# Impact Assessment, The Home Office

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|---|---|
| **Title:** The Immigration and Nationality (Fees) (Amendment) (No. 3) Regulations 2020 | **Date:** 7 July 2020 |
| | **Stage:** Final |
| **IA No:** HO0369 **RPC Reference No:** N/A | **Intervention:** Domestic |
| **Other departments or agencies:** Department of Health and Social Care | **Measure:** Secondary legislation |
| | **Enquiries:** feesandincomeplanning.requests@homeoffice.gov.uk |

| | |
|---|---|
| **RPC Opinion:** Not Applicable | **Business Impact Target:** Non qualifying provision |

**Cost of Preferred (or more likely) Option** (in 2019 prices)

| | | | | | |
|---|---|---|---|---|---|
| **Net Present Social Value NPSV (£m)** | -126 | **Business Net Present Value BNPV (£m)** | -2 | **Net cost to business per year EANDCB (£m)** | 0 |

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

Health and care professionals from outside the European Economic Area (EEA) who wish to work in the UK are required to apply for a Tier 2 (General) visa. There is no dedicated visa route for health and care workers. This policy does not attempt to modify the provisions of the Tier 2 (General) route. The Government will introduce a new visa route with additional benefits for eligilble health and care professionals to reflect the contribution they make to the health and wellbeing of the UK population. The Government needs legislation to amend Immigration & Nationality (Fees) Regulations to bring the Health and Care Visa into effect from August 2020.

**What are the policy objectives and the intended effects?**

To provide a route which will provide qualified doctors, nurses and other allied health professionals working both in the NHS and social care fast-track entry, reduced visa fees and dedicated support to come to the UK with their families to ensure the long-term sustainability of the health and care sectors. The cohort will also be eligible for an IHS exemption and IHS rebate for IHS payments made since 31st March 2020, which will be brought into effect through amendments to the Immigration (Health Charge) (Amendment) Order 2020. This visa will form part of the UK's points-based immigration system from January 2021.

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

**Option 0** – Do nothing: Visa-liable health and care professionals migrating to the UK continue to use the Tier 2 General visa route.

**Option 1** – Introduce the Health and Care Visa: applications will be fast-tracked by a dedicated Home Office team, which would also offer support to aplicants during the application process. Applicants would pay a reduced visa fee of £232 for a visa length of up to three years and £464 for a visa lasting more than three years. Applicants would be exempt from liability to pay the IHS. This is the **Government's preferred option**.

| **Main assumptions/sensitivities and economic/analytical risks** | **Discount rate (%)** | 3.5 |
|---|---|---|

The volume of applications for 2020/21 are based on Home Office internal planning assumptions. The Health and Care Visa will be open for EEA and non-EEA NHS workers alike under the new Points Based System. No adjustment has been made in the central case for the potential impact of Covid-19 and the introduction of the Points Based System. Price elasticity of demand assumptions for visas are used to estimate the effects of a lower Health and Care Visa fee. Exchequer effects use assumed income, direct and indirect tax contributions and the unit costs of public service provision.

**Will the policy be reviewed?** It will be reviewed. **If applicable, set review date:** 08/2025

***I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.***

Signed by the responsible Minister: Kevin Foster Date: 14 July 2020

# Summary: Analysis & Evidence

Policy Option 1

**Description:**

**FULL ECONOMIC ASSESSMENT**

| Year(s): | Price Base | 2019/20 | PV Base | 2020/21 | Appraisal | 5 | Transition | 1 |
|---|---|---|---|---|---|---|---|---|

| Estimate of Net Present Social Value NPSV (£m) | | | | | | Estimate of BNPV (£m) | |
|---|---|---|---|---|---|---|---|
| **Low:** | **-141** | **High:** | **-112** | **Best:** | **-126** | **Best BNPV** | **0** |

| COSTS, £m | Transition Constant Price | Ongoing Present Value | Total Present Value | Average/year Constant Price | To Business Present Value |
|---|---|---|---|---|---|
| Low | 0 | 141 | 141 | 28 | 0 |
| High | 0 | 160 | 160 | 32 | 0 |
| Best Estimate | 0 | 149 | 149 | 30 | 0 |

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

**1. Home Office**: A reduction in fee revenue of **£134 million** and Priority Service revenue of **£7 million**. The Home Office may need to process additional applications at a cost of **£0.1 million**.

**2. UK Exchequer**: An increase in the number of applicants may increase public service provision costs to about **£8 million**.

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

The monetised cost of migrant spending modelled in this IA covers the proportion of spending that accrues to the Government. Employers will need to evidence the eligibility of their applicants for an Health and Care Visa. This is not expected to be a significant time cost.

| BENEFITS, £m | Transition Constant Price | Ongoing Present Value | Total Present Value | Average/year Constant Price | To Business Present Value |
|---|---|---|---|---|---|
| Low | 0 | 0 | 0 | 0 | 0 |
| High | 0 | 48 | 48 | 10 | 0 |
| Best Estimate | 0 | 23 | 23 | 5 | 0 |

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

1. **Home Office:** The lower visa fee may attract additional applications, **£0.3 million.**
2. **UK Exchequer**: Additional migrants entering the UK may increase tax revenue, **£23 million.**

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

Medical professionals play a vital role in supporting the health and well-being of the UK. Health and care professionals will continue to make a fair contribution to the cost of processing their migration applications whilst also ensuring that the visa is attractive. The Health and Care Visa will offer applicants a faster result on the outcome of their application, reducing waiting time.

