DANIEL LYNCH/REX

New NHS boss: nothing simple about this Simon

His appointment as the head of NHS England has been greeted with messianic enthusiasm. But who is the real Simon Stevens, asks **Peter Davies**

There is no one like him. He is intellectually gifted, charming, funny, and a great communicator. He is a natural and persuasive leader who exudes quiet confidence. He is widely read and writes superbly. The NHS is lucky to get him. "I can't think of anyone better able to face what's coming our way."

Those who know Simon Stevens greeted his appointment from next April as chief executive of NHS England with messianic enthusiasm. Others may take more convincing. They see a former NHS manager and leading Blairite special adviser, an unapologetic proponent of competition in the health service who has spent the last nine years at the top of an American health insurance company. Does this CV represent unrivalled experience for his new job or cumbersome baggage that will arouse suspicion and mistrust?

Some are puzzled that Stevens should wish to return. Long settled in Minneapolis, with an American wife and two young children, he has been a success as executive vice president of UnitedHealth and president of its global division. He likes the job and earns many times more than he will attempting to sort out a dysfunctional NHS. He seemed destined for a glittering career in the United States, so why return? Apparently he took some persuading, but friends say he is "absolutely committed" to the NHS in a way that "transcends all other considerations."

All agree that Stevens is a complex individual. "He's very ambitious, but there's more to him than that," says one insider. "He's a multi-layered character." Another says: "He'll talk to you openly and patiently if you sit next to him at dinner, but he can be quite aloof." One friend concedes: "He's got such a big brain he can be easily bored. You never quite know what he's thinking. He plays his cards close to his chest." Colleagues claim he is a "natural egalitarian" whose heart lies in the public sector. "He's not just Mr Insurance USA."

From a Birmingham comprehensive Stevens won a place at Balliol College, Oxford. His contemporaries, the prime minister, David Cameron, and the health secretary, Jeremy Hunt, may recall him as president of the Oxford Union debating society when it invited Sinn Fein leader Gerry Adams to speak—a controversial move in the mid-1980s. On graduating he spent a year as an economic analyst in Guyana, then joined the NHS management training scheme, where his abundant ability earned him the nickname Wunderkind. Appointments followed in primary care, mental health services, hospitals, and commissioning in the north east, south coast, and London. "He's seen the rough end of the NHS," says a friend—Stevens's predecessor in one post had committed suicide.

"When Simon was in Downing Street it didn't matter much who was in the Department of Health—Simon was running the service"

When a Labour government was elected in 1997 Stevens became a special adviser to health secretary Frank Dobson, then to Dobson's successor Alan Milburn, and from 2001-04 to Prime Minister Tony Blair. Between 1998 and 2002 he also found time to be a Labour councillor in Brixton, south London. Policy analysts tend to credit Stevens with masterminding most of Labour's NHS reforms. "Tony Blair really trusted Simon and he was allowed to just get on with it," says a friend. "When Simon was in Downing Street it didn't matter much who was in the Department of Health—Simon was running the service."

Paradoxically, he may find it harder to run the service as chief executive of the commissioning body, NHS England. As one observer puts it, he will have rather fewer levers to pull, and those at his disposal are either bust or disconnected. However, well-wishers note that he did not control all the levers under the US system but flourished there. "He's very good at knowing how to get people to do what he wants, whether by flattery, threat or offering them something," says one. Another comments, "The new system is about distributed leadership. That will play to his strengths. He's very collegiate." A third says, "He's pragmatic and not ideologically driven. He'll ask how we can make this work."

