

Cost Recovery Impact Assessment

<p>Title: Visitor and Migrant NHS Cost Recovery – Amending and Extending the Charging Regulations</p> <p>IA No: 5006</p> <p>Lead department or agency: Department of Health</p> <p>Other departments or agencies: None applicable</p>	<h2 style="margin: 0;">Impact Assessment (IA)</h2> <p>Date: 19th July 2017</p> <hr/> <p>Stage: Final</p> <hr/> <p>Source of intervention: Domestic</p> <hr/> <p>Type of measure: Secondary Legislation</p> <hr/> <p>Contact for enquiries: nhs-costrecovery@dh.gsi.gov.uk</p>
Summary: Intervention and Options	RPC Opinion: n/a

Cost of Preferred (or more likely) Option				
Total Net Present Value	Business Net Present Value	Net cost to business per year (EANCB on 2009 prices)	In scope of One-In, Three-Out?	Measure qualifies as
1,417	n/a	n/a	n/a	Out of scope

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

These amendments take forward planned amendments to the National Health Services (Charges to Overseas Visitors) Regulations 2015. The key objective is to increase visitor and migrant cost recovery income recovered by the NHS. Government intervention is necessary to increase the scope of charging, ensure awareness of and adherence to best practice and improve compliance with cost recovery regulations more generally.

What are the policy objectives and the intended effects?

The policy objective is to increase the recovered cost of NHS services provided to visitors¹ and migrants² and thereby contribute to long-term NHS financial sustainability. This will be achieved by extending the scope of charging and improving incentives for NHS trusts to comply with cost recovery legislation more widely.

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

Option 1 – Do nothing. The current Charging Rules remain unchanged.

Option 2 – Amend The National Health Service (Charges to Overseas Visitors) Regulations 2015 to give the Government the powers to:

1. Extend charging to:
 - i. apply to non-NHS providers of NHS-funded care; and
 - ii. secondary care delivered outside of the hospital setting.
2. Require upfront charging for non-urgent, planned care;
3. Remove assisted reproduction services from the scope of what is available free of charge to immigration health charge payers (or equivalent);
4. Remove the current exemption category relating to a subset of ship workers;
5. Require NHS trusts and foundation trusts to flag a patient’s record to indicate chargeable status.

Option 2 is the preferred option because it generates the maximum benefit for the NHS.

Will the policy be reviewed? If applicable, set review date:

Does implementation go beyond minimum EU requirements?	n/a				
Are any of these organisations in scope? If Micros not exempted set out reason in Evidence Base.	Micro	< 20	Small	Medium	Large
	n/a	n/a	n/a	n/a	n/a
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)	Traded:		Non-traded:		
	n/a		n/a		

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

Signed by the responsible Minister Lord O'Shaughnessy Date: 17th July 2017

¹ Such as individuals entering the country to visit family or for a holiday.
² Such as individuals who enter the country to live and work.

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Summary: Analysis & Evidence

Policy Option 1

Description: Do nothing

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: 0	High: 0	Best Estimate: 0

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	0	0	0
High	0	0	0
Best Estimate	0	0	0

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

Zero. This is the do nothing option and consequently no additional costs versus the counterfactual will be incurred by any party.

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

Zero, please see above.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0	0	0
High	0	0	0
Best Estimate	0	0	0

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

Zero. This is the do nothing option and consequently no additional benefits versus the counterfactual will accrue to any party.

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

Zero, please see above.

Key assumptions/sensitivities/risks	Discount Rate	N/A
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BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:	In scope of OITO?	Measure qualifies as
Costs: 0 Benefits: 0 Net: 0	No	Out of Scope

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Summary: Analysis & Evidence

Policy Option 2

Description: Introduce secondary legislation

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
			Low: 404	High: n/a	Best Estimate: 1,417
2016/17	2017/18	10			

COSTS (£m)	Total Transition (Constant Price)	Year	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	n/a	1	n/a	n/a
High	0.2		8	279
Best Estimate	0.1		4	140

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

The majority of the forecast costs are generated by NHS trusts who currently do not undertake any charging activity employing and training new staff, undertaking screening for all patients, and making and recovering charges. These costs fall to NHS trusts. Introducing upfront charging for non-urgent, planned care is expected to generate minor costs, also to NHS trusts, via a rise in administrative burden and costs of taking payment for additional income, for example by card machine.

Employers of overseas workers on UK registered ships will also incur the cost of paying for these individuals' healthcare.

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

Time burden of recording patients' chargeable status via the Summary Care Record Application.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	0	n/a	18	683
High	0		n/a	n/a
Best Estimate	0		42	1,557

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

Increased income for the NHS generated by increasing the value of costs recovered from visitors and migrants using the NHS.

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

Time saved for NHS trusts in reducing repetitive identity checks by requiring patients' chargeable status to be recorded on patient records via the Summary Care Record Application. Anticipated to significantly outweigh the time taken to record status initially.

Extending charging to secondary care delivered outside hospitals future proofs the legislation.

Benefit to UK society of reducing the pool of individuals eligible for NHS-funded assisted conception services.

Key assumptions/sensitivities/risks	1.5%
<p>The data available to assess the impacts is in virtually all cases incomplete or inconsistent with cost recovery definitions.</p> <p>Data from different sources has had to be combined and broad assumptions applied in order to generate estimated impacts (see assessment of each measure for more detail). Changing these assumptions would alter the estimated scale of impacts. However, worst case scenario analysis indicates the net impact is extremely likely to be a benefit overall.</p>	

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			In scope of OITO?	Measure qualifies as
Costs: n/a	Benefits: n/a	Net: n/a	n/a	n/a

Evidence Base (for summary sheets)