**BUSINESS ASSESSMENT (Option 1)**

| Direct impact on business (Equivalent Annual) £m: 0 | | | | | |
|---|---|---|---|---|---|
| Cost, £m | 0 | Benefit, £m | 0 | Net, £m | **0** |
| Score for Business Impact Target (qualifying provisions only) £m: | | | | | **N/A** |
| Does implementation go beyond minimum EU requirements? | | | | | N/A |
| Is this measure likely to impact on trade and investment? | | | | | N |

| Are any of these organisations in scope? | Micro | Y | Small | Y | Medium | Y | Large | Y |
|---|---|---|---|---|---|---|---|---|

| What is the $CO_2$ equivalent change in greenhouse gas emissions? (Million tonnes $CO_2$ equivalent) | Traded: | N/A | Non-Traded: | N/A |
|---|---|---|---|---|

**PEOPLE AND SPECIFIC IMPACTS ASSESSMENT (Option 2)**

| Are all relevant Specific Impacts included? | Y | Are there any impacts on particular groups? | N |
|---|---|---|---|

## Evidence Base (for summary sheets)

# A. Problem under consideration

Visa-liable health and care professionals wishing to migrate to the UK to work are currently required to apply for a Tier 2 General visa. The cost of a Tier 2 General visa offering leave of up to 3 years is £610, or £464 if the profession is on the Shortage Occupation List (SOL). The equivalent visa fees for a visa lasting more than 3 years are £1,220 and £928 per year. Applicants are also required to pay the Immigration Health Surcharge (IHS) up front for each year of their stay, which will increase from October 2020 from £400 to £624 per person per year, with the discounted rate for students and those on the Youth Mobility Scheme increasing from £300 to £470 per year. A new discounted rate for all children under the age of 18 will also be introduced. This rate will also be £470 per person per year, in line with students and the youth mobility scheme.

In November 2019, the Government announced plans for a new visa to attract doctors and nurses to the NHS as part of the points-based immigration system.

## A.1 Groups Affected

Migrants wishing to come to the UK are required to pay the appropriate visa fee associated with their application as set out in The Immigration and Nationality (Fees) Regulations 2019[1] and IHS as set out in The Immigration (Health Charge) (Amendment) Order 2020[2].

Migrants with the following characteristics who wish to migrate to the UK will be eligible for the Health and Care Visa and are therefore the group that will be affected:

- A health professional working for one of the professions listed in Annex 1.
- Holding a job offer from the NHS or an organisation which provides services to the NHS, or working in social care.
- Trained to a recognised standard with good working English.

The list of eligible Standard Occupational Classification codes set out in Annex 1 has been agreed by the Department of Health & Social Care and the Home Office. As with all immigration routes, the Health and Care Visa will be kept under regular review. Applicants for the Health and Care Visa will need to meet all of the other criteria for a Tier 2 General migrant.

The visa fees, IHS and processing times for other products will remain unchanged from those outlined in The Immigration and Nationality (Fees) Regulations 2019 and The Immigration (Health Charge) (Amendment) Order 2020.

The Health and Care Visa will be open to eligible health and care professonials applying under the UK's Tier 2 (General) immigration route and the Isle of Man's Worker Migrant route.

# B. Rationale for intervention

The Government has committed to ensuring that qualified doctors, nurses and allied health professionals from overseas with a job offer from the NHS, or organisation which provides services to the NHS, or working in social care are offered an IHS exemption, fast-track entry, reduced visa fees and support from a dedicated team which offers support to applicants regarding the application process. At the same time, doctors, nurses and allied health professionals will continue to make a fair contribution towards the cost of processing their visa application.

[1] http://www.legislation.gov.uk/uksi/2019/475/made
[2] http://www.legislation.gov.uk/ukia/2020/30

Under the existing system applications can take between eight and twenty weeks to process. The service level agreement for Health and Care Visa applications will be two weeks from the point that an individual enrols biometrics, making it significantly quicker for medical professionals to come to the UK. They will pay a reduced fee which strikes a balance between supporting the wider policy of ensuring that those who use the immigration system pay the majority of the cost and attracting skilled professionals. Applications will also be processed by a dedicated team which will offer support to applicants regarding the application process.

The Health and Care Visa will offer a reduced visa fee of £232 for eligible health and care professionals applying to enter or stay in the UK for up to 3 years, a reduction of £378 on the equivalent standard Tier 2 General visa. The reduction for those applying for an Health and Care Visa lasting 3 years or more is £944. The reduced fee will also apply to dependants. The discount will be lower for those applying to professions on the Shortage Occupation List as they already pay a lower fee. The fee for the Health and Care Visa has been set at a flat rate of 50 per cent of the cost of a Tier 2 General Visa for an occupation on the Shortage Occupation List.

The visa fee is one part of the cost of migrating to the UK. Visa-liable health and care professionals wishing to migrate to the UK are also required to pay the Immigration Health Surcharge (IHS) for each year of their stay. From October 2020, subject to Parliamentary approval, the Government has committed to increasing the IHS for most applicants to ensure that visa liable migrants make a 'fair contribution' to the cost of the NHS services available to them and ensure the long-term sustainability of the NHS[3]. To recognise the essential function that medical professionals play in society, the Government has committed to introducing an exemption for eligible health and care workers, and their immediate family members from having to pay the Immigration Health Surcharge. **Analysis of the effect of introducing an IHS exemption and rebate for those entering the UK on a Health and Care Visa will be set out as part of a separate impact assessment on the Immigration Health Surcharge.**

## C. Policy Objective

The policy objective is to improve the visa offer for skilled health and care professionals from overseas to encourage them to migrate to, and remain in the UK to provide their services to the health and care sectors.

## D. Options

### Option 0: Do Nothing

Visa liable health and care professionals would continue to apply for the Tier 2 General route. The visa fee incurred would remain at the levels set out in Section A.

### Option 1: Implementing the Health and Care Visa

Under option 1, visa-liable health and care professionals who meet the criteria outlined in section A.1 would receive a faster application outcome, dedicated support and be liable for lower visa and IHS fees. The dedicated support would come through establishing a team to process Health and Care Visa applications within two weeks, and to offer support to applicants throughout the application process.

