspect it is about different practices and wider issues like ID cards and retirement. Is that right?

Laura Brackwell: This was something we just touched on in the margins of our work. You are right: it is reasonable to assume that some of the difference is down to the practice and culture of the different health systems, and the fact that the NHS in this country is residency-based, which is particularly difficult to evidence. For example, even if you take

your passport, it does not necessarily mean that you are entitled to free NHS care.

This was something that came up in the Public Accounts Committee session. The Committee was looking at those lists of numbers between the amount that the UK got back and the amount it paid out. There were some where the Committee felt that it was reasonable to say, for example with Spain, that a lot more UK pensioners retire to Spain than go in the other direction. There were some other countries—I think one of the Members picked up on Poland—where they could not quite understand the variation. We are not able to comment on why. I do not know whether you have anything to add.

Bob Alexander: If the Department of Health cannot, I am certainly sure that I would not be able to proffer a view.

Q29 **Lord Watts:** Mr Alexander, can I clarify where emergency treatment ends and recovery treatment starts? It seems to be unclear. If someone has a heart attack, they go in, but where does the emergency treatment end and where do the recovery costs start?

Bob Alexander: I would not want to hazard a clinical view on that point. We need to make the guidance clearer than is currently the case, but I believe this has always been a policy that is geared more towards elective planned care cost recovery than getting into the more difficult situation of how urgent treatment has to be before somebody asks for identification. Again, this is a policy issue that I would have expected the department to have given clarity on, rather than myself, a humble accountant, trying to do that.

David Raraty: If you look at people arriving at A&E departments, my understanding is that the treatment you get in the A&E room is not chargeable. At the point a clinical decision is made to admit you to a ward, at that point you potentially become chargeable.

Bob Alexander: That is the word: "potentially".

Lord Soley: You trigger another coronary on that basis.

Q30 **Lord Ribeiro:** My first question is this: can you give a sense of the main challenges there are in collecting the data? Since 1982, the NHS has had a statutory and legal obligation to collect data on overseas people using our services, and clearly it has failed to do so for the last 30 years, for whatever reason—costs, I suspect. Can you give us a sense of what the key information gaps are in collecting the data?

Laura Brackwell: Part of the issue is that, for EEA patients, there is a reasonable data source for those patients who are identified, in that the hospital trusts input details of the patients and the treatment to the Department for Work and Pensions online system. That is then available at a national level. For non-EEA patients, the data are essentially at trust level. They are not brought together in any way, so you can identify them in individual trust accounts, but they are not brought together at a

central level. Of course, that simply tells you the patients who have been treated; it does not tell you those who have been treated and charged, nor those who ought to have been charged. That is one of the difficulties when it comes back to trying to estimate potential shortfalls or differences between potentially chargeable and chargeable. There is simply not the information out there to know, for example, how many overseas visitors the NHS as a whole or individual trusts are treating.

David Raraty: It is probably fair to say that there is a system issue and a cultural one. There may be a cost one; I do not know. Part of the problem is that, as you have just heard, proof of identity does not prove entitlement to free treatment. Just recording people through the door is not good enough. You need something else, and systems have not been good at capturing that, historically. IT changes are being planned to make that a bit easier to capture, but it has been very difficult to record that in a coherent way.

It is probably also fair to say that there has not been a cultural tradition of doing it. The research that the department commissioned in 2013 found that a high proportion of staff just did not think it was part of their job to look for people who should be chargeable. Staff surveys that we saw, which the department has commissioned since then, found an increasing awareness among staff that this is important and necessary, and more a part of their job, but not in the majority of staff, in the last survey I saw, which was 2016. There was progress.

The Chairman: Whose job is it to make certain that it is there and they see it as part of their job?

David Raraty: I am looking to my right on that.

Bob Alexander: If I might add a bit more, supplementary to the previous question, Chair, I will go on to the next part afterwards. There are myriad issues that we have to address. Some of them are quite legitimate and some of them are more a function of happenstance. There is a genuine question as to where, on the clinical journey, you engage with an individual to say, "Are you or are you not entitled to NHS care, free at the point of delivery, because of your circumstances"? Where do you do that? I would innocently suggest it is a bit tricky in a clinical setting, so it needs to be brought forward. That will mean a set of operational processes that most NHS trusts do not have.

