National Health Service or National Safe Haven

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Foreword by Rt Hon Sir Sajid Javid

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Foreword

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The NHS is one of our most precious national institutions because it reflects the values at the heart of our society.

That includes the principle of fairness. Everyone contributes to our health service according to their means, and in return everyone is cared for according to their need. Break that model, and you weaken the social contract on which services like the NHS depend.

This sobering report from Policy Exchange demonstrates why that principle is under threat. The rules on who can expect free treatment are clear under law. If you are resident in the UK, you are eligible. If you are an overseas visitor who does not meet the criteria, you are not.

Despite this, NHS Trusts in England failed to recover more than a quarter of a billion pounds over three years from overseas visitors. That's enough to pay the salaries of 3,200 more GPs, or build almost 70 new GP surgeries.

This would be serious enough if the NHS was functioning well. However, by the government's own admission, it is not. Public satisfaction is the lowest it's ever been. Patients are waiting months, or even years, for treatment.

Against that backdrop, asking those who pay for the NHS to shoulder the cost for those who haven't made the same contribution is fundamentally unfair. When a taxpayer in Manchester or Birmingham is denied timely treatment, yet sees resources diverted to write off millions in unrecovered costs from overseas patients, confidence in the system is corroded.

Many of those who are cared for by the NHS without paying for it do, in fact, have the means to pay. Some will have insurance policies that would cover the cost of their treatment. By failing to collect what is owed, NHS Trusts are effectively boosting the profits of private insurers while passing the bill to British taxpayers.

They are also undermining efforts to manage migration. Allowing those coming from overseas to access world-class healthcare at no cost is a clear incentive to illegal migrants. It is neither compassionate nor sustainable to maintain a model in which those who play by the rules, pay their taxes, and contribute to the system are asked to subsidise those who do not.

The NHS is not a charity. It is not an international aid organisation. It is a public service - funded out of the hard-earned money of British taxpayers, for the benefit of British taxpayers. Every doctor, every nurse

and every hospital is paid for by hard working families up and down the country.

Maintaining their confidence and trust must be a priority. Rules mustn't just exist on paper. They must be enforced. This report demonstrates how to do just that.

Executive Summary

There are three words that make up the NHS: National, Health and Service. Of these, the first – 'National' – is the least examined. What does it mean for a Health Service to be 'national', in an era of mass migration and porous borders? To what extent to the NHS's actions and policies reflect this founding principle, as well as the need for neutrality in the public space? This paper, the first of a series looking at the NHS's relationship with non-UK nationals and how this is reflected in its policies and practices, examines the issue of charging and cost-recovery for treatment.

The NHS operates on a clear statutory principle with regards to treatment: treatment is available to those ordinarily resident in the UK, with certain exemptions, but charges must be recovered from overseas visitors who do not meet those criteria. This principle is embedded in legislation and backed by regulations that place a direct statutory duty on NHS providers to identify chargeable patients, issue invoices, and recover costs.

This paper explores what happens when that principle is put to the test, not in theory, but in the day-to-day practice of NHS trusts, integrated care systems, and clinical leadership teams. It documents how some NHS Trusts have entered into partnerships with charities and pressure groups such as the 'Cities of Sanctuary' movement. It examines how policies concerning cost recovery from overseas visitors and the identification of chargeable patients are implemented across the health system. It asks how national legislation translates into institutional behaviour, and what role organisational culture, professional norms and third-sector influence play in that process. Following papers will address immigration law compliance and right to work checks.

After an extensive FOI exercise during which trusts were asked to provide details of their overseas health costs collections from the last three years, headline findings include:

Between 2021 and 2024, NHS trusts in England invoiced £384,245,201 to overseas patients.

The total value of unrecovered charges over the three years is over £250 million.

That's enough to pay the annual salaries of around 3,200 GPs or to fund the building of approximately 68 new GP surgeries. The national average recovery rate[1] over the period was 39 percent.

The top 10 trusts with the most uncollected overseas health costs over the last three years are:

1. Among trusts that provide chargeable care

Name of the Trust	Uncollected (£)	Collection Percentage
Imperial College Healthcare NHS Trust	29,937,936	19%
Barking, Havering and Redbridge University Hospitals NHS Trust	17,426,970	29%
Barts Health NHS Trust	14,819,000	Incomplete FOI Data
University College London Hospitals NHS Foundation Trust	13,900,320	45%
Northern Care Alliance NHS Foundation Trust	13,139,944	5%
King's College Hospital NHS Foundation Trust	11,852,755	19%
Guy's and St Thomas' NHS Foundation Trust	11,757,000	44%
Lewisham and Greenwich NHS Trust	10,830,000	31%
The Hillingdon Hospitals NHS Foundation Trust	10,674,145	29%
Sandwell and West Birmingham Hospitals NHS Trust	9,047,511	8%

While NHS Trusts formally record overseas debts as either "written off" or "uncollected," the reality is that both categories represent sums that are overwhelmingly unlikely ever to be recovered. The FOI dataset spans a 36-month period, meaning many of the debts captured are already two to three years old. Medway NHS Foundation Trust illustrates the scale of the problem starkly: it has recovered just £335,000 over the past three years, only 4 per cent of the total, leaving £7.85 million unrecovered. The problem is highly concentrated: the ten trusts with the largest uncollected amounts account for £143.4 million, over 56 per cent of the national total, and Imperial College NHS Trust alone has more uncollected charges than the bottom 55 trusts combined.

There is no correlation between the size or location of a trust and its collection percentage. Therefore, the issue is not one of capacity but prioritisation. Nineteen NHS Trusts recovered less than 20 per cent of the charges they issued over the past three years, together collecting only £15.26 million; had they performed merely at the national mean collection rate of 39 per cent, the NHS would have gained an additional £14.6 million. Some trusts with no formal recovery policy account for more than £20 million in uncollected charges, while even where policies exist, they are often poorly enforced. Audits have revealed systemic weaknesses, including periods when no cover was provided for absent Overseas Visitor Managers and invoices that took up to 660 days to be raised.

The current state of overseas health cost collection in the NHS is so

poor that a few small improvements could save tens of millions of pounds for the taxpayer. Raising all trusts operating below 39% to 39% would yield just over £40 million, without touching half of all trusts in the FOI exercise. Furthermore, setting a minimum 50% recovery rate, the current level of the top quartile, would save £68.7 million for the taxpayer. These improvements are the minimum required for a system currently failing the taxpayer.

The paper also examines the role of external advocacy and professional networks; and considers the extent to which they may shape local approaches to interactions with foreign nationals and non-residents, including charging and cost recovery.

Initiatives such as City of Sanctuary partnerships, the Patients Not Passports campaign, Docs not Cops and Medact promote alternative interpretations of eligibility rules and seek to influence how charging regulations are applied in practice. Some NHS organisations have entered into formal arrangements with the City of Sanctuary movement, incorporating their training materials or policy frameworks into local operations. In recent years, NHS organisations have entered into formal partnerships with the City of Sanctuary network, including Trusts, Integrated Care Boards, and training bodies. In 2023, the West Yorkshire Health and Care Partnership became the first ICB to adopt the "Partnership of Sanctuary" [2] label, with accreditation involving retraining of GP staff, adjustments to frontline and administrative practice, and assessment by local City of Sanctuary panels. Other trusts have also engaged, such as Solent NHS Trust's support for Portsmouth's City of Sanctuary chapter, which publicly characterises the UK border regime as "unfair, cruel, confusing, and ineffective." [3]

While these initiatives vary in scope and emphasis, they share a focus on promoting access to healthcare for people with insecure immigration status. Their presence forms part of the broader environment in which local charging practices are developed and implemented.

Another prominent group, Docs Not Cops, has also mobilised directly against NHS charging and enforcement practices. In 2018, Barts Health NHS Trust became the focus of their activism, with a protest outside the Trust's annual general meeting in Mile End leading to the suspension of ID checks, the removal of posters, and a review of patient pre-attendance forms[4]. This was later cited this as evidence of effective mobilisation, describing East London as "at the centre of the fights to stop checks and charges for migrants." [5] Today, Barts Health NHS Foundation Trust holds the highest volume of written-off overseas patient charges nationally, with more than £14.8 million written off in the past three years alone, over £6 million more than the next highest trust.

Alongside Docs Not Cops, Patients Not Passports represents another major strand of organised resistance to NHS charging. Unlike protest-led mobilisation, its focus has shifted toward embedding resistance within the health service itself, actively recruiting NHS staff and equipping them with resources to challenge or circumvent charging rules. On their website, they urge employees to "equip yourself with knowledge to be confident

2. West Yorkshire recognised for providing welcoming and accessible healthcare services - Link
3. Portsmouth City of Sanctuary "Not in our name" Link
4. Socialist Worker - East London health trust drops racist ID checks after protest – 2018 Link
5. Socialist Worker - 'Campaign in every way we know how' for safety of child refugees, says Alf Dubs – 2020 Link

to challenge any decision made to charge someone for care"[6] and to "get your colleagues to support you, especially senior staff who may feel more able to challenge the Overseas Visitor Team." [7] Their toolkits explain how to reclassify cases as "urgent or immediately necessary" in order to avoid pre-operative charging, and note that "treatment will be exempt from charge where that treatment is an ongoing or 'continuous course of treatment' that started while the person was entitled to free secondary care." [8] They highlight this exemption as "a little understood part of the Charging Regulations," instructing staff to notify both patients and colleagues to ensure charges are not applied. This illustrates a systematic effort to provide NHS workers with strategies for contesting or neutralising cost-recovery procedures from within clinical settings.

Medact, which describes itself as a movement of health workers campaigning for "health justice" and to "dismantle oppressive systems," has also given academic weight to opposition against NHS charging. In 2023, its Research and Policy Manager Hil Aked co-authored a peer-reviewed article in the International Journal of Human Rights based on interviews with twelve healthcare professionals, all recruited via Medact's membership. The study examined what it called "everyday resistance," documenting how staff quietly refused to implement charging rules. Testimony included: *"I just didn't do it. I was just like 'I'm not going to be asking people for passports'," "We just didn't play ball. We didn't follow the guidance…we just didn't ask people the questions that you were meant to ask them,"* and *"You just conveniently don't do it. Or you forget. Or the form gets lost. Or whatever."* Several participants referred to a *"tacit agreement among staff not to engage with it,"* while one described their refusal as *"my own little bit of civil disobedience"*.

A national healthcare system must be both trusted and sustainable. That means applying consistent standards of care to each patient while ensuring that costs are recovered where required by the law. Fairness is not an abstract principle in a system funded by taxpayers; it is the foundation of the legitimacy of that system.

Yet rules on their own are not enough, their impact depends on organisational enforcement and on the culture set by its leaders. It is whether it is being applied with the consistency, clarity, and operational discipline required to protect public funds and maintain fairness across the NHS estate. This report demonstrates that, in the area of cost recovery, the NHS is constantly failing to fulfil its statutory obligations, at significant cost to the taxpayer.

6. Patients not Passport Easement Clause Link
7. A PATIENT IS BEING CHARGED. HOW CAN I HELP? – Patients not Passports Link
8. Patients not Passport Easement Clause Link

Recommendations

1. The Department of Health and Social Care should require NHS trusts to publish in their annual reports the total amounts billed to overseas visitors, collected, written off, and still uncollected.
At present, most trusts only publish the amounts they have collected from overseas visitors and the sums written off, omitting any figure for charges that remain uncollected. This creates a misleading picture of performance and hides the true scale of unpaid debt. Trusts should instead be required to publish four figures annually: total billed, total collected, total written off, and total still outstanding. Standardising these disclosures would close the transparency gap, allow for year-on-year performance tracking, and enable Parliament and the public to assess whether statutory cost recovery obligations are being met in practice.

2. The Department of Health and Social Care should produce an annual league table ranking trusts by overseas billing performance and conduct in-depth audits of the twenty trusts with the worst performance each year.
The Department of Health and Social Care should publish each year a league table of the ten NHS trusts with the highest value of uncollected overseas patient charges, showing for each trust the total billed, total collected, total written off, and total still outstanding. This would expose persistent underperformance, support Parliamentary scrutiny, and guide targeted intervention. Any trust in the top ten should face an automatic audit of its overseas visitor cost recovery policy and operational processes, including billing procedures, follow-up systems, and enforcement practices, ensuring reputational and regulatory pressure to improve. Additional audits could also be conducted as required.

3. Every NHS Trust CEO should have a mandatory performance objective to achieve at least 50% collection – with bonuses automatically denied to any CEOs who fail to achieve this.
There is currently no requirement for trusts to maintain dedicated full-time Overseas Visitor Department staff. In practice, staffing levels vary considerably, with some trusts employing full-time managers while others rely on part-time staff or individuals who combine the role with unrelated duties. Raising the collection level of all Trusts below 50% collection rate to a minimum 50% collection rate nationally would have raised an extra £68 million over the last three years.

4. The Department of Health and Social Care should mandate that all NHS Trusts and other NHS bodies include in their annual reports a full account of all formal partnerships and policy positions involving external charities or NGOs.

The Department of Health and Social Care should require all NHS trusts to include in their annual reports a clear register of relationships, funding arrangements, and joint activities with external charities and advocacy groups, particularly those engaged in migration, asylum, or health-access campaigning. Greater transparency would not prohibit legitimate partnership working but would ensure that decisions taken in NHS settings can be properly scrutinised for potential conflicts of interest or policy misalignment. The NHS should also prohibit trusts from partnerships with external organisations that seek to influence trust policy.

5. Professional regulatory bodies should embed patient eligibility and immigration status checks into official professional guidance, setting out clear responsibilities, timelines, and enforcement measures, including sanctions for non-compliance.

Professional regulatory bodies should update clinical guidance to explicitly include the legal duties of NHS staff in relation to patient eligibility and immigration checks. Such clarification would remove ambiguity, ensuring that all healthcare professionals understand when and how these checks must be carried out in compliance with existing regulations. Embedding this into professional standards would help normalise lawful cost recovery practices within routine clinical and administrative processes, while still safeguarding patient confidentiality and clinical ethics. Regulatory bodies should also have the power to sanction doctors who knowingly disregard these regulations, reinforcing that compliance is a professional as well as legal obligation.

6. The Home Office should not issue new visas to those with outstanding payments for care from the NHS unless these charges are paid in full.

