Quantitative Assessment of Visitor and Migrant Use of the NHS in England

Exploring the Data

SUMMARY REPORT

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This is the summary of the report of the "Quantitative Assessment of Visitor and Migrant Use of the NHS in England: Exploring the Data" completed by Prederi in July to September 2013. The views expressed are those of the authors and do not necessarily represent those of the Department of Health or Government policy

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1 Summary – approach and key findings

This is the summary of the report of the "Quantitative Assessment of Visitor and Migrant Use of the NHS in England: Exploring the Data", 3 October 2013.

The approach and key findings are presented first. A summary of the analysis and the results follows. The detail is available in the Main Report. Definitions of the terms used in this summary are provided in Annex A.

1.1 Approach

This study is looking at the **cost to the NHS in England of providing services to people who are not 'ordinarily resident'**[1] and therefore may not be entitled to healthcare from the NHS free at the point of delivery. It is also looking at groups who may be charged for services in future.

The groups who are **in-scope** of the analysis are: visitors and short-term migrants who are in England for less than a year; students; some non-permanent residents from the EEA[2] who are not settled in the UK; 'irregular migrants'; and 'health tourists'. Also included in the analysis are people from outside the EEA who are resident for more than a year but who are not settled in the UK – typically people with a visa that gives them the right to be in the UK for certain purposes for a set length of time.

Groups who are **not in scope** are migrants who are settled in the UK and some non-permanent residents who are currently eligible for free healthcare. The migrants or non-permanent residents who are currently eligible for free healthcare and for whom there are no proposals to change that eligibility, are principally EEA nationals residing to work, and also those present under humanitarian immigration provisions (refugees and asylum seekers).

The analysis is a top-down estimate based on data from the Census 2011, the International Passenger Survey 2012 and Immigration and other statistics from the Office of National Statistics, the Department of Health and the Home Office. The costs are 2012-13. These are the best available data in the public domain at the time of the analysis (July and August 2013).

The visitor numbers and population estimates have been adjusted to account for the various durations of stay in England to derive a **daily equivalent population** ie the number of people present in England on an average day. This has then been analysed by age and gender to enable the populations to be associated with the relevant health costs.

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[1] Ordinarily Resident (OR): Eligibility for OR is assessed on a case-by-case basis. An individual is OR if they can prove that they are lawfully and properly settled in the UK for the time being. In reality this is assessed using factors such as whether an individual is employed, is a settled resident and the length of time they have been in the country. The individual must be legally entitled to live in the UK.

[2] European Economic Area ie the European Union plus Iceland, Lichtenstein, Norway and (depending on the detail) Switzerland.

Assumptions have been made to allow for differences in underlying **health needs**, using data from the Census, and for differences in the **ability to access the NHS** during the relevant length of stay.

The estimated costs are based on an apportionment of current **total expenditure of NHS England in 2012/13**, covering primary and secondary care. These costs of the NHS services provided to visitors and migrants include fixed costs and other overheads.

Under current domestic and EEA charging rules, **not all of these costs are chargeable to patients**. GP care, A&E and some public health services are available to all free of charge at the point of delivery. Most visitors from the EEA are covered under the EHIC[3] scheme for most services and there are reciprocal arrangements with some countries (notably Australia and New Zealand) to provide urgent care. **The rules are complex** and Annex B summarises the extent to which different visitor and migrant groups may be eligible for free treatment in NHS hospitals.

We have made some estimates of the costs that appear to be **chargeable to patients**. These estimates do not take account possible policy decisions to apply higher or lower charges to those who should pay. Nor do the estimates look at how different charges could change the overall use of the NHS.

Not all the sums that are chargeable are collected as revenue for the NHS. We have looked at the likely rates of identifying people who should be charged, the number of those identified who are then invoiced, and how much of the invoiced sum is collected.

This study forms one part of the 'audit' announced by the Secretary of State at the launch of the consultation. The audit has two phases. Phase 1 is a qualitative assessment based on discussions with clinicians and managers in NHS Trusts and in primary care[4]. This study, Phase 2, is a complementary, top-down quantitative assessment that has, where possible, drawn on the findings from Phase 1.

The depth and completeness of our **analysis has been constrained by the time limitations as well as limitations on the data**. The Department of Health is considering what further work is required to assess the policy options.

[3] European Health Insurance Card

[4] Creative Research, Qualitative Assessment of Visitor and Migrant Use of the NHS in England, DH, October 2013

1.2 Key Findings

The **summary findings** of the study are set out in the tables below. Although the results are presented as single figures, they are points within likely ranges and are subject to various estimating errors. Numbers in the tables and charts may not add exactly due to rounding.

1.2.1 Regular Visitors and non-permanent residents

Table 1 is about **regular visitors and non-permanent residents from the EEA and non-EEA**. This shows our estimates of the annual gross cost to the NHS of the expected use of services by lawful visitors and temporary migrants in the normal course of events (ie routinely arising health needs while here, for which the migrant needs access to NHS services, with or without charge according to current rules).

The table shows that of a daily equivalent population of just under two million, about three-quarters are from non-EEA countries. Non-EEA temporary migrants, mostly in the country to work or study, account for the larger proportion of the total.

The cost per head is the average for that population group of migrants or visitors. It is weighted to adjust for the demographic profile of that group, for differences in health needs and for differences in the ability to access services. This is explained further at section 3 below. Expats appear to have the highest average cost per head in the daily equivalent population.

Table 1: Summary of Regular Visitor and Migrant Use of the NHS

Visitor/Migrant Group	In-scope Population (Daily Equivalent, 000s)	Gross Cost (£M)	Weighted average Cost Per Head (£)
Total EEA	**443**	**261**	**588**
Non-EEA			
Visitors (<3 Months)	170	76	449
Temporary Migrants (>3 months, <12 months)	55	49	884
Temporary Migrants (>12 months)	634	521	822
Students (any time period)	603	430	713
Total Non-EEA	**1,461**	**1,075**	**736**
Total Expats	**65**	**94**	**1,449**
Total	**1,969**	**1,430**	**726**

Source: Prederi model

To this baseline cost and use we need to add the impact of groups whose levels of use and resulting cost of healthcare are exceptional. These include irregular migrants (who remain here unlawfully and whose health needs and access are very uncertain and may be untypical of migrants more generally) and 'health

tourists' whose explicit intentions result in higher than normal usage and higher costs per case.

1.2.2 Irregular Migrants

The next table shows the estimated gross costs of the use of the NHS by **irregular migrants**, a group that includes Failed Asylum Seekers (FASs), over-stayers and illegal migrants. These numbers are **very uncertain** and based on historical population estimates, constrained by the lack of detailed up to date statistics from the Home Office. This calculation takes account of assumed higher individual health needs and assumed reduced access to services. The FASs in receipt of support, who are exempt from charges for secondary care, are a small proportion of the total.

Table 2: Irregular Migrant Use of the NHS

Migrant Group	In-scope Population (Daily Equivalent, 000s)	Gross Cost (£M)	Weighted average Cost Per Head (£)
Irregular Migrants			
Irregular migrants excluding supported FASs	*564*	*322*	*571*
Failed Asylum Seekers – in receipt of support	*16*	*8*	*531*
Total - Irregular Migrants	***580***	***330***	***570***

Source: Prederi model

1.2.3 Health Tourists

The definition of **health tourists** can vary widely. Based on the findings of the Creative Research study, we have focused on two groups, namely:

- **Deliberate intent**: people who have travelled with a deliberate intention to obtain free healthcare to which they are not entitled, and therefore use the NHS to a greater extent than they would routinely need during their limited stay. This is typically for urgent or emergency hospital treatment sought on arrival, usually but not always as a one-off, and may include maternity care.
- **Taking advantage**: frequent visitors registered with GPs and able to obtain routine treatment including prescriptions and some elective (non-emergency) hospital referral

As with any irregular activity the numbers are very uncertain and are plausible ranges rather than distinct estimates. These numbers should be used with caution. The table below sets out our estimates, which are plausible ranges of the additional costs, generated by these two groups, over and above the normal use of the NHS by visitors and other migrants.

Table 3: Health Tourism

Health Tourism	Plausible additional cost (£M)	
	Central Estimate	Range
Incremental cost of **deliberate health tourism** for urgent treatment	**60-80**	**20-100**
Incremental cost of regular visitors **taking advantage**	§[5]	**50-200**

Source: Prederi model

1.2.4 Summary of gross costs

We now have estimates for three different groups – the regular visitors and temporary migrants, making normal use of the NHS during their stay; the irregular migrants, about whom there is considerable uncertainty; and people who are deliberately misusing the NHS or taking advantage of the relatively easy access – for this group as with all irregular activity the estimates are very uncertain. The groups are summarised in the table below

The table shows that the **daily equivalent population of visitors and temporary migrants is around 2.5 million and the costs are about £1.8 billion for the normal use of the NHS**. We think that this probably in the range £1.5 billion to £1.9 billion. On top of this, there is a plausible range of around £100m to £300m attributable to health tourism.

Table 4: Summary of Visitor and Migrant Use of the NHS

Visitor/Migrant Group	In-scope Population (Daily Equivalent, 000s)	Gross Cost (£M)	Weighted average Cost Per Head (£)
Total EEA	443	261	588
Total Non-EEA	1,461	1,075	736
Total Expats	65	94	1,449
Total Regular Visitors and Migrants	**1,969**	**1,430**	***726***
Total Irregular Migrants	*580*	*330*	*570*
Total "normal" use of NHS	**2,549**	**1,760**	**690**
Deliberate health tourism for urgent treatment	§[6]	60-80	§
Incremental cost of regular visitors taking advantage	§	50-200	§
Total – 'normal' use plus abuse and misuse	§	**1,870-2,040**	§

[5] § - Unable to estimate
[6] § - Unable to estimate

Source: Prederi model

1.2.5 Chargeability under current rules

We need to make a final set of calculations to assess what sums are chargeable to patients. Within the identified groups of visitors and migrants, some are exempt from charges (e.g. people who are 'ordinarily resident' under the rules). Then for those who are chargeable, charges do not apply to all areas of healthcare (e.g. nobody is charged for primary care or treatment in Accident & Emergency).