You asked why it is different in other places. Where you have explicit social insurance or health insurance schemes to fund, it is part of the business process to access a service; here, that is not the case. We are silent in all this on primary care, GPs and heaven knows what else. I am just talking here about the acute trust space, so that needs to be addressed.

There is certainly something about the ease with which individuals can be identified once and then subsequently tracked, so there is something about using the national summary record to recognise that an individual

has presented as an overseas visitor so, frankly, people know when they look at that record that there is a question to ask. I believe that is in process.

There is a parallel project running. In addition to looking at 20 organisations around their practice for capture and their practice for recording, we have asked those same 20 to pilot the two forms of identification, not to turn treatment away, but to try to identify just how difficult that is, what it tells you, what difficulties or otherwise it gives in the clinical or the operational setting, and how it plays to individuals, because if you are asking for one you have to ask for all. Those projects are going to materialise hopefully towards the end of the autumn, and by that I probably mean the end of November, to be honest. That will be interesting because it will set the tone of what people can expect as a sensible business process to improve cost recovery.

In terms of your question, Chairman, where does the responsibility sit? The responsibility sits with the statutory organisation that has regulations and laws to abide by, so there are three pieces there that are relevant. First, NHS Improvement, supported by the department, has to try to issue clear best practice guidance that people can follow more easily than deciding it for themselves, so it is a bit of what works and what does not work.

Secondly, we have to uprate the recognition among organisations—let us be frank: it is the bigger ones, not the smaller ones, if you are looking at it from a Pareto principle perspective—and get the engagement of senior leaders in those organisations. We are in the process of putting together an appropriate advisory group, which will have senior management and clinicians from the trust sector, to support the cost recovery programme. Finally, and I say "finally" as in order, regulation will inevitably have a responsibility to intervene where the evidence indicates that organisations should be doing things that they are not doing. That is the end of the process, though; it is not the start of the process. The start of the process is getting the best practice out there, trying to get organisations to put their systems in place and raising the profile of importance. That is then followed up with an audit or compliance regulatory aspect.

Lord Ribeiro: The Health and Social Care (Safety and Quality) Act 2015 provided you with some of the mechanisms for doing that. One was the issue around a duty to share information, and the other one was around specific patient identifiers. Those two things that came out of that regulation should enable the NHS to share information and get the sort of data you have referred to.

Can you elaborate a little more on the difference in cost recovery among trusts and why there is such a significant variation? You have already mentioned the bigger trusts and the smaller trusts, and clearly we also know that London and the north-east are huge. Your report, which is a very good report I have to say, identified these particular areas. The fact that 10 trusts are responsible for probably 60% of the total amount of

money that we have pulled in suggests that there is a problem. Can you say anything about that and why there is such a variation? It is probably addressed to you, Mr Alexander.

***Bob Alexander*:** To be honest with you, I can only hypothesise, really. There is bound to be an implication for where your pockets of transient visitor people happen to be. That might lead you towards cities rather than rurality, but not necessarily. I am absolutely sure that there is then a relationship between the intensity of overseas visitor traffic, the perceived operational burden of collecting one or two bits of information, as opposed to 200 or 300 bits of information, and what the benefit to the organisation is. Actually, our overall commissioning processes are not so sophisticated and one or two people might not naturally be charged to a local commissioner for relatively ordinary treatments. There are some obvious reasons why you would expect to see quite wide variety, even if you were confident about data capture.

Lord Ribeiro: In its report, the NAO made a very important point from talking to trust staff, and one of its recommendations was that the Home Office could be used to flag up when people had not paid and, on their visa application, you could have a system whereby, if someone had not paid up, the multiagency groups could pass that information over. Is that something that is worth while and something you are looking at?

***Bob Alexander*:** It is something that is being looked at as part of the projects that I referred to earlier. The Home Office has been part of the conversations in terms of what it can do to help with access to its systems and, by the same token, what information it could be given that would do exactly as the report suggested.

***Laura Brackwell*:** The information that the Home Office has is for those people who are now paying the immigration health surcharge as part of their visa application. When we were doing this work, there were moves in place to improve the data sharing and the IT systems, so that there would be some kind of banner, when a student or a temporary migrant had paid the surcharge, that would pop up within the NHS and you would know that that person had paid and was not therefore potentially chargeable. That is part of trying to build a picture, of helping trusts to identify potentially chargeable people.