Issue under consideration

1. In 2015 significant amendments were introduced to consolidate the NHS (Charges to Overseas Visitors) Regulations. This formed the first stage of a national programme of work to increase cost recovery from visitors and migrants who access NHS-funded treatment when in the UK. Alongside other non-legislative policy actions this has been achieved to some extent in the interim, with income identified by the NHS rising from £97m to £146m between 2014/15 and 2016/17.
2. The overarching policy aims of the introduction of the 2015 Charging Regulations have been met. These included the introduction of the immigration health charge (“the surcharge”) and the introduction of an incentive for charging and recovering costs from visitors outside of the EEA. However, as set out in the Implementation Plan 2014-16, it was always the intention to further amend the regulations³ to bring more NHS-funded services and settings into the scope of charging.
3. We are also aware of significant variation in the extent to which NHS trusts and foundation trusts (collectively known as “NHS trusts”) are checking patients’ identity to confirm chargeable status and in making and recovering charges. In some cases, data suggests a number of NHS trusts might not be undertaking charging at all or to a limited extent only. This may be due, for example, to incorrect assumptions around services that are in or out of scope, or perceived difficulties with recovering income identified reducing the incentives to charge. So whilst the 2015 consolidation of the Regulations set up the baseline, amendments were always planned and remain needed.
4. In summary, the amendments to the Regulations covered in this assessment are required to:
 - Extend the scope of charging to increase identified NHS cost recovery income; and,
 - Improve adherence with and delivery against the existing Charging Regulations by addressing disparities between the charging rules for different types of care and different types of providers; and by amending the rules to improve the ability/incentives for NHS trusts to effectively apply the cost recovery rules.

³ We do not expect that these amendments will be the final we make to the Charging Regulations, with further changes expected later in the financial year. The requirement to carefully test and negotiate proposals (for example charging in A&E and primary care respectively) before we can change the law means it is not feasible to implement all the proposals at once.

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5. In the longer term, increasing cost recovery income will contribute to achieving financial sustainability in the NHS.

Rationale for intervention

6. Amendments to extend the scope of charging have been planned for since an early stage of the Programme. These amendments enact this intention and also seek to address a minor discrepancy relating to overseas workers on ships.
7. Maintaining the relatively narrow charging scope set out in the existing Charging Regulations would represent a failure to deliver on a policy commitment. It is considered this may foster continuing under-recovery by incentivising behaviours that increase demand for NHS healthcare from chargeable patients. For example:
 - Individuals travelling to the UK specifically to access free healthcare; or
 - Visitors and migrants who purchase health insurance when visiting other countries not doing so when travelling to the UK in the knowledge that they can access free healthcare regardless.
8. This generates negative impacts on UK society because the NHS is not a free service; it is financed by general taxation. To accommodate increasing demand for NHS healthcare either the amount society pays to finance it rises, or the scope of services offered is reduced/waiting times increased to spread the impact of the demand increase over a longer time period.
9. Overall, incomplete Charging Regulations will continue to generate excess demand for NHS healthcare and therefore pressure on supply. This negatively impacts on UK society either through increased costs of financing the NHS or a reduction in the supply of healthcare (fewer treatments available on the NHS or increased waiting times).

Policy objective

10. The ultimate aim of these planned amendments to the 2015 Regulations is to further improve cost recovery across the NHS in England and thereby contribute to the financial sustainability of the NHS.
11. We will achieve this via extending the scope of secondary care services that can be charged for by NHS trusts already complying with the Charging Regulations to some extent, and by improving the efficiency with which they recover income identified.
12. We will also bring the Regulations more into line with the current models of delivery, where non-NHS providers are working alongside NHS trusts to provide certain

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services. We will seek to 'level the playing field' so that services that are chargeable if delivered by an NHS organisation will also be chargeable if delivered by NHS-funded, non-NHS organisations.

13. The amendments will be achieved by a combination of:
 - Removing some of the existing exemptions from charging in secondary care (relating to specific groups of visitors and migrants and different types of treatments/providers);
 - Increasing the amount of income NHS trusts identify that is recovered, and thereby improve incentives to comply with the regulations, by mandating best practice; and
 - Simplifying/future-proofing the existing rules to incentivise their application across the NHS.
14. As noted we anticipate these amendments will incentivise NHS trusts that currently do not, or only partially, comply with the current charging regulations to improve. This will be partly due to increasing awareness of the charging requirements and, for example, that they apply to community and mental health trusts as opposed to just acute trusts. It will also be by improving the incentives for NHS trusts to comply by clearly setting out best practice and enabling NHS trusts to avoid failing to recover income they identify, which would then add to their debt. In this assessment we have termed the costs and benefits that arise from this secondary impact as "indirect".
15. These amendments will also be introduced alongside further non-legislative policy action to provide the NHS frontline with bespoke and intensive support to improve cost recovery processes.

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Options Considered

Option 1: Do nothing.

16. In the absence of Government intervention none of the objectives identified above would be achieved. The scope for some overseas visitors and migrants not making appropriate contribution to the costs of their NHS treatment would remain.
17. The ability of the NHS (and non-NHS organisations providing NHS-funded services) to charge and recover costs from eligible visitors and migrants would continue to be hampered by a system with unnecessarily complex rules around secondary care. Furthermore, there will be little to drive culture change in the NHS around identifying chargeable patients and less support to enable providers of NHS-funded care to recover costs by mandating upfront charging.
18. The opportunity for this area to contribute further towards the financial sustainability of the NHS going forward will be lost.

Option 2: Introduce secondary legislation – this is the preferred option.

19. The preferred option is to proceed with implementing secondary legislation that will amend the Charging Regulations to:
 - Level the playing field for charging across NHS secondary care services provided inside and outside hospitals and by NHS and non-NHS providers of NHS-funded care;
 - Improve cost recovery from patients who are not entitled to free NHS hospital treatment by requiring upfront charging for all non-urgent, elective care provided to chargeable patients;
 - Require NHS trusts and foundation trusts to record patients' chargeable status via the Summary Care Record Application (SCRa);
 - Bring the immigration health charge more in-line with private medical insurance available on the international market by removing assisted conception services from its scope; and
 - Address the disparity in the Charging Regulations relating to overseas workers on UK versus non-UK registered ships.

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Alternatives to Regulation

20. No alternatives to regulation have been considered. Regulation is considered necessary to drive a culture change in the NHS to embed identifying and charging overseas visitors and migrants not eligible for free NHS healthcare.
21. These regulatory changes lie outside the scope of the Better Regulation Framework and as such no OI3O or EANDCB assessments are presented.