A lack of coordination between NHS trusts and the Home Office means that overseas visitors who fail to pay NHS charges can re-enter the UK on new visas without settling previous debts. Every NHS Trust should be required to regularly provide the details of all non-resident individuals who have unpaid bills to the Home Office, a list which would automatically be checked on any future visa application, and the visa denied unless payment is made in full prior to or alongside the application being submitted by requiring full repayment, including statutory interest charged at 8% per annum to reflect the cost of delayed payment, before any new visa is issued, the UK would force applicants to settle debts promptly and ensure that public funds are recovered in full. This policy would align immigration and health cost recovery regimes, closing a loophole that allows repeat use of NHS services without accountability.

Introduction

The NHS was founded on a radical and enduring idea: that healthcare should be available to all, free at the point of use, and based on need rather than ability to pay. That principle, established in 1948 amid the post-war settlement, continues to shape public expectations and national self-understanding. The NHS is still routinely described as a cornerstone of British life, a common good that binds together an increasingly diverse society. It is one of the few institutions in the country that commands support and respect across generations, social classes and political affiliations.

Migrants have always been part of the NHS, as doctors, nurses and patients. Some of the earliest NHS hospitals were staffed by Commonwealth nurses and Caribbean auxiliaries. Today, around one in six doctors and nurses working in the NHS were trained overseas.

The NHS, however, is an explicitly *national* service, and access to NHS care, though generous by international standards, has never been intended to be without limit. Since the 1980s, successive governments have introduced legislation to ensure that certain categories of care are chargeable to those not ordinarily resident in the UK. These rules were formalised and expanded in the 2010s, when the Immigration Health Surcharge was introduced and clearer statutory obligations were placed on NHS trusts to identify chargeable patients, recover costs, and verify eligibility at the point of care. These changes were not designed to curtail the founding vision of the NHS, but to protect its long-term sustainability. The idea was simple: a national health service must remain fair and viable, which means applying the same standards to all users and recovering public costs where legally appropriate from those who are not nationals.

This paper explores what happens when that principle is put to the test, not in theory, but in the day-to-day practice of NHS trusts, integrated care systems, and clinical leadership teams. It examines how policies concerning cost recovery from overseas visitors and the identification of chargeable patients are implemented across the health system. It asks how national legislation translates into institutional behaviour, and what role organisational culture, professional norms and third-sector influence play in that process.

It tracks how ideas of 'sanctuary' have moved from civic activism into official NHS partnerships and whether third-sector campaigns have influenced staff attitudes and training. It identifies both the formal and informal levers that shape compliance. And it asks, what kind of institutional culture is needed to ensure that the NHS remains both compassionate and

compliant, a system where openness and accountability reinforce, rather than weaken, its founding promise.

It also considers the degree to which different NHS bodies interpret and enforce the same regulations in different ways. While the legal framework is nationally defined, much of its application is locally managed. The guidance on who must be charged, how costs should be recovered, and what exceptions apply is complex. In practice, it falls to individual trusts, boards and clinical staff to make key decisions. That discretion is necessary, but it also introduces variation in policy, in attitude, and in compliance.

The consequences of these variations can be significant. If charging practices differ widely across trusts, patients may be treated differently not because of clinical need but because of institutional approach. If costs owed to the NHS are not recovered, the financial burden shifts quietly to general budgets, with implications for already-stretched services.

This paper begins from the position that a national healthcare system rooted in public trust must also be anchored in clarity, fairness and legal integrity. Rules must not only be well designed; they must also be enforceable and enforced. Whether or not that happens is shaped not only by formal guidance, but by organisational ethos, leadership culture, and the networks of influence that shape operational practice.

NHS Partnerships and their influence on NHS Policy

The NHS is the largest employer in the UK and like any organisation of a similar scale, it contains a wide range of policies, practices and cultural norms. At the most basic level, these are formed by the individuals who work within the NHS. Healthcare workers bring their own experiences, backgrounds. political opinions and it is right that such diversity exists. Yet organisational culture is not reducible simply to personal opinion. It is formed by more formal forces, fundamentally the law and regulatory framework that establishes statutory obligations to be carried out by the leadership and staff. It is the leadership that determines priorities and professional bodies that influence standards of practice.

The law, setting the framework in which the organisation operates, is a significant driver of organisational behaviour. It sets out the duty to provide care as well as the conditions under which care is to be charged or exempt. Ideally, the law sets out a consistent national standard that guides the operating standards of all trusts. Regulation and statutory guidance are designed to lessen ambiguity so that each trust knows what duties are expected of them under the law.

The NHS is governed by a combination of statutory obligations and values set out in the NHS Constitution[9]. Government legislation requires NHS bodies to conduct eligibility checks and recover costs from certain categories of overseas patients. At the same time, the NHS Constitution for England articulates a set of values such as "compassion," "respect and dignity," and the belief that "everyone counts". These values also shape professional identity and clinical culture. These frameworks can produce areas of practical ambiguity and institutional tension. Leadership within trusts then determines to what extent these rules are embedded, prioritised and enforced in practice.

Alongside formal mechanisms, medical professional bodies also influence the culture of the NHS. The British Medical Association, the main representative organisation for doctors, has long shaped debates over clinical priorities and the employment conditions for NHS staff, a history of political involvement dating back to drafting the Medical Act of 1858. It has used lobbying, public campaigning and industrial action to push for change across the NHS. Other unions such as the Royal College of Nursing, representing other healthcare workers, often play a similar role, mobilising collectively to influence workplace and workforce policy. These organisations do not formally set policy, but they can and do

9. The NHS Constitution for England – DHSC 2023 Link

influence how the law is interpreted and then applied in practice.

Other external organisations, including NGOs, campaign groups and lobbyists may also seek to influence the policies and practices of the NHS. At times, engagement with charities and other groups can support NHS Trusts in delivering their statutory duties more effectively or efficiently. Yet at other times, particularly if these groups are seeking to influence policies and practices, it can contribute to a divergence from established regulations and statutory duties.

It is important to acknowledge that NHS staff have the right to engage in political discourse and action outside of their professional roles. NHS neutrality is not the same as Civil Service impartiality. Outside of working hours, doctors, nurses and other healthcare workers are entitled to join political parties or unions, protest, campaign and express their views. There is however an expectation that, whilst in the workplace, they operate within the set duties and regulations of the organisation and do so under the principles of the neutrality of the public space.

Partnerships with Migration and Refugee Organisations

Immigration enforcement and policy can occasionally rest in an uneasy tension with the ethos of frontline NHS care. For some healthcare professionals, altruistic motivations play a significant role in their decision to enter medicine or nursing. In this context, legislative requirements to verify immigration status or assess one's eligibility for free care may be perceived as secondary to the core clinical mission of providing treatment. This may help to explain why the introduction of the Immigration Health Surcharge (IHS) has, in some quarters, been met with ongoing unease or resistance. Criticism of the IHS among some NHS staff has persisted since its inception, particularly where its implementation is seen as complicating the patient–clinician relationship.

Yet no matter the work environment, the law must be followed. We find ourselves in the position today, amidst greater public concern over border control and with the fairness surrounding access to key public services. Far greater scrutiny over the role that our largest public service plays at the border of healthcare provision, national public service and immigration enforcement is required.

There is a wide variation in the extent to which policies that relate to migration – including workplace checks, charging and status verification – are applied and enforced. These patterns are rarely documented as formal policy changes but emerge instead through local practices, leadership, and evolving norms around access, entitlement and institutional prioritisation. It is in such an environment that greater scrutiny of which external organisations may be influencing NHS policy and practice, at the individual trust level, is warranted.

'City of Sanctuary'

The origins of the "sanctuary" framing can be traced, in part, to the United States, where the term "sanctuary city" has been used since at least the 1980s to describe municipalities that adopt policies limiting cooperation with federal immigration enforcement. These U.S. sanctuary jurisdictions often adopted formal resolutions or local laws to protect undocumented migrants from detention or deportation.

The U.K.'s City of Sanctuary movement was founded in Sheffield in 2005, inspired by the Sanctuary City movement in the US which started in 1985 in San Francisco[10]. It reflects similar ethical aspirations: creating a local civic infrastructure that views inclusion as foundational principles even at the expense of existing legislation. Over time, "sanctuary" in the U.K. has evolved from a grassroots ethos into an increasingly formalised brand, recognised by schools, universities and local councils.

Over time, the City of Sanctuary network has also established formal partnerships with NHS Trusts, Integrated Care Boards and professional training bodies. In 2023, the West Yorkshire Health and Care Partnership became the first Integrated Care System (ICS) in the country to brand itself a "Partnership of Sanctuary."[11] [12]

In March 2023 we becoming the first Partnership of Sanctuary in the country for going above and beyond to welcome people seeking sanctuary into West Yorkshire.

The City of Sanctuary made the award following an assessment of our activities to provide safe, welcoming and accessible healthcare for refugees and asylum seekers.

This includes:

- setting up a Health Inequalities Academy and active Health Inequalities Network to understand and help address inequalities across West Yorkshire's 2.3 million population
- migrant health communities of practice to aid collective learning, encourage innovation and create a support network for members
- fellowship projects focusing on reducing inequalities for refugees, asylum seekers and people seeking sanctuary
- co-funding an animation by Bevan to help refugees and asylum seekers navigate NHS services

Next steps include continuing to deliver Safe Surgeries training to primary care networks through Doctors of the World.

10. The first US city to pass legislation banning the use of public funds to assist federal immigration enforcement. Prior to this, the sanctuary movement consisted of independent churches who refused to collaborate with federal immigration enforcement.
11. West Yorkshire recognised for providing welcoming and accessible healthcare services - Link
12. Health, Mental Health and Wellbeing Stream of Sanctuary – Sanctuary Awards in Health Link

Rob Webster CBE, and CEO Lead for the Partnership, said: "Achieving the status as a system of sanctuary is recognition of our ambitions and a reflection of our values as a Partnership.

"We will continue to learn from people seeking sanctuary to develop services where refugees, migrants and asylum seekers can flourish, thrive, and live healthy lives. In doing so, we will enrich the way we work in ways that will benefit everyone."

Jeff Morgan, City of Sanctuary Trustee, who presented the award said: "One of the many reasons why the journey to become a Partnership of Sanctuary started was to give back dignity and purpose to people who have lost everything – supporting them to achieve their potential."

Linda Fielding, Studio of Sanctuary Programme Coordinator, said: "Let us be the alternative to a hostile environment, let us be the way forward. West Yorkshire has set the standard and we hope that it will act as a catalyst for other health and care partnerships to follow and keep spreading the welcome."

People who have sought sanctuary in West Yorkshire talked about their experiences, including **Bryan, an artist and Wakefield District City of Sanctuary Trustee**, who said: "We want to be a part of the community, but if we're not given the chance it's very hard to do that. It's not about the language, we can communicate through our actions. You guys understand that."

This was not simply a symbolic designation. The designation committed the ICS to specific actions, requiring every NHS healthcare provider within the ICS footprint actively embed a set of 'principles' which they would be tested upon[13].

Awards

Our latest Sanctuary Awarded organisation!

We are delighted to welcome West Yorkshire Health and Care Partnership as our latest Sanctuary Awarded organisation! West Yorkshire Health and Care Partnership is committed to offering sanctuary to all people who are fleeing violence and persecution, their work focuses on all aspects of healthcare, including primary, secondary, mental health sectors and embed the sanctuary principles through all they do.

Progress of implementation was judged by the 'City of Sanctuary' organisation, requiring "safe surgeries" retraining for staff in GP clinics[14], adjustment of front-line care and administrative procedures as recommended and judged by City of Sanctuary Wakefield[15]. It also required alignment with a broader ethos that requires a provider to "learn, embed and share[16]" City of Sanctuary principles. This type of affiliation is merely the latest in the growing trend documented by Policy Exchange in recent years in recent years where NHS organisations have entered into partnership with external organisations with an activist agenda, who 'accredit' an organisation, according to their own criteria. Such a case

13. West Yorkshire Health and Care Partnership of Sanctuary Link
14. West Yorkshire Health and Care Partnership Partnership of Sanctuary - Our journey to become an organisation of sanctuary – YouTube Link
15. *Ibid.*
16. Minimum Criteria: Health Stream of Sanctuary - Link

was documented in Policy Exchange's "Case of the Royal Free", where the hospital partnered with the LGBT Foundation to accredit healthcare professionals in their allyship for the LGBT community, whilst implying that those who did not complete the accreditation may be deemed "unsafe"[17].

Whilst the schemes may appear to be benign on the surface – and are specifically targeted at enhancing the inclusivity of these public sector organisations – they in fact lack sufficient oversight or accountability, with different NHS organisations often being held to different standards.[18]

Other trusts have also engaged with the City of Sanctuary network. Solent NHS Trust (now Hampshire and Isle of Wight NHS Foundation Trust) is a formal supporter of Portsmouth's City of Sanctuary chapter, a group advocating the position of the UK Border Regime as wholly "unfair, cruel, confusing, and ineffective".[19]

'Patients Not Passports'

James Skinner, the campaign strategist at Medact and a former A&E nurse, led the 'Patients not Passports' initiative, an a group that campaigns to challenge and resist charging in the NHS[20]. The Open University describes Patients Not Passports as "a campaign led by Medact, Docs not Cops, Migrants Organise, and the New Economics Foundation, that seeks to challenge and organise against the imposition of border controls within healthcare institutions in England[21]". Patients not Passports, unlike other groups such as Citizens Gateway, does not limit itself to critiques of immigration enforcement, it is "organising to end racist immigration controls in the NHS[22]".

The central belief of 'Patients not Passports' is that "Britain's racist border regime is designed to divide us[23]" and that there is a need to "end all charging & data-sharing in the NHS, to remove racist border controls from healthcare, and to institute a truly universal NHS[24]". On their website they demand the end of the 'hostile environment', which in their eyes includes scrapping the IHS and any data sharing between the NHS and the Home Office[25].

Britain's immigration system is not broken: it is hostile by design, underpinned by state racism. Borders are designed to divide us from each other and pit us against each other, fighting for scraps. Britain's immigration and asylum systems were developed through the expansion of colonialism and empire, and the racism, dehumanisation and injustice experienced by migrants and racialised communities is not a failure of the system, it is the system. This is why we ultimately demand the end of the entirety of the hostile environment, and we dream of and build towards a world based on our collective liberation and the flourishing of all life on earth.