Chargeability is based on complex rules that NHS staff must apply on a case-by-case basis. When the complexity of the rules on charging is overlain on the uncertainty inherent in the visitor and migrant numbers, the estimates for what is chargeable become very uncertain when broken down in detail. We have therefore only been able to make a provisional assessment at this time.

In the tables below, the daily equivalent population is shown for various migrant and visitor groups. For each group the estimate of the gross cost is given. These estimates of gross costs cover all of the primary and secondary services that the age-weighted population are likely to require, taking account of lengths stay and health need as discussed above. In the final column of the table is an initial estimate of the sums that might be chargeable to individual patients under the current rules. These charges are predominantly for General & Acute and Maternity care in NHS hospitals for patients who are not otherwise exempt. The estimate of the potentially chargeable values is subject to further uncertainty since the model does not capture the full complexity of the eligibility rules.

Table 5: Summary of potential charges to individuals from EEA countries (current rules)

Visitor/Migrant Group	In-scope Population (Daily Equivalent, 000s)	Gross Cost (£M)	Costs potentially chargeable to individuals (£M)
EEA			
EEA visitors and non-permanent residents	**443**	**261**	**29**
British Expats living in the EEA (here <3 months)	*32*	*44*	*5*
Total Visitors and non-residents from EEA countries	*475*	*305*	*34*

Source: Prederi model

Table 5 shows that most costs for the EEA are not chargeable to individual patients. In the case of EEA nationals, most of the cost is a recoverable charge due from an individual's home country (Member State) where that state retains competency for the healthcare costs incurred by their citizens. This applies in particular to short term visitors and students using EHIC cards, and state pensioners (under the S1 scheme).

On the face of it, the sum that appears to be potentially recoverable from other member states under the EHIC scheme is considerably more than the amount

currently recovered by DH. More analysis is required to unpick the rules of exactly what is recoverable as the detailed arrangements vary from state to state.

The following table sets out the equivalent information for people who are visiting or temporarily resident from non-EEA countries.

Table 6: Summary of potential charges to individuals from non-EEA countries (current rules)

Visitor/Migrant Group	In-scope Population (Daily Equivalent, 000s)	Gross Cost (£M)	Costs potentially chargeable to individuals (£M)	
Visitors (<3 Months)	*170*	*76*	*21*	
Temporary Migrants (>3 months, <12 months)	*55*	*49*	*22*	
Non-EEA - Temporary Migrants (>12 months)	*634*	*521*	*75*	Under consultation[7]
Non-EEA Students (any time period)	*603*	*430*	*19*	
Non-EEA nationals	***1462***	***1076***	***137***	
British Expats from Non-EEA countries	*34*	*50*	*19*	
Total from Non-EEA countries	**1,496**	**1,126**	**156**	

Source: Prederi model

Table 6 shows the **potentially chargeable sums under the current rules**. We explore later how far this is actually collected as revenue for the NHS. The table also highlights the main groups whose eligibility for free health care is the subject of consultation.

We have not shown in Table 6 the potential income from irregular migrants. There are two reasons. First, the estimates for gross costs (£330m) for the use of the NHS by irregular migrants are very uncertain. Second, we would expect many irregular migrants to have no means to pay for chargeable care. To show a large chargeable figure here would give a misleading impression of what revenue is potentially realisable.

The estimates of the chargeable income also exclude the potential charges that might be made for health tourism, which is an additional cost to the regular use of the NHS. It may be reasonable to assume that charges might be made for 'deliberate intent' types of health tourism, since these appear from the Phase 1 evidence to occur mainly in secondary care settings in hospital. However, it

[7] These are groups where the proposals would change the exemption from 'ordinarily resident' to 'permanently settled' in the UK, which would bring them into the scope of charging.

seems likely that much of the 'taking advantage' type of tourism is in primary care settings. In the absence of better evidence we have not made an estimate of chargeability.

1.2.6 Collecting the charges

Having derived some estimates of the sums that could potentially be chargeable to individuals, we have then looked at how these relate to the amounts that are actually billed to individuals by Trusts. A previous DH study has shown that only about £23m is collected of the £57m that is invoiced, a realisation rate of 40%. The £57m represents income from non-EEA patients, so this represents about 37% of the chargeable sums from non-EEA patients as calculated in Table 6. Based on evidence from Phase 1, this suggests to us that about 43% of the chargeable patients are identified as being chargeable and perhaps 85% of the identified cases are subsequently invoiced. Overall, **the indications are that Trusts collect about 15% of the sums that are potentially chargeable to non-EEA patients** (excluding irregular migrants). These figures are uncertain and should only be taken as indicative of the scale of under-collection rather than a sound estimate.

1.2.7 Note of caution

All of the estimates presented are subject to varying degrees of **uncertainty**, relating to the numbers of people and their behaviour. The estimates for the irregular migrants are very uncertain and based on out of date population estimates. The estimates for health tourism, as for any unlawful activity, are impossible to estimate with confidence and are a structured judgement. The estimates for chargeability are also uncertain because of the complexity of the rules. **The estimates are presented as the best that can be made at present, recognising that they are based on incomplete data, sometimes of varying quality, and a large number of assumptions. The analysis is intended to inform policy development around visitor and migrant access to NHS, alongside the DH consultation and work with the NHS.**

2 Background

The Department of Health (DH) is examining access to the NHS by migrants and visitors to England. A public consultation[8] was launched on 3 July 2013 about how the recognised weaknesses and issues might best be addressed in the NHS in England. When launching the consultation the Secretary of State announced an 'audit' of the costs of the use of the NHS by migrants and visitors.

The audit has two phases. Phase 1 is a qualitative assessment based on discussions with clinicians and managers in NHS Trusts and in primary care[9]. This study, Phase 2, is a complementary, top-down quantitative assessment that has, where possible, drawn on the findings from Phase 1. We have been asked specifically to provide:

- "An estimated cost of the current use of the NHS in England by visitors (including health tourists) and non-permanent residents (temporary residents including workers students and others), split by EEA and non-EEA residents
- An estimate of the future costs to the NHS if the current overseas visitors charging system continues.
- How these estimates will change in the future alongside changing composition of migrant users in the identified sub-groups and impact of external factors"
- For each group for which there is an estimated cost this should show the use of Primary, Secondary and A&E services

This work sits at the intersection of two of the most contentious areas of public debate: the NHS and immigration. It is important to stress what this report is NOT looking at:

- The economic or social case for migration
- How far taxes from visitors or migrants cover the costs of health care
- The cost of implementing any changes to the current charging rules in the NHS
- The financial and non-financial consequences of introducing new rules for charging particular groups of visitors or migrants
- The moral case for charging particular groups in the population.

[8] Sustaining services, ensuring fairness: A consultation on non-permanent resident access and their financial contribution to NHS provision in England, Department of Health, 3 July 2013

[9] Creative Research, Qualitative Assessment of Visitor and Migrant Use of the NHS in England, DH, October 2013

3 Analysis

We have approached the task by estimating the equivalent daily population of each group of visitor and migrant; that means allowing for example for visitors to England who are here just a week on average. Overall, we estimate the daily equivalent population to be about 2.5m.

We have then established the age profile and gender balance of each group, because we need to allow for the fact that people over 65 on average cost the health service almost nine times as much as people aged 15-44. Most migrants and visitors are in this younger age group.

Having calculated the cost by each health service (such as General & Acute, Maternity, A&E, GPs and so on), we need to make adjustments for different health needs and ability to access the services. On average migrants and visitors are healthier; and regular visitors and short-term migrants do not stay here long enough to arrange much more than urgent care through GPs and A&E.

Before turning to the results, we want to stress that the analysis uses the best available information as far as we were able to identify it at the time of the study and in the time available. In many cases, though, that **information is not available in the detail or definition that is needed**. As the Public Administration Select Committee concluded: "[the migration statistics] are not accurate enough to measure the effect of migration on population, particularly in local areas, and they are not detailed enough to measure the social and economic impacts of migration"[10].

We have also had to make use of a large number of assumptions, some of which are of necessity judgements. All the numbers are subject to various levels of uncertainty, which we have explained fully in the report. The results are presented as single points for the sake of clarity, but all are estimated ranges with varying degrees of uncertainty.