Key Risks and Uncertainties

22. There is a significant lack of data to inform an impact assessment for such a niche set of policy measures. The responses to the consultation did not unfortunately provide sufficient information of the necessary type to use in this final stage IA. Instead a wide range of published and unpublished data is used here, in tandem with extremely broad assumptions, to approximate the potential impacts of the measures.
23. As a result there is a high level of risk around the precise value of the costs and benefits estimates. However, the scale of the impacts are in line with expectations and appear reasonable given the nature of the cost and benefit creation mechanisms.
24. There are also challenges with establishing the level of compliance with the current Regulations across the system and how introducing these amendments may change that. This does not affect the counterfactual baseline nor therefore the direct costs and benefits estimates, as these are predicated on the amount of income actually identified in 2016/17. The baseline is therefore already representative of current compliance.
25. An approximation has been developed to assess the scale of potential indirect impacts that could be generated if these amendments were to increase compliance with cost recovery more widely. However, this is subject to significant uncertainties.
26. Furthermore, this policy area is characterised by a high level of inter-dependency on factors which are extremely difficult to control and or robustly forecast for. The key examples being:
 - The number of visitors and migrants entering England/the UK in the future;
 - The average length of time visitors and migrants may remain in the country for in the future; and
 - The treatment requirements future visitors and migrants might have during their stay.
27. As there is no evidence we have identified that could inform expected developments in these areas (for example Home Office do not forecast visa numbers), it is assumed throughout this IA that each of these factors remains constant going forward.

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28. Finally, given the international nature of the policy, any estimates will inevitably be impacted by the outcomes of the EU exit process/negotiations. It is not considered appropriate to try and “second guess” what the implications of these may be, so the assumption of “no change driven by EU exit” is also applied throughout.

Option One: Do Nothing

29. By definition the ‘do nothing’ option has no additional costs or benefits versus the counterfactual. The opportunity costs of pursuing the do nothing option (option 1) are comprised of the net benefits from implementing option 2. These are outlined in detail in the following section.

Option Two: Introduce secondary legislation to amend the Charging Regulations

Costs and Benefits of the Options

30. These measures are not considered to be of a high impact nature, particularly in relation to the the additional costs generated. The aggregate undiscounted value of the costs are estimated at circa £40 million (before being converted into the value society would be willing to pay for the associated health impacts) across the entire ten year forecast period.
31. These are comprised almost entirely of NHS trusts’ administrative staff time costs from identifying chargeable patients plus the making and recovering of charges (billing individuals and actually collecting the money respectively). Note that no new burden will be placed on clinical staff. They will simply continue, as they do now, to make the clinical decision as to whether a patient’s treatment requirements are urgent or immediately necessary.
32. The only other costs included in the NPV estimates are:
- a. those that will accrue to employers of overseas workers on UK-registered ships who will become responsible for financing these individuals’ NHS treatment (circa £0.1 million per annum).
 - b. the administrative costs of identifying chargeable patients and making and recovering charges to non-NHS providers of NHS funded care.
33. Costs will accrue to visitors and migrants as they will pay for more of their NHS treatment than currently. However these are not costs to any part of UK society so are not included in the NPV estimate. They are however noted throughout for

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completeness and, by definition, equal the additional income trusts will receive from the amendments.

34. In terms of the forecast benefits, virtually all (~95% of direct benefits or roughly £20 million per annum) are attributable to introducing a legal requirement for NHS trusts to charge upfront for non-urgent, planned treatment.
35. A further indirect benefit of circa £20m on average per annum may be generated if the introduction of these regulations incentivises an increase in compliance with cost recovery more widely.
36. Table 1 shows the over-arching estimate for the value society would be willing to pay for the estimated number of QALYs the net benefits forecast for these amendments would generate. The ten year aggregates correspond to the total present value best estimates in the summary sheets.
37. Note that the impacts of the different measures are adjusted differently to estimate their value to society, because they impact different groups. A summary of the adjustments applied by measure is provided below followed by followed by more detail on the adjustments themselves.
 - Any impacts on trusts are expressed as health impacts. They are first converted from monetary values to QALY equivalents, before the value society would be willing to pay for that number of QALYs is estimated. Note a lower discount than standard rate is also applied, see below for further detail.
 - Impacts on non-NHS providers of NHS funded care are also expressed in terms of health impacts under the assumption that the NHS will ultimately receive any additional income generated and effectively pay the costs (via funding the activity).
 - Impacts on employers of relevant ship workers will not generate health impacts so are not adjusted in to QALY terms, and the standard 3.5% discount rate is applied.
 - As noted above, the costs accruing to overseas visitors and migrants are not included in the NPV estimate.
38. Where the impacts translate in to health impacts, the calculations first discount the aggregate net benefits at a rate of 1.5%. This is lower than the standard 3.5% as the 2 percentage points representing diminishing marginal utility of consumption if consumption is expected to increase over time are not applicable to health impacts
39. The discounted figures are then converted into QALY numbers using the £15k cost per marginal QALY on the frontline estimate. The value society would be willing to pay for this number of QALYs is then calculated as the final step using the standard £60k value as that society is willing to pay per QALY.
40. **The overall value society would be willing to pay for the QALYs generated is in the region of £1.4 billion across the ten year forecast period, following the**

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standard DH methodology for valuing the societal impacts of health improvements.

Table 1:

Present value of costs and benefits generated by this package of measures and the resulting net present value to society £ million											
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	10 year cumulative aggregate
Net present value to society £m	67	159	157	154	152	150	148	145	143	141	1,417
Present value benefits to society £m	75	175	172	170	167	165	162	160	157	155	1,557
Present value costs to society £m	7	16	15	15	15	15	14	14	14	14	140

41. In the following pages table 2 summarises the key findings and notes the evidence and assumptions used to develop the estimates. Table 3 then provides a more detailed summary of the annual monetary impacts by measure.