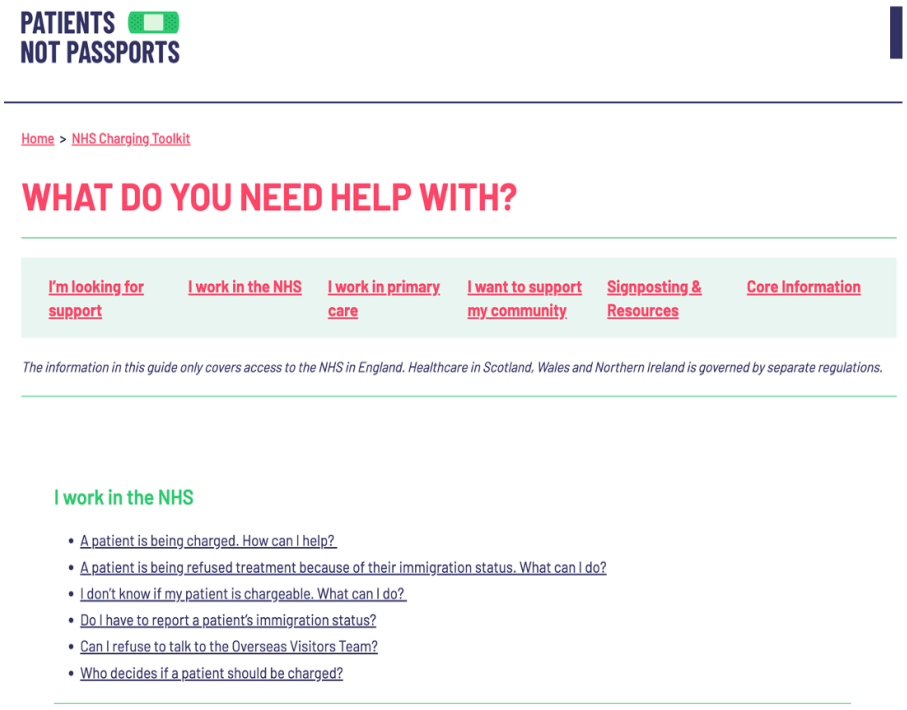
What is the Hostile Environment in the NHS?

The NHS has been one of the primary targets of expanding border policies. The Hostile Environment in the NHS works by:

1. charging some migrants up to 150% of the cost for secondary healthcare;
2. sharing migrants' data between the NHS and the Home Office;
3. checking ID at the front door of hospitals and using other mechanisms to identify someone's immigration status;
4. using debt collectors to recover money owed to the NHS.
5. The Immigration Health Surcharge requires migrants to pay an additional cost when applying for a visa or regularising their immigration status, in order to access the NHS.

17. Policy Exchange - THE PROBLEM WITH 'ALLYSHIP' SCHEMES AT NHS HOSPITALS: THE CASE OF THE ROYAL FREE – 2023 Link
18. See for instance – The Problem With 'Allyship' Schemes At NHS Hospitals: The Case Of The Royal Free – Briefing Note August 2023 Policy Exchange Link
19. Portsmouth City of Sanctuary "Not in our name" Link
20. James Skinner – Medact Link
21. The Open University - Patients Not Passports: Challenging border controls in healthcare Link
22. Patients not Passports Homepage Link
23. Patients not Passports – How do we win? Link
24. *Ibid.*
25. Patients not Passports – What is the Hostile environment? Link

The initiative began as a public-facing activist campaign but has now transformed into a comprehensive training infrastructure, for staff training on policy reinterpretation and internal procedural avoidance. 'Patients not Passports' offers, on their website, downloadable toolkits and provides one-to-one advice for staff who object to a role which encompasses the enforcement of immigration rules, on moral grounds. [26] The resources explain how to identify and re-classify cases as "urgent or immediately necessary"[27], thereby avoiding pre-op charging obligations.


PATIENTS NOT PASSPORTS

Home > NHS Charging Toolkit

WHAT DO YOU NEED HELP WITH?

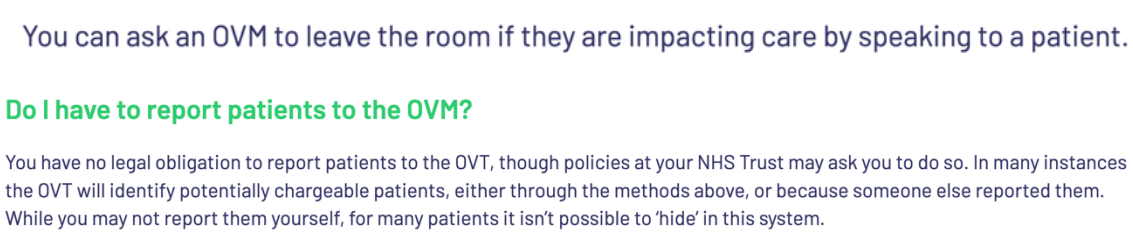
I'm looking for support | I work in the NHS | I work in primary care | I want to support my community | Signposting & Resources | Core Information

The information in this guide only covers access to the NHS in England. Healthcare in Scotland, Wales and Northern Ireland is governed by separate regulations.

I work in the NHS

- A patient is being charged. How can I help?
- A patient is being refused treatment because of their immigration status. What can I do?
- I don't know if my patient is chargeable. What can I do?
- Do I have to report a patient's immigration status?
- Can I refuse to talk to the Overseas Visitors Team?
- Who decides if a patient should be charged?

There are also toolkits on how to avoid recording a patient's nationality in order to reduce the chance of triggering Home Office data sharing protocols, such as asking the Overseas visitors team to leave the room whenever speaking to a patient in case they are "impacting care" negatively due to their presence.


You can ask an OVM to leave the room if they are impacting care by speaking to a patient.

Do I have to report patients to the OVM?

You have no legal obligation to report patients to the OVT, though policies at your NHS Trust may ask you to do so. In many instances the OVT will identify potentially chargeable patients, either through the methods above, or because someone else reported them. While you may not report them yourself, for many patients it isn't possible to 'hide' in this system.

Patients not Passports toolkits also provide guidance to NHS employees on how to contest invoices on clinical or procedural grounds. These include arguing that pursuing cost recovery, in the form of reminder emails, could compromise continuity of care, violate the patient's right to privacy and exacerbate health inequalities.

26. Patients not Passports NHS Charging Toolkit Link
27. Patients not Passports A patient is being charged. How can I help? Link

The language of Patients not Passports is sanitised and professional. It does not explicitly advise for healthcare professionals to break any laws, but rather to "uphold clinical ethics", "ensure informed consent" and "protect patients trust". Patients Not Passports also engages within universities, for example through seminars such as the 2020 event at the University of Birmingham, where the principles taught in medical education are presented in contrast to the framework of overseas charging. Patients not Passports encourages NHS staff to raise issues around charging overseas patients with their colleagues, referring to them as 'harmful and racist policies'.

Raise the issue with your colleagues

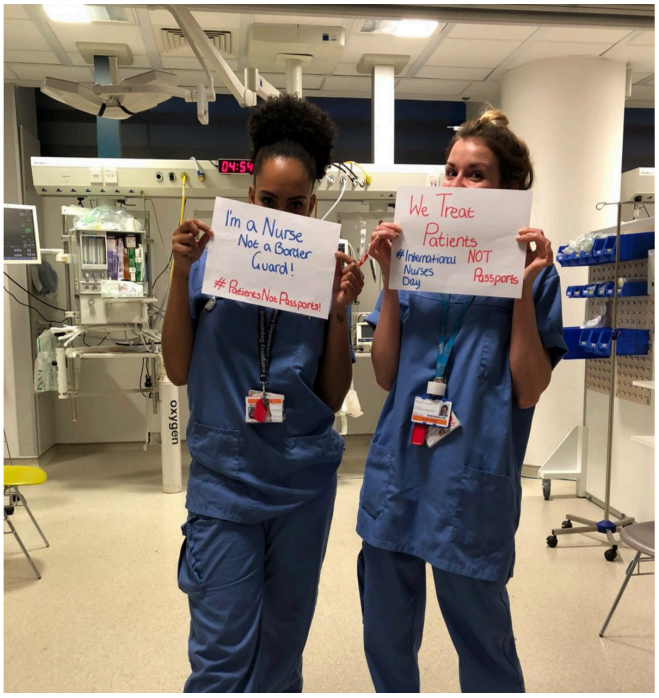
We are stronger together! Remember to get your colleagues to support you, especially senior staff who may feel more able to challenge the Overseas Visitor Team, or other colleagues who are not offering support to patients facing charging.

Many people do not know about the charging regulations, or the role clinical staff can play in advocating for patients and ensuring they get the care they need. We also often see the charging policies applied incorrectly, which is why it is always important to equip yourself with knowledge to be confident to challenge any decision made to charge someone for care.

Read our key arguments page for support in talking to colleagues and friends that don't understand the impact of these harmful and racist policies.

NHS charging is inherently harmful and is widening health inequalities in Britain. While it is important to support patients right now, we know there is no 'good' way to charge people for healthcare. Find out how the Patients Not Passports campaign is working towards an NHS that cares for everyone, regardless of their ability to pay, and get involved with your local group and our campaigns to end hostile border controls in the NHS.

The content of the Patients Not Passports guidance illustrates that their work is not limited to public campaigning but also involves deliberate efforts to promote their views within NHS settings. The image below, from the Patients Not Passports website[28], shows healthcare staff displaying activist material in a clinical setting during what appears to be working hours.



28. HOW CAN HEALTHCARE WORKERS SUPPORT THE CAMPAIGN? – Patients not Passports Link

They encourage staff to "get your colleagues to support you, especially senior staff who may feel more able to challenge the Overseas Visitor Team[29]" and to "equip yourself with knowledge to be confident to challenge any decision made to charge someone for care." Their materials describe NHS charging as "inherently harmful" and claim it is "widening health inequalities in Britain," concluding that "there is no 'good' way to charge people for healthcare." This is presented alongside calls to "get involved with your local group and our campaigns to end hostile border controls in the NHS.[30]"

One of the core organisations behind the Patients Not Passports campaign is Docs Not Cops. The group's strapline on their own website reads: "Fighting xenophobia, racism, borders, and charging in the NHS. #PatientsNotPassports. [31]"[32] Their website lists four core demands: "We demand the end of the Hostile Environment in the NHS," "End upfront charging for secondary care," "Scrap ID checks," and "Don't double the Health Surcharge – drop it!"[33]

The campaign also engages with other migration policies. For example, Docs Not Cops explicitly oppose the government's Prevent strategy, a statutory duty within the NHS.[34] On their website they state: "We work in solidarity with Together Against Prevent, a group challenging the government's Islamophobia in targeting all Muslims as potential terrorists, as well as other groups (we regularly work with Medact, Migrants Organise, and Feminist Fightback in particular)."[35]

In some instances, the campaign has provided support for wider activist causes. A September 2022 tweet from Migrants Organise, retweeted by Docs Not Cops, declared: "Solidarity with Chris Kaba's family, friends and community. From the #PatientsNotPassports national gathering we demand #JusticeForChrisKaba." [36] Kaba was shot by armed police while under pursuit. While his death led to significant protest activity, it later emerged in court that Kaba had shot a man in a nightclub a week earlier and had been a core member of the Brixton Hill-based 67 gang.

The movement claims to have directly shaped NHS policy. In 2018, a Socialist Worker article headlined "East London health trust drops racist ID checks after protest[37]" cited a protest outside the Barts NHS Trust annual meeting in Mile End. The article stated:

> *"The climbdown followed a dozens-strong lobby of Barts Health NHS Trust annual general meeting outside Mile End Hospital on Wednesday. It was organised by North East London Save Our NHS and supported by Docs Not Cops and Stand Up To Racism.*
>
> *The lobby followed revelations that Barts Health was making up to 100 enquiries a week to the Home Office about patients. This involved passing on "demographic data"; name, date of birth and address."* [38]

The article went on to add "Now the trust has agreed to stop asking patients for ID, remove posters and is "reviewing" a patient pre-attendance form."[39] This example was subsequently cited by Patients Not Passports at

29. A PATIENT IS BEING CHARGED. HOW CAN I HELP? – Patients not Passports Link
30. *Ibid.*
31. Docs not Cops Link
32. Patients not Passports NHS Charging Toolkit Link
33. *Ibid.*
34. Prevent duty: guidance for healthcare professionals Link
35. Docs not Cops Link
36. Migrants Organise - Solidarity with Chris Kaba's family, friends and community – 'X' September 2022 Link
37. Socialist Worker - East London health trust drops racist ID checks after protest – 2018 Link
38. *Ibid.*
39. *Ibid.*

their 2020 national conference as evidence of effective mobilisation. The campaign described East London as being "at the centre of the fights to stop checks and charges for migrants.[40]" The same trust, Barts Health NHS Foundation Trust, now holds the highest amount of written-off overseas patient charges in the country, with over £14.8 million already written off in the last three years alone, more than any other NHS trust and over £6 million more than the second worst.

In 2024 the campaign group Solidarity Knows no Borders held a series of online training workshops for those opposed to public services becoming "a tool of hostile immigration enforcement."[41] Among the groups running training sessions was Patients not Passports. The advertising for these sessions stated:[42]

> *"Last year we trained over 1000 people – in 2024 we're back with more resources to resist the hostile environment. Sessions include: asylum system 101; everyday borders; NHS Charging; Housing justice; Collective care; Climate justice and migrant justice."*

A national conference held by Patients Not Passports in May 2024 gathered 45 activists. A report on the Migrants Organise website portrayed the event as part of a contest between two competing visions for NHS provision[43].

"We heard directly from healthcare workers and migrants whose access to healthcare has been restricted by 'hostile environment' immigration policies," the report states. "Seasoned campaigners from movements like Docs Not Cops and Keep Our NHS Public [joined] first-time attendees, all united by a commitment to end borders in the NHS and a belief in universal healthcare for all."

The report also framed the campaign as addressing structural injustice beyond the medical setting. One organiser stated that the Liverpool chapter of Patients Not Passports was "combat[ing] not only inequities in healthcare, but also other manifestations of the hostile environment, from violent immigration raids to oppressive reporting conditions for migrants seeking asylum."