A 50 per cent reduction to the standard Tier 2 (General) fee was considered as an alternative to setting the visa fee at 50 per cent of the cost of a Tier 2 (General) Visa for an occupation on the Shortage Occupation List. However, this would have resulted in Health and Care Visa applicants paying a different fee depending on whether the occupation was on the national shortage list. To simplify the fee and reduce the risk of discrimination for individuals working in certain sectors, a 50 per cent reduction on the Shortage Occupation fee was chosen.

[3] http://www.legislation.gov.uk/ukia/2020/30

# E. Appraisal (Costs and Benefits)

The substantive provision set out in the application guidance for migrants and the guidance for sponsors, and in The Immigration and Nationality (Fees) (Amendment) (No. 3) Regulations 2020 is the enablement of the reduced visa fee. This impact assessment sets out the economic costs and benefits associated with introducing a visa fee reduction for eligible health and care professionals. An exemption from payment of the IHS for successful applicants to the Health and Care Visa will be brought about by changes to the Health Charge Order. **The costs and benefits of the IHS exemption for Health and Care Visa applicants will be set out in the associated IA.**

The analysis produces a Net Present Social Value (NPSV) under Option 1, using central assumptions on the responsiveness of applicants to changes in visa fees (price elasticity of demand). The analysis also produces a range around this central scenario using high and low elasticity assumptions. Section F on sensitivity analysis considers the ranges around the central estimate based on elasticity assumptions.

The IA applies a methodology broadly in line with that used for the impact assessments for the Immigration and Nationality Fee Order 2016, the Immigration and Nationality (Fees) Regulations 2018[4], the Immigration and Nationality (Fees) Regulations 2019 and The Immigration (Health Charge) (Amendment) Order 2020.

Any reduction in the visa fee for medical professionals will apply to EEA and non-EEA workers alike under the new Points-Based System in place from January 2021. This impact assessment includes the impact based on the current immigration system for non-EEA workers only.

## General Assumptions & Data

### Objective function

In line with previous Home Office analysis and following recommendations made by the Migration Advisory Committee (MAC)[5]; this IA considers the impact of the options on the welfare of the UK resident population. Besides the affect on government revenue and processing costs due to the implementation of the Health and Care Visa, the NPSV calculation includes the effect of changes in contributions to direct and indirect taxes, the effect on consumption of public services and the effect on the labour market for the resident population where possible. Foregone migrant wages are not included in the NPSV calculations in line with MAC recommendations, as the IA does not consider the impact on overall GDP.

This IA is based on the current immigration system, which applies the IHS and visa fees to non-EEA applicants under current immigration rules. It does not attempt to quantify the impact from any change to the immigration system from January 2021.

### Baseline volumes

The Health and Care Visa will be available for individuals who would otherwise be applying under Tier 2 (General) for Entry Clearance or Leave to Remain, working either directly for the National Health Service, for an organisation which provides services commissioned by the NHS, or for a social care provider employing individuals working in Standard Occupational Classification codes (SOC codes) set out in annex 1.

The volume estimates for the Health and Care Visa are therefore based on Home Office data on the number of applicants for the Tier 2 General visa. This data includes applications for the Isle of Man's Skilled Worker migration route.

[4] http://www.legislation.gov.uk/ukia/2018/59/pdfs/ukia_20180059_en.pdf
[5] MAC; "Analysis of the Impact of Migration"; January 2012. https://www.gov.uk/government/publications/analysis-of-the-impacts-of-migration

The baseline volume of applications for the Health and Care Visa in 2020/21 is derived by estimating the proportion of Tier 2 General applicants in 2018/19 who would be eligible for an Health and Care Visa.

Using Home Office internal planning assumptions, it is estimated that around 43 per cent of out of country and 31 per cent of in country Tier 2 (General) applications in 2018/19 were associated with the NHS, organisations that provide services to the NHS, or a social care setting and employed in one of the SOC codes listed in Annex 1. These proportions are applied to the total number of estimated Tier 2 (General) applications for 2020/21 to derive the annual Health and Care Visa volume estimates outlined in Table 1.

In March 2020 the Government announced that it would automatically extend the visas of migrant doctors, nurses and paramedics employed by the NHS whose visa is due to expire before 1 October 2020[6]. For the purposes of this IA, it has been assumed that no extensions for the Health and Care Visa are applied for in 2020/21. Published migration statistics[7] for 2018 were used to forecast the proportion of In Country applications for 2020/21 that are considered extensions, and these have been excluded from the baseline volumes for that year[8].

The inherent uncertainty around the effect of Covid-19 on volumes, the effect of any NHS policy responses to maintain or expand doctor and nursing recruitment, and the introduction of the Points Based System from January 2021 will each affect the volume of potential Health & Care visa eligible inflows into the UK over the appraisal period.

Due to the level of uncertainty around the potential impact of Covid-19 on the number of applications for visas, no adjustment has been made to the forecast volumes or the net present value of the policy over the appraisal period in the central case. Instead, this impact assessment presents a sensitivity analysis with a range of NPSV estimates in F.4 based on different assumptions about the potential effect of Covid-19 on volumes.

Table 1 presents the estimated baseline volume of applications for the Health and Care Visa for each year of the appraisal period.

**These volumes are used as the baseline against which the potential behavioural effect of introducing a reduced fee route for eligible health and care professionals is assessed.**

**Table 1: Estimated annual application volumes, 2020/21***

| Visa type | Baseline annual applications (planning assumption) | |
|---|---|---|
| | < 3 years | >3 years |
| **Out of Country** | | |
| Health and Care Visa- Main applicant | 4,100 | 11,700 |
| Health and Care Visa- Dependant | 2,500 | 7,100 |
| **In Country**** | | |
| Health and Care Visa- Main applicant | 4,400 | 4,800 |
| Health and Care Visa- Dependant | 3,900 | 4,400 |

Source: Home Office internal analysis, 2020. Figures rounded to nearest 100.
*2020/21 is modelled as two quarters of these annual applications to reflect implementation of the policy in Q2 2020.
** The annual application volumes for 2020/21 will be lower due to the exclusion of applications for extensions.