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Table 2:

Summary table by measure - 10 year cumulative costs and benefits, undiscounted, plus identified non-monetised impacts and evidence/assumptions used in the analysis					
Measure	Approx. monetised benefits - over 10 years £m	Approx. monetised costs - over 10 years £m	Net monetised impact	Non-monetised impacts	Evidence & Assumptions
Require upfront charging for non-immediately urgent/necessary treatments	212	4	208 ~		<p>a) Evidence from Peterborough and Stamford Foundation Trust (who already undertake upfront charging).</p> <p>b) Assumed adjustments to approximate a potential national impact.</p> <p>c) Unpublished trusts accounts data 2015/16.</p> <p>d) Unpublished DH estimates for aggregate recoverable costs of EEA residents' NHS treatment 2015/16.</p> <p>e) Assumptions around time taken to identify patients plus make and recover charges.</p> <p>f) Estimated average cost per hour of admin staff time given an assumed distribution across AfC bands.</p>
Indirect impact of all measures if the amendments increase compliance with cost recovery activity more widely.	161	32	129 ~		<p>a) Unpublished trust level reporting on income identified (known to be incomplete to the point of being misleading).</p> <p>b) DH assumed definitions for fully, partially and non-compliant.</p> <p>c) Previous analysis on financial opportunity from cost recovery.</p> <p>d) 2015/16 aggregate cost recovery income identified by type.</p> <p>e) Proportion of the aggregate health budget attributable to community and mental health.</p> <p>f) Assumptions re time taken to identify patients plus make and recover charges at inexperienced trusts (from a baseline of no or less than full screening of all patients).</p> <p>g) Publicly available estimates for recruitment costs.</p> <p>h) Assumptions around time to complete cost recovery training modules.</p>
Remove assisted conception therapies from the scope of treatments covered under the Immigration Health Surcharge	1	0.1	0.9 ~	Societal benefit via reducing the pool of individuals eligible for highly sought after NHS Funded Assisted Conception Therapies (ACTS).	<p>a) Population by English region.</p> <p>b) ONS data on regional distribution of long term international migrants.</p> <p>c) Home Office data on the number of visas granted by tier/type and estimated proportion of these eligible to pay the IHS to inform actual (Q1 and Q2) plus DH forecasts (Q3 and Q4) IHS visas granted 2016/17.</p> <p>d) Various estimates for the cost of IVF and Direct insemination therapies.</p> <p>e) Human Fertilisation and Embryology Authority data on annual number of IVF and Direct insemination cycles and the % of these that are NHS funded by English region.</p> <p>f) Assumptions around time taken to identify patients plus make and recover charges.</p> <p>g) Estimated average cost per hour of admin staff time given an assumed distribution across AfC bands.</p>
Remove exemption from charging from overseas workers on non-UK registered ships and confer responsibility for treatment costs to their employer	1	1	0.0 ~		<p>a) Department for Transport 2016 Seafarer Statistics.</p> <p>b) Chamber of Shipping Survey 2016.</p> <p>c) DFT Port Statistics - Freight Activity.</p> <p>d) Data on amounts recovered from University Hospital Southampton.</p> <p>e) Estimated average cost per hour of admin staff time given an assumed distribution across AfC bands.</p> <p>f) Average cost of EHC treatment.</p>
Extend charging to NHS funded care delivered by non-NHS providers	3	1	2 ~		<p>a) DH National Schedule of Reference Costs.</p> <p>b) ONS stock 1 - 12 months short term international migrants (STIM) (inc. by age group).</p> <p>c) HO data on average short term visa lengths.</p> <p>d) NHS England data on indexed costs for general and acute treatments by age bracket (85+ = 1).</p> <p>e) Annual Survey of Hours and Earnings.</p> <p>f) Various DH assumptions.</p>
Extend charging to secondary care delivered outside hospitals	~	~	~	Benefit - future proofing the legislation. Benefit - will reduce duplication of effort where a patient accesses the NHS more than once during their stay and has several identification checks.	<p>a) Definition of "a hospital".</p> <p>b) Intelligence from NHS England around provision of care.</p>
Require trusts to record patients' chargeable status on their records using the Summary Care Record Application (SCRa)	~	~	~		None applicable

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Table 3:

Undiscounted costs and benefits (exc. those to overseas visitors/migrants) split by measure - £ million constant prices													
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	10 year aggregate		
Benefits	Require upfront charging for non-immediately urgent/necessary treatments (coming into force October 2017)	9	23	23	23	23	23	23	23	23	231	212	
	Indirect impact of all measures if the amendments increase compliance with cost recovery activity more widely.	9	21	21	21	21	21	21	21	21	21	193	
	Remove assisted conception therapies from the scope of the Immigration Health Surcharge	0.5	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	9	
	Extend charging to NHS funded care delivered by non-NHS providers (coming into force October 2017)	0.1	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	3	
	Remove exemption from charging from overseas workers on non-UK registered ships and confer responsibility for treatment costs to their employer	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1	
	AGGREGATE MONETISED BENEFITS	19	44	44	44	44	44	44	44	44	44	441	418
	Costs	Require upfront charging for non-immediately urgent/necessary treatments (coming into force October 2017)	0.2	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	4
		Indirect impact of all measures if the amendments increase compliance with cost recovery activity more widely.	2	3	3	3	3	3	3	3	3	3	32
		Remove assisted conception therapies from the scope of the Immigration Health Surcharge	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.1
		Extend charging to NHS funded care delivered by non-NHS providers (coming into force October 2017)	0.04	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	0.09	1
Remove exemption from charging from overseas workers on non-UK registered ships and confer responsibility for treatment costs to their employer		0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1	
AGGREGATE MONETISED COSTS		2	4	4	4	4	4	4	4	4	4	38	
Aggregate Net Monetised Impacts		17	40	40	40	40	40	40	40	40	40	40	380

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Summary for the decision maker