Medact

Medact describes itself as a movement of health workers campaigning for "health justice," whose mission is to "dismantle oppressive systems[44]" and "stand with oppressed communities around the world." Its campaigns span a broad set of political aims including opposition to militarism, climate policy, economic inequality, and immigration enforcement.

The organisation maintains formal partnerships with groups such as *Docs not Cops*, *Migrants Organise* and *Keep Our NHS Public*.[45] It receives funding from the Joseph Rowntree Charitable Trust, Paul Hamlyn Foundation, Polden Puckham Charitable Foundation, Trust for London, Friends Provident, Energy Transition Fund, and the European Public Health Association[46].

In Medact's 2024 Impact Report, James Skinner wrote that[47]:

40. Socialist Worker - 'Campaign in every way we know how' for safety of child refugees, says Alf Dubs – 2020 Link
41. Stand Up! Speak Out! Solidarity Knows No Borders Training Series 2024 training series – Online from March- July 2024 Link
42. *Ibid.*
43. Migrants Organise - Patients Not Passports: National Gathering 2025 Link
44. About Medact Link
45. *Ibid.*
46. Medact – Funders Link
47. Medact 2024 Impact Report Link

> *"Across the Medact movement we have seen another tireless year of organising against the racist systems designed to exclude migrant communities from healthcare. From assessing health needs and improving access to care with asylum seekers housed in hotels, supporting anti-raids groups in resisting deportation vans, and running rights and advocacy trainings to challenge NHS charging – everywhere Medact members are fighting to improve conditions right now and win the bigger battles against the hostile immigration system.*
>
> *The Patients Not Passports campaign continues to support a thriving network of groups, coalitions and individuals working towards no borders in our NHS. This year we re-launched our NHS Charging Toolkit, a detailed resource to support patients, health workers, community support workers, and anyone facing NHS charges."*

Hil Aked, Medact's Research and Policy Manager, is a central figure in the academic framing of NHS charging as a site of "resistance." In a peer-reviewed article published alongside Ryan Essex, Jess Dillard-White and Guy Aitchison in the International Journal of Human Rights (2023), Aked draws on interviews with Medact members and campaigners to document how some NHS staff navigate, resist, and subvert immigration enforcement duties.[48]

The study draws on interviews with twelve healthcare professionals, all recruited via the Medact membership database and openly aims to document, legitimise, and possibly encourage quiet subversion of the NHS's migrant charging regime. The tone is analytical, but the practices detailed are significant.

> *"Much of the literature on medical activism focuses on collective, visible campaigns. But this article focuses on quieter, more discrete and informal acts of resistance to UK healthcare border controls. It is interested in how individuals practice dissent from within the institution often while trying not to be seen doing so."*

The authors construct the idea of "everyday resistance" as an important counterweight to official NHS policy. They frame the testimony of doctors who report even minor refusals such as withholding forms, omitting questions, losing documents as deliberate acts of opposition.[49]

> *"I just didn't do it. I was just like 'I'm not going to be asking people for passports'. I just didn't do it."*
>
> *"We just didn't play ball. We didn't follow the guidance. It's not like we were constantly fighting it. But we just didn't ask people the questions that you were meant to ask them."*
>
> *"You just conveniently don't do it. Or you forget. Or the form gets lost. Or whatever."*

The authors also detail how *"a number of participants spoke of actions related to the enforcement of migration controls within the NHS. Many participants simply refused to*

48. Everyday Resistance in the U.K.'s National Health Service PubMed - Link

49. *Ibid.*

ask about the migration status of their patients, while others undermined staff who sought to check migration status."

> *"Two further examples referred to the NHS's approach to identifying and charging those who have undocumented migration status. One participant spoke about the importance of context in navigating acts of resistance. They noted how, when they worked at a GP surgery, providing care for undocumented patients was not considered subversive or controversial. Another described resistance from a colleague who actively subverted her job role, while working as a manager for "overseas visitor charging" understanding this as an opportunity to "persuad[e] the Trust not to charge people if they couldn't afford it[50]"*

This resistance, as it is described , is not framed as sporadic or marginal. The authors present it as a shared understanding between staff, an unspoken culture of defiance that acts as a substitute for formal instruction.

> *"It was unspoken. We all knew. We just didn't go there."*

> *"I think there was a tacit agreement among staff not to engage with it."*

> *"Nobody explicitly said 'don't do it', but we all just didn't."*

framing of these actions as morally necessary refusals of an unjust system is explicit in the language of the interviewees.

> *"It was my own little bit of civil disobedience. I knew it was against Trust policy. But I did it anyway."*

> *"It wasn't just about this one policy. It was about a general erosion of the NHS's founding principles."*

> *"Charging migrants goes against everything I believe the NHS stands for[51]."*

The paper gives weight not only to the political content of these refusals, but to their emotional and symbolic significance:

> *"While these micro-resistances rarely disrupted institutional functioning in any significant way, they provided an important means for individuals to negotiate their complicity, assert their values, and preserve a sense of moral integrity."*

> *"I don't think it made a massive difference. But it made me feel like I hadn't totally sold out."*

The authors final argument positions these scattered actions as part of a broader anti-enforcement struggle within the NHS.

> *"These quiet acts of resistance reveal how healthcare workers may reject complicity with unjust systems not through overt confrontation, but through subtle refusals, omissions, and disengagements. They may not dismantle the system, but they do mark a refusal to fully internalise or enact it[52]."*

50. Ibid.
51. Ibid.
52. Ibid.

Doctors of the World

In 2018, Doctors of the World launched the 'Safe Surgeries' program "to create a community of GPs committed to welcoming everyone in need of a doctor, no matter their circumstances".[53] By 2022, over 1,000 GP practices and surgeries had signed up with over 1,017 members. These surgeries agree to refrain from asking patients for proof of ID or immigration status at the first point of registration. Whilst this may not directly conflict with the 2017 charging regulations, it speaks to a veiling culture around identification.[54] Safe surgeries have been publicly endorsed by some Integrated Care System leaders in London such as Dr Sam Hepplewhite at a South London Listens online conference; some advocating that Safe Surgery style regulations should be the nation-wide goal.

At the Summit. both South East and South West London ICBs committed to delivering a plan to remove barriers to healthcare access for migrants by March 2024. This includes promises to work with community leaders to co-produce and disseminate a patient advocacy guide so migrants can better understand their healthcare rights; embed Safe Surgery champions at a local level to support and encourage GP practices to enact safer surgery guidance; and exploring the establishment of a cross-borough network so surgeries can support each other on work around health inequalities.

Representing South East London ICB, Dr Sam Hepplewhite, Director of Partnerships and Prevention said: *"Hearing first-hand about the consequences on migrant communities is an important part of the vital conversation we need to have across our GP practices to improve access. We are absolutely committed to working across our Boroughs to make sure that we get as many practices as possible to Safe Surgeries.*

South West London ICB representative Attracta Asika, Head of Transformation, said: *"I have been honestly humbled to be here and hear these lived experiences,"* affirming that *"registering with a GP is a fundamental right"* and *"nobody in South West London should be refused registration for any reason…we will work together to get that done."*

This position is also reflected in some of the institutional language used in formal communications by some NHS organisations as shown below.

91/22 MATTERS ARISING NOT COVERED ELSEWHERE ON THE AGENDA AND ACTION LOG

There were no matters arising not covered elsewhere on the agenda.

The action log was reviewed and updates duly noted.

Further explanation was given regarding the action under minute reference 72/22 regarding the feasibility of the Trust becoming a Hospital of Sanctuary. 'Foluke Ajayi said she had

2

reviewed the matter and concluded that whilst it was not pertinent to commit to being a Hospital of Sanctuary, the Trust would support the ICB in their approach as a System of Sanctuary. Nadira Mirza said in light of the earlier patient story Airedale needs to be able to offer a safe space. 'Foluke Ajayi agreed and indicated that the provision of compassionate care should be offered as a matter of course for all patients and service users and should not require public statements for different sections of the community.

Minutes from a board meeting at Airedale NHS Foundation Trust detail a discussion on whether to adopt the official "Hospital of Sanctuary" title. The executive decision not to publicly commit to the label was not due to an ideological disagreement, but rather the view that sanctuary principles

53. Doctors of the World - 1,000+ Safe Surgeries: GPs stand up for all in their community Link

54. National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017 Link

should already be fundamentally embedded into the mainstream business of the organisation without the need for the designation. "Compassionate care", one director argued, should be the status quo for all patients and "should not require public statements for different sections of the community" to signpost that the hospital is a "safe space"[55]. Whilst "compassionate care" is a legitimate priority, the need to be a "Safe space" is prioritised in the minutes and begs the question to what extent the sanctuary ideology is prioritised over a legitimate discussion about eligibility.

The challenge is not a lack of rules, but a shifting context in which rules are interpreted, prioritised, or sidelined according to prevailing institutional norms. While statutory duties relating to cost recovery and eligibility checks remain clear, as our investigation – detailed in the next chapter – demonstrates, their day-to-day implementation is highly inconsistent.

This evolution has consequences. Systems designed to uphold immigration policy within the NHS risk becoming symbolic rather than functional. Where overseas charging is not embedded in operational practice, compliance becomes partial and uneven. Without sustained scrutiny and reinforcement, there is a risk that statutory duties erode not through explicit opposition, but through the quiet normalisation of non-enforcement.

55. AIREDALE NHS FOUNDATION TRUST BOARD OF DIRECTORS' PUBLIC MEETING AGENDA – Feb 2023 Link

What do non-British nationals pay for the NHS?

The National Health Service is primarily a residence-based system. For British citizens ordinarily resident in the UK, care is provided free at the point of use. This core entitlement also applies to certain categories of non-nationals, including people with indefinite leave to remain, refugees, and those granted asylum. These groups are considered ordinarily resident for the purposes of NHS eligibility and do not face NHS charges for either primary or secondary care.

Exemptions also apply to people whose status is still being determined. Asylum seekers awaiting a decision, children looked after by local authorities, victims of modern slavery or human trafficking, and recognised refugees are all eligible for free NHS treatment. No charges are applied during the period their applications are under consideration. Some treatments are always exempt, regardless of a patient's immigration status. These include accident and emergency services, diagnosis and treatment of certain infectious diseases, and treatment required under mental health legislation. General practice (GP) consultations are also not subject to charging, though access to specialist services via referral may trigger charges if the patient is not otherwise eligible.

For those not meeting residency or exemption criteria, entitlement to NHS care varies. Visitors from countries with which the UK holds reciprocal healthcare agreements, such as Australia and New Zealand, receive free care for specific services, usually emergency treatment or short-term needs. However, most short-term visitors, including tourists and individuals on short business or family visits are chargeable for non-exempt NHS services, particularly secondary care provided by hospitals.

The most significant charging mechanism, however, applies to long-term migrants. Since 2015, most non-UK nationals applying for visas to live, work, or study in the UK for more than six months must pay the Immigration Health Surcharge (IHS) as part of their visa application. The table below sets out what those with different visa / residency statuses pay for the NHS.

Visa / Residency Status	What they pay for the NHS
British citizens ordinarily resident in the UK[56]	Free at the point of use
Asylum seekers (including refused)	Free at the point of use
Indefinite Leave to Remain (ILR)	Free at the point of use
Refugee status (and their dependants)	Free at the point of use
Short term (less than 6 months) Visa	150% of the national NHS rate[57]
Long term (more than 6 months) Visa	Must pay the IHS then free at the point of use

Short Term Visas (Less than 6 months)

Visitors who arrive to the UK on short term visas such as standard visitor visas for tourism, business, visiting friends and family or for private medical treatment are not eligible to pay the Immigration Health Surcharge and therefore are not able entitled to gain automatic access to NHS care. Instead, they are charged at a rate of 150% of the standard NHS tariff for any non-exempt treatment that they receive. The rate and cost of treatment is determined by the Nation Tariff Payment System which calculates using average costs reported by NHS providers for that treatment. This means that for a treatment originally costed at £1,000 by the NHS, a visitor would be required to pay £1,500 for that same treatment. The percentage increase is designed to recover the full economic cost of the care and to create a deterrent against short term visitors using the NHS as a substitute for private healthcare in their home country, otherwise known as health tourism.

The 150 percent charging structure covers a wide range of short-term visa categories for which applicants do not pay the IHS. Migrants who enter the UK unlawfully or who overstay their visas are also subject to this charging regime. Emergency care provided in Accident and Emergency wards, along with care for select public health conditions and infectious diseases, is exempt from charging, but secondary care once admitted to a hospital or given specialist outpatient care, visitors become chargeable. Maternity care, even when deemed urgent or immediately necessary, is also chargeable at the 150% rate.

The responsibility for the application and collection of the 150% charge lies with NHS trusts and specifically their Overseas Visitors department. The Overseas Visitor Manager of each trust is tasked with the identification of chargeable overseas visitors, checking visa status and confirming that invoices have been raised for chargeable periods of care. For non-urgent treatment, patients are expected to pay in advance, with providers legally mandated[58] to withhold care until full payment has been received. In cases where treatment is urgent or immediately necessary, treatment must be provided regardless of the patient's ability to pay, but the individual remains liable for the costs and should face debt-recovery actions from

58. **The National Health Service (Charges to Overseas Visitors) Regulations 2015 - Link**

56. The NHS determines chargeability by residence not nationality. Whilst anyone who is subject to immigration controls necessarily cannot be a resident, excluding ILR and settled status, nationality alone is not enough to qualify for free care. British citizens who are not ordinarily resident in the UK are subject to the same rules as non-citizens; pay the IHS for long term visas and 150% of NHS rate for short term visas. There is no set time after which a citizen loses their eligibility to the NHS after emigrating from the UK, it is whether they have moved abroad permanently.

57. NHS - How to access NHS services in England if you are visiting from abroad Link

the Trust.

Long Term Visas (6 months+)

The Immigration Health Surcharge (IHS) is a fee imposed on the majority of temporary migrants as part of their visa application to the UK. The IHS currently stands at £1,035 per year for regular applicants and £776 for students and under 18s[59]. The IHS was introduced in 2015 under the Coalition Government to ensure that migrants make an appropriate financial contribution to the costs of their use of NHS services[60].