[6] https://www.gov.uk/government/news/nhs-frontline-workers-visas-extended-so-they-can-focus-on-fighting-coronavirus
[7] https://www.gov.uk/government/statistical-data-sets/managed-migration-datasets
[8] It should be noted that the policy to automatically extend visas for NHS doctors, nurses and paramedics will remove the need for some applicants to extend their application in Q1 and Q2 2021/22. In the absence of evidence, and in light of the wider uncertainty over baseline volumes, no further adjustment has been made to account for this.

Applicants will be able to apply to the Priority or Super Priority Service that is currently available to Tier 2 General applicants, which offer a faster turnaround for an additional fee. Table 2 shows, of those already considered in Table 1, the estimated number of visa applications for a premium service, based on Home Office management information**.**

**Table 2: Estimated annual application volumes for the Priority and Super Priority Service, 2020/21***

| Visa type | Baseline annual applications (planning assumption) |
|---|---|
| **Out of Country** | |
| Priority Health and Care Visa- Main applicant & Dependant | 4,600 |
| Super Priority Health and Care Visa- Main applicant & Dependant | 300 |
| **In Country**** | |
| Priority Health and Care Visa- Main applicant & Dependant | 2,300 |
| Super Priority Health and Care Visa- Main applicant & Dependant | 4,100 |

Source: Home Office internal analysis, 2020. Figures rounded to nearest 100.
* 2020/21 is modelled as two quarters of these annual applications to reflect implementation of the policy in Q2 2020.
** The annual application volumes for 2020/21 will be lower due to the exclusion of applications for extensions.

**Baseline Fees and Immigration Health Surcharge**

The Immigration and Nationality (Fees) Regulations 2019 set out the level of visa fees to be charged from the financial year 2019/20. As the policy is scheduled to be implemented in August 2020, this IA applies the level of visa fees as set out in these Regulations as the baseline for its analysis. These are set out in Table 6.

The Immigration (Health Charge) Order 2015 requires that non-EEA temporary migrants who make an immigration application to come to the UK for more than six months, or who apply to extend their stay in the UK, make a direct contribution to the NHS via payment of an immigration health charge (often referred to as the immigration health surcharge or IHS). Since 2018, the rate has been set at £400 per person per year (£300 for students, their dependants and Youth Mobility Scheme applicants).

**Appraisal Period**

The estimates presented in this IA assume that the Health and Care Visa comes into effect in August 2020 and accordingly impacts have been modelled from this date. All other fees will remain unchanged from those outlined in the Immigration and Nationality Fee Regulations 2019 and The Immigration (Health Charge) (Amendment) Order 2020. The policy is appraised for the following five years, in line with standard appraisal practice. This should not however be interpreted as an indication of future visa fee and IHS levels beyond 2020/21, as these will be set in future regulations.

**Price Elasticity of Demand for Visa**

The implementation of a reduced visa fee for migrants from a number of professions through the Health and Care Visa could encourage additional migrants to apply to enter the UK. The Home Office has developed a methodology to estimate the potential impact on application volumes.

This methodology has been used for previous IAs on the impact of changes in visa fees[9] and on the immigration health surcharge[10]. The analysis treats the Health and Care Visa as a reduction in the cost of moving to the UK and estimates the effect that this may have on volumes of visa

[9] http://www.legislation.gov.uk/uksi/2016/177/impacts and http://www.legislation.gov.uk/uksi/2018/330/impacts
[10] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251972/Health_impact_assessment.pdf

applications by applying estimates of the responsiveness of demand for visa to changes in fees (price elasticity of demand for visa products).

The increase in visa applications, and therefore increase in individuals entering or remaining in the UK for work-related reasons as a result of the implementation of the Health and Care Visa has been estimated by applying estimates of the wage elasticity of labour supply, which measures the responsiveness of the supply of labour to changes in wages, to the expected earnings over the duration of the visa. A decrease in immigration costs is treated as equivalent to an increase in the expected earnings over the duration of the visa period. The central scenario assumes a small increase in the willingness to supply labour as a result of changes in immigration costs, applying an elasticity of -0.3. The low scenario assumes a zero response to the change in wage and the high scenario uses an elasticity of -0.6. The analysis assumes a different price sensitivity for dependants applying out of country and those extending in the UK. The central scenario assumes a zero response to the change in earnings for in country dependants and an elasticity of -0.3 for out of country dependants. The wide range of estimates used as sensitivity reflects the available evidence and the uncertainty around the central estimates.

The elasticity estimates used to estimate the effect of the change in earnings on Health and Care Visa application volumes are set out in Table 3. Annex 3 provides a high-level summary of the available literature and elasticity estimates used. Further detail can be found in the publication "*A review of evidence relating to the elasticity of demand for visas in the UK*" published in March 2020.[11]

**Table 3: Elasticities used to analyse the impact of changing fees**

| Elasticity | Justification | Products | Magnitude | | |
|---|---|---|---|---|---|
| | | | Low | Central | High |
| Wage elasticity of labour supply | Migrants demand Home Office products in order to supply labour in the UK. The wage elasticity of labour supply is thus used to estimate the impact on volumes of the proposed fee change. e.g. an increase in fee is a reduction in expected wage, so should reduce labour supply. | Health and Care Visa-Main applicant | 0 | -0.3 | -0.6 |
| Wage elasticity of labour supply (dependants) | For in-country dependant applications, the central scenario assumes no price sensitivity of visa demand as applicants are already in the UK with their family member (the main migrant), but in the high scenario assumes sensitivity akin to that of workers in the central scenario. The central scenario for out-country-dependants also assumes a sensitivity akin to that of workers in the central scenario. | Health and Care Visa-Dependant | In-Country<br>-0<br>Out-of-Country<br>-0 | In-Country<br>0<br>Out-of-Country<br>-0.3 | In-Country<br>-0.3<br>Out-of-Country<br>-0.6 |