Stevens is unlikely to be under any illusions about what he is returning to. "He knows everybody and has kept a close eye on the NHS," says a friend. He has written prolifically about the service from exile, expressing opinions that may now become hostages to fortune. He greeted the coalition's reforms enthusiastically in 2010, perceiving them as a logical extension to Labour's, which Blair was blocked from enacting by his own "virtual coalition" government.[1] Writing in the *BMJ* he reaffirmed his commitment to competition not as a "silver bullet" but to "raise standards, unleash productivity, and improve equity."[2]

Observers note another signal from Stevens "about how he thinks the world should operate"—his request for a 10% cut in the chief executive's £211 000 salary, given NHS spending pressures. One calls it simply "leadership of the best kind." Another sees it as a reflection of Stevens' complex personality: "It says a lot about him. I think it's meant to, quite deliberately. He would have been very careful about it. Simon doesn't do anything without a reason."

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References are in the version on bmj.com.

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ARE MIGRANTS A DRAIN ON HEALTH SYSTEMS?

Access to health services by migrants is being tightened; does the evidence show this is necessary? **Sophie Arie** reports

What's changing?

Britain is proposing to introduce a levy on temporary migrants from outside the European Economic Area (EEA), such as students and people on temporary permits (allowing them to work in the UK for six months to five years), who until now have had free access to the NHS. Students will be charged £150 (€176; $242) a year and others £200. The Immigration Bill also proposes that general practitioners should charge for services to short term migrants (those with permission to live in the country for up to six months), and illegal migrants, who currently have access to free primary care. And a better system is being created for retrieving costs that should be paid by foreign patients or by their countries under EU agreements.[1]

How about the rest of Europe?

Many European countries are tightening access to healthcare for visitors and migrants as health budgets are squeezed. Since 2012, Spain has barred illegal migrants from receiving any healthcare except emergency care (including childbirth).[2] In Spain, non-EU students pay €59 (£50; $80) a month for access to health services and those over 60 must pay €259 a month for the same access.[3] In Greece, although healthcare has been free at the point of access, from January it will introduce a €25 charge for entry to all hospitals and health centres (people earning less than €11 000/year are exempt) and a €30 charge for any interventions after an initial consultation as part of the country's efforts to reduce its health budget.[3]

What does the European Union require?

Since 1971, EU regulations have obliged EU countries to provide the same access to healthcare for visiting EU citizens and non-resident migrants as they do for their own nationals. The costs are then supposed to be reimbursed by the visitor's country of origin. Just as Britain is recognising it has difficulty retrieving the costs of treating other Europeans, a new European directive on cross border healthcare, which came into effect on 25 October, seeks to make it easier for Europeans to have treatments in whatever European country they choose,[4 5] This allows people to choose, for example, to travel to countries that have shorter waiting lists for treatment or to be closer to their relatives during treatment.

The new research suggests that "deliberate health tourism" accounts for just £60m- £80m

Do migrants drain national resources?

In economic hard times, public opinion perceives migrants as a drain on resources.[6] Yet several recent studies conclude that the majority of migrants travel for work, many paying taxes in the host country. "The fiscal impact of immigration is close to zero," across the countries of the Organisation for Economic Co-operation and Development (OECD) according to the organisation's *International Migration Outlook 2013*.[7] "Regarding healthcare expenditure, although little direct information is available, there are a number of indications suggesting that immigrants are on average less costly for the public purse than the native-born."

Other studies point out that most migrants do not access healthcare in the host country because of lack of knowledge of the services available, bureaucratic hurdles, and language problems.[8]

So why are European visitors part of the problem?

In many EEA countries patients pay up-front for health services and claim back costs through social security and insurance programmes. Non-resident patients from other European countries are therefore obliged to pay for most care they receive and then claim back the costs from their own national health service. In the UK, care is free at point of entry so the onus is on the health system to secure the payment afterwards. In practice, UK hospitals often do not bill foreign patients because they do not have systems in place to pursue those payments even though trusts are liable for these costs if they cannot be recovered. The government's latest research says that it spends £388m each year on patients who should be paying for their care and most of that—£305m—is incurred by patients from the European Economic Area.[9]

How much is too much?