Lord Ribeiro: The report calls on NHS Improvement to analyse available data on charging and cost recovery, to identify outliers. Based on the NAO report, the Public Accounts Committee called on NHS Improvement to collect and share data on the performance of the trusts in charging and recovering money. You were going to come up with a report on that in June this year. Given the elections and so forth, have you actually done that? This is that NHS Improvement and the Department of Health should publish, by June 2017 at the latest, action plans setting out the specific points. You mentioned what you were doing towards this. When do you expect to do that—in the autumn?

***Bob Alexander*:** Yes, and there is an additional piece that we have already done because it was not subject to any election impact. We have already started the quarterly collection from all NHS trusts as to their income charging for overseas and migrant visitors through their in-year processes. That is available to all trusts to review against their peers, against benchmarking. When we can triangulate that with what we think an opportunity for a trust might be, it will allow us to have a more comprehensive conversation with them about performance. I do not think we will be able to do that until later on in this calendar year, because we need the triangulation point. At the moment it is just a graph that shows you who is at what end of it, which is helpful but not the finished article.

Lord Ribeiro: You expect to flex some muscle at some stage.

***Bob Alexander*:** At some point, conversations will need to be had.

Q31 **Lord Kirkhope of Harrogate:** I am quite interested in the comparison between certain words. I am interested in the comparison between "ambition"—I am less ambitious now than I used to be—and "estimate", because in your report there seems to be an enormous disparity between the two things. While I am happy enough that we should all have ambitions, I am not so happy about performance. In the context of the work we do in relation to our future with the European Union, it is very, very important to try to eliminate areas of uncertainty so that there is some clarity here. I am concerned about the total amount of resources that we have lost over a long period of time, by the look of it, because our systems have not collected what we were entitled to collect.

I am disappointed that, in fact, we now seem to be ending up with an acceptance, by the Department of Health in particular, through its forecasting, about recovering future costs; these are the EEA chargeable costs. I know we have gone through this question already with other questioners about identification of patients who are covered and the difficulties that there are, but I am very unhappy about the nature of our intentions here and I really would like to get to the bottom of this.

I think Mr Raraty mentioned culture issues and ways in which we do or do not do things in the health service because different trusts or different parts of the health service do not wish to or whatever. Are you of the view that enough has been done to oblige our health institutions to collect the money that the state is entitled to have?

As a final point, on comparison to other EU countries in terms of their processes, how much work have we done to compare our own system, which I know is a different system in the first place, and their systems in relation to collection of money that is due?

***Laura Brackwell*:** I will say something about the view we have reached from carrying out our work. You are right: it came up at the Public Accounts Committee that the NHS or the bodies that preceded trusts have had some responsibility to charge people since the 1980s, yet clearly it was not at the top of people's radars, such that in 2014 the Department of Health decided to launch its cost recovery programme. At

the time of our work, we saw some progress being made. As you say, the projected performance is still a long way from the ambition that the department had set. Therefore, good things were being done, but they needed to be seen through and to be supplemented by more work, as Bob Alexander has described, particularly around those trusts where the gap between what is being charged and what could be charged appears to be the greatest. That is a whole range of things – around IT, staff engagement, culture, pursuing debts – which together ought to start closing that gap.

***David Raraty*:** There are lots of different sub-questions buried under that. One answer might be that the ambition is wrong. The department, in evidence to the Public Accounts Committee, said that it was not an exact science, so that is one possible interpretation. The research that the department commissioned suggested that it was not far off the mark; if the research was accurate, it was not a bad guess.

The performance against that ambition has clearly fallen short of the target, from which the conclusion you might draw is that we must try harder, particularly in the EEA cases. How you understand what the difference is perhaps comes back to our discussion earlier about what the causes of variation are. There are some trusts that we know are charging visitors from outside the EEA but are not recording any patients from within the EEA. There may be good reasons for that, but unless we go and ask them, it is very difficult to understand what is going on.

Lord Kirkhope of Harrogate: It is outside of your competence, but the devolved authorities, of course, have a different approach in some of these contexts. You do not have control other than over England.