## Costs and benefits

**The analysis models the introduction of the Health and Care Visa as a reduction in the visa fee on the Tier 2 General fee or reduced Shortage Occupation fee.** The first direct impact of the reduction in fees and the application of central behavioural assumptions is an increase in visa applications and therefore visas granted. This IA does not include the additional IHS revenue that would result from this behavioural response, as the current position is that applicants will be exempt from payment the IHS. **Appraisal of the IHS exemption for eligible Health and Care Visa applicants will be set out in a separate IA.**

[11] https://www.gov.uk/government/publications/a-review-of-evidence-relating-to-the-elasticity-of-demand-for-visas-in-the-uk

As can be inferred from Tables 4 and 5, the modelled change in the cost of migrating is expected to have a relatively small impact on visa applications and visas granted. This is largely because the visa fee is a small proportion of the expected value of coming to or remaining in the UK. **The change in applications and granted visas are not adjusted for the potential effect of Covid-19.**

**Table 4: Estimated increase in visa applications, 2020/21 to 2025/26**

| | | Baseline annual applications* | Estimated change in applications vs baseline | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 |
| **Out of Country** | | | | | | | | |
| Out of Country | Health and Care Visa- Main applicant: < 3 years | 4,100 | +10 | +10 | +10 | +10 | +10 | 0 |
| Out of Country | Health and Care Visa- Main applicant: >3 years | 11,700 | +50 | +70 | +60 | +60 | +60 | +20 |
| Out of Country | Health and Care Visa- Dependant: < 3 years | 2,500 | +10 | +10 | +10 | +10 | +10 | 0 |
| Out of Country | Health and Care Visa- Dependant: >3 years | 7,100 | +30 | +40 | +40 | +40 | +40 | +10 |
| **In Country**** | | | | | | | | |
| In Country | Health and Care Visa- Main applicant: < 3 years | 4,400 | 0 | +20 | +14 | +10 | +10 | 0 |
| In Country | Health and Care Visa- Main applicant: >3 years | 4,800 | +10 | +30 | +32 | +30 | +30 | +10 |
| In Country | Health and Care Visa- Dependant: < 3 years | 3,900 | 0 | 0 | 0 | 0 | 0 | 0 |
| In Country | Health and Care Visa- Dependant: >3 years | 4,400 | 0 | 0 | 0 | 0 | 0 | 0 |

Source: Home Office internal analaysis, 2020. Rounding: baseline volumes rounded to the nearest 100, change rounded to nearest 10.

* 2020/21 is modelled as two quarters of these annual applications to reflect implementation of the policy in Q2 2020.

** The annual application volumes for 2020/21 will be lower due to the exclusion of applications for extensions.

**Table 5: Estimated increase in visa grants, 2020/21 to 2025/26**

| | | Baseline annual applications granted* | Estimated change in grants vs baseline | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 |
| **Out of Country** | | | | | | | | |
| Out of Country | Health and Care Visa- Main applicant: < 3 years | 4,100 | +10 | +10 | +10 | +10 | +10 | 0 |
| Out of Country | Health and Care Visa- Main applicant: >3 years | 11,700 | +50 | +70 | +60 | +60 | +60 | +10 |
| Out of Country | Health and Care Visa- Dependant: < 3 years | 2,500 | +10 | +10 | +10 | +10 | +10 | 0 |
| Out of Country | Health and Care Visa- Dependant: >3 years | 7,100 | +30 | +40 | +40 | +40 | +40 | +10 |
| **In Country**** | | | | | | | | |
| In Country | Health and Care Visa- Main applicant: < 3 years | 4,000 | 0 | +10 | +10 | +10 | +10 | +10 |
| In Country | Health and Care Visa- Main applicant: >3 years | 4,700 | +10 | +30 | +30 | +30 | +30 | +10 |
| In Country | Health and Care Visa- Dependant: < 3 years | 3,500 | 0 | 0 | 0 | 0 | 0 | 0 |
| In Country | Health and Care Visa- Dependant: >3 years | 4,300 | 0 | 0 | 0 | 0 | 0 | 0 |

Source: Home Office internal analysis, 2020. Rounding: baseline volumes rounded to the nearest 100, change rounded to nearest 10.
* 2020/21 is modelled as two quarters of these annual applications to reflect implementation of the policy in Q2 2020.
** The annual application volumes for 2020/21 will be lower due to the exclusion of applications for extensions.

## COSTS

### Direct Costs

The main direct costs to the introduction of the lower visa fee Health and Care Visa are likely to be foregone fee revenue, the cost of setting up and running the dedicated processing team and an increase in public service provision costs.

### E.1 Reduction in visa fee revenue for non-Priority Service applicants

The introduction of the Health and Care Visa with the associated lower fee level for those eligible, would result in foregone fee revenue over the period for the Home Office.

The size of the reduction in fee revenue per applicant depends on the route through which the applicant would otherwise have applied in the absence of this new Health and Care Visa route. Table 6 sets out the routes through which an applicant to the Health and Care Visa may currently enter or remain in the UK, estimates of the volume of applicants to each route in 2019/20 who would have been eligible for the Health and Care Visa and the fee associated each route.