42. Table 3 demonstrates that in the central scenario the forecast benefits significantly outweigh the forecast costs. However there are inherent uncertainties surrounding each estimate. As such, this section outlines an extreme worst-case scenario to ascertain whether such circumstances could push these measures from generating a net benefit to a net cost.
43. The principal factors that might drive such a shift have been identified as:
 - Low returns from upfront charging;
 - Higher than estimated administrative costs introduced by the new measures;
 - Low returns from indirectly increasing compliance with cost recovery more widely if NHS trusts and non-NHS providers new to the processes perform poorly in recovering income; and
 - Higher than estimated indirect costs as NHS trusts performing poorly at cost recovery increase resources to address this.
44. Scenario analysis was undertaken to estimate the potential benefit of mandating upfront charging. In the worst case scenario with the low over-arching growth assumption applied, the estimated aggregate benefit per annum falls to below £10 million. We assume this transpires in the worst case scenario.
45. The direct administrative costs of introducing the new measures are entirely predicated on assumptions around time taken to process cost recovery information and charges and the cost of the staff time. The assumptions applied are thought to be prudent in nature, but there is no identified evidence to inform this. As such, this 'worst case scenario' simply assumes the costs are double those estimated initially.
46. The central scenario estimates that moving to full compliance with the current cost recovery regulations could generate an average of circa £20 million per annum across the ten year forecast period. This estimate is based on a percentage increase in actual 2016/17 identified income. It therefore already takes into account the fact that the NHS is imperfect at identifying and charging patients even where compliance is identified as full.
47. However, NHS trusts and non-NHS providers completely new to charging may not achieve the same level of performance in identifying, making and recovering charges as their more experienced counterparts. The central estimate is not adjusted for this because these NHS trusts will be able to exploit best practice established from learning at other trusts and not have to go through a "learning phase" themselves.
48. For a worst case scenario, we could assume that NHS trusts new to charging will only recover 42% of the potential circa £20 million. This is the percentage of aggregate income the NHS is aiming to identify in 2017/18 that was identified in 2015/16 and reduces the possible benefits down to an average of roughly £8 million per annum.

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49. Finally, in a worst case scenario higher than expected indirect costs might be generated from a rise in compliance. As noted in paragraph 25, the uncertainty surrounding this measure makes it difficult to develop an intelligent, evidence-based sensitivity test. Once again the blunt, pessimistic assumption that actual costs could reach double the central forecasts in a worst case scenario is applied.
50. Table 4 shows the resulting net position of this worst case scenario test. **We can see that, even in this context, introducing these measures still generates an average around £10 million per annum in net benefits. With the forecast benefits reduced as above, forecast costs would need to increase by a factor of five versus the central estimate to generate a net cost overall.**

Table 4:

Worst case scenario costs and benefits to assess risk of measures generating a net cost, £ million												
<i>Benefits reduced as described above Costs assumed to be double central estimate</i>		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	10 year aggregate
Net aggregate impact		5	11	11	11	11	11	11	11	11	11	107
Costs (all exc. to V&Ms)	Direct & indirect costs (all) £m	4	8	8	8	8	8	8	8	8	8	77
	Upfront charging benefits £m	4	10	10	10	10	10	10	10	10	10	90
Benefits to trusts	Indirect benefits increased compliance £m	4	9	9	9	9	9	9	9	9	9	81
	Other benefits (unchanged vs central estimates) £m	1	1	1	1	1	1	1	1	1	1	13

51. Overall, this indicates that the likelihood of these measures generating a net cost impact overall is low.

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Estimated direct benefits

52. The benefits of implementing the proposed amendments will fall across a number of areas. The affected parties also vary by each proposed amendment. This section therefore first considers the benefits estimated for each separate amendment, and which areas these fall on. These individual considerations are then aggregated to give an overall level of the potential benefits for the whole package of measures.

Extending Charging to Secondary Care Provided Outside Hospitals

53. Based on current models of care the monetary impact of extending charging in to this area is anticipated to be zero/marginal. The driver for this expectation lies in the extremely wide definition of “a hospital” specified as below in the existing Regulations:

- any institution for the reception and treatment of persons suffering from illness,
- any maternity home, and
- any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation, and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution, and “hospital accommodation” must be construed accordingly.

54. So under this definition the vast majority of, if not all, Community care for example could be defined as taking place in a hospital as it would fall under medical rehabilitation, clinics etc. This assertion is as per advice from NHS England.

55. As a result, no estimates have been made for monetised benefits generated by this measure. It is expected to have no application in practice under the current models of delivering care and so is not forecast to generate benefits (or to have so few applications as to render any benefits entirely negligible).

56. However this amendment does have associated non-monetised benefits. The first being introducing an element of future-proofing to these Regulations. If models of care change in the future resulting in more treatment taking place outside hospitals, this amendment will ensure that the Charging Rules remain fit for purpose with no further changes necessary.

57. Furthermore the amendment addresses the current discrepancy in the regulations between the treatment of secondary care delivered inside and outside hospitals. This will make the Regulations easier for trusts to understand and therefore apply correctly.

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Extending Charging to NHS Funded Care Delivered by non-NHS Providers

58. The monetised benefits that will arise from this amendment will be comprised of the additional income the NHS will receive from charging eligible visitors and migrants for NHS funded care delivered by non-NHS providers (denoted as sub-contracted activity). This category of healthcare is currently out of scope of the charging regulations, so all the income generated will be additional versus the counterfactual.
59. To summarise, aggregate trust spending on sub-contracted treatments was adjusted down to account for the approximate proportion of the population attributable to visitors and migrants.
60. Further adjustments were then applied to account for the demographic characteristics of this cohort and how this might impact the proportion of these costs attributable to them.
61. **Overall, the aggregate PV (discounted at 3.5%) of the benefits arising from this measure across the 10 year forecast period are anticipated to be in the region of £3m.**

Introducing a Requirement for Upfront Charging for All Treatments not Urgent or Immediately Necessary

62. Although it is encouraged, NHS trusts are not currently required to charge upfront for non-immediately necessary or urgent care they provide to chargeable/recoverable visitors and migrants. Introducing this as a requirement will increase the number of chargeable/recoverable patients identified, as patients will be required to demonstrate their status prior to their first appointment.
63. Furthermore, it will reduce the amount of charges made that are subsequently not recovered from individuals if they, for example, have already left the country when the charge is made and are unable to be contacted.
64. The possible scale of the benefit is very difficult to assess and there is little data available upon which to base analysis. In summary, Peterborough and Stamford Foundation Trust (P&SFT) have implemented early identification and upfront charging throughout virtually all their service lines. The rise in income experienced at P&SFT is used as a baseline for the potential rise in cost recovery income upfront charging could generate.
65. Adjustments are applied to mitigate the (lack of) applicability of one NHS trust's data at the national level and the difficulty in establishing the causality between the rise in income and this specific policy.