Under the IHS scheme, visa applicants from outside the EEA (and from inside the EEA who still require visas) must pay a sum up-front as part of the visa process. IHS payment is mandatory for each applicant and is a necessary requirement for a UK visa[61]. The IHS permits migrants access to NHS services in a near identical manner as a UK resident for the duration of their visa. Migrants on short-term visas of less than six months, or who are in the UK unlawfully, are not eligible for this route and are generally expected to pay for non-exempt treatment in full.

Having paid the Immigration Health Surcharge (IHS), migrants are entitled to access the majority of NHS services on the same terms as UK residents, without additional charges at the point of use. This includes primary care services such as GP consultations, hospital treatment, emergency care, and maternity services. However, migrants remain liable for statutory charges that also apply to UK residents. These include fees for NHS dental treatment, optical services such as eye tests and corrective lenses, prescription charges in England, and certain assisted conception services, including in-vitro fertilisation (IVF). Migrants must also pay for services that fall outside standard NHS provision, such as some travel vaccinations, medical reports for visa or employment purposes, and private healthcare services.

Broadly, any person wishing to apply for leave to remain in the UK for a period over six months must pay the designated fee up-front for the duration of their applied leave to remain. The IHS applies to visa applicants and for those already in the UK who wish to extend their leave to remain. The IHS is paid through an online portal that provides a unique IHS reference number that is included in the visa application. If the visa is denied, the IHS is fully refunded.[62]

59. **Impacts of the changes to the UK immigration policy – NHS Employers 2025 Link**
60. **Migrant 'health surcharge' to raise £200 million a year – Gov.UK 2015 Link**
61. Guidance: Immigration Health Surcharge: caseworker guidance – Gov.UK June 2025 Link
62. See Annex A for additional information on the Immigration Health Surcharge

Methodology

This chapter sets out the methodology used to investigate the effectiveness of cost recovery from overseas visitors in the NHS. The analysis is based on original data collected through Freedom of Information (FOI) requests submitted to NHS trusts and Integrated Care Boards (ICBs) in England, supported by manual collation of policy documents and financial figures provided by respondents included in the Freedom of Information request. The objective was to assess the extent to which NHS trusts are identifying, invoicing, collecting from, and writing off charges associated with overseas patients not entitled to free care at the point of use.

The research was designed as a full census of NHS delivery bodies in England. FOI requests were sent to all 202 NHS trusts, including acute hospital trusts, mental health trusts, community and ambulance trusts. A further 42 Integrated Care Boards were included given their increasing role in system-level financial oversight and coordination. No organisations were purposefully excluded. NHS trusts were selected on the basis of their statutory obligations under the NHS (Charges to Overseas Visitors) Regulations, which place responsibility for identifying chargeable patients and recovering associated costs on the provider of care.

Where any trusts merged, the trusts were included as a separate entity for the duration of time prior to the merger and were added as the merged trust for the duration afterwards in order to avoid duplication.

Although ICBs oversee multiple trusts and shape system-wide financial priorities, the legal and operational responsibility for overseas charging remains with individual trusts. As a result, many ICBs reported that they did not hold data relevant to this request, deferring instead to constituent trusts. Similarly, a number of mental health, community and ambulance trusts indicated they had no relevant overseas visitor charging data because they provide services, such as primary care, mental health, or emergency ambulance treatment, that are universally exempt from charging. These cases were retained in the dataset to ensure the final picture accurately reflects where cost recovery obligations apply and where they do not, but not included in the averages of cost recovery so not to distort and dilute the data for trusts that have a responsibility to do so.

Below is the Freedom of Information request sent to all trusts:

> *"Dear Sir/Madam,*
>
> *Under the Freedom of Information Act 2000, I would like to request the following information:*

1a. A copy of any policies, standard operating procedure or guidance that sets out how the Trust identifies who qualifies as a foreign national or overseas visitor required to pay the Immigration Health Surcharge (IHS).

1b. Please provide the results of the last audit of this policy and compliance levels with it. If such an audit has not been conducted within the last five years, please say so.

2. A copy of any policies that set out what steps are taken if a patient, eligible to pay the Immigration Health Surcharge (IHS), seeks to access (or in fact has already accessed) services provided by the Trust for which payment would be owed.

3a. A copy of any policies, standard operating procedure or guidance which set out the steps taken to invoice a foreign national for any episode of care delivered by the Trust which was not billed/ invoiced for prior to the episode of care being delivered.

3b. A copy of any policies, standard operating procedure or guidance that set out the steps the Trust takes to collect unpaid debts where an episode / episodes of care have been provided to a foreign national.

3c. Data which sets out the total amount (in GBP) for each of the last 3 calendar years that has been collected for the provision of any episode of care for a foreign national (i.e. any individual who is not entitled to that care free at the point of use).

i. Collected by the Trust

ii. Collected by a third party

iii. That the Trust has written off

3d. The total amount (in GBP) which remains uncollected by the Trust for the provision of any episode of care for a foreign national.

I understand that under the Act I am entitled to a response within twenty working days of your receipt of this request. If any part of the request exceeds the appropriate cost limit, kindly supply the material that can be disclosed within the limit and advise how I might refine or narrow the scope, in accordance with your duty to assist (Section 16 duty to provide advice and assistance under the FOIA).

If clarification is required, please contact me at the earliest opportunity.

If you believe any exemption applies, please state the specific exemption, explain your reasoning, and release all disclosable information with redactions clearly marked and referenced.

If my request is denied in whole or in part, I ask that you please justify all

deletions by reference to specific exemptions of the FOIA.

I would prefer to receive all information electronically, Please provide documents in electronic form (PDF or Word for narrative documents; CSV or Excel for datasets)."

Classification of Responses

Responses[63] were classified on the following basis:

- Full response (82 received): All requested financial fields were completed and all relevant policy document were responded to.
- Partial response (5 received): At least one field or document request was unanswered.

Aggregate figures were calculated for total amounts invoiced, collected, written off and outstanding. Averages were calculated across all reporting trusts for each variable, and high and low performers were identified.

The analysis included a comparison between trusts that provided an identifiable overseas visitor charging policy and those that did not. This allowed a basic assessment of whether the presence of internal guidance is associated with stronger performance on cost recovery. Although the data does not permit causal interference, the pattern aligns with what one might expect to see if such a relationship existed.

Two main limitations apply to the methodology.

First, the data are self-reported by trusts under FOI and are not subject to independent audit or verification. There is no guarantee that figures were extracted using consistent internal methods across all organisations.

Second, there is variation in how trusts interpret the concept of "chargeable" overseas visitors, and how they account for related debt. Some distinguish Immigration Health Surcharge (IHS) payments from direct charges; others do not.

The findings are presented using individual trust-level tables and summary charts. Where possible, visualisations illustrate the volume and proportion of unrecovered debt, and highlight variation between trusts that report having dedicated policies / audits and those that do not. All charts use nominal values and are based entirely on the responses provided.

63. From trusts that provide chargeable services. Non-response is difficult to quantify, as some trusts were not required to reply because they do not provide chargeable services.

An investigation into Overseas Health Cost charging and recovery in the NHS

Between 2021 and 2024, NHS trusts invoiced £384,245,201 to overseas patients.

- Of that total, £131,843,335 was successfully collected.
- A further £167,911,874 remains outstanding on NHS ledgers.
- An additional £84,489,992 has been formally written off.

On average, NHS trusts recovered 39% of the sums they invoiced over the three-year period.

This results in a combined total of £252,401,866 in overseas charges that remain unrecovered, of which over £84 million is permanently lost. These are not symbolic figure, they represent funds that could have supported frontline services, covered staffing shortfalls, or reduced local deficits.

According to the NHS, saving £250m equates to providing enough funding to build around 68 new GP surgeries or pay the annual salaries of around 3,200 GPs.[64]

The following analysis dissects performance trust by trust, showing which institutions manage to enforce payment effectively and which allow losses to accrue without consequence.

Trusts with the most uncollected overseas health costs

The 10 trusts with the largest uncollected amounts from the last 3 years are:

Name of the Trust	Uncollected (£)	Collection Percentage
Imperial College Healthcare NHS Trust	29,937,936	19%
Barking, Havering and Redbridge University Hospitals NHS Trust	17,426,970	29%
Barts Health NHS Trust	14,819,000	Incomplete FOI Data
University College London Hospitals NHS Foundation Trust	13,900,320	45%

64. NHS Property Services saves £250 million for NHS over last five years – Link

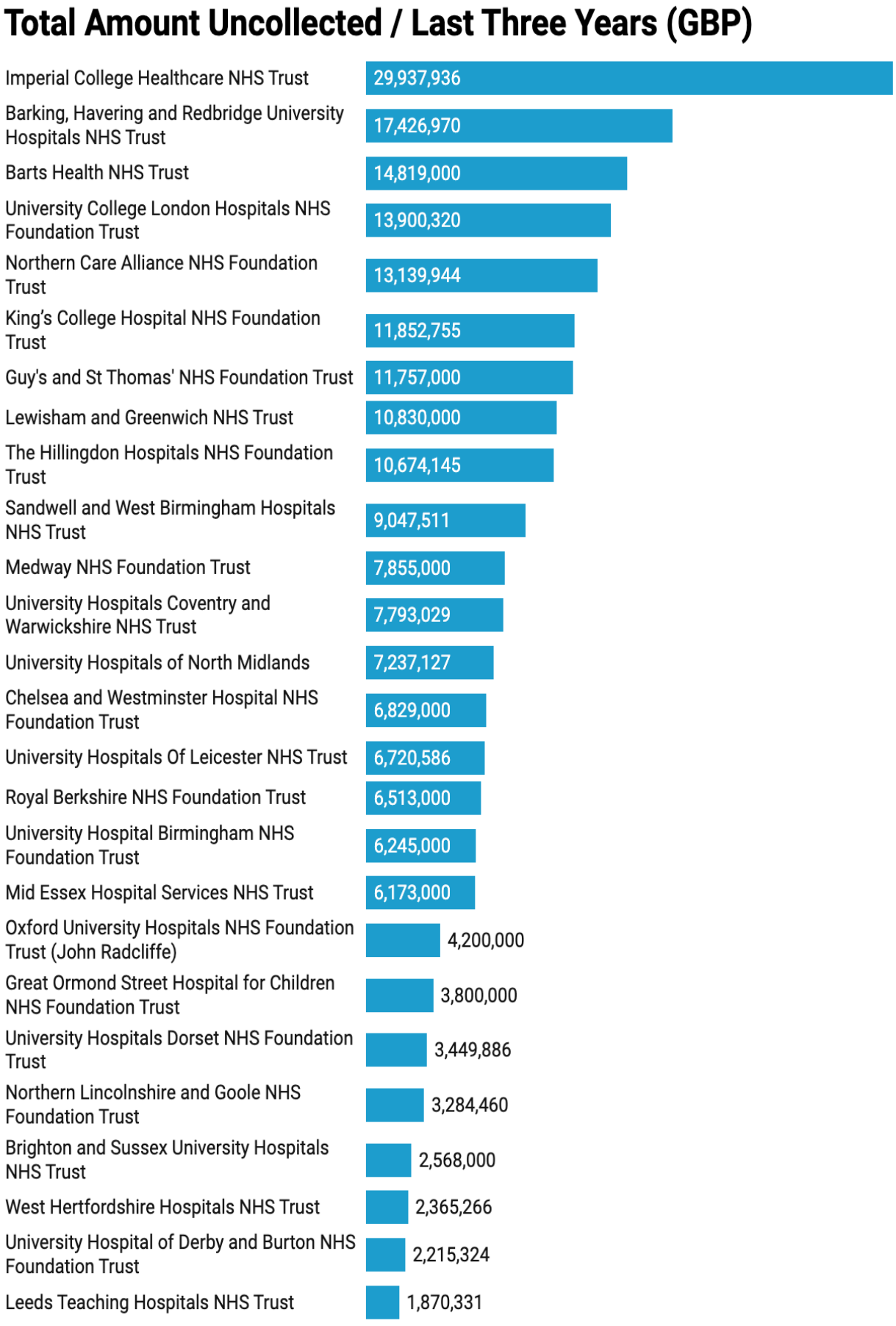
Northern Care Alliance NHS Foundation Trust	13,139,944	5%
King's College Hospital NHS Foundation Trust	11,852,755	19%
Guy's and St Thomas' NHS Foundation Trust	11,757,000	44%
Lewisham and Greenwich NHS Trust	10,830,000	31%
The Hillingdon Hospitals NHS Foundation Trust	10,674,145	29%
Sandwell and West Birmingham Hospitals NHS Trust	9,047,511	8%

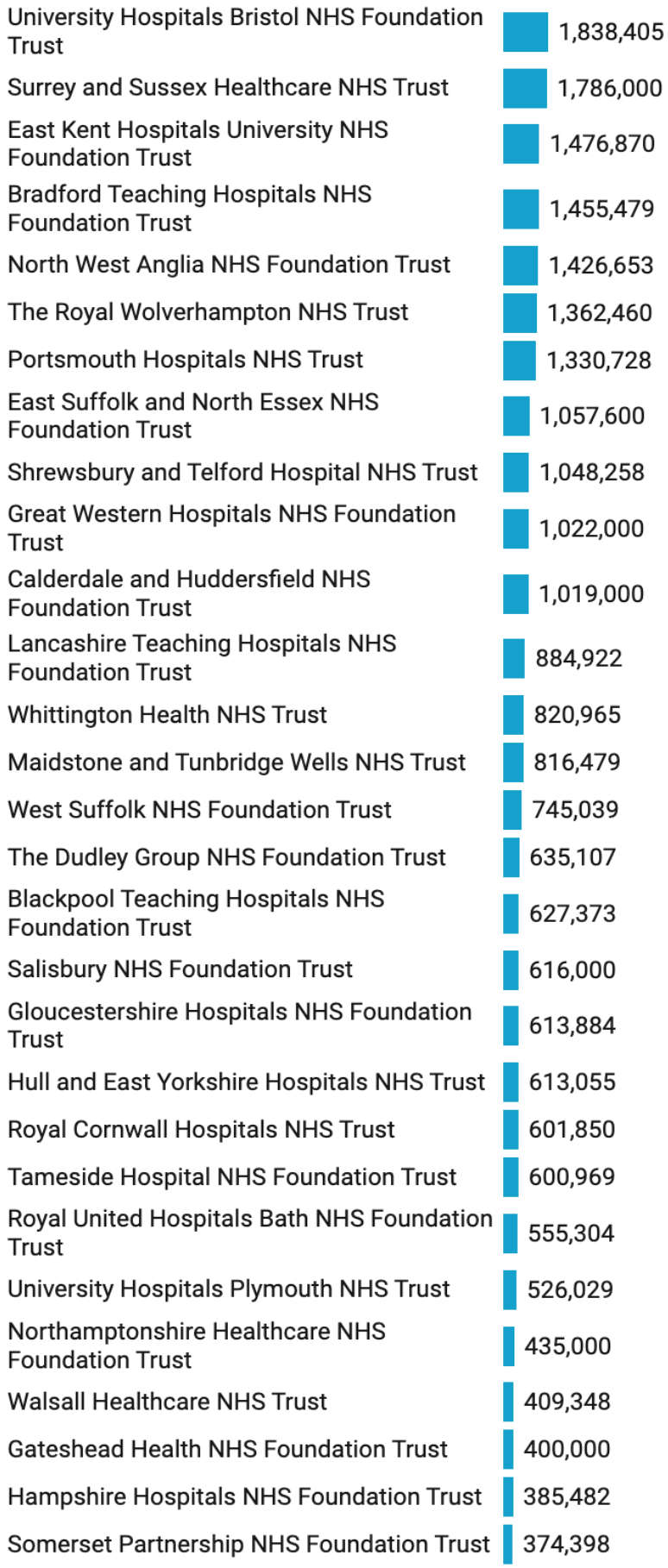
Of these ten trusts, only two, UCL Hospitals Foundation Trust and Guy's and St Thomas' Foundation Trust have collected costs at a rate higher than the average – and neither of these have achieved over 50% collection.