***David Raraty*:** No, these are all English trusts we are talking about here.

Lord Kirkhope of Harrogate: I do not want to be pedantic about this at all, but you can look at these things in gradation. First of all, a target is a very clear thing that is set down: we have a target to do this. Then you go to an estimate, in relation to which we seem to have failed, and below that we have an ambition, which we have not met in any way at all. Then we have a forecast. I love words and I am sure you do too. The Government use words all the time to try to get round all kinds of obligations. However, it seems to me that we have ended up here with nothing, really. I do not mean this rudely, because I share the view that this is a good report, but it seems to be so nebulous as to be unhelpful in the context, particularly over the next two years or so. There is great attention being paid to the issues of how much this country is paying or not paying to Europe, and how much they are paying to us. In those contexts, to have this kind of nebulousness is, in my view, unacceptable.

***David Raraty*:** I cannot disagree. The National Audit Office picks its words very carefully in the way we draft our reports. It is also fair to say that a target to invoice £500 million does not mean the same thing as getting that much money back, because we know that not all of it will be

paid when it is invoiced. You are absolutely right to highlight the muddiness that there is about what is likely to happen.

***Laura Brackwell*:** Interestingly, as I said at the beginning, the progress that has been made is largely due to the changing of the regulations and rules, with the introduction of the immigration health surcharge, rather than because there was a big step change in trusts identifying patients. There has been a bit of a boost in the number of patients from the EEA that trusts have identified, and there is some possibility that that has been encouraged by the incentive scheme that the department introduced. It is harder to see a lot of progress in that basic identification of people who need to be identified when they access care rather than paying in advance.

***David Raraty*:** On the other question that you asked about the comparison with other countries, this was something else that came up in the Public Accounts Committee hearing. Again, we come across the challenge that most other countries are just different because they have different regulations. As Bob said a few minutes ago, they have a different approach and a different way of managing people through the health system, because they tend to have an insurance-based system rather than a residency-based system. It is quite difficult to find close enough comparators to make that apples and apples.

Lord Kirkhope of Harrogate: How far back can we retrospectively make the charges that we are entitled to charge?

***Laura Brackwell*:** I do not know.

***Bob Alexander*:** I do not know that.

Lord Kirkhope of Harrogate: Does it have to be within a financial year or can it be right back?

The Chairman: Would it be possible to find that out and let us know?

***Bob Alexander*:** I am sure it would be possible to find out. I suspect there is some difference between EEA arrangements and non-EEA arrangements, which tend to be with the individual. All I would say is that the longer you deal with debt with an individual, the less likely it is that it gets settled.

The Chairman: If you could write to us on that, it would be very helpful.

Q32 **Lord Crisp:** I have two quick questions of clarity; I hope the answers are quick as well. First, the figures here are all gross, are they not? They are not net of the costs of collecting the balance due.

***Laura Brackwell*:** Yes.

Lord Crisp: Do you have that analysis?

***Laura Brackwell*:** No, we do not. Information was not available on the implementation costs.

Lord Crisp: It would be useful analysis to know how much it cost to collect. Okay, so it is gross. Secondly, in response to a question from Lord Watts earlier about where emergency becomes something else, it seemed to me that you were all very vague about the definition. Do we have clear definitions about what it is we are charging for? I think Mr Raraty referred to the fact that, if it was in A&E, it was definitely not chargeable, and then if it became somebody in a bed it became chargeable. That sounded a bit vague, because if you have a heart attack you might end up in a bed. Are those definitions clear and understood, because that is very relevant to everything we are talking about, is it not?

***Bob Alexander*:** I do not think they are fully understood yet, because we use the word "urgent". A&E is off; you then get into planned elective care, which is definitely chargeable, and you have the piece in the middle where somebody will say, "That is urgent". Is it urgent enough that you can get into a charging conversation, or is it urgent enough that something needs to happen now? We need to explore that in the pilots that we are currently doing in 20 large organisations, because some of it will be clinically judged.

***Laura Brackwell*:** I remember when we were finishing the work there was also the distinction as to whether something is urgent and therefore the patient should receive treatment immediately, regardless of any questions about charging. As I understand it, maternity care is always regarded as urgent because of its nature. That does not mean you cannot subsequently be charged, so there is the clinical decision about whether something is urgent and has to be treated immediately, and there is the separate question about whether it is chargeable.

Lord Crisp: I can understand there is a difference between the clinical process, which is what you are talking about, and the business process. That is absolutely clear. It seems to me that there would be scope here for having as clear definitions as you possibly can, which you do in commissioning in other areas

***David Raraty*:** That is right. There is no definition of "ordinarily resident" in statute, or at least there was not.