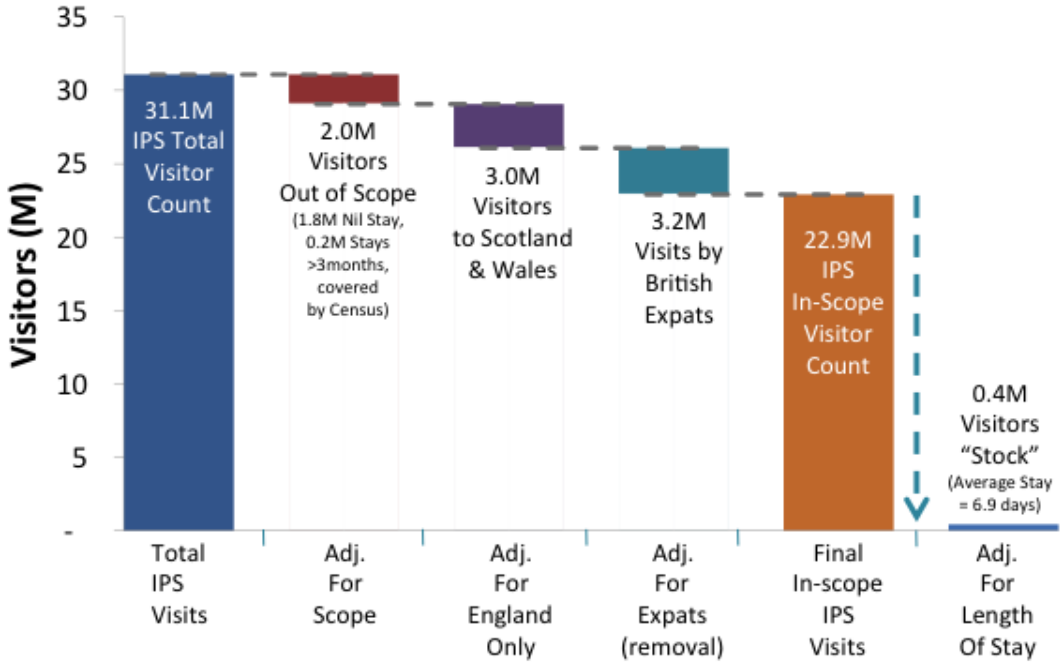
We have been asked to estimate separately the cost to the NHS of health tourism: people who visit with the deliberate intent to access services to which they are not entitled and people how take advantage of the system while they are here. As with any irregular activity, this cannot be estimated with confidence.

[10] Public Administration Select Committee (PASC), Migration Statistics, Seventh Report of Session 2013–14, HC 523, 28 July 2013

3.1 Visitors

We start by looking at visitors, excluding British expats (who are dealt with separately to adjust for people returning permanently), as identified in the International Passenger Survey (IPS)[11]. The first point to note is that while there are large numbers of visitors to Britain, around 30m a year, some are not in scope for this exercise – this is an England only review. More significantly, though, most visitors are here for just under a week on average. The equivalent average daily population[12] is therefore much lower – about 0.4m. This is shown in the diagram below.

Figure 1: Daily Equivalent Population of Visitors



Source: Prederi model

[11] International Passenger Survey – a sample survey of passengers arriving at, and departing from, United Kingdom air and sea ports and the Channel Tunnel.

[12] As the ONS explain: "Short-term migration estimates can be used to estimate the impact on the population stock. For example, if four non-permanent residents each stayed in England and Wales for three months, this would be the equivalent of one person for one year, and so the stock count would be 1. Likewise two non-permanent residents staying for six months would give the equivalent of one person staying for one year. In the second example the number of arrivals is half that of the first example, but results in the same stock estimate. Stocks are calculated from the number of stays and the length of stay, so an increase in either can lead to an increase in stocks. Stocks give an average number of non-permanent residents in the country on an average day."

3.2 Short-term migrants (non-EEA) and non-permanent residents (EEA)

We have used the International Passenger Survey to estimate the numbers of short-term migrants, people who are in the country for 3-12 months. This group includes people from the EEA and the non-EEA. The non-EEA migrants will sometimes require visas, but some will be nationals of visa waiver countries. The daily equivalent population is 0.2m, with most people in the 3-6 months category.

We have estimated the numbers of EEA students and pensioners in England as being a daily equivalent population of 0.2m. We have assumed, in discussion with DH, that EEA students are only present in the UK for 9 months of the year, and factored their daily equivalent population to reflect this.

3.3 Non-EEA migrants in England for more than a year

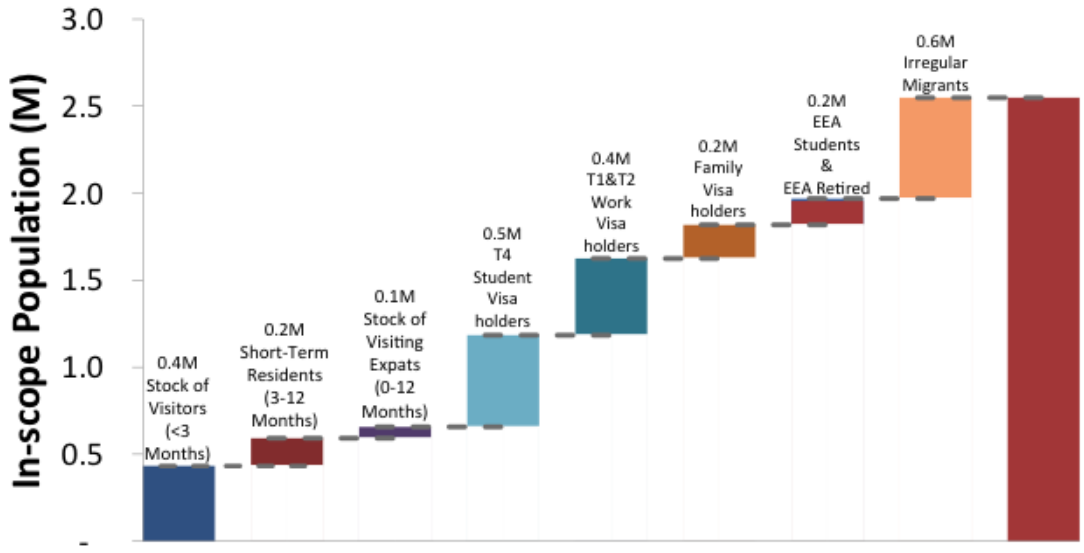
We need to add to the short-term visitors the people who are resident in England for more than 12 months but who are not permanent residents. This group are mainly visa holders, in England to work or study. We estimate that there are the equivalent of about 0.5m students from non-EEA countries; about 0.4m people who are here for work under Tier 1 or Tier 2 visas; and a further 0.2m people here on family visas. We have based these estimates on numbers of visas issued by the Home Office and the Home Office estimates of average visa duration. They have been reconciled with the Census data that we have used elsewhere; this enables us to associate these visitors with other characteristics linked to country of birth.

3.4 Other groups

To the groups of EEA and non-EEA non-permanent residents we need to add visiting expats, ie British citizens who are usually resident overseas. Expats visiting for up to 12 months are estimated to have a daily equivalent population of 0.2m. They have been identified from the IPS.

Finally, we need to add the 'irregular migrants'. This group consists of Failed Asylum Seekers, overstayers, and illegal migrants. This is a very uncertain estimate, compromised by the lack of data from the Home Office. Based on the latest generally accepted figures we have estimated there are 580,000 irregular migrants in England. This brings the number of people in scope to around 2.5m as shown in the diagram below.

Figure 2: Summary of visitors, migrants and non-permanent residents – daily equivalent population



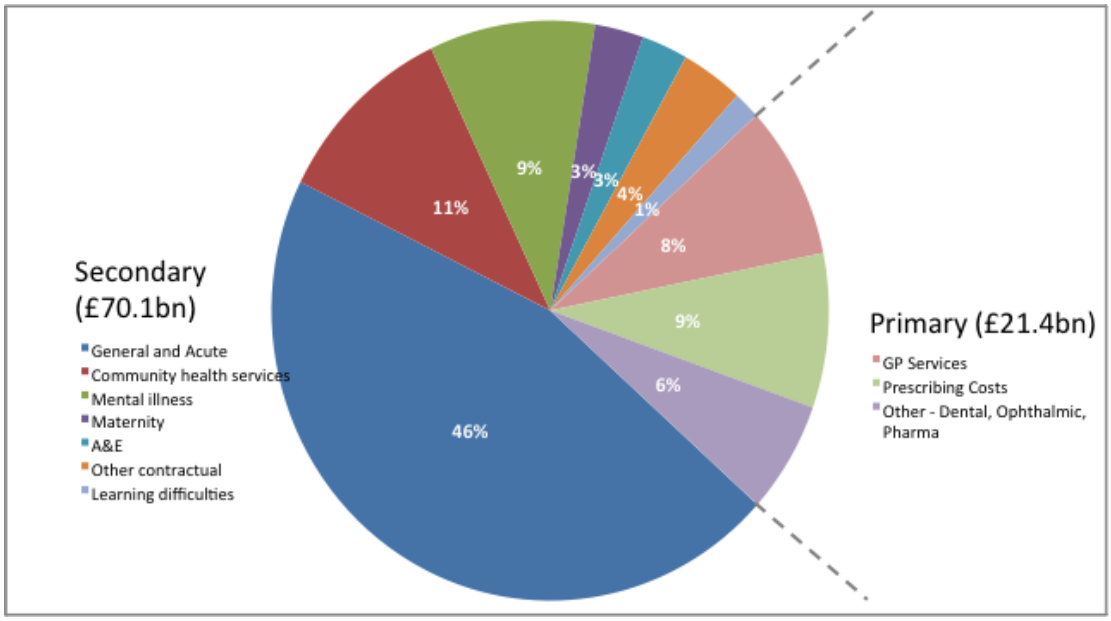
Source: Prederi model

EEA non-permanent residents should include people here to work, study and here reliant on their own means. While the numbers of students can be discerned from the statistics, it is difficult to identify other EEA non-permanent residents. There is some information in the Census about when EEA nationals arrived in the UK, but this doesn't necessarily equate to whether someone is in England temporarily or not. In the absence of reliable data, we have not made an estimate for this group. The effect is to treat the EEA non-permanent residents (other than students) as being Ordinarily Resident, which indeed many may be. The consequence is that there is an underestimate of EEA figures but the scale of this underestimate does not distort the overall conclusions.