These ten NHS trusts alone account for £143.4 million in uncollected charges, over 56% of the total uncollected overseas costs across the entire NHS.

Most of these providers operate in high-turnover urban environments where cost recovery should be routine, not exceptional. That some of the largest, best-resourced trusts are also the worst performers raises serious questions about institutional prioritisation, not capacity.

The chart that follows visualises the cumulative sums uncollected by each trust over the three-year reporting window. Notably, the majority of the uncollected overseas health costs from the last 3 years are concentrated in a few of the trusts at the top. Imperial College NHS Trust, the trust with the highest uncollected health costs over the last 3 years, has more uncollected overseas health costs than the bottom 55 trusts combined.


Total Amount Uncollected / Last Three Years (GBP)
Imperial College Healthcare NHS Trust
29,937,936
Barking, Havering and Redbridge University Hospitals NHS Trust
17,426,970
Barts Health NHS Trust
14,819,000
University College London Hospitals NHS Foundation Trust
13,900,320
Northern Care Alliance NHS Foundation Trust
13,139,944
King's College Hospital NHS Foundation Trust
11,852,755
Guy's and St Thomas' NHS Foundation Trust
11,757,000
Lewisham and Greenwich NHS Trust
10,830,000
The Hillingdon Hospitals NHS Foundation Trust
10,674,145
Sandwell and West Birmingham Hospitals NHS Trust
9,047,511
Medway NHS Foundation Trust
7,855,000
University Hospitals Coventry and Warwickshire NHS Trust
7,793,029
University Hospitals of North Midlands
7,237,127
Chelsea and Westminster Hospital NHS Foundation Trust
6,829,000
University Hospitals Of Leicester NHS Trust
6,720,586
Royal Berkshire NHS Foundation Trust
6,513,000
University Hospital Birmingham NHS Foundation Trust
6,245,000
Mid Essex Hospital Services NHS Trust
6,173,000
Oxford University Hospitals NHS Foundation Trust (John Radcliffe)
4,200,000
Great Ormond Street Hospital for Children NHS Foundation Trust
3,800,000
University Hospitals Dorset NHS Foundation Trust
3,449,886
Northern Lincolnshire and Goole NHS Foundation Trust
3,284,460
Brighton and Sussex University Hospitals NHS Trust
2,568,000
West Hertfordshire Hospitals NHS Trust
2,365,266
University Hospital of Derby and Burton NHS Foundation Trust
2,215,324
Leeds Teaching Hospitals NHS Trust
1,870,331


University Hospitals Bristol NHS Foundation Trust
1,838,405
Surrey and Sussex Healthcare NHS Trust
1,786,000
East Kent Hospitals University NHS Foundation Trust
1,476,870
Bradford Teaching Hospitals NHS Foundation Trust
1,455,479
North West Anglia NHS Foundation Trust
1,426,653
The Royal Wolverhampton NHS Trust
1,362,460
Portsmouth Hospitals NHS Trust
1,330,728
East Suffolk and North Essex NHS Foundation Trust
1,057,600
Shrewsbury and Telford Hospital NHS Trust
1,048,258
Great Western Hospitals NHS Foundation Trust
1,022,000
Calderdale and Huddersfield NHS Foundation Trust
1,019,000
Lancashire Teaching Hospitals NHS Foundation Trust
884,922
Whittington Health NHS Trust
820,965
Maidstone and Tunbridge Wells NHS Trust
816,479
West Suffolk NHS Foundation Trust
745,039
The Dudley Group NHS Foundation Trust
635,107
Blackpool Teaching Hospitals NHS Foundation Trust
627,373
Salisbury NHS Foundation Trust
616,000
Gloucestershire Hospitals NHS Foundation Trust
613,884
Hull and East Yorkshire Hospitals NHS Trust
613,055
Royal Cornwall Hospitals NHS Trust
601,850
Tameside Hospital NHS Foundation Trust
600,969
Royal United Hospitals Bath NHS Foundation Trust
555,304
University Hospitals Plymouth NHS Trust
526,029
Northamptonshire Healthcare NHS Foundation Trust
435,000
Walsall Healthcare NHS Trust
409,348
Gateshead Health NHS Foundation Trust
400,000
Hampshire Hospitals NHS Foundation Trust
385,482
Somerset Partnership NHS Foundation Trust
374,398

Wrightington, Wigan and Leigh NHS Foundation Trust	367,763
County Durham and Darlington NHS Foundation Trust	364,330
Milton Keynes University Hospital NHS Foundation Trust	363,372
Barnsley Hospital NHS Foundation Trust	335,167
Worcestershire Acute Hospitals NHS Trust	317,515
Royal Devon and Exeter NHS Foundation Trust	311,271
Countess of Chester Hospital NHS Foundation Trust	246,212
University Hospitals Of Morecambe Bay NHS Foundation Trust	237,000
Mid Cheshire Hospitals NHS Foundation Trust	214,388
South Warwickshire NHS Foundation Trust	177,880
East Cheshire NHS Trust	162,000
Sherwood Forest Hospitals NHS Foundation Trust	161,000
Liverpool Heart and Chest NHS Foundation Trust	155,982
Warrington and Halton Hospitals NHS Foundation Trust	152,594
Royal Papworth Hospital NHS Foundation Trust	147,999
The Walton Centre NHS Foundation Trust	147,620
Royal National Orthopaedic Hospital NHS Trust	120,808
North Cumbria University Hospitals NHS Trust	109,000
Torbay and Southern Devon Health and Care NHS Trust	80,778
Wye Valley NHS Trust	79,694
London North West University Healthcare NHS Trust	58,000
Chesterfield Royal Hospital NHS Foundation Trust	46,023
Alder Hey Children's NHS Foundation Trust	28,262
Airedale NHS Foundation Trust	22,084
Dorset County Hospital NHS Foundation Trust	5,877
University Hospital of Derby and Burton NHS Foundation Trust 0	0
Nottinghamshire Healthcare NHS Trust 0	0
Oxford Health NHS Foundation Trust 0	0
Essex Partnership University NHS Foundation Trust 0	0

Trusts with collection rates below 20%

The table below identifies 19 NHS trusts that recovered less than 20% of the charges they issued to overseas patients over the past three years. Together, they collected just £15.26 million.

Had each of them performed merely at the national mean collection rate of 39%, the NHS would have recouped an additional £14.6 million, a near doubling of their current yield.

Name of the Trust	Collection Percentage	Amount Uncollected (£)
Medway NHS Foundation Trust	4%	7,855,000
University Hospitals Coventry and Warwickshire NHS Trust	4%	7,793,029
Northern Care Alliance NHS Foundation Trust	5%	13,139,944
Barnsley Hospital NHS Foundation Trust	6%	335,167
Royal National Orthopaedic Hospital NHS Trust	7%	120,808
Sandwell and West Birmingham Hospitals NHS Trust	8%	9,047,511
Northern Lincolnshire and Goole NHS Foundation Trust	10%	3,284,460
The Dudley Group NHS Foundation Trust	14%	635,107
Lancashire Teaching Hospitals NHS Foundation Trust	15%	884,922
Shrewsbury and Telford Hospital NHS Trust	15%	1,048,258
The Royal Wolverhampton NHS Trust	16%	1,362,460
Calderdale and Huddersfield NHS Foundation Trust	16%	1,019,000
Walsall Healthcare NHS Trust	16%	409,348
University Hospitals Bristol NHS Foundation Trust	17%	1,838,405
Bradford Teaching Hospitals NHS Foundation Trust	18%	1,455,479
Wrightington, Wigan and Leigh NHS Foundation Trust	18%	367,763
Royal Berkshire NHS Foundation Trust	19%	6,513,000
Imperial College Healthcare NHS Trust	19%	29,937,936
King's College Hospital NHS Foundation Trust	19%	11,852,755

What distinguishes this group is not complexity of caseload or the size of the community it serves. Most operate in well-resourced urban or regional centres with functional administrative estates. Their failure to meet even baseline expectations points to wider challenges, suggesting that cost recovery is not consistently prioritised and is consistent with what we would expect to see where cost recovery is not embedded as a routine part of NHS management.

In policy terms, it damages legitimacy. How can a system credibly invoice overseas patients if a significant chunk of providers fail to pursue those invoices meaningfully?

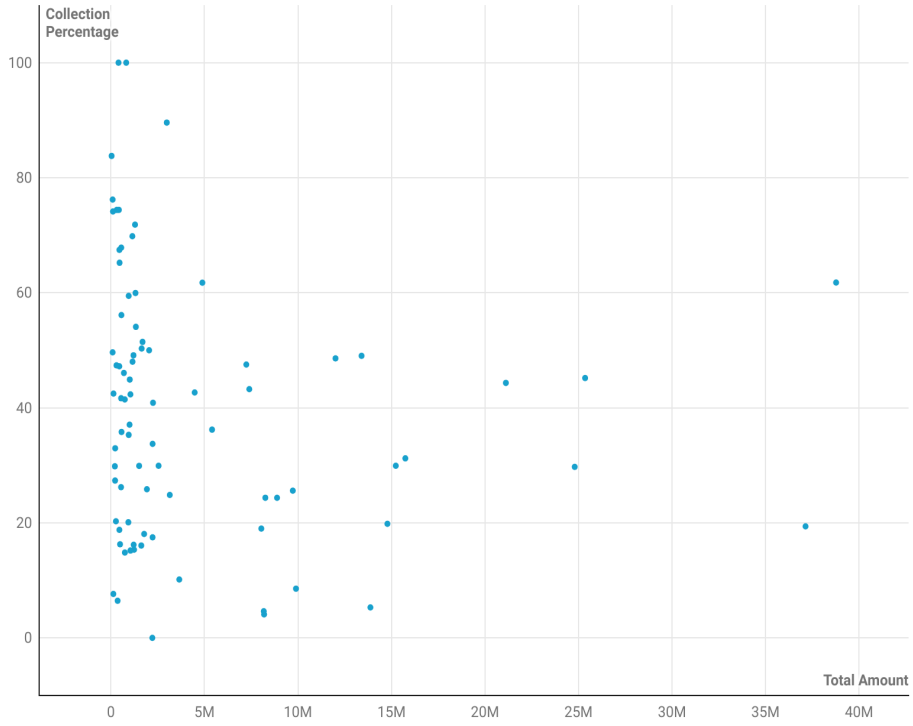
Trusts with the largest financial exposure

9 of the 10 trusts with the largest sums of uncollected overseas health costs are also in the top 10 trusts with the largest financial exposure regarding overseas health costs.

Name of the trust	Total Financial Exposure (£)
Barts Health NHS Trust	38,776,000
Imperial College Healthcare NHS Trust	37,142,204
University College London Hospitals NHS Foundation Trust	25,355,770
Barking, Havering and Redbridge University Hospitals NHS Trust	24,799,970
Guy's and St Thomas' NHS Foundation Trust	21,119,000
Lewisham and Greenwich NHS Trust	15,743,000
The Hillingdon Hospitals NHS Foundation Trust	15,232,407
King's College Hospital NHS Foundation Trust	14,784,314
Northern Care Alliance NHS Foundation Trust	13,875,103
Chelsea and Westminster Hospital NHS Foundation Trust	13,402,000

Some may argue that larger trusts face greater logistical challenges in recovering overseas costs, simply due to volume. Yet this assumption is not borne out by the data.

Total Financial Exposure Relation to Collection Percentage



In other words, being large does not explain being ineffective. Scale does not necessarily inhibit cost recovery; it merely increases its importance. The fact that some of the largest trusts are among the worst performers indicates not a problem of capacity, meaning the issue lies elsewhere.

10 Trusts with highest write-off percentages

Whilst trusts that have large uncollected overseas costs are undoubtably cause for concern, trusts that write off debt at high rates are also a significant issue. This is because once a trust has written off a debt, there is no further collection attempt, fundamentally ruling out the possibility of the state ever recovering those costs.

There is significant variation between trusts when reporting the amounts written off. While some trusts, with hundreds of thousands of pounds uncollected, report substantial write offs, other trusts with similar uncollected totals report none written off at all, suggesting that, in practice, much of the 'uncollected' funds may, in some Trusts, never be collected.