A recent report from the European Commission attempts to assess the effect on health services of migrant EU citizens who have residency but do not work in the country they have moved to.[10] The report finds that "non-active" EU migrants—that is, students, pensioners, spouses, and job seekers—represent a very small share of the total population of migrants resident in each member state.

The commission estimates that on average, the costs of treating this group amount to 0.2% of total health spending. Cyprus has the highest costs for this group—close to 4% of total health spending, followed by Ireland (2.3%), the UK (1.1%), and Malta (1%).

In the UK, this translates to €1.8bn annual spending on this group. The EU sees this as a relatively small amount compared with the overall size of national economies and points out that most "non-active" EU migrants live in working families who are paying taxes. But the government is concerned that these EU citizens should not be using NHS services without personally contributing to them. And the numbers of unemployed EU citizens resident in the UK and other EU countries have been growing in recent years (in the UK there was a 42% rise between 2006 and 2012, from 432 000 in 2006 to 612 000 last year).

Elderly migrants

France has the largest share of "non-active" EU migrants who have lived in the country for over 10 years (71% in 2012). Many of those are UK pensioners. France has changed its system in recent

years so that foreign pensioners now must have health insurance as a condition of residency.[10] Until 2012, EU pensioners in Spain often needed only to be registered as residents in a municipality to access the Spanish healthcare system. Now to register as residents they too must provide evidence of minimum resources and healthcare insurance.

So who are the "health tourists" the government is concerned about?

The EU says there is little evidence to suggest that the "main motivation of EU citizens to migrate and reside in a different member state is benefit-related as opposed to work or family-related." The commission says it has called on the UK to provide evidence of so called benefit tourism among this group and so far has not received any.

Details on those who travel to the UK deliberately to use the health services without paying for them are hard to find, and the government's latest research does not specify numbers of people who use the system this way. The research estimates that the cost of treating people who deliberately travel to the UK to get free NHS treatment is between £70m and £300m.[11] It also refers anecdotally to "whole maternity wards" full of eastern Europeans, without specifying how many may be members of tax-paying families.

What about British patients who travel for healthcare elsewhere?

Research published in *PLoS ONE* on 24 October suggests that Britain in fact exports more health tourists than it imports.[12] The study by researchers at the London School of Hygiene and Tropical Medicine and the University of York found that only 7% of patients at 18 NHS foundation trust hospitals were international private patients and that their treatment generated £42m for the trusts involved, almost a quarter of the trusts' private income. In 2010 an estimated 63 000 UK residents travelled abroad for treatment, while around 52 000 patients came for treatment in the UK. The number of patients travelling to the UK has remained relatively stable over the past decade, while there has been a substantial increase in the number of UK residents travelling abroad for medical treatment. However, this research only compares figures for health visitors who pay in full for the services they use.

Illegal migrants

Most countries have laws that give illegal migrants the right to free access to essential healthcare. Many countries have reduced access for non-documented (illegal) migrants recently. In Spain, they have not had access to any healthcare since 2012. In the UK, undocumented migrants have access to primary care services, but the government is proposing they should pay for that. In Belgium, illegal migrants can access healthcare only by going through a series of bureaucratic steps, which often prevents them from doing so. One of those is a mandatory visit by authorities to the applicant's home to establish financial hardship. Many undocumented migrants do not apply because they do not wish to impose that visit on the people who are hosting them. Organisations like Médecins du Monde provide vaccination programmes for undocumented migrants.

Germany is one of the few countries in which doctors, social workers, and civil servants can face legal action if they fail to report illegal migrants.[13] A report from Médecins du Monde, which provides care to people unable to access health services in seven countries of the EU, found that many do not seek care for fear of being reported to immigration authorities.[3]

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EDITORIAL, p 7

While there has been much heat generated by the charging suggestions in the government's new Immigration Bill, there has been less light, finds **John Appleby**

Despite the NHS being designed expressly on the basis of free access, the complications of who, exactly, is entitled to free access and who should be charged for what type of care has a long history.