3.5 NHS costs

The NHS costs in scope of the analysis are the operating costs of the health services that are provided by NHS England. In 2012-13 the cost of these health services amounted to £91.5Bn (excluding capital and revenue grants (£203m) which are not allocated to services) and the composition of the expenditure was as shown in the chart below:

Figure 3: Service analysis of NHS England expenditure



Source: DH Annual Report and Accounts 2012-13

By using these operating costs,, we believe we have incorporated the relevant overheads associated with healthcare. The overall figures we use for health services contain a share for the management of hospitals and other providers. They also include the costs of commissioning.

We have used Department of Health information to calculate the average cost per head for each of all health services for the age groups for which we have data in the Census and IPS. We have also calculated the average cost for men and women for each age group. **The overall average cost per head for health services for residents in England is £1,726.**

3.6 Adjusting for migrant birth rate

The Maternity costs have been adjusted for different levels of fecundity in different migrant groups. We have based this on the ONS report, which shows that the Total Fertility Rate for non-UK born women was 2.29 in 2011; for UK-born women it was 1.90. We have assumed that the non-UK born women in scope are similar to the non-UK born women who are settled in England. This is a subtle effect at an overall level, adding £10 per head, resulting in the overall average cost per head for health services for visitors/migrants in England of £1,736.

3.7 Adjusting for age and gender

Our estimates calculate the cost of using the NHS by multiplying the daily equivalent population by the average health cost per head. We begin with the average health cost per head for the NHS in England, which means that we have a 2.5m daily equivalent population multiplied by £1,736, which is just over £4.4bn.

We know, however, from the Census and the International Passenger Survey that visitors and migrants have a younger age profile than the resident population in

England. In the UK-born population, about 41% are aged between 15 and 44, but about 76% of non-UK born population is in this age range. The contrast is clear in the histograms[13] below.

Figure 4: Age Profile for residents of England

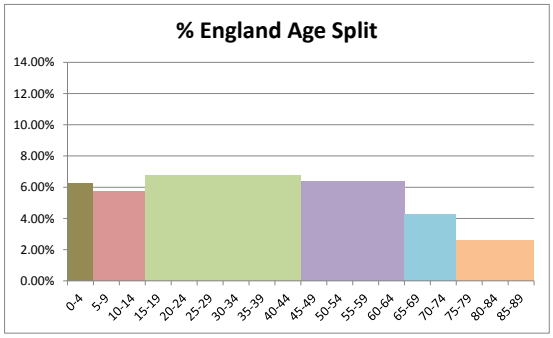
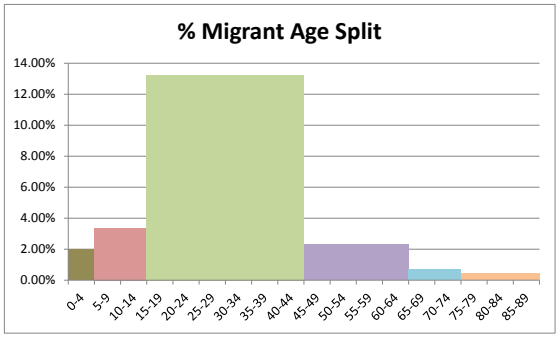


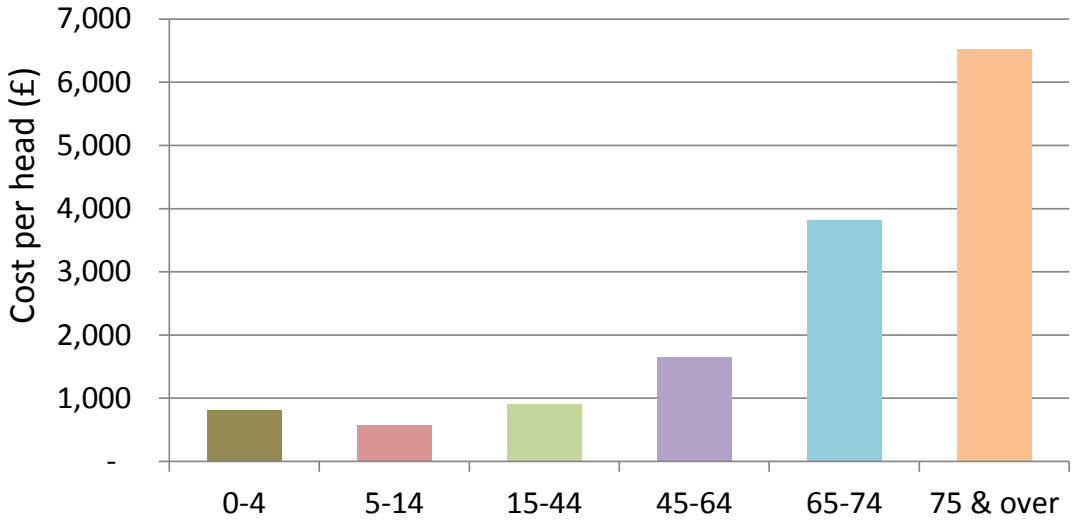
Figure 5: Age Profile for Visitors and Migrants



Source: Derived form ONS and IPS

We also know from DH information that average health costs per head for the population in England change markedly over an individual's lifetime as Figure 6 below shows. These figures cover all the health services (Primary and Secondary) in the NHS in England. As the chart shows, the average health care cost per head for people over 75 is almost nine times as much as the 15-44 age range – the age range to which most migrants belong.

Figure 6: Average cost per head of health services in England by age group



Source: Department of Health

[13] The diagrams are histograms. Each histogram shows frequencies, shown as adjacent rectangles for each group e.g. 0-5. The height of the rectangle for each age group shows the percentage of the population in that age group. The area of the rectangles for the age ranges e.g. 15-44 is equal to the proportion of that age range in the total population. The total area of the histogram is equal to the population in that category (ie UK born or non-UK born).

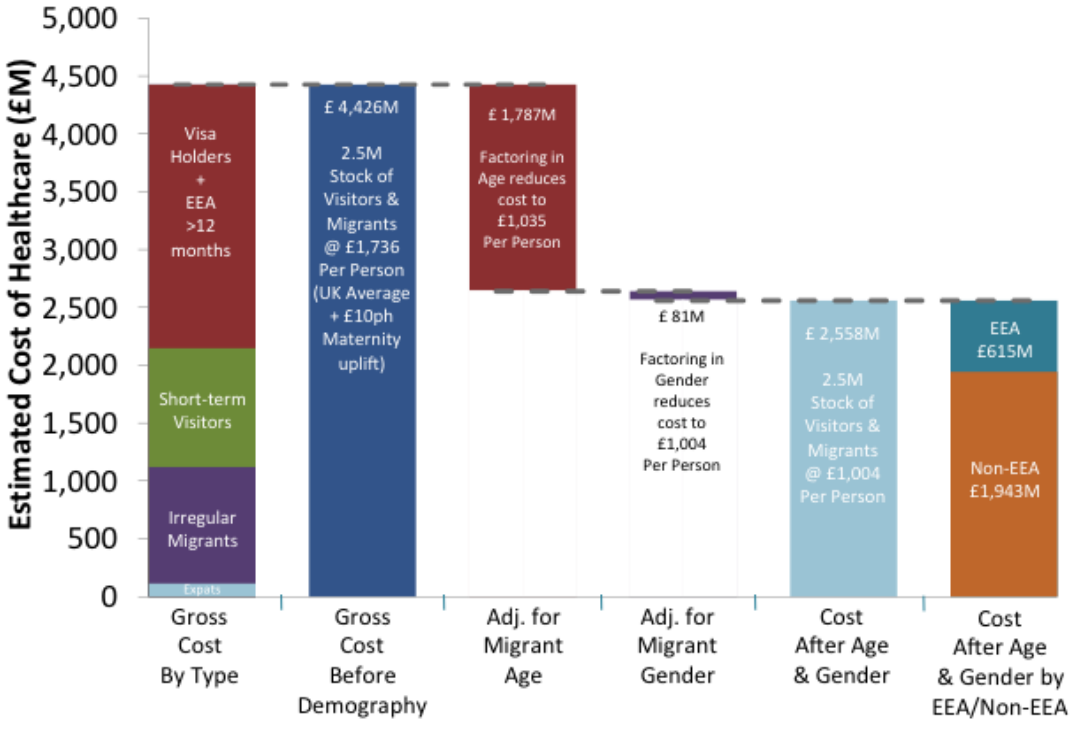
The high average cost-per-head for older people means that most health costs in the resident population are associated with the older age groups, especially the over 65s. In contrast, in the migrant population there are few people in these older age groups, so most of the cost for visitors and migrants is associated with much lower cost-per-head age groups.

3.8 Adjusted cost per head

We started with the unadjusted cost of the use of the NHS by non-permanent residents, calculated as a 2.5m daily equivalent population multiplied by £1,736, which is just over £4.4bn. Allowing for the age of migrants reduces the cost-per-head to around £1,035, thereby reducing the total by around £1.8bn. We go on to adjust for gender, since there are proportionately more men in the visitor and migrant populations. Women in this age group have higher cost per head, which is largely associated with maternity. Adjusting for gender reduces the overall cost by a further £80m to an average of £1,004 per head. This reduces the overall total from £4.4Bn cost to around £2.5Bn per year. This is shown in Figure 7 below.

Most of the people in the non-permanent resident population are from outside the EEA, so the majority of the costs relate to non-EEA migrants and visitors, some £1.9Bn compared to £0.6Bn.