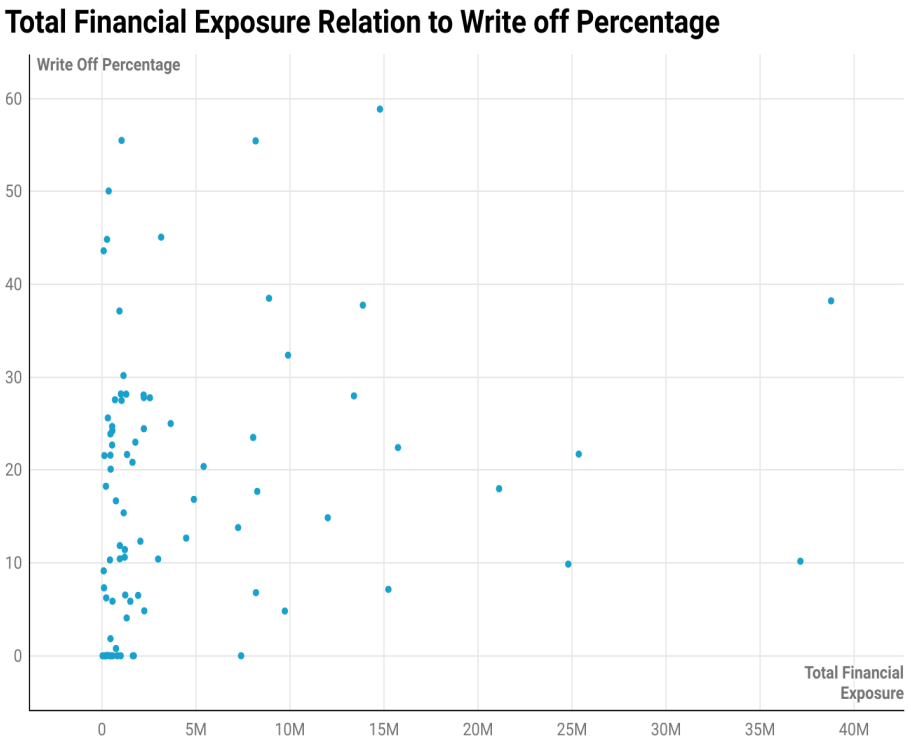
This divergence suggests that statutory obligations surrounding overseas cost reporting, as well as the trust's operational performance, may influence the data provided through the FOI responses. Write-off totals are disclosed annually in a trust's annual accounts report whereas uncollected costs that have yet to be formally written off do not. The data therefore may reflect differences in the way trusts treat and report these debts as well as their success in debt recovery.

The trusts with the 10 highest percentage of overseas health costs written off for the past three years are:

Name of the Trust	Write-off Percentage	Amount written-off last three years (£)
King's College Hospital NHS Foundation Trust	58%	8,701,393
Lancashire Teaching Hospitals NHS Foundation Trust	55%	578,979
University Hospitals Coventry and Warwickshire NHS Trust	55%	4,531,298
Barnsley Hospital NHS Foundation Trust	50%	179,297
West Hertfordshire Hospitals NHS Trust	45%	1,418,738
Mid Cheshire Hospitals NHS Foundation Trust	44%	120,575
Chesterfield Royal Hospital NHS Foundation Trust	43%	39,862
University Hospitals of Leicester NHS Trust	38%	3,420,000
Barts Health NHS Trust	38%	14,819,000
Northern Care Alliance NHS Foundation Trust	37%	5,237,526

These ten NHS trusts with the highest overseas charge write-off rates demonstrate a structural tolerance for loss far beyond the estate norm. While the average write-off percentage across all trusts is 18%, these providers consistently record figures at double, or even triple, that level.

Importantly, the problem is not limited to smaller, less-resourced providers. As shown by the table above, high-profile trusts like King's (£8.7m written off), Barts (£14.8m), and Northern Care Alliance (£5.2m) combine high loss ratios with large financial exposure leading to high write off totals. They are not just frequent collection failures, but expensive ones.



The scatterplot above shows no strong relationship between financial exposure and write-off percentage. Both large and small trusts exhibit extreme attrition, suggesting that write-off rates reflect internal culture more than case volume. High-exposure providers are just as likely to abandon charges as lower-volume peers, exposing systemic inconsistency. This result also follows the pattern of limited correlation between a trust's financial exposure and collection percentage.

That many of these trusts are geographically dispersed and operationally diverse challenges any structural defence. Furthermore, the chart above shows little correlation between the overall financial exposure of a trust with the write-off percentage.

Trusts with no policies

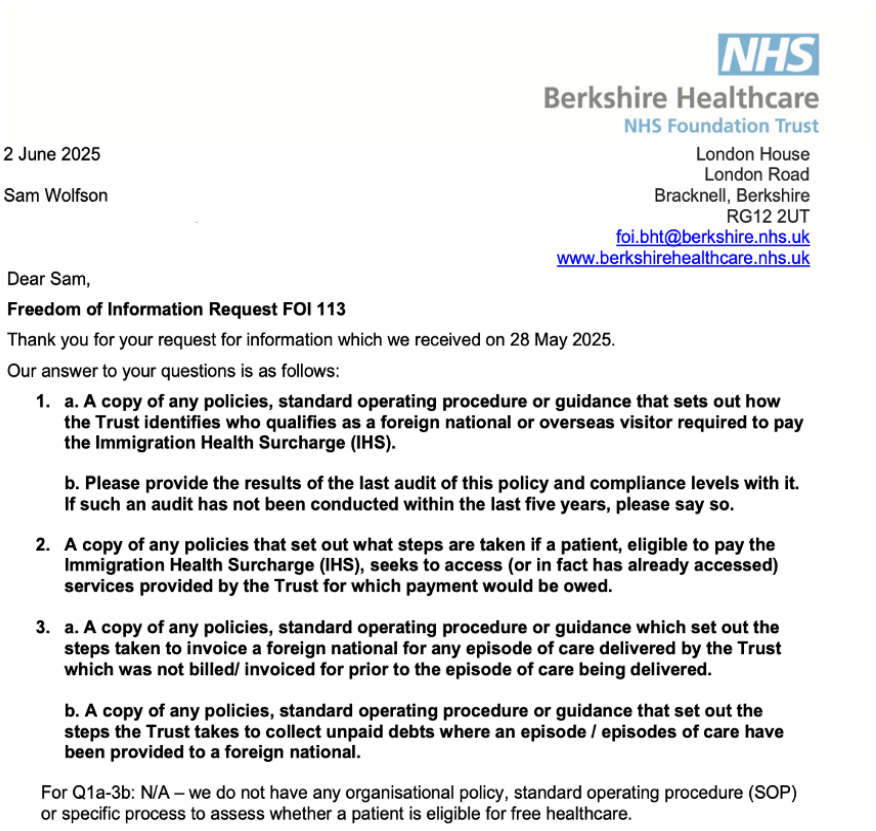
The table below highlights four NHS trusts: Guy's and St Thomas', University Hospital Birmingham, University Hospitals Coventry and Warwickshire, and Royal Berkshire. Each report over £3 million in uncollected overseas charges while simultaneously failing to maintain (according to their FOI responses) a formal cost recovery policy.

Combined, these trusts account for £20.6 million in uncollected debt, over 8% of the total outstanding across the NHS. Guy's alone stands at nearly £8m million uncollected, with a 44% collection rate, while Coventry recovers just 4.7%, effectively defaulting on almost all charges.

Name of the trusts	Amount uncollected + written off(£)	Collection Percentage
Guy's and St Thomas' NHS Foundation Trust	11,757,000	44%
University Hospital Birmingham NHS Foundation Trust	6,245,000	24%
University Hospitals Coventry and Warwickshire NHS Trust	7,793,029	4%
Royal Berkshire NHS Foundation Trust	6,513,000	19%

This absence of policy, or inability to provide one when asked, is not neutral. It signals an operational vacuum where overseas cost recovery is left to the discretion of staff rather than embedded in systematic governance.

The response below from Royal Berkshire sets out their FOI response detailing that "we do not have any organisational policy, standard operating procedure (SOP) or specific process to assess whether a patient is eligible for free healthcare".



NHS
Berkshire Healthcare
NHS Foundation Trust

2 June 2025

Sam Wolfson

London House
London Road
Bracknell, Berkshire
RG12 2UT
foi.bht@berkshire.nhs.uk
www.berkshirehealthcare.nhs.uk

Dear Sam,

Freedom of Information Request FOI 113

Thank you for your request for information which we received on 28 May 2025.

Our answer to your questions is as follows:

1. **a. A copy of any policies, standard operating procedure or guidance that sets out how the Trust identifies who qualifies as a foreign national or overseas visitor required to pay the Immigration Health Surcharge (IHS).**

   b. Please provide the results of the last audit of this policy and compliance levels with it. If such an audit has not been conducted within the last five years, please say so.

2. **A copy of any policies that set out what steps are taken if a patient, eligible to pay the Immigration Health Surcharge (IHS), seeks to access (or in fact has already accessed) services provided by the Trust for which payment would be owed.**

3. **a. A copy of any policies, standard operating procedure or guidance which set out the steps taken to invoice a foreign national for any episode of care delivered by the Trust which was not billed/ invoiced for prior to the episode of care being delivered.**

   b. A copy of any policies, standard operating procedure or guidance that set out the steps the Trust takes to collect unpaid debts where an episode / episodes of care have been provided to a foreign national.

For Q1a-3b: N/A – we do not have any organisational policy, standard operating procedure (SOP) or specific process to assess whether a patient is eligible for free healthcare.

Trusts with full policy coverage

Conversely, the trusts set out in the table below present a contrasting failure. All have full overseas identification and cost recovery policies and have conducted audits within the last 5 years, yet still continue to recover less than 25%, 14% below the national average.

Name of the trust	Amount uncollected (£)	Collection Percentage
Imperial College Healthcare NHS Trust	29,937,936	19%
King's College Hospital NHS Foundation Trust	11,852,755	19%
Northern Care Alliance NHS Foundation Trust	13,139,944	5%
Medway NHS Foundation Trust	7,855,000	4%
Northern Lincolnshire and Goole NHS Foundation Trust	3,284,460	10%
The Royal Wolverhampton NHS Trust	1,362460	16%
West Suffolk NHS Foundation Trust	745,039	20%
Wrightington, Wigan and Leigh NHS Foundation Trust	367,763	18%

Combined, these eight trusts account for over £68 million of uncollected overseas patient costs. Imperial College Healthcare alone accounts for just under £30 million with a recovery rate below 20%, only marginally better than Royal Berkshire, which lacks any formal policy at all. King's College Hospital and the Northern Care Alliance each report over £11 million and £13 million respectively in unrecovered charges, despite having full policy and audit structures in place.

These figures challenge the assumption that introducing a formal policy can, by itself, lead to adequate cost recovery. These underperformers demonstrate that compliance on paper does not necessarily translate into results.

Not all underperformance is dramatic. A significant share of unrecovered revenue is concentrated in mid-performing trusts that fall between 25 and 50 percent collection rates. These are not the worst offenders, yet because they operate at scale, each with more than £5 million at stake, their middling results accumulate into major systemwide losses.

University College London Hospitals, for example, collects 45% but still leaves £13.9 million uncollected. Guy's and St Thomas' perform similarly, recovering 44% while allowing £11.75 million to go unpaid. Lewisham and Greenwich, Hillingdon, and BHRUT all hover around the 30% mark, with individual uncollected sums between £10–17 million. These are large, well-resourced institution falling short of their potential.

The implication is clear. If these trusts lifted their collection rates by even 10–15 points, bringing them closer to the top quartile, tens of millions of pounds could be recouped without requiring wholesale structural reform.

These are realistic efficiency gains, not abstract targets.

More importantly, performance at this level creates a drift in the system's recovery baseline. When major providers consistently deliver below-50% recovery, that becomes the new norm. Over time, this resets expectations downward, institutionalising loss and hollowing out the credibility of the overseas charging framework. What was designed as a targeted enforcement regime risks degrading into an uneven, discretionary system where moderate failure is functionally accepted.

To stop that slide, focus should not only fall on the outliers at the bottom. It must also address this middle tier, where substantial sums are lost not through incapacity or chaos, but through steady, unremarkable corrosion.

Policies and Audits

A closer look at Wrightington, Wigan and Leigh NHS Foundation Trust reveals the extent to which even a trust with formal policy coverage can fall short in practice. According to its own audit, the Trust failed to implement basic controls to identify overseas visitors prior to treatment, leading to the near-total absence of upfront payments.

Staff reported that patients were typically only flagged as chargeable after care had already commenced, significantly reducing the chance of overseas cost recovery. In a sample of ten known overseas visitors, only two invoices had been fully paid, with seven entirely unpaid. One invoice took 660 days to be raised following the patient's initial attendance.

Areas for improvement

The Trust did not have cover arrangements in place to deputise for the Overseas Visitor Officer in their absence. The Overseas Visitor Officer is part time and also had other responsibilities as part of their day to day role, including being the Private Patient Officer for RAEI and Leigh Infirmary. **(See Recommendation 4)**

The Trust's Overseas Visitors (OV) Policy and SOP details the processes in place, to ensure that potential overseas visitors are identified and that checks are completed to determine their eligibility for free NHS care. However it was acknowledged that the OV SOP needed to be updated to reflect the processes that were currently being followed when completing the checks to identify potential overseas visitors. **(See Recommendation 2)**

Through discussion it was found that the Trust currently did not have robust processes in operation at the initial point of entry into the Trust to identify potential overseas visitors who

were and were not eligible for free NHS care. It was also confirmed that generally eligibility checks are completed retrospectively, following patients being identified as an overseas visitor during or following the receipt of their treatment provided by the Trust. **(Recommendation 5 – High Priority)**

The Overseas Visitor Officer maintained an Overseas visitor matrix that recorded all OSV referrals received and the checks undertaken to determine if patient eligible for free care. An extract of the matrix was provided that related to overseas visitors that had been identified as being 'chargeable' for the treatment received. A review of the spreadsheet found that there was a significant amount of information that had not been recorded in relation to the overseas visitor checks that had been completed. We were advised that some of the information may not be required and therefore the field is blank. **(Recommendation 6 – Medium Priority)**

Areas for improvement

The Trust did not have robust controls in place to identify overseas visitor before their treatment had commenced, resulting in the Trust not obtaining upfront payments from overseas visitors. Through discussions with staff we were informed that the Trust does not generally obtain an upfront payment from overseas visitors before they receive treatment from the Trust, as they are generally only identified as being an overseas visitor once their treatment had commenced. **(See Recommendation 5)**

A sample of 10 overseas visitors were reviewed who had been identified as not being eligible to receive free NHS care and who had not made an upfront payment for the treatment that they had received. Testing was completed to confirm that the Trust had promptly raised an invoice and that a payment had been received. Our review found that overseas visitor invoices had not been raised promptly. For the sample invoices reviewed we found that the total number of days taken to raise an invoice from the date that the overseas visitor first attended the Trust for treatment ranged between 15 days and 660 days. The reasons for the delays in raising the invoices included delays in the OSV officer being informed of potential overseas visitor, time involved in undertaking investigation, obtaining evidence from OSV, waiting for costings information from the Finance team, waiting for response from the Home Office and lack of capacity of the

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ing Hospitals NHS Foundation Trust

Key Themes

OSV officer. Of the ten invoices reviewed, two had been paid and one had been part paid. For the remaining seven invoices, totalling £[redacted] no payment had been received. **(Recommendation 7– High Priority)**

The audit paints a picture of fragmented responsibility and delayed action. The Overseas Visitor Officer (OVO) was described as "part time", with "no cover arrangements in place" during absences and additional duties unrelated to cost recovery, including serving as the "Private Patient Officer for RAEI and Leigh Infirmary." The Trust acknowledged that while a policy existed, the latter needed updating to reflect "the processes that were currently being followed" in practice.