Since almost the day of its inception the NHS has had the power to charge people not "ordinarily resident." In practice this has been somewhat ad hoc. This is partly because of the costs of collection relative to income, misaligned incentives (hospitals now get paid for their work by commissioners regardless of who they treat, for example), and possibly a degree of ambivalence about charging.

Costs of treating non-residents

A review of charging policy in 2012 presented some tentative figures on the scale of use of the NHS by overseas visitors.[1] It suggested that in 2010-11 the total cost of NHS services consumed by non-permanent residents and visitors to England could amount to around £1.4bn (€1.6bn; $2.3bn)—around 1.2% of the total NHS spend. But only about £125m of this was possibly recoverable under existing charging and recovery rules.[2 3] Now, following new research to try to establish a more accurate estimate of the scale of use of the NHS by migrants and visitors in 2012-13, the figures have been revised. The authors of the new research are at pains to point out that their estimates should be treated with caution as they are based on incomplete data and a large number of assumptions.

The new estimates have revised the amount spent to just under £2bn (around 1.8% of total English NHS spending) with £328m potentially recoverable.[4 5] Of the £328m, around £261m (of which around £50m is currently actually recovered) is either chargeable or recoverable from European Economic Area (EEA) governments as part of the European health insurance card scheme (figure).[6] Non-EEA temporary visitors and British ex-patriots visiting the UK account for just £67m of chargeable costs.

The new research suggests that "deliberate health tourism" accounts for just £60m-£80m, and, what the research terms "taking advantage"—such as overseas relatives of British citizens using (mainly primary) care services while visiting—could amount to between £50m and £200m.

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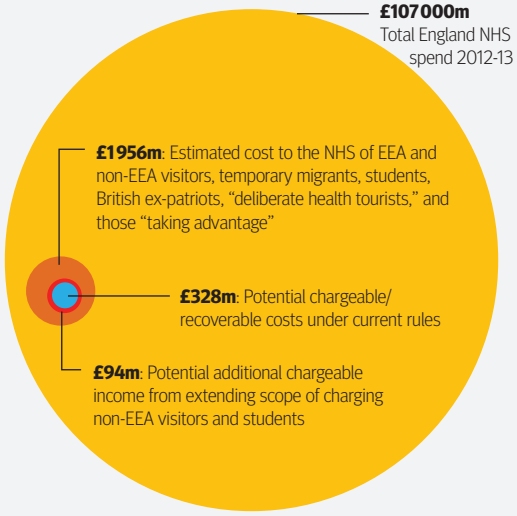
Estimates of total UK NHS spend on non-permanent residents and visitors, total possible income under current charging/recovery arrangements and additional potential income from widening the scope of chargeable non-European Economic Area (EEA) visitors[4]



thebmjawards

NOMINATIONS OPEN

The BMJ Awards has rapidly become the biggest night of the year for the medical profession in the United Kingdom. And 2014 will be no exception, with new categories, an enhanced judging process, and a strong focus on UK medical talent. Nominations are now open for the awards (www.thebmjawards.com), back for a sixth year with the ceremony's headline sponsor, the MDDUS (Medical and Dental Defence Union of Scotland).

For 2014, doctor led teams in the UK have the opportunity to enter 13 categories. Cancer care, diabetes, gastroenterology, primary care, and respiratory medicine are just a handful of specialties recognised.

We have also shaken up some of the categories—introducing, for example, a patient safety team award to mark Don Berwick's recent review of the NHS. But popular awards remain, such as Research Paper of the Year and our surgical award, which each year remembers British doctor Karen Woo, who was killed while delivering healthcare in Afghanistan.

So why enter? Over the years, the awards have honoured international medical luminaries such as Richard Peto and Bernard Lown, but also doctors who are inspirations in their own backyard, such as Jon Cardy, of West Suffolk Hospital emergency department (box).