**Table 6: Estimated total applications for 2019/20, curent visa fee (£) and fee reduction (£,%)**

| Visa type | Number of eligible applications 2019/20 | | Current Visa fee (£) | | Health and Care Visa fee reduction on current visa fee (£) | |
|---|---|---|---|---|---|---|
| | <3 years | >3 years | <3 years | >3 years | <3 years | >3 years |
| **Out of Country** | | | | | | |
| Tier 2 General - Main applicant | 3,400 | 10,400 | 610 | 1,220 | -378 (62%) | -756 (62%) |
| Tier 2 General - Dependant | 2,100 | 6,300 | 610 | 1,220 | -378 (62%) | -756 (62%) |
| Tier 2 General Shortage Occupation List - Main applicant | 800 | 1,600 | 464 | 928 | -232 (50%) | -464 (50%) |
| Tier 2 General Shortage Occupation List - Dependant | 500 | 900 | 464 | 928 | -232 (50%) | -464 (50%) |
| **In Country** | | | | | | |
| Tier 2 General - Main applicant | 3,700 | 3,900 | 704 | 1,408 | -472 (67%) | -944 (67%) |
| Tier 2 General - Dependant | 2,800 | 3,000 | 704 | 1,408 | -472 (67%) | -944 (67%) |
| Tier 2 General Shortage Occupation List - Main applicant | 300 | 500 | 464 | 928 | -232 (50%) | -464 (50%) |
| Tier 2 General Shortage Occupation List - Dependant | 300 | 400 | 464 | 928 | -232 (50%) | -464 (50%) |

Source: Home Office internal analysis, 2020. Rounding: number of applications granted rounded to the nearest 100.

Across the five-year appraisal period, these fee changes represent a reduction in revenue for the Home Office of **£133.6 million** (PV, 2020/21 prices).

### E.2 Reduction in revenue from Priority Service

Currently, the standard processing time for a visa application through Tier 2 (General) is between eight and twenty weeks. However, applicants can pay extra for the Priority or Super Priority Service which offer faster application processing.

The standard service level agreement for processing Health and Care Visa applications under this new route will be two weeks. This will reduce the relative benefit for an in-Country applicant in paying extra for a the premium services.

This would result in a reduction in revenue of **£7.1 million** (PV, 2020/21 prices) over the five-year appraisal period. In the absence of evidence on the magnitude of this behavioural response, in a

central scenario, this assessment assumes a 50 per cent reduction in the number of applicants opting to pay for the premium services.

Noting the inherent uncertainty in this assumption, sensitivity analysis has been performed whereby the reduction in premium service applications varies between 25 per cent and 100 per cent as a result of this change and can be found in Section F.3.

### E.3 Higher Home Office processing costs

An increase in visa applications is expected to result in an increase in administrative costs to the Home Office.

The **additional cost to the Home Office of processing additional applications at the current service level is estimated to be up to £0.3 million with a central estimate of £0.1 million** (PV, 2020/21 prices) over the five-year appraisal period. Unit costs of processing a visa application for 2019/20 are outlined in Annex 1. Unit costs are assumed to stay flat in nominal terms over the appraisal period as these costs are reviewed year-on-year and do not necessarily grow in line with inflation.

There will be dedicated support to Health and Care Visa applicants and sponsors during the application process. The cost of this redirected resource is estimated to be negligible (below £0.1 million per annum) and so has not been included in the NPSV estimates for the policy.

### Indirect Costs

### E.4 Increase in public expenditure

The increase in the volume of migrants entering the UK or extending their visa, as a result of the elasticity effect on visa applications is expected to result in an increase in public expenditure on public services as more people would use such services. The **increase in expenditure on public services is estimated to be up to £19 million with a central estimate of £8.4 million** (PV, 2020/21 prices) over the five-year appraisal period. Results are calculated by applying the unit cost on expenditure for public services for different types of migrant groups to the expected increase in grant volumes due to the elasticity effect. The range set out here is driven by the change in volumes from applying the range of elasticity estimates set out in table 3. Further sensitivity analysis on the value of public service consumption per person is set out in section F.2.

### Non-Quantified costs

There is likely to be a limited impact on business resulting from this policy. The employer will be required to include an explanation in the Certificate of Sponsorship which sets out how the applicant will meet the Health and Care Visa requirements. The employer will also be responsible for informing the applicant that they are eligible for the Health and Care Visa so that the applicant can correctly complete the visa application form. The employer and applicant will therefore need to familiarise themselves with the limited updates to the Tier 2 Sponsor Guidance[12]. Because the requirements are relatively concise and clear, there is not expected to be a significant cost associated to these additional requirements.

### Total Costs

The total cost in the low, central and high scenarios is estimated at £140.8 million, £149.3 million and £159.8 million respectively. These are set out in Table 8.

[12] https://www.gov.uk/government/publications/guidance-on-application-for-uk-visa-as-tier-2-worker

**BENEFITS**

**Direct Benefits**

**E.5 Increase in visa fee revenue for standard and Priority Service applicants**

The reduction in fees is expected to generate an increase in fee revenue by increasing the number of applications. As the visa fee is levied on each application, the additional fee revenue is calculated as the change in the number of applications times the Health and Care Visa fee. The **increase in fee revenue is estimated to be up to £0.7 million with a central estimate of £0.3 million** (PV, 2020/21 prices) over the five-year appraisal period.

The small magnitude of additional fee revenue stems from the small increase in volumes modelled in the central scenario.

While, overall, a reduction in the volume opting to pay the additional premium service fees is expected, Priority Services still offer a comparably quicker service. As a result, a minority of the additional applicants may still opt to pay this additional service fee. This **increase in Priority Service fee revenue is estimated to be negligible** over the five-year appraisal period.