Staff confirmed that the Trust "did not have robust processes in operation at the initial point of entry" to identify chargeable patients, and that potential overseas visitors were often only flagged after treatment had already begun. Even when chargeable status was identified, "invoices had not been raised promptly", with delays ranging from "15 days to 660 days". Causes included "delays in the OSV officer being informed," "time involved in undertaking investigation," "waiting for response from the Home Office," and "lack of capacity of the OSV officer." These admissions suggest not simply underperformance, but a system functionally incapable of recovering costs in a timely or reliable manner.

Comparatively, the Countess of Chester's overseas visitor policy is clear, practical, and framed in unambiguous statutory terms.

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Purpose and Scope

This short form interim Overseas Visitor policy provides guidance to staff on how to identify overseas visitors, what evidence document to request when a patient claims to free treatment, and how to inform Income/Contracts Team. Income/Contracts Team will review the eligibility of exemption in the absence of Overseas Visitor Manager/Team, and issue invoices to overseas patients accordingly.

Identification of an Overseas Visitor

Most people will not be liable for charges – nonetheless, the same questions must be asked of every single patient, in every single department, whose chargeable status is not known, to identify potentially chargeable patients.

For the Trust to identify an overseas visitor, baseline questions must be asked to all patients of the Trust. The Trust cannot discriminate and ask questions of people with certain protected characteristics only, under the Equality Act 2010 and the Human Rights Act 1998. These baseline questions are to establish whether any patient is entitled to free NHS care, or if they should be charged for their treatment.

If a patient is classed as 'ordinarily resident' in the UK, the Charging regulations cannot apply to them. The Trust needs to establish whether a patient is

- Living lawfully in the UK voluntarily and for settled purposes as part of the regular order of their life for the time being.
- Whether they have identifiable purpose for their residence here; and
- Whether that purpose has a sufficient degree of continuity to be properly described as 'settled'.

Baseline Questions

Questions to ask all patients to avoid allegations of discrimination:

- **"Where have you lived in the last 3 years?"**
- If the UK only, no further action
- If outside the UK, or UK plus other country, then please ask the patient to complete the Undertaking to Pay Overseas Visitor form, and ask the second question:
- **"Do you have a Global / European Health Insurance Card (GHIC or EHIC) or other document to show that you're entitled to free NHS care?"**

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NHS
Countess of Chester Hospital
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- If the GHIC/EHIC card or relevant document is provided, please take a photocopy.
- Once the form is completed, please send the form alongside the photocopies to Income/Contracts team via Overseas Visitor email coch.overseasvisitors@nhs.net.

If a patient is an EEA national, their GHIC / EHIC card should be photocopied and sent along with the Undertaking to Pay form.

If the person claims to free treatment, please ask for the supporting documentary evidence in one of below.

- GHIC or EHIC card.
- Proof of being lawfully in the UK – UK/EEA national, valid to leave to enter documents issued by the Home Office, or a valid long-term visitor/work/student visa.
- Proof of residence – visa stamps (if applicable), utility bills paid, regular attendance at clubs and classes, housing contracts.

Please accept original documents only. Please take photocopy and send along with the Undertaking to Pay form.

If any of the above is not presented, the patient must be informed that their treatment will be chargeable.

Income/Contracts team members will categorise the patients appropriately on EPR, and issue invoices when non-exempted treatments occur.

Exempted treatments can be found on NHSE website here: How to access NHS services in England if you are visiting from abroad - NHS

Undertaking to Pay NHS hospital costs - Overseas Visitor

Why have I been asked to complete this form?

NHS hospital treatment is not free to all. All hospitals have a legal duty to establish if patients are entitled to free treatment. Please complete this form to help us with this duty. A parent/guardian should complete the form on behalf of a child. **On completing the form, you must read and sign the declaration below.**

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It tells patients plainly that "NHS hospital treatment is not free to all. All hospitals have a legal duty to establish if patients are entitled to free treatment. Please complete this form to help us with this duty." This matters because it frames cost recovery as a legal requirement, not an optional exercise, giving staff a firm basis for enforcement.

NHS
Countess of Chester Hospital
NHS Foundation Trust

Please complete this form in BLOCK CAPITALS			
Family name/surname:		**Medical Record Number:**	
First name/given name:		**Date of birth:**	D D M M Y Y Y Y

DECLARATION: TO BE COMPLETED BY ALL			
This hospital may need to ask the Home Office to confirm your immigration status to help us decide if you are eligible for free NHS hospital treatment. In this case, your personal, non-clinical information will be sent to the Home Office. The information provided may be used and retained by the Home Office for its functions, which include enforcing immigration controls overseas, at the ports of entry and within the UK. The Home Office may also share this information with other law enforcement and authorised debt recovery agencies for purposes including national security, investigation and prosecution of crime, and collection of fines and civil penalties. **If you are chargeable but fail to pay for NHS treatment for which you have been billed, it may result in a future immigration application to enter or remain in the UK being denied. Necessary (non-clinical) personal information may be passed via the Department of Health to the Home Office for this purpose.** **DECLARATION**: • I have read and understood the reasons I have been asked to complete this form • I agree to be contacted by the trust to confirm any details I have provided. • I understand that the relevant official bodies may be contacted to verify any statement I have made. • The information I have given on this form is correct to the best of my knowledge. • I understand that if I knowingly give false information then action may be taken against me. This may include referring the matter to the hospital's local counter fraud specialist and recovering any monies due.			
Signed:		**Date:**	D D M M Y Y
Print name:		**Relationship to patient:**	
On behalf of:			

1. ALL: PERSONAL DETAILS – Please answer all questions that apply to you			
Do you usually live in the UK?	YE ☐ NO: ☐	Nationality:	
Address in the UK:		Passport number:	
		Country of issue:	

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Telephone number:		Passport expiry date:	D D M M Y Y
Mobile number:		Dual Nationality:	
Email:		Date of entry into the UK:	D D M M Y Y
Will you return to live in your home country?	YES: ☐ NO: ☐	If yes, when?	D D M M Y Y
Address OUTSIDE the UK:		Name and address of Employer (UK or overseas):	
Country:		Country:	
Contact telephone:		Employer telephone:	

2. ALL: YOUR STAY IN THE UK – You may be required to provide documentation

Please tell us about the purpose of your stay in the UK (check all that apply):

☐	Holiday/visit friends or family	☐	On business	☐	To live here permanently
☐	To work	☐	To study	☐	To seek asylum
☐	Other – please state:				

How many months have you spent OUTSIDE the UK in the last 12 months?

☐	None	☐	Up to 3 months	☐	3-6 months	☐	Over 6 months

Please indicate the reason for any absence from the UK in the last 12 months (check all that apply)

☐	I live in another country	☐	A holiday/to visit friends	☐	To work
☐	I frequently commute (business/second home overseas)			☐	To study
☐	Other – please state:				

3. GLOBAL HEALTH INSURANCE CARD (GHIC) DETAILS – *If you live in another EEA country*

Do you have a non-UK GHIC?	YES: ☐ NO: ☐	If yes, please enter the data from your GHIC below:

If you are visiting from another EEA country and do not hold a current GHIC/EHIC, you may be billed for the cost of any treatment received outside the Accident and Emergency (A&E) dept. Charges will apply if you are admitted to a ward or need to return to the hospital as an outpatient.

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It sets out exactly what evidence is needed, how it should be collected, and the process for determining chargeable status, supported by direct instructions such as "Please accept original documents only. Please take photocopy and send along with the Undertaking to Pay form."

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4. PATIENTS ORDINARY RESIDENT IN THE UK – Proof that may be required

If **ordinary resident in the UK**, the following may be required to be provided as evidence. If more than one document is relevant to you then send all the relevant documents.

A) At least one item with your photo:

☐ Passport	☐ UK Biometric Residence Permit (BRP)
☐ National ID card	☐ Driving licence (if it has a photo)

B) At least one item to prove where you live:

(The proof you use must be less than 3 months old. Your name and address need to be on the letter.)

☐ Water, gas, electric or Council Tax bill	☐ Bank or building society statement
☐ Phone bill	

C) Any other personal documents that can help establish your eligibility:

☐ Global / European Health Insurance Card (GHIC / EHIC)	☐ Provisional Replacement Certificate (PRC)
☐ Wage slip or a P60	☐ Letter or statement from HMRC or DWP
☐ National Insurance or benefits letter	☐ Evidence of sickness insurance
☐ A letter from your college confirming you are attending a full-time or part-time course of study (including course duration and number of hours per week of attendance)	☐ Copy of any birth/marriage certificates
	☐ An IND and ARC (for patients claiming asylum)
	☐ Any other Home Office issued documents which are relevant to your application.

Please note that having an NHS number does not automatically make you eligible for free NHS treatment.

If you have completed this form in the A&E department, please give it to a receptionist or nurse before leaving. If you are admitted to any ward or referred for further treatment outside the A&E department, charges may apply. Please expect to be interviewed by a member of our Overseas Visitors Team.

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In contrast to audit findings from other trusts with "no cover arrangements" and "no robust processes in operation at the initial point of entry," The Countess of Chester's approach ensures early identification and consistent handling of chargeable patients. Its 56.13 per cent collection rate shows what clear policy can deliver. Replicating this model in trusts operating at 25 to 50 per cent could raise collection rates, recovering tens of millions without structural overhaul.

Potential for significant cost savings

By raising all the trusts that operate below 39% to 39% we can raise just over £40 million.

By raising all the trusts below 50% to 50% we can raise £68.7 million.

Annex A: The International Health Surcharge

Policy Rationale

Prior to the introduction of the IHS, migrants who arrived from states outside the European Economic Area (EEA) were able to use NHS services at no cost almost immediately after arriving. The Government of the time viewed this policy as "extremely generous"[65] compared to international allies and inconsistent with the general Government policy on temporary migrant access to public services.

The Immigration Health Surcharge (IHS) was introduced in 2015 to ensure greater "fairness" by requiring long-term migrants who benefit from NHS services to contribute to its costs. As the Home Office stated in 2015, "in England alone, use of the NHS by overseas visitors and migrants is estimated to cost up to £2 billion a year, with £950 million of this being spent on temporary, non-EEA workers and students[66]." The IHS aimed to bring the UK "in-line with international partners" who already charged long-term migrants for healthcare through insurance or other fees.

The IHS has risen consistently since its introduction in 2015. The most significant increase came in February 2024, raising the IHS to £1,035 for adults and £776 for students, over 60% higher than 2020 rates[67]. The Home Office said this matched "the average annual healthcare cost for migrants (£1,036 according to the 2013 DHSC figures[68])." The Treasury indicated the extra revenue would help fund measures like "increasing wages for doctors."

While the IHS began as a modest contribution toward NHS costs, it has evolved into a substantial financial burden on migrants, reflecting a broader policy shift toward recovering more of the NHS costs associated with migration.

To summarize the timeline of IHS rate changes:

- April 2015 launch: £200 per year (standard); £150 (students).
- January 2019: £400 per year; £300 (students).
- October 2020: £624 per year; £470 (students and all under-18s).
- February 2024: £1,035 per year; £776 (students and under-18s).

65. Theresa May on the Immigration Bill – House of Commons Hansard 2013 Link
66. Migrant 'health surcharge' to raise £200 million a year – Gov.UK 2015 Link
67. What is the Immigration Health Surcharge and how much does it cost? 2024 – FreeMovement Link
68. The Immigration (Health Charge) (Amendment) Order 2023 - UK Draft Statutory Instruments, Impact Assessment 2023 No.138 – Legislation.Gov Link

Healthcare Workers Exemption

Following concerns about rising Immigration Health Surcharge (IHS) costs during the Covid pandemic, the government introduced the Health and Social Care Visa[69], under which eligible migrants were and still are exempt from paying the IHS to avoid disincentivising key workers from coming to the UK[70].

By the end of 2021, legislative changes meant that majority of key healthcare workers either benefited from an IHS exemption via their visa or could recover their IHS payments through six-monthly reimbursements.

Revenue Impact

The IHS is a significant additional source of funding for the UK's healthcare system. According to a House of Commons Research Briefing, the IHS "raised over £1.7 billion in gross surcharge revenue in 2023/24, and £6.9 billion since it was introduced in 2015[71]". While these funds may seem relatively insignificant compared to the entire NHS budget (DHSC day-to-day spending reached £188.5 billion in 2023/24[72]), the IHS helps to offset the costs of treating migrants by matching the IHS to the average annual cost of healthcare per capita, increasing sustainability even if only slightly.

Scope of Care

It is important to distinguish between eligibility and the scope of charging. Primary care, especially general practice, is broadly free, and emergency treatment at A&E is never chargeable. But secondary care, such as inpatient hospital treatment, outpatient consultations, diagnostic tests, surgery, and maternity care, is subject to charging unless the individual is part of an exemption category or has paid the IHS.

69. Immigration health surcharge: guidance for health and care reimbursements 2021 – Gov.UK Link
70. THE IMMIGRATION (HEALTH CHARGE) (AMENDMENT) ORDER 2020 – Hansard Link
71. Immigration Health Surcharge Research Briefing 2014 – House of Commons Library Link
72. The NHS budget and how it has changed 2025 – The King's Fund Link

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