Trophies have gone to innovations such as the polystyrene foam vaccine boxes repurposed as incubators to keep newborn babies warm, and to a research paper showing that the impact the low cost drug tranexamic acid can have on reducing deaths from bleeding. We have seen a team of airborne Scottish doctors honoured, as well as the cardiac surgeons who bravely became the first to publish their mortality data.

For David Cohen, clinical lead for the stroke team at Northwick Park Hospital, crowned Clinical Leadership Team of the Year 2013, the recognition has been "fantastic."

"It's no exaggeration to say it was the best night of the year," says Cohen, whose team built and operates the hyperacute stroke unit at the hospital. "It was a fantastic recognition of work that has been going on at Northwick Park for many years. Apart from relatives' thank you notes, there aren't many avenues for recognition of good work in the NHS. So to have the *BMJ* say 'your team is the best' is wonderful. It's great to have that external validation. The entry process wasn't difficult and the rewards of winning are great."

MY BMJ AWARD: JON CARDY

Jon Cardy, consultant intensivist and clinical director for accident and emergency at West Suffolk Hospital, won Clinical Leader of the Year at the BMJ Awards 2012.

He led a dramatic transformation in performance over the whole range of national emergency care quality indicators, including hitting the number one spot in England for the four hour wait indicator.

"It was very flattering to be recognised for the work I do. Up until then I was a local district general hospital consultant working in the middle of nowhere and I was suddenly projected into the national view, standing in front of hundreds of people in London making a speech. It was a massive team effort and gave us all a morale boost; the department was buzzing afterwards. I was burning the candle at both ends in the hospital and it was bloody hard work but this award shows that if you do something special it does eventually get noticed and talked about."

"It was very flattering to be recognised for the work I do . . . It's great to have the opportunity to inspire the next generation of doctors"

The accolade has led to national speaking invites, such as to a recent junior doctors' gathering, on the bill with NHS medical director Bruce Keogh. "It's great to have the opportunity to inspire the next generation of doctors," says Cardy.

Cardy returned to the BMJ Awards in 2013, this time as a judge: "I read all of the shortlisted submissions and there were some amazing things going on, some really excellent and innovative projects. I was aghast at the standard and diversity of entrants."

FOR 2014

The BMJ Awards 2014 will honour doctors making a difference in the UK. **Rebecca Coombes** invites you to enter and explains what's new this year

THE BMJ AWARD CATEGORIES 2014

Cancer Team
For the team who has made measurable improvements in cancer care

Diabetes Team
This award recognises an innovative project or initiative that has measurably improved care in diabetes

Healthcare Professional Education Team
A team judged to have made an outstanding innovation in healthcare, professional education, and performance improvement

Gastroenterology Team
Judges are looking for a team that has delivered an innovative project or initiative that has measurably improved care in gastroenterology

Emergency Medicine Team
This award recognises the vibrant and rapidly evolving multidisciplinary specialty of emergency medicine

Karen Woo Surgical Team
Sponsored by Bupa, and inspired by the exceptional work of Karen Woo, this award honours an innovative project or initiative from a UK based surgical team that has measurably improved surgery; submissions from teams involved in relief projects are also welcome

Primary Care Team
This award, sponsored by MDDUS, recognises primary care teams that have had a significant impact on the health and wellbeing of the wider community

Respiratory Medicine Team
The winners will have measurably improved care in respiratory medicine

The Berwick Patient Safety Team
To mark Don Berwick's 2013 review into improving patient safety in the NHS, this award, sponsored by the Health Foundation, goes to a team that can provide evidence of progress against two or more recommendations in Berwick's report

UK Research Paper
This award recognises original research that has the potential to contribute significantly to improving health and healthcare

Clinical Leadership Team
This award, sponsored by the GMC/Faculty of Medical Leadership and Management, recognises a team that exemplifies the qualities of clinical leadership

Innovation Team
An award for the team that has delivered innovation to improve the experience and outcomes of patients

Just under 300 entries were received last year, and the *BMJ* spent weeks sifting them, drawing up a shortlist of candidates who went through to a final round of judging by an expert panel.