**Indirect Benefits**

**E.6 Increase in revenue to the Exchequer**

An increase in visas granted and therefore the number of migrants working in the UK would result in a gain to the exchequer from fiscal contributions via direct and indirect taxes. Annex 4 provides further details on how estimates of fiscal contributions are derived. The **additional revenue to the Exchequer is estimated to be up to £46.8 million using the high elasticity estimate, with a central estimate of £23 million** (PV, 2020/21 prices) over the five-year appraisal period.

**Non-Quantified benefits**

Despite the quantified negative NPSV of introducing the Health and Care Visa, which is predominantly a result of foregone visa fee revenue, the Government is committed to introducing a route to attract doctors, nurses and allied health and care professionals to the UK. Medical professionals play a vital role in supporting the health and well-being of the UK. Any additional workers attracted by lower fees are likely to provide non quanitified benefits (other than the quantified fiscal benefits) from filling gaps in the health and care workforce.

## Total benefits

The total benefit in the low, central and high scenarios is estimated at zero, £23.3 million and £47.5 million respectively. These are set out in Table 8.

## Summary of results

The results for the central scenario are summarised in Table 7.

**Table 7: Cost and benefits of Option 1 under central assumptions, £ million, 2020/21 to 2025/26**

| Present Values (2020/21 prices) | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 | NPSV |
|---|---|---|---|---|---|---|---|
| **Benefits** | | | | | | | |
| Revenue raised from increase in applications | 0 | 0.1 | 0.1 | 0.1 | 0.1 | 0 | 0.3 |
| Exchequer gain from increase in migrants coming to and remaining in the UK | 1.0 | 3.2 | 4.8 | 6.3 | 6.2 | 1.5 | 23.0 |
| **Total benefits** | **1.0** | **3.3** | **4.9** | **6.3** | **6.3** | **1.5** | **23.3** |
| **Costs** | | | | | | | |
| Reduction in visa fee revenue | -14.8 | -29.6 | -28.6 | -27.6 | -26.7 | -6.4 | -133.6 |
| Reduction in Priority & Super Priority Service revenue | -0.9 | -1.6 | -1.5 | -1.4 | -1.4 | -0.3 | -7.1 |
| Increase in Home Office processing costs | 0 | 0 | 0 | 0 | 0 | 0 | -0.1 |
| Increase in public expenditure | 0.4 | -1.2 | -1.8 | -2.2 | -2.3 | -0.5 | -8.4 |
| **Total costs** | **-16.1** | **-32.4** | **-31.9** | **-31.3** | **-30.3** | **-7.3** | **-149.3** |
| **Net benefit** | **-15.1** | **-29.0** | **-27.0** | **-25.0** | **-24.1** | **-5.8** | **-126.0** |

Source: Home Office internal analysis, 2020. Figures may not sum due to rounding.

**NPSV, BNPV and EANDCB**

**Under central assumptions the estimated quantified total costs and total benefits are £149 million and £23 million respectively, resulting in an estimated NPSV of -£126 million** (5-year PV, 2020/21 prices).

**Changes to the assumptions on price elasticity of demand for a visa, keeping all other assumptions constant, produces a range around the NPSV result for the central case of -£141 million to -£112 million** (5-year PV, 2020/21 prices).

Under the low elasticity scenario, where applicants do not have any behavioural response to the reduction in fees, the NPSV of the policy decreases to **-£141 million** over the five-year appraisal period. Under the high scenario, where applicants have a stronger behavioural response to the reduction in the visa fee, the NPSV of the policy is **-£112 million**.

The impact on business is expected to be negligible which results in an estimated Business Net Present Value (BNPV) and EANDCB of zero.

Table 8 summarises the impact of changes in elasticity assumptions on the NPSV of the policy, broken down by cost and benefit.

**Table 8: NPSV range under different elasticity assumptions**

| Present Values – Five-year appraisal period (2020/21 prices)<br>Price elasticity of visa demand assumptions | Low elasticity / Low NPSV | Central NPSV | High elasticity / High NPSV |
|---|---|---|---|
| **Benefits** | | | |
| Revenue raised from increase in applications | 0 | 0.3 | 0.7 |
| Exchequer gain from increase in migrants coming to and remaining in the UK | 0 | 23.0 | 46.8 |
| **Total benefits (PV)** | **0** | **23.3** | **47.5** |
| **Costs** | | | |
| Reduction in visa fee revenue | -133.6 | -133.6 | -133.6 |
| Reduction in Priority & Super Priority Service revenue | -7.1 | -7.1 | -7.1 |
| Increase in Home Office processing costs | 0 | -0.1 | -0.3 |
| Increase in public expenditure | 0 | -8.4 | -18.7 |
| **Total costs (PV)** | **-140.8** | **-149.3** | **-159.8** |
| **Net Present Social Value (NPSV)** | **-140.8** | **-126.0** | **-112.3** |

Source: Home Office internal analysis, 2020. Figures may not sum due to rounding.

## In Country Transfers

### E.7 Immigration Skills Charge

A reduction in the fee level is expected to lead to a small increase in the number of Immigration Skills Charge (ISC) liable visa applications. The ISC was implemented in April 2017 as part of a package of wider government reforms to Tier 2 and is designed to ensure that employers invest in skills training for the domestic workforce. The obligation to pay the ISC sits with the migrant's sponsor, an employer operating in the UK. The ISC is collected by the Home Office as part of the visa sponsorship process and the income is transferred by the Home Office to HM Treasury Consolidated Fund, less an amount to cover collection and administrative costs. The population percentages underlying the Barnett formula are used by HM Treasury to determine the split of funding between the Department for Education and each of the Devolved Administrations.

The increase in the ISC payable by UK operating employers is regarded as a transfer payment between UK employers and the UK Government; this is because the increase in ISC payable represents an increase in revenue for the Government and a cost to UK operating employers. Transfer payments may change income or wealth distribution of the resident population, but do not give rise to direct economic costs and benefits, and thus are not counted in the NPSV of the option considered. Keeping all assumptions at their central scenario level, the estimated increase in cost to employers and therefore the increase in government revenue associated with the fee decrease is **estimated to be £1.7 million** (PV, 2020/21 prices).