Figure 7: Adjusting for age and gender for average visitor and migrant health costs



Source: Prederi model

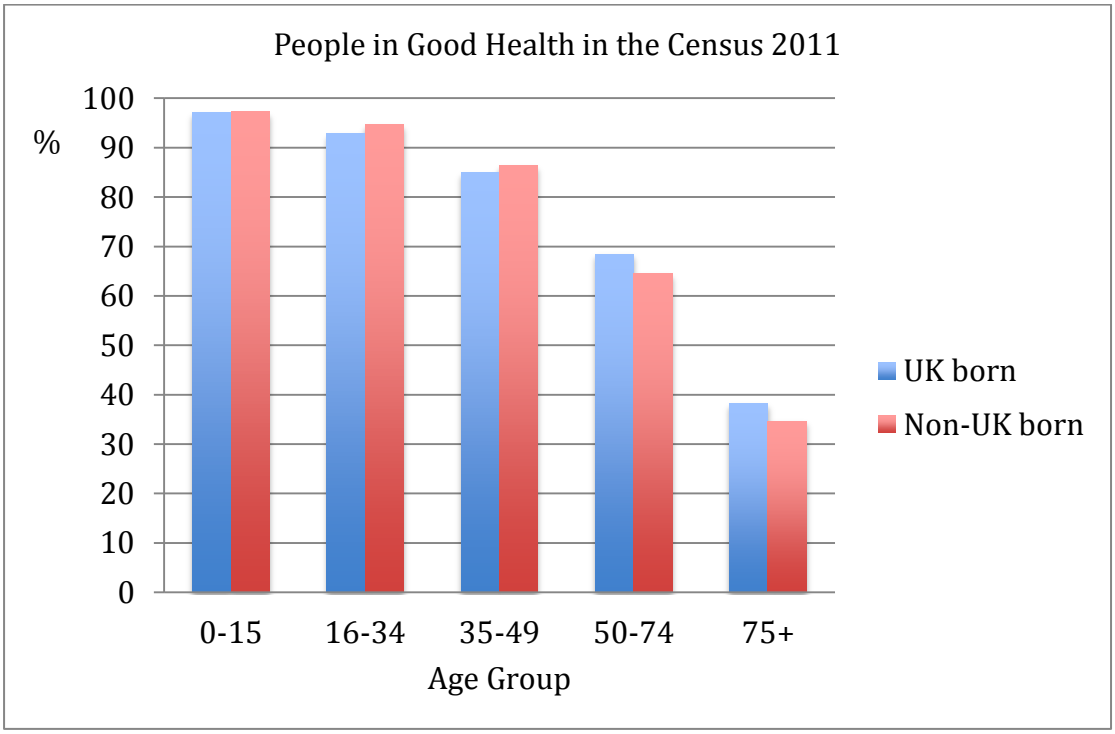
3.9 Adjusting for propensity to use the NHS

We have reviewed the medical literature to try to find evidence of how visitors and migrants use healthcare compared to the host population. The findings[14] suggest overall that recent migrants are less likely to use UK primary and secondary care services than UK-born residents. However, the literature is mostly qualitative and the findings do not provide the basis for a numerical estimation of the differences in the use of services relative to the host population. At this time, as a starting point, we have therefore assumed in the model that migrant propensity to use NHS services is equivalent to the non-migrant population of the same age and sex.

3.10 Differences in reported health

We do know, however, from the medical literature that typically migrant populations healthier than host populations: the so-called "healthy migrant" effect. We can also see from the Census that on average non-UK born population reports better health than the average for the resident population especially in the age groups of most interest, though there are variations between nationalities and different migrant groups. This is illustrated in the graph below.

Figure 8: Comparison of self-reported health between UK born and non-UK born people



Source: ONS

We have looked at the statistical links between health costs for specific age groups and the reported health of different countries of birth. Allowing for the better health of migrants and visitors appears to reduce the cost per head from £1,004 to £866, which reduces the overall cost by about £350m. This statistical link may include some socio-economic or geographic factors as well as

[14] See Annex B of the Main Report – this is a review of the medical literature.

nationality, but the general sense is consistent with what we have found in the literature review.

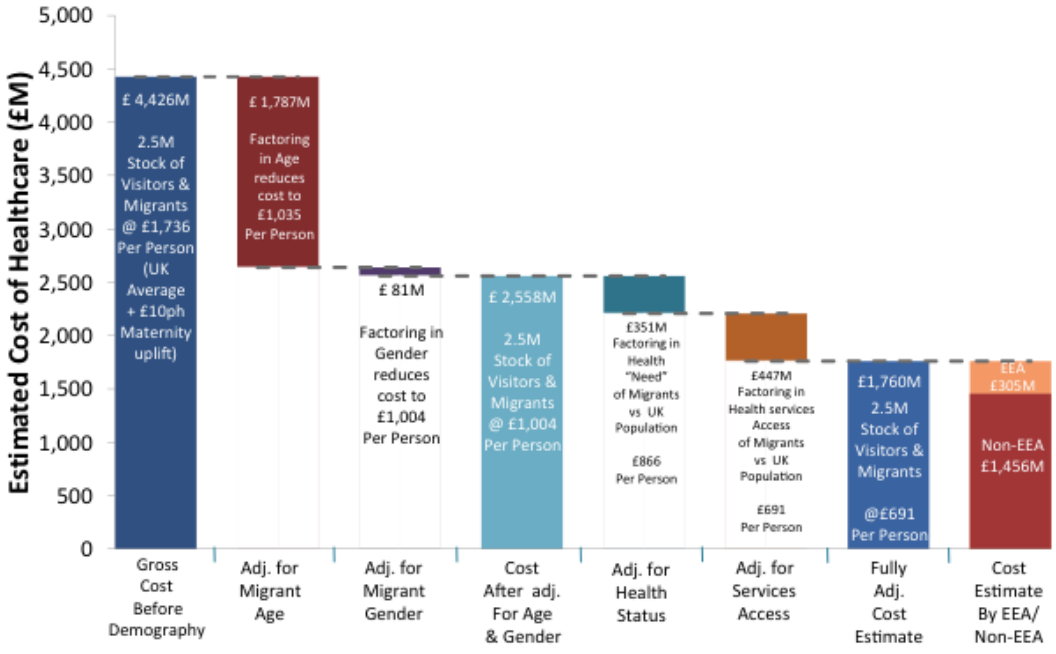
3.11 Access to the NHS and duration of visit

Besides the difference in health, we can also reason that most visitors will have reduced access to the NHS because their visits are short. While there would be time, even for a regular short-term visitor to consult a GP or access A&E if they needed to, it would simply take too long to use most other medical services. However as the length of stay increases, so does the ability to access services. We have therefore reasoned that, on average, access for visitors and short-term migrants is less than the average for the resident population. This reduces the per capita cost from £866 to about £691, which reduces the estimated overall costs by a further £540m to £1.76Bn. British expats are assumed to have the same access as the resident population.

The values used for this adjustment are not derived empirically, but are a judgement based on the literature and a general understanding of how long it takes to progress from GP to any other services.

The effect of these adjustments for health 'need' and for access to the NHS is summarised in the chart below.

Figure 9: Visitor and Migrant health costs adjusted for age, gender, health and access



Source: Prederi model

We now have a cost for the use of the NHS by visitors and temporary migrants of about £1.8bn, of which almost £1.5bn is attributable to people from non-EEA countries and about £305m to people from the EEA (recognising that this under-represents some non-permanent residents from the EEA.)

3.12 Health Tourism

So far we have looked at people who are using the NHS in the course of a normal visit or stay in England. But there are also people who make unfair use of the NHS: health tourists. Based on the Phase 1 report we have focused on two categories, namely:

- Deliberate intent: people who have travelled with a deliberate intention to obtain free healthcare to which they are not entitled, and therefore use the NHS to a greater extent than they would routinely need during their limited stay. This is typically for urgent or emergency hospital treatment sought on arrival, usually but not always as a one-off, and may include maternity care.
- Taking advantage: frequent visitors registered with GPs and able to obtain routine treatment including prescriptions and some elective (non-emergency) hospital referral

In this context, it is important to draw a distinction between the entirely legitimate commercial health tourism - sometimes known as medical tourism – and the health tourism that is the concern in this report. The term 'health tourism' has been used to cover a number of categories of abuse or misuse of the NHS. These are set out in the table below along with a summary assessment of the scale.