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66. **Overall, the aggregate PV (discounted at 3.5%) of the benefits arising from this measure across the 10 year forecast period are anticipated to be in the region of £180m.**

Removing the exemption from charging for overseas workers on UK registered ships and conferring the responsibility for paying for treatment on to the employer

67. There is currently a discrepancy in the charging regulations between the chargeability status of overseas workers employed on UK and non-UK registered ships. These amendments will address this discrepancy by replicating current arrangements of non-UK registered ships for UK registered.
68. Exemption from charging will be removed from overseas workers on UK registered ships. However, in line with maritime law, seafarers must be able to access healthcare at no personal cost when ashore in a country they are not insured for healthcare/ordinarily resident (or similar) in. The amendment therefore confers responsibility for paying the costs of overseas workers on UK registered ships NHS healthcare on to their employer.
69. One trust was able to provide the amount of income accrued at the trust between April 2016 and February 2017 from charging for overseas workers on non-UK registered ships healthcare. This figure was adjusted up to approximate potential national income and then scaled down to reflect the smaller population of overseas workers on UK versus non-UK registered ships.
70. **Overall, the aggregate PV (discounted at 3.5%) of benefits arising from this measure across the 10 year forecast period are anticipated to be around £1m.**

Removing assisted conception therapies (ACTs) from the scope of the Immigration Health Surcharge (IHS)

71. The monetised benefits of removing ACTs from the scope of the IHS can be defined as the income received from charging IHS payees for assisted conception therapies. But, because they are not currently chargeable, no system-wide data is collected around IHS payees' use of ACTs.
72. To develop an assessment of the income that could be generated, we started with population and ONS Long Term International Migration (LTIM) data, plus DH estimates

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of IHS visa numbers. Applying the percentage of England's stock of LTIMs⁴ to estimated aggregate IHS visas produced an estimated regional split of IHS payees across English regions.

73. Dividing this by the aggregate regional population gave an estimate of the proportion of each region's population that may be accounted for by IHS payees. The assumption is applied that IHS payees are no more or less likely to seek ACTs versus the rest of the population.
74. These percentages were then applied to data published by the Human Fertilisation and Embryology Authority around the number of IVF and Direct Insemination treatments funded by the NHS in 2014 per region. This demonstrated how many ACTs might, on aggregate, be attributable to IHS payees.
75. Finally, the estimated number of IVF and DI treatments that may be attributable to IHS payees was multiplied by estimated average prices of these treatments (assumed representative of costs, based on publically available figures) to estimate potential additional income.
76. **Overall, the aggregate PV of the benefits arising from this measure across the 10 year forecast period are anticipated to be in the region of £8m (discounted at 3.5%).**

Indirect benefits if the amendments increase compliance with cost recovery more generally across the system

77. NHS Trusts have been legally required to make and recover charges for visitors and migrants use of the NHS under various iterations of charging rules since 1982. As such it is not unreasonable to assume that the majority of trusts will already:
 - Have staff allocated to cost recovery; and
 - Have a screening system set-up to identify potentially chargeable individuals from their patient population.
78. However, we are aware anecdotally that some NHS trusts do not engage with cost recovery activities at all, whilst some others do not maintain full compliance with the charging regulations.
79. The measures contained within this IA will simplify the current charging rules (making them easier to apply in practice) and also increase confidence that charges made will be recovered via the upfront charging measure. Both these factors are anticipated to

⁴ Judged the appropriate measure of international migrants as applies to individuals with a length of stay > one year which average length of stay data suggests applies to IHS payees other than short term students.

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act as incentives for NHS trusts to comply with the regulations as a whole and/or to improve their current compliance.

80. Levels of current compliance, and the extent to which these amendments might indirectly increase this, are extremely uncertain and hard to quantify. An initial approach is outlined below, however the figures should be used with extreme caution given the level of data gaps, assumptions applied and mixing of information from various datasets. They are appropriate as an indication of the potential scale of the indirect impacts as opposed to a robust estimation of these.
81. The first step was to develop a proxy to assess current compliance with the regulations. Cost recovery income reported by NHS trusts was deemed the most appropriate factor to base this on. Note that the reported nature of the data is critical. Trust level data does not present the full picture of cost recovery income and there is no way to distinguish between NHS trusts not reporting cost recovery activity and not undertaking cost recovery activity. As such it is thought to present a prudent assessment of the possible baseline.
82. Trusts were deemed as entirely non-compliant if they had no reported cost recovery income in 2016/17. Or partially compliant if they had only reported certain types of cost recovery income (e.g. some EEA income but no directly chargeable income or vice versa).
83. The second stage was to assess the change in costs and benefits that could be generated by non and partially compliant NHS trusts moving to full compliance. Note that moves from non to partial compliance or increases in compliance that fall short of making it "full" have not been considered. This is driven by the lack of data or evidence upon which to base assumptions around this.
84. The potential benefit of moves from non to full compliance were particularly uncertain given the lack of a trust specific baseline grounded in actual data. Previous analysis undertaken in conjunction with NHS Improvement was instead utilised for this purpose. The analysis estimated the potential financial opportunity by NHS trust generated by their cost recovery potential, according to trusts' turnover (from chargeable services) and location.
85. Average financial opportunity per trust, by region, was calculated and adjusted down to account for the fact that virtually all non-compliant NHS trusts were mental health or community trusts. These are assumed to have lower cost recovery financial opportunity versus acute trusts because a smaller proportion of the NHS budget is allocated to these service lines.
86. Further adjustments were required to account for characteristics of the STIM data used in the initial analysis. Firstly, it included STIMs staying in the country for between six and 12 months. The vast majority of non-EEA STIMs with a visa length of 6 months or longer will have paid the IHS and therefore be ineligible for charging. As such they needed to be removed.