The Chairman: We are running out of time, so swift questions and swift answers, if we may.

Q33 **Lord Watts:** My first question I will not touch on, because you have dealt with who is statutorily responsible for the collection. I would be interested to know if there are any penalties or incentives in place to enforce the charging policy. It seems to me that there are two ways of doing that: one is a financial penalty for failure to do so, and the other is through the chief executive and the management's assessment when they are setting salary and conditions. I wondered whether either of those are in place at the present time or if there are any plans to introduce them.

***Bob Alexander*:** There have been some financial incentives to encourage trusts to take overseas and visitor charging more seriously in terms of how much you charge, so there is a premium associated with it. In October, there are regulations coming in that organisations have to identify upfront patients who may be, and commissioners are within their rights to withhold payment if they are being charged and have a right to test trust processes to ensure that that information capture is there.

In so far as what the implications for the leadership of organisations might be, that comes back to my earlier response. When we have a more systematic sense of what good looks like and a better view of triangulated opportunity that you can assess actual performance against, it will become more straightforward to have a conversation between the regulator and the management team about shortcomings or otherwise in that performance. You take it in the round of service performance and delivery generally.

The Chairman: Thank you, that is very helpful.

Q34 **Lord Condon:** The report noted that a more vigorous cost recovery programme might have the unintended consequence of deterring certain vulnerable candidates from seeking treatment, whether they are ethnic minorities, homeless, mentally ill or whatever. I know that the report data stopped at last October, but is there any anecdotal evidence or empirical data to suggest that that fear is being realised and vulnerable people are being deterred?

***Laura Brackwell*:** To answer from the position when we were doing our work, at that point, there was no robust evidence either way. It was certainly a concern that we heard from some interest groups and, as you say, I am sure there is anecdotal evidence. The department at that point was working with relevant bodies to try to make sure that people were not deterred, but I do not know whether there is any better evidence now.

***Bob Alexander*:** I may be putting an awful lot of weight behind these, but we have the projects running in the 20 chosen organisations for the questions of how you do this and what the feedback of doing it is. We will probably do some cost capture there as well. Also, how has the evidence of identity project worked and what issues is it flagging up in outpatients, in the clinical space, in the hospital environment when those conversations happen between a booking clerk and a member of the public who has turned up for something? There must be some analysis, both quantitative and quantifiable, coming out of that. I am just not in a position to evidence that into the Committee.

Lord Condon: Will that other side of the coin, so to speak, the deterrence rather than the cost recovery, feature in the work being done or will it just be an accidental product?

***Bob Alexander*:** I expect to get some outcome to enable that conversation about deterrents to be had by the department, which of course is the policy-setter.

***David Raraty*:** The department was actively working with stakeholder groups. It did not have any evidence to conclude either way, but it was actively working with them and clearly aware that the primary objective was that nobody with an urgent need was turned away or discouraged. We should not be overly concerned about them lacking concern about that issue.

Q35 **Baroness Pinnock:** Good, you have exactly one minute to answer this. If reciprocal healthcare arrangements were to end, what would the financial, staffing or other implications be for the UK and for the health sector?

***Bob Alexander*:** I am afraid I am not qualified to answer that question. I have not had a conversation with anybody in the Department of Health about it and it is not an area that we inherently deal with. That feels like a policy question associated with exiting arrangements and it is really not for me to say.

***Laura Brackwell*:** I suspect it is even less for the NAO to say. It would obviously depend on the deal that was done and the alternative arrangements that were put in place.

Baroness Pinnock: What if there were not any?

***Laura Brackwell*:** Again, I am not in a position to say.

***Bob Alexander*:** We currently have two charging arrangements: one for individuals who are identified as EEA and others who are identified as non-EEA. If there is no EEA arrangement, I would assume that the default is that everybody is a non-EEA individual and will be charged according to the policy in existence at the time.

***Laura Brackwell*:** If that were the case, that raises interesting issues because of the different arrangements for non-EEA visitors in terms of people being personally charged and therefore personally liable.

Baroness Pinnock: That is the key, is it not, that it becomes personal liability?

***Laura Brackwell*:** That is the position at the moment for non-EEA visitors.

The Chairman: Thank you very much indeed for coming and talking to us, and for giving us evidence. We have benefited greatly from it. It is an important part of our work and we are very grateful to you all.