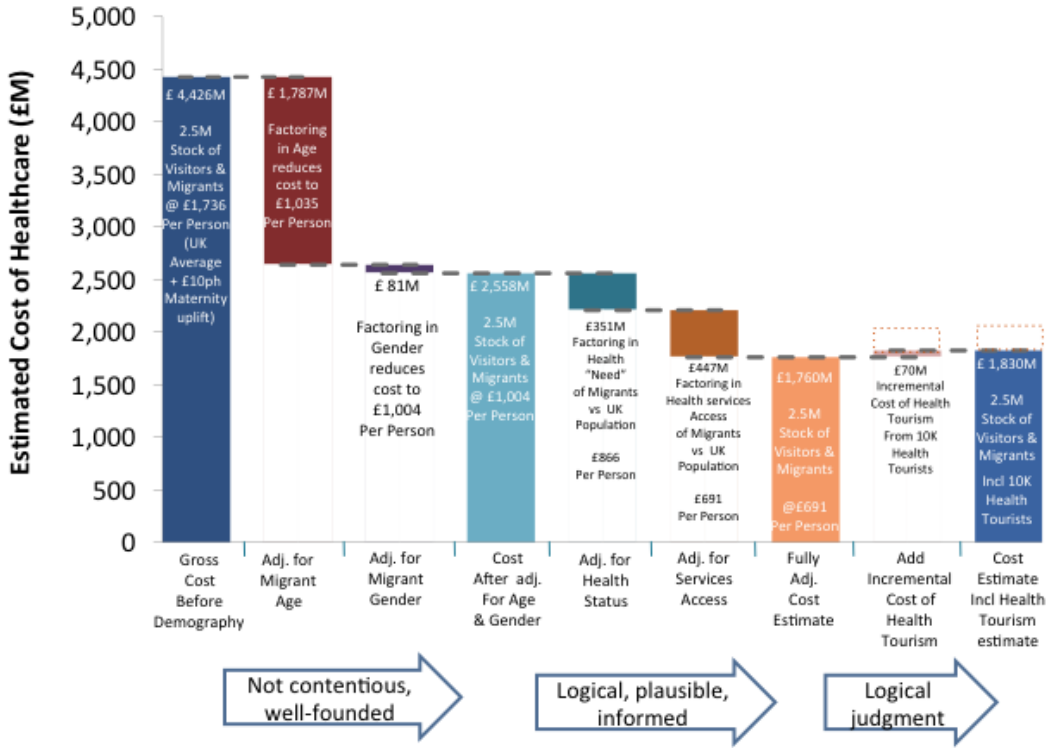
Table 7: Categories of abuse and misuse of the NHS

Category of abuse or misuse	Findings from this study
Deliberate Intent: Visitors who conceal the fact that they have come to the UK specifically to use NHS services that they are not entitled to access for free. They intend to avoid detection or, if charged, payment.	Very uncertain, but estimated at about £70m with a range of £20m to £100m. These are people who 'fly in and fly out' for treatment.
Taking Advantage Expatriate British citizens seeking NHS treatment may also return to the UK specifically to use the NHS, because either it is familiar or the care in the country in which they now reside has expensive or poorer health services. Foreign nationals who are regular visitors or who have family or friends based in England may have a NHS numbers and may be able to maintain GP registration, making it relatively easy to access NHS services. These groups may not visit explicitly to use NHS services, but can readily take advantage when in England. They may not even see this as an abuse of the system.	These extra costs are partly reflected in higher propensity to access services assumed for expats in the 'normal' model. Expat health tourism implicitly included here through the risk model. We note that there are around 350,000 expat visits a year where people could be motivated to make the most of access to the NHS which could create an additional burden of £millions even if this simply consisted of extra visits to GPs or setting up repeat prescriptions. As to other visitors, given the scale of the gross costs, over £1Bn, then even small percentages of people taking advantage of current lawful access would result in tens of £millions. We have suggested a plausible range of between £50m to £200m additional costs not already included in the 'normal' usage in the model.
Visitors who, when receiving unexpected treatment whilst in the UK, seek to **evade identification or payment**.	Included in the under-recovery form chargeable patients. This is part of the 'normal' model in terms of usage and incidence.
Those who are residing here unlawfully and who receive emergency treatment but have **no resources** to pay for this.	The gross cost of services provided to Irregular Migrants is very uncertain but is estimated to be over £300m; see the chapter in the Main Report on Irregular Migrants
Others, who may be perceived as health tourists, are only taking advantage of current (lawful) exemption categories under the Charging Regulations to access extensive and/or expensive treatment for pre-existing needs.	This group is not readily discernible and we have not ventured an estimate.

As with most unlawful or irregular activities, we do not have a good estimate for health tourism as it is impossible to capture through routine data collection, but a plausible value for the people deliberately coming to England to use the NHS without paying is around 5,000 to 20,000 cases at an average cost per case of around £7,000. Allowing for costs already in the estimates for compliant use of the services, this may translate to an overall cost of about £20m to say £100m. These estimates for the costs of health tourists are very rough and far from certain.

Adding £70m for 'deliberate intent' health tourism would bring the total cost to around £1.8bn. Adding the costs of 'taking advantage' health tourism brings the likely total to between £1.9bn and £2.1bn. The estimated range for the 'taking advantage' category is indicated by the areas inside the dotted lines.

Figure 10: Adjusted Visitor and Migrant health costs plus 'deliberate intent' health tourism costs



Source: Prederi model

We believe that the adjustments for age and gender are based on sound information from the Census, IPS, Immigration Statistics and Department of Health data. The logic for the adjustments is well founded. Together, these adjustments account for the £1.9Bn of the £2.7bn adjustment.

The adjustment for health need is statistically based and is logical, but is open to debate. The adjustment for access is logical but is not empirically based.

The calculation for the health tourism costs is a logical assessment of risk but is based on judgements.

4 Summary of Findings

Table 8 below sets out our estimate of the costs of overseas visitors and migrants as defined for the main service categories of NHS England.

Maternity costs stand out. This is because maternity costs have been adjusted for different levels of fecundity in different migrant groups. We have based this on the ONS report, which shows that the Total Fertility Rate for non-UK born women was 2.29 in 2011; for UK-born women it was 1.90. We have assumed that the non-UK born women in scope are similar to the non-UK born women who are settled in England.

Table 8: Summary of costs of use by type of service

Service	Gross Cost (£M)	Modelled Overseas Visitor Cost (£M)	Overseas Visitor Cost as % of total gross cost England	Comments
General and Acute	41,778	546	1.31%	Assumed that age and access limit use
Community health services	9,749	117	1.20%	Assumed that age and access limit use
Mental illness	8,796	291	3.31%	Overseas Visitors are mostly aged 15-44
Maternity	2,583	177	6.84%	Overseas Visitors are mostly aged 15-44 and tend to have a higher birth rate
A&E	2,462	59	2.38%	Access similar to resident population
Other contractual	3,311	65	1.95%	-
Learning difficulties	1,406	27	1.95%	-
GP Services	7,841	202	2.58%	Access similar to resident population
Prescribing Costs	7,895	166	2.03%	-
Other - Dental, Ophthalmic, Pharma	5,694	116	2.04%	-
Total	91,515	1,760	1.92%	

Source: Prederi model

The access limitations assumed in the model bring down the costs in General and Acute and in Community Services. In contrast, GP services and A&E are higher than the average costs because access is not constrained and is assumed to be more like the main resident population. In the case of Mental Health and Maternity services, the model is reflecting the way that most migrants are in the 15-44 age group, which has a higher proportionate use of these services.

4.1 EEA non-permanent residents and visitors

The next table sets out our estimates of the costs of the use of the NHS services from the EEA, including expats, who are visitors or non-permanent residents to England. Although the results are presented as single figures, they are points within likely ranges and subject to various estimating errors. The breakdown of the modelled figures should only be taken as indicative and there is a considerable margin of uncertainty.

Table 9: Summary of costs of use by type of service - EEA

Service	Gross Cost (£M)	Modelled EEA Visitor Cost (£M)	EEA Visitor Cost as % service total	Comments
General and Acute	41,778	103	0.25%	Assumed that age and access limit use
Community health services	9,749	20	0.20%	Assumed that age and access limit use
Mental illness	8,796	34	0.39%	-
Maternity	2,583	21	0.80%	Overseas Visitors are mostly aged 15-44 and tend to have a higher birth rate
A&E	2,462	13	0.54%	Access similar to resident population
Other contractual	3,311	10	0.29%	-
Learning difficulties	1,406	4	0.29%	-
GP Services	7,841	44	0.56%	Access similar to resident population
Prescribing Costs	7,895	39	0.50%	Access similar to resident population
Other - Dental, Ophthalmic, Pharma	5,694	17	0.30%	-
Total	91,515	305	0.33%	

Source: Prederi model

As noted above, this does not include non-permanent residents from the EEA where we have not found a satisfactory way of identifying them in the time available. However, the overwhelming majority of this group are entitled to free

access to the NHS on the same ordinary residence basis as any other permanent resident.

4.2 Non-EEA Visitors and Migrants

The following table sets out our estimates of the costs of the use of the NHS services from the number of visitors and migrants from non-EEA countries, including expats and but excluding 'irregular' migrants. Although the results are presented as single figures, they are points within likely ranges and subject to various estimating errors.

Table 10: Summary of costs of use by type of service – non-EEA

Service	Gross Cost (£M)	Modelled Non-EEA Visitor Cost (£M)	Non-EEA Visitor Cost as % service total	Comments
General and Acute	41,778	443	1.06%	Assumed that age and access limit use
Community health services	9,749	98	1.00%	Assumed that age and access limit use
Mental illness	8,796	257	2.92%	Overseas Visitors are mostly aged 15-44
Maternity	2,583	156	6.04%	Overseas Visitors are mostly aged 15-44 and tend to have a higher birth rate
A&E	2,462	45	1.84%	Access similar to resident population
Other contractual	3,311	55	1.66%	-
Learning difficulties	1,406	23	1.66%	-
GP Services	7,841	158	2.02%	Access similar to resident population
Prescribing Costs	7,895	121	1.53%	-
Other - Dental, Ophthalmic, Pharma	5,694	99	1.74%	-
Total	91,515	1,456	1.59%	

Source: Prederi model

The breakdown of the modelled figures should only be taken as indicative and there is a considerable margin of uncertainty

4.3 Recovering costs

Under current domestic and EEA charging rules, not all of these costs are chargeable to patients. GP care, A&E and some public health services are available to all free of charge at the point of delivery. Most visitors from the EEA are covered under the EHIC[15] scheme for most services and there are reciprocal arrangements with some countries (notably Australia and New Zealand) to provide urgent care. When we look at the services where charges should be made, it appears that around £190m of the £1.8bn should be charged to patients and a further £220m recovered under the EHIC scheme.