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87. Secondly, the STIM rates related to the inflow of STIMs. To convert these into “person year equivalents” assumptions around STIMs length of stay were applied.
88. The resulting average financial opportunity estimates were then allocated to NHS trusts classed as non-compliant, according to their regional location, as a proxy for potential cost recovery income.
89. To estimate the potential rise in income for partially compliant trusts moving to full compliance:
 - The percentage change between the aggregate value of income from the streams they reported on and aggregate cost recovery income identified by trusts in 2016/17 was applied to their reported 2016/17 income.
90. Applying this methodology suggests a move to full compliance could generate ~£30 million additional income per annum.
91. **Across the 10 year forecast period, the present value of the benefits (discounted at the standard 3.5%) equates to around £165 million.**

Estimated direct costs

92. The costs of implementing the proposed amendments will fall across a number of areas. The affected parties also vary by each proposed amendment. This section therefore first considers the costs estimated for each separate amendment, and which areas these fall on. These individual considerations are then aggregated to give an overall level of the potential costs for the whole package of measures.

Extending Charging to Secondary Care Provided Outside of Hospitals

93. Based on current models of care the impact of extending charging in to this area is anticipated to be marginal. The driver for this expectation lies in the extremely wide definition of “a hospital” specified as shown below in the Regulations:
 - any institution for the reception and treatment of persons suffering from illness,
 - any maternity home, and
 - any institution for the reception and treatment of persons during convalescence or persons requiring medical rehabilitation, and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution, and “hospital accommodation” must be construed accordingly.

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94. So under this definition the vast majority of, if not all, Community care, for example, could be defined as taking place in a hospital as it would fall under medical rehabilitation, clinics etc. as per advice from NHS England.
95. As a result, no estimates have been made for monetised costs generated by this measure. It is expected to have little application under the current models of delivering care and so is not forecast to generate costs (or to have so few applications as to render any costs entirely negligible).

Extending Charging to NHS Funded Care Delivered by non-NHS Providers

96. There are two principle areas of cost driven by extending charging to sub-contracted treatments:
 - Chargeable non-EEA patients will incur the cost of paying for their care; and
 - There will be an additional administrative burden on non-NHS providers of NHS funded care in making and recovering the charges.
97. The cost of treatment invoiced to chargeable non-EEA patients will by definition equal the sum of the benefits; however these are not eligible for inclusion in the NPV estimate.
98. The administrative burden of making and recovering charges will be a function of the number of chargeable non-EEA patients receiving sub-contracted treatment. An assumed unit cost was estimated based on various scenarios for time taken to administer the charges and assumptions around the cost of staff time.
99. This was then multiplied by the estimated number of patients the aggregate income benefit identified might plausibly be generated by.
100. Furthermore, if we assume payments are taken electronically via a card machine, initial research suggests a transaction fee of ~1.25% of the transaction value.
101. **Overall, the aggregate PV (discounted at 3.5%) of the costs arising from the administrative requirements of this measure, across the 10 year forecast period, are anticipated to be in the region of £1m.**

Introducing a Requirement for Upfront Charging for All Treatments not Urgent or Immediately Necessary

102. The costs of introducing a requirement for upfront charging will fall into the same broad groupings as noted above for extending charging to sub-contracted care. More

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chargeable individuals receiving care will be identified, plus more charges will be made and recovered by mandating payment upfront. This will increase NHS trusts' administrative costs.

103. The cost of treatment invoiced to chargeable non-EEA patients will again by definition equal the sum of the benefit however these are not eligible for inclusion in the NPV estimate.
104. It is anticipated that four elements of requiring upfront charging will require the dedication of additional staff time and thereby increase administrative costs:
- Confirming chargeable status of a patient based on identification they provide and making/recovering the charges – various assumptions applied around time taken according to potential complexity scenarios;
 - Estimating the amount to be charged upfront according to planned treatments – assumed to take on average 15 minutes;
 - Comparing the amount charged upfront with estimated costs for actual treatment received and correcting any discrepancies – assumed to take around 20 minutes; and
 - Ongoing transaction charges for taking payments – assumed to be via a card machine with average charge ~1.25% of transaction value.
105. Applying the same assumed weighted average paybill of ~£18 per OVM hour implies a total staff time cost of between £60k and £200k per annum for the central scenario.
106. Using the derived estimated additional income estimate as a proxy for the aggregate value of transactions processed and applying the 1.25% average charge figure implies aggregate cost of card machine use at £125k - £440k in the central scenario.
107. **Overall, the aggregate PV of the costs arising from the administrative requirements of this measure, across the 10 year forecast period, are anticipated to be in the region of £3m.**

Removing the exemption from charging for overseas workers on UK registered ships and conferring the responsibility for paying for treatment on to the employer

108. The costs of charging employers of overseas workers on UK-registered ships will fall on two parties:
- The employer who will now be liable to cover the cost of healthcare administered to their overseas employees when ashore in the UK; and

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- Trusts who will see an increased administrative burden in identifying and charging for overseas workers on UK-registered ships NHS treatment.
109. The cost to employers of overseas workers on UK-registered ships of paying for any NHS treatment they receive will by definition equate to the additional income trusts will accrue. Under the methodology outlined in the benefits section, this is in the region of £130k per annum.
110. In terms of administrative costs, University Hospital Southampton (UHS) provided intelligence to the DH around the processes and staff time requirements for charging employers of overseas workers on non-UK registered ships. They estimate that it takes an average 60 minutes of staff time to complete the entire invoicing/charging process.
111. If we assume that the average NHS treatment cost per overseas worker on non-UK registered ships treated at UHS will be applicable and divide total estimated annual income by this, it implies ~50 patients may present within this charging category per annum. An hour of staff time per case combined with the weighted average OVM paybill per hour estimate of ~£18 implies an aggregate cost per annum of roughly £1k.
112. **Overall, the aggregate PV (discounted at 3.5%) of the costs arising from the administrative requirements of this measure, across the 10 year forecast period, are anticipated to be in the region of £0.1m and the costs to employers circa £1m.**

Removing Assisted Conception Therapies from the Scope of the Immigration Health Surcharge

113. The direct benefits section described how estimates were derived for the number of ACTs that might become chargeable per annum if they were removed from the scope of the IHS. As with previous measures, the cost implications are driven by the staff time taken to make and recover charges and the transaction costs of processing payments, assumed to be taken via card machine.
114. Because ACTs are not immediately necessary or urgent treatments, it is assumed payment will be required upfront. Table 5 shows the assumptions made about the time to identify IHS payees, make and recover the charges plus the assumed split of total IHS payees across each 'time taken' bracket.