This year, for the first time, shortlisted entries will go through peer review, a move designed to make the awards the most rigorous and a true reflection of clinical talent in the UK.

A specially convened senior judging panel will be the final arbiters of who wins a coveted trophy. Also new for 2014 is the inclusion of interviews with finalists in the judging process.

There is also a new opportunity for feedback: teams can sign up for a benchmarking report to find out how their submission compared to those of competing entrants.

The 2014 awards will culminate on 8 May, when the winners will be announced at a gala dinner in central London.

Sara Hedderwick, a consultant in infectious disease in Belfast and deputy chair of the BMA's consultant committee, was a judge for the 2013 awards. "The awards ceremony was full of clinicians doing fantastic work. They were still as enthusiastic about medicine as the day they had started and hadn't become cynical or ground down. It was incredibly uplifting."

"The quality of entries was high and I imagine we could have picked many more winners from the applicants—it was a hard job. What struck me are the clinical outcomes that can be achieved if you find the right team synergy in the health service."

To nominate your team go to thebmjawards.com to view relevant category criteria and guidelines for entry.

Good luck!

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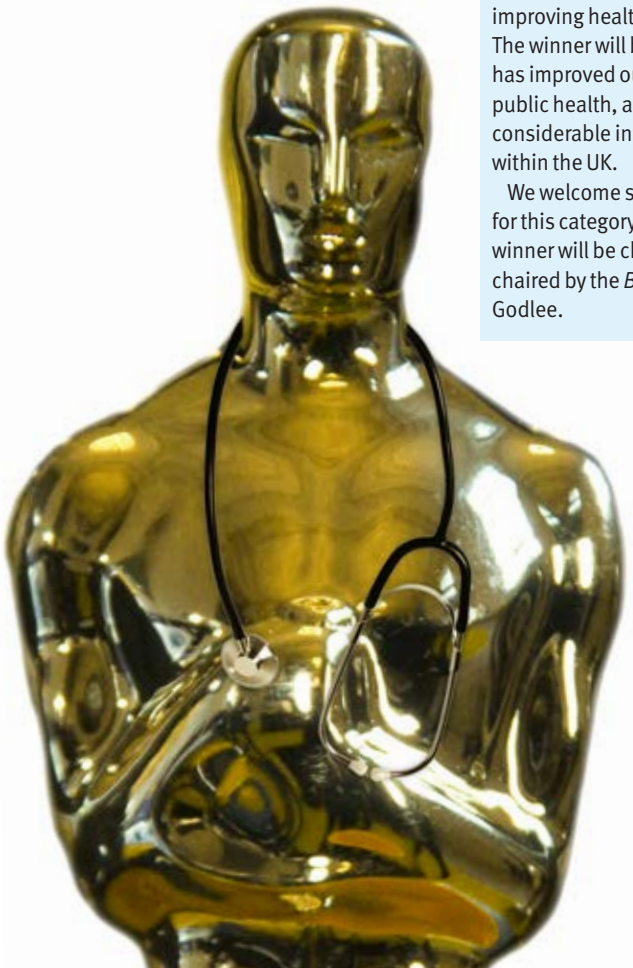
Over the years, the awards have honoured international medical luminaries and doctors who are inspirations in their own backyard



NOMINATE YOUR MEDICAL INSPIRATION

The Lifetime Achievement award, sponsored by GlaxoSmithKline, celebrates a doctor—not necessarily near the end of their career—who has made an outstanding contribution to improving health or healthcare in the UK. The winner will be someone whose work has improved outcomes for patients or public health, and whose career has had considerable influence outside as well as within the UK.

We welcome suggestions for nominations for this category at thebmjawards.com. The winner will be chosen by our panel of judges, chaired by the *BMJ*'s editor in chief Fiona Godlee.

bmj.com
Read more about the awards at http://thebmjawards.com/