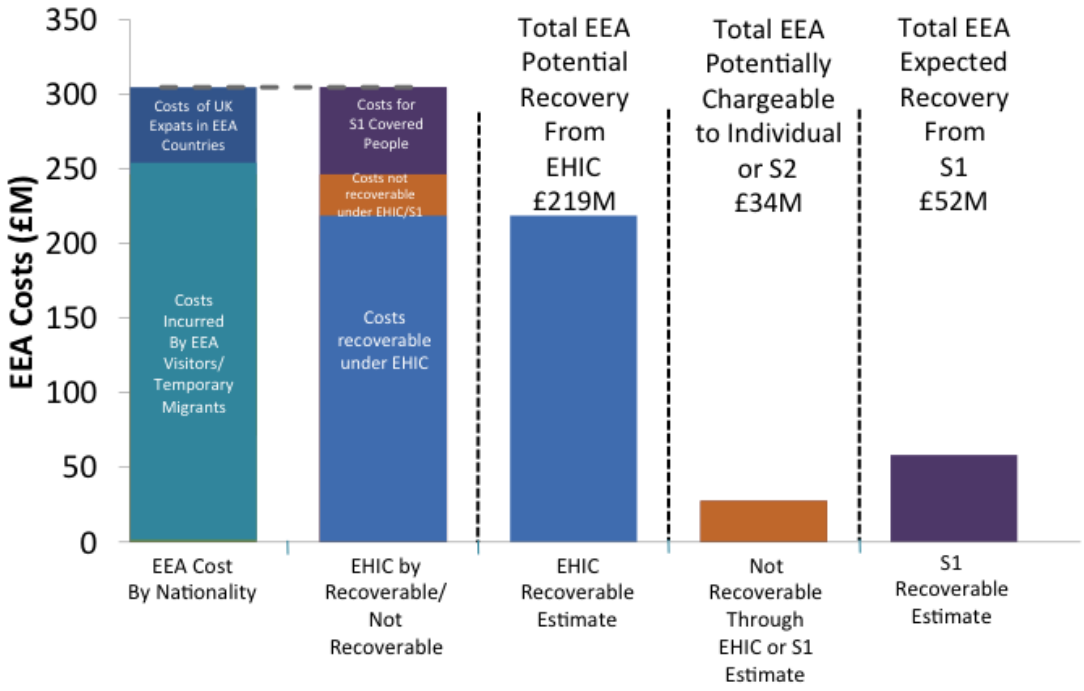
When the complexity of the charging is combined with the uncertainty inherent in the visitor and migrant numbers, the estimates for what is chargeable become very uncertain when broken down in detail. As with the other results, although the results are presented as single figures, they are points within likely ranges and subject to various estimating errors.

4.3.1 EEA

In the case of EEA visitors and non-permanent residents, the gross cost to the NHS is estimated to be about £305m. This figure includes £44m for British expats living in EEA countries. Applying the charging rules suggests that up to £220m is recoverable under the EHIC scheme. Some £52m is recoverable from other member states under the S1 scheme that provides healthcare for state pensioners. Further sums are recoverable under S2 where people travel to the UK to receive pre-arranged medical treatment. Some of the expected charges to individuals relate to chargeable treatment for expats. The summary is shown in Figure 11 below.

[15] European Health Insurance Card

Figure 11: Cost recovery – EEA



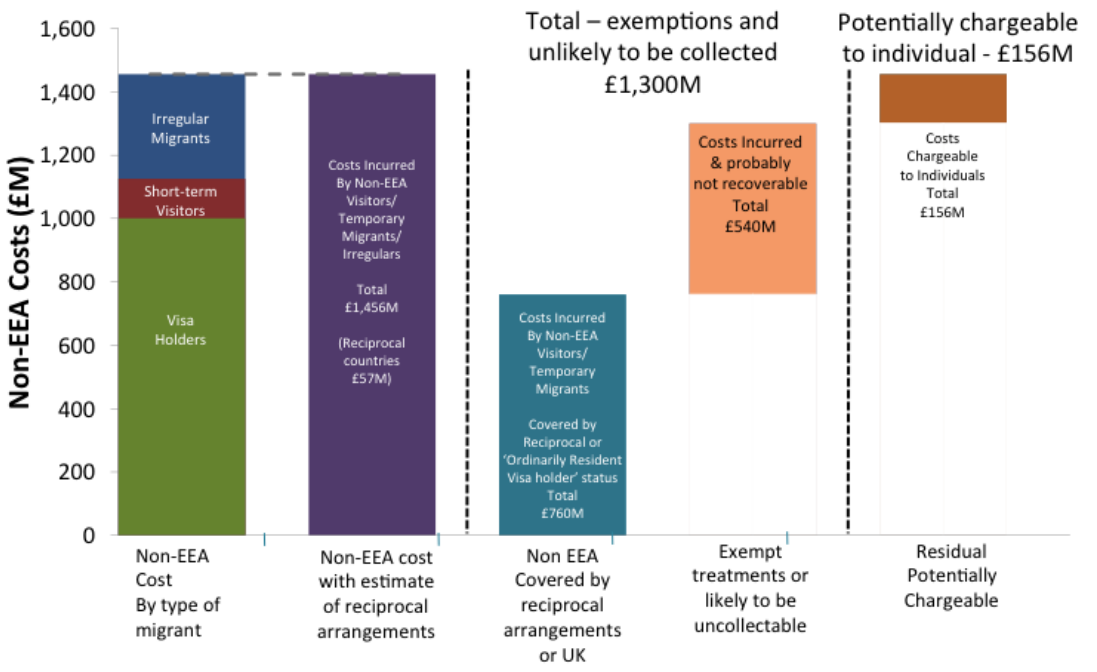
Source: Prederi model

The DH accounts for 2012-13 show that about £50m is recovered from EEA countries. It is noticeable that this is less than is paid out for British visitors to EEA countries, namely £173m. It also seems out of line with the balance of visits with the EEA. There are some differences in patterns of visits and the demographic characteristics of the visitors that appear to explain some of the difference in the 'balance of payments'. The arrangements also vary between countries. This is an area that needs further investigation that we have not had time to undertake.

4.3.2 Non-EEA

In the case of non-EEA visitors and migrants there appear to be costs of £1.4Bn for providing healthcare under the NHS. The £1,4Bn includes £50m for British expats living in non-EEA countries. Of the £1.4BN total, some £1.3Bn is borne by the UK Government under the current charging rules because people, though here temporarily, are deemed "Ordinarily Resident' or they are receiving care such as GP or A&E services for which no charge is made. This £1.3Bn includes costs that are unlikely to be recoverable because a significant (but unknown) proportion of the irregular migrants have no means. This leaves around £150m to be invoiced to individuals among the regular visitors and migrants who will need the NHS in the normal course of events. This is illustrated in Figure 12 below.

Figure 12: Cost recovery – non-EEA



Source: Prederi model

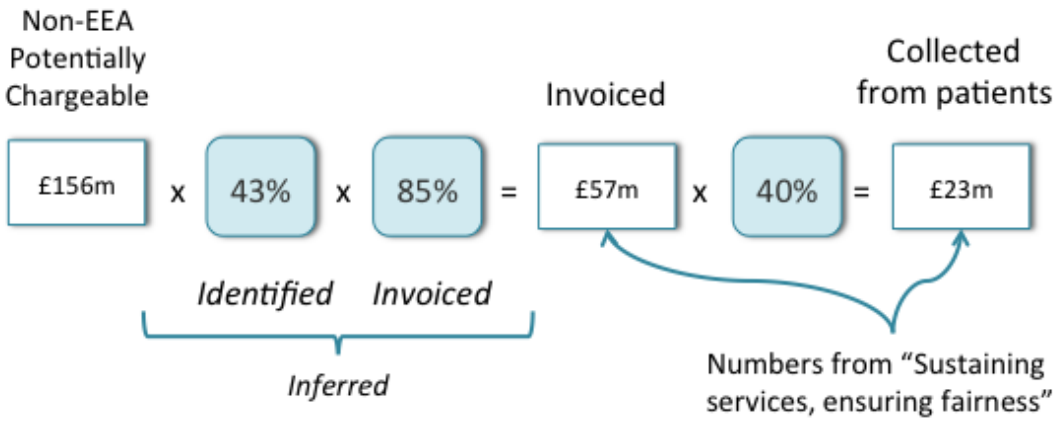
4.3.3 Collecting the revenue

Having derived some estimates of the sums that could potentially be chargeable to individuals, set out in the tables above, we have also looked at how these relate to the amounts that are actually billed to individuals by Trusts. It is apparent from the Phase 1 research and information from Trusts that there are very low rates of identifying patients who should be paying, tracking and invoicing them, and collecting the payment.

A previous Department study figure has shown that only about £23m is collected of the £57m that is invoiced, a realisation rate of 40%. The £57m represents income from non-EEA patients, so this represents about 37% of the chargeable sums from non-EEA. Based on evidence from Phase 1, this suggests to us that about 43% of the chargeable patients are identified as being chargeable and perhaps 85% of the identified cases are subsequently invoiced. Overall, the indications are, therefore, that Trusts realise about 15% of the sums that are potentially chargeable to non-EEA patients (excluding irregular migrants).

These numbers must be treated with caution. The estimated rates are simply indicative since the scope and dates are not exactly the same. Furthermore the model does not reflect the full complexity of the charging rules. This relationship between the non-EEA potentially chargeable sum and what is realised from patients is summarised in Figure 13 below.