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Table 5:

Estimated number IHS Payees Assisted Conception cases by length to complete and associated costs				
Minutes to identify, make & recover costs	Assumed % of all patients in time taken brackets	Implied Number of Cases	Implied Cost £	
<i>Directly chargeable patients (IHS payees)</i>				
5	30%	81	179	
15	40%	108	716	
30	25%	68	895	
60	3%	8	215	
120	2%	5	286	

115. This approach suggests circa £1k staff time costs per annum (applying the average paybill per OVM hour of ~£18. In addition, we assume that transaction costs will be generated if card machines are used as the payment mechanism. This could equate on average to 1.25% of transaction values, i.e. 1.25% of the additional income NHS trusts recover, or roughly £13k per annum.
116. **Overall under this approach, the implied aggregate PV (discounted at 3.5%) of the costs arising from the administrative requirements of this measure, across the 10 year forecast period, are anticipated to be in the region of £0.1m.**

Indirect Costs if the Amendments Increase Compliance with Cost Recovery More Generally Across the System

117. The benefits section outlined the methodology for estimating that, if these measures increased cost recovery compliance across the system, roughly £20 million additional income per annum could be generated. This additional income estimate is used as the basis for this element of the cost estimate also.
118. There is no data available on the volume of directly chargeable patients that generate the value of income we see from this stream. As such the average value of reported recoverable EEA treatments was used to estimate that this approximate £30 million income might be generated by charging around 19k individuals.
119. Because the processes differ between recovering EEA costs and charging directly chargeable individuals, the burden on NHS trusts per patient of complying with cost recovery requirements does too. So these ~19k individuals were split between EEA recoverable and directly chargeable according to the equivalent split of aggregate 2016/17 income.
120. A set of assumptions were then applied as to the range of times it might take NHS trusts to process EEA information and to make and recover charges from directly chargeable individuals. These are assumed to be higher than equivalent estimates applied in other sections of this IA given that this cohort of trusts are assumed to be entirely or relatively new to charging/recovering.

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121. This approach suggests a staff time requirement equivalent to circa 27k hours. Applying the assumed average paybill per OVM hour of ~£18 as previously, this equates to an ongoing annual staff time cost of approximately £480k.
122. But that assumes that it is existing, trained staff that cover the additional checks. If we relax this assumption and instead assume that part-time staff are recruited this introduces one-off transition costs from recruiting and training the new staff of circa £100k.
123. **Overall under this approach, the implied aggregate PV (discounted at 3.5%) of the costs arising from this measure across the 10 year forecast period are anticipated to be in the region of £30m.**

Non-Monetary Benefits Arising from Implementation of Option Two

124. There are two measures for which quantifying the estimated impacts has not been possible. These are comprised of:
- Extending charging to secondary care delivered outside hospitals; and
 - Requiring trusts to record a patients' chargeable status using the Summary Care Record Application.
125. Firstly, enquiries suggest that at present little or no secondary care is delivered outside of a hospital, given the extremely wide definition of "hospital" that is applicable. As such we expect a zero monetary impact currently. If however in the future models of care alter so that secondary care does move to delivery outside of hospital, this would change. If this occurred it is assumed to generate a net benefit, in line with the net benefit generated by extending charging to new areas under other measures contained within this IA, as the costs and benefits would be of the same nature.
126. There is also a non-monetised benefit in that addressing this discrepancy now will "future-proof" the regulations and ensure that they remain fit for purpose if the above change to models of care does occur going forward.
127. Secondly, recording patients' chargeable status via the Summary Care Record Application will take a small amount of administrative staff time. However, having a reliable repository of chargeable information status for patients not accessing the NHS for the first time during their stay will significantly reduce time spent checking identification repeatedly.
128. Repeating an identity check would take longer than recording the information in the first place and, as such, this measure is assumed to generate a net benefit. It has not been possible to quantify this given the significant uncertainties surrounding the number of

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times patients' status will be recorded and how many times they may subsequently "re-access" the NHS.

129. Finally there is an element of non-monetised benefit to the measure which removes assisted conception therapies (ACTs) from the scope of the IHS. The change will reduce the pool of individuals eligible to access highly sought after NHS funded ACTs. This is expected to improve access for individuals who are entitled to free assisted conception therapies through the NHS, and thereby benefit UK society.

Public Sector Equality Duty

130. We have considered equalities issues throughout the course of the cost recovery Programme, including the completion of a comprehensive assessment in February 2017 to support the publication of the government response to the consultation of charging overseas visitors and migrants using the NHS in England. We have built on this analysis to inform these Regulations.
131. In particular, our analysis has highlighted that upfront charging (and the process of estimating charges) may have some impact on certain low income groups, such as older or disabled people, who are more likely to need hospital services. However, we believe these impacts would not be a significant as this is already the policy as set out in published guidance, and charges are already made at some point in the treatment process. Therefore making these charges at an earlier stage in the process would not have a significant effect.
132. We also recognise that the Regulations may have a potential impact on low income groups as they may need to pay for treatment that previously they were not charged for, and this may represent a higher proportion of their income/living allowance. We believe that any impacts are justified as we consider that ensuring the long-term sustainability of the NHS is a legitimate aim and ensuring that those who are required to pay for NHS healthcare are identified and charged correctly, this is a proportionate way of achieving this aim. It is important to note that any impact is also mitigated as immediately necessary or urgent treatment will not be withheld due to payment.
133. The equalities analysis sets out more detail on these and any other impacts, as well as justifications and mitigating actions.

Timing of implementation

134. The regulations are being made and laid in time for a coming into force date of 21st August 2017. However, the measures relating to upfront charging and NHS funded care delivered by non-NHS providers will not come into force until 23rd October 2017. This is to allow for more detailed stakeholder engagement to inform the optimal implementation processes.