Figure 13: Revenue Collection - non-EEA



Source: Prederi model

5 Forecast of future use

Turning now to the forecast, we have looked at the long-term trends and the expected changes over the next 10 years. We think that the influences of migrant numbers over next 10 years are likely to include:

- Political
  - EU enlargement and the UK relationship to the rest of the EU
  - Control of immigration to UK
- Economic
  - Performance of EU and relative performance of the UK
  - Global trends in economic growth and trade
- Social
  - Attitudes towards immigration
  - Increased readiness to move for work
- Technological
  - Minimal impact on these forecasts but e.g. innovations in medicine and remote working
- Environmental
  - Minimal impact on these forecasts but e.g. limits to growth of air travel
- Legal
  - Convergence of EU rules on eligibility for benefits
  - Immigration law
- Organisational
  - NHS reforms e.g. GP/A&E balance; use of non-hospital settings for treatment

We do not think that there is value in calculating some crude projections working from baselines that are already surrounded by considerable uncertainty. It would suggest a level of confidence in the numbers that would be unwarranted. Instead, we tentatively offer this assessment of trends for the major groups we have assessed.

Table 11: Summary Forecast by visitor or migrant category

Visitor or migrant category	Currently estimate daily equivalent population (000s)	Forecast
Non EEA -Visitors/short-term visitors (<12 months)	230	Growth of 1%-2% a year over the period
Non-EEA – work >12 months	440	Steady
Non-EEA – study >12 months	600	Steady/some growth
Non-EEA – family >12 months	190	Steady/some reduction
EEA - Visitors/short-term visitors (<12 months)	240	Growth of 1%-2% a year over the period
EEA workers	Not baselined	Growth/strong growth
EEA Students	190	Some growth
EEA retired	20	Some growth
Irregulars	580	Asylum - steady/reducing Overstayers – steady/reducing Illegals – steady/reducing
Expats	70	Steady/ some growth; increased share of older people

Source: Prederi

6 Caution in using the estimates

As noted already, the findings have been presented as single point estimates. This has been done for clarity. **Any point is just a likely value in a plausible range.** For instance, our calculation of the cost of the regular use of the NHS in England by visitors and migrants is £1.76 billion. We think that this is 50% likely to be in the range £1.53 billion to £1.94 billion. Care should therefore be used when using the findings especially the results for more detailed breakdowns of figures.

As we highlighted at the start, the information that has been used for the analysis is the best available in the public domain. Some of the sources such as the Census and the DH accounts are sound; but others are hedged with uncertainty, such as the International Passenger Survey. We have had to stretch the data to make calculations that they were not originally designed for. We have also used a large number of assumptions, to some of which the results are markedly sensitive. **There is a great deal of uncertainty in the results**. The short period of time for the study has limited the extent of refinement of the estimates so all of the values should used with considerable caution.

Our intention has been to make estimates that are the **best that can be made right now** without large-scale surveys, but we recognise that they are based on incomplete and sometimes unreliable data and a large number of assumptions and judgements. We hope that **the analysis will inform policy development around visitor and migrant access to NHS, alongside the DH consultation and work with the NHS.**

Annexes

Annex A: Glossary

Term	Explanation
A&E	Accident & Emergency – Secondary healthcare
A2	Accession 2 ie Bulgaria and Romania
A8	Accession 8 ie the eastern European countries that joined the EU in 2004 ie Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia
Daily equivalent population	This is the number of visitors or short-term migrants in a particular category that has been adjusted to allow for the length of stay (e.g. three months would be ¼ of a unit of the daily equivalent population). This gives a figure for the population who would be resident on an average day.
DfT	Department for Transport
DH	Department of Health
EEA	Austria, Belgium, Bulgaria, Croatia, Cyprus (Southern), Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Republic of Ireland, Romania, Slovakia, Slovenia, Spain, Sweden, UK, plus Iceland, Liechtenstein and Norway. Switzerland by special arrangement
EHIC	European Health Insurance Card – a scheme to help EEA citizens to access health when visiting other EEA states on the same basis as the host citizens, subject to some constraints
EU15	The EU member states prior to expansion in 2004 ie Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Luxembourg, Netherlands, Portugal, Republic of Ireland, Spain, Sweden and the UK
Failed Asylum Seeker (FAS)	Someone whose application to remain in the UK has been refused and who has exhausted the appeal process. FASs who have had their claim refused but are receiving section 4 or section 95 support from the UK Border Agency are entitled to free secondary health care.
Family Visa	A visa that enables someone to come to the UK to join his or her family.
G&A	General & Acute - Secondary healthcare
GP	General Practitioner – Primary healthcare
Health Tourist	Someone who has travelled to England with the deliberate intent to obtain healthcare to which they are not entitled
Illegal Migrant	An undocumented migrant who has entered the country illegally
ILR	Indefinite Leave to Remain – a permission to settle in the UK granted after an application to the Home Office
IPS	International Passenger Survey – a sample survey of passengers arriving at, and departing from, United Kingdom air and sea ports and the Channel Tunnel.
Irregular Migrant	An undocumented migrant – includes Failed Asylum Seekers, Visa Overstayers and Illegal Migrants (people who have entered the country clandestinely)

Term	Explanation
Migrant	People who come to the country to live, work or study, sometimes with a view to settlement in the longer term
Non-EEA	Countries other than the EEA
Non-permanent resident	A citizen from an EEA country who is resident in the UK but has not yet acquired permanent residence in the UK. (An EEA national has an initial right to reside in the UK for three months. Beyond that there is an extended right if the EEA national is exercising 'EU treaty rights' as a worker, a self-employed person, a job-seeker, a student, or a self-sufficient person.)
ONS	Office for National Statistics
Ordinarily Resident	An individual is Ordinarily Resident if they can prove that they are lawfully and properly settled in the UK for the time being. In reality this is assessed using factors such as whether an individual is employed, is a settled resident and the length of time they have been in the country. The individual must be legally entitled to live in the UK.
Overstayers	People who have stayed in the UK beyond the validity of their visa
PH	Public Health
PBS	Points Based System – the scheme that regulates visas issued to non-EEA citizens who wish to come to the UK to work or study and for some other miscellaneous purposes. See Tier 1,2,4 and below.
Reciprocal health arrangements	Arrangements between the UK and other countries that enable visitors to obtain urgent healthcare in each other's country. The main countries are Australia and New Zealand plus the states of the former Soviet Union and the former Yugoslavia (that have not yet joined the EU).
S1	The EEA scheme to provide healthcare services for state pensioners when they are resident in another EEA state
S2	The EEA scheme to allow people to travel for pre-arranged and approved treatment of medical conditions
Tier 1, 2 4 and 5 migrant visas	These are categories in the PBS, namely: Tier 1 - for highly skilled workers, such as scientists and entrepreneurs. Tier 2 - Points based visa system for skilled workers with a job offer, such as teachers and nurses. Tier 3 – not used. Tier 4 - Points based visa system for students. Tier 5 - Points based visa system for temporary workers, such as musicians coming to play in a concert, and participants in the youth mobility scheme.
Temporary Migrant	A citizen from outside the EEA who has been granted a right of residence for a limited period (usually between six months and five years). They may or may not go on to acquire ILR.
Usually resident	People resident in the UK for more than 12 months at the time of the Census
Visa Waiver Countries	Countries with which the UK has put in place arrangements that allow some categories of visitor to come to the UK without a visa for up to six months other than to work.

Term	Explanation
Visitors	People who come to the country for up to 6 months for holidays, business, study, visits to family and friends and various other purposes.

Annex B: Summary of eligibility for free NHS hospital treatment

Categories of people living in the UK who may or may not be eligible for free NHS hospital treatment
The following groups are all likely to pass the current 'ordinary residence' test and therefore be entitled to free NHS hospital treatment.
British nationals who have a right of abode and who live in the UK: this will include immigrants and/or their descendants who have applied for, and been granted British citizenship.
Migrants with 'indefinite leave to remain' (ILR) who are living in the UK on a permanently settled basis.
European Economic Area (EEA) temporary residents: EEA nationals (and their family members) who are resident in the UK but have not yet acquired permanent residence in the UK. An EEA national has an initial right to reside in the UK for three months. They have an extended right beyond that if exercising 'EU treaty rights' as a worker, a self-employed person, a job-seeker, a student, or a self-sufficient person. Until an EEA national acquires 'ordinarily resident' status, they would be chargeable for their hospital treatment unless covered by an exemption under the charging regulations, e.g. they have an EHIC card or are students. In practice this means that most EEA nationals are entitled to free treatment.
EEA permanent residents: EEA nationals who have been residing in accordance with the above conditions for five continuous years, at which point they acquire a right of permanent residence in the UK, which means they no longer need to exercise treaty rights in order to have a right of residence here.
Non-EEA temporary residents: people from outside the EEA (and their family members) who have been granted a right of residence for a limited period (usually between six months and five years). They may or may not go on to acquire ILR.
The following groups (with the possible exception of refugees) will not pass the current OR test, so are chargeable except where exemptions from charge in the Charging Regulations apply.
Asylum seekers: anyone who has made a formal application with the Home Office to be granted temporary protection, asylum or humanitarian protection that has not yet been determined. Formal applications are those made under the 1951 UN Convention and its 1967 Protocol and also some claims made on protection from serious harm grounds under Article 3 of the European Convention on Human Rights. A person whose application for asylum (or humanitarian/temporary protection) is accepted becomes a refugee.
Irregular migrants: any non-EEA national who does not have immigration permission to be in the UK.
British expats: British nationals (or others not subject to immigration control in the UK) who are former residents of the UK but who now live overseas.
Visitors: those, of any nationality, who live overseas, but are visiting the UK.