### E.8 Transfer payment from the Department of Health & Social Care (DHSC) to the Home Office

The lower visa fee offered by the Health and Care Visa will result in foregone fee revenue to the Home Office, estimated at **£133.6 million** (PV, 2020/21 prices)**.** DHSC will cover the cost of this foregone fee revenue. This represents a transfer payment between Government departments. Transfer payments are not usually included in estimates of the NPSV as they do not give rise to direct economic costs and benefits. However, this transfer payment will compensate the Home Office for the loss in fee revenue income that may result from the policy, which constitutes a direct economic cost for the Government and therefore is represented in estimates of the NPSV.

# F. Sensitivity Analysis

This IA further builds on results for the central scenario to present sensitivity analysis. The assumptions below are varied while holding all others constant, allowing the assessment of the impact that different assumptions have on the results in the central scenario.

### F.1 Employment opportunities for UK residents

The increase in the volume of migrants entering the UK could have an impact on the labour market by affecting the employment opportunities of UK residents. In previous impact assessments, the Home Office has included an assessment of this displacement effect of lower skilled workers in the central scenario. Given the fact that the policy applies predominantly to skilled Health and Care workers, **this impact assessment has not attempted to capture such effects as part of the central Net Present Social Value (NPSV) estimates.**

However, as the policy is estimated to also increase the volume of dependants of Health and Care Visa applicants, there may be some degree of displacement that arises as a result of any increase in lower skilled employment of this cohort. Due to the small volumes involved, **this impact is expected to be negligible, and has not been quantified here.**

### F.2 Public Service Provision

The range of estimates for the increase in public expenditure and revenue to the exchequer given in this IA are based on the low, central and high elasticity of demand estimates set out in table 3, which drive different estimates of the volume of visas granted.

To reflect the uncertainty around the fiscal impact of a migrant, sensitivity analysis has also reflected various estimates of the value of average public service consumption by migrants. The difference between the low and high scenario is the inclusion of pure public goods and welfare costs in the estimate; while the central case does not include pure public goods, it does include half of the estimated welfare cost reflecting that migrants may not be eligible to receive welfare payments. For further detail about the methodology used to determine the fiscal impact of migrations, see Annex 4.

Keeping all other assumptions at their 'central scenario' level:

- **Assuming public spending is at the 'Low' level, the NPSV of the option is estimated at -£120.8 million** (5-year PV, 2020/21 prices). This sensitivity result assumes that the Government spends less on migrants that are attracted to or remain in the UK. This cost reduces from **£8.4 million** in the central case to **3.3 million** (5-year PV, 2020/21 prices) if the low assumptions are used.

- **Assuming public spending is at the 'High' level, the net impact falls to -£133.3 million** (5-year PV, 2020/21 prices). This sensitivity result assumes that the Government spends more on migrants that are attracted to or are encouraged to remain in the UK. Expenditure increases from **£8.4 million** in the central case to **£15.7 million** (5-year PV, 2020/21 prices) if high assumptions are used.

The difference in NPSV between these two public spending levels is relatively small in magnitude compared to the NPSV of the policy. This can be attributed to the reduction in the IHS and visa fee having a relatively small effect on the volumes of migrants that are encouraged to enter or remaining in the UK, to whom public service costs are applied.

### F.3 Priority Service substitution

The analysis in this impact assessment makes a high-level assumption that 50 per cent of applicants for the current Priority and Super Priority Service routes switch to the standard product after the Health and Care Visa is introduced. The rationale for this is the diminished value of the

premium service routes given the two-week processing offer standard as part of the new Health and Care Visa.

To reflect the uncertainty in this assumption, a further two scenarios are considered, a higher 100 per cent adjustment and a lower 25 per cent adjustment.

Holding all other assumptions as per the 'central' scenario, **assuming that 100 per cent of Priority service applicants move to the standard channel, Home Office income would fall by an additional £7.1 million which results in a reduction in the NPSV of the proposed policy to -£133.1 million** (5-year PV, 2020/21 prices).

In turn, **assuming that 25 per cent of Priority service applicants move to the standard channel, this would result in a lower reduction in Home Office revenue of £3.6 million and therefore a NPSV of the proposed policy of -£122.4 million** (5-year PV, 2020/21 prices).

### F.4 Covid-19

The analysis in the central case of this IA makes no adjustment for the potential impact of Covid-19 on baseline volumes or on the net impact of the policy over the appraisal period due to the high level of uncertainty. This section outlines an indicative estimate of the potential net impact of the policy assuming an impact of Covid-19 on the number of additional visa-liable migrants entering the UK over the financial year 2020/21. Covid-19 is not assumed to have an effect on inflows in subsequent years.

We have assumed a 50% reduction in the number of Health & Care Visa eligible applications relative to the pre-Covid forecast for 2020-21. This would result in a fall in the estimated cost of the policy for 2020/21 from £16.1 million to £8.0 million and a fall in the estimated benefit from £1.0 million to £0.5 million. This would lead to a decrease in the net cost of the policy over the appraisal period from £126.0 million to **£118.4 million (5-year PV, 2020/21 prices).**

### Small and Micro Business Assessment

As the volume of additional migrants encouraged to migrate or remain in the UK is small relative to total volumes, it is not expected that there will be a large impact on business. In addition, since this policy is principally targeted at those employed by the NHS, one of the largest employers in the UK, small and micro-businesses will be much less likely to be affected.

## G. Proportionality

The level of analysis used in this impact assessment was reasonable considering the complexity of the immigration system and the related changes to the Tier 2 visa route. The best available data has been used along with sensible and proportionate assumption, some of which are taken from the published literature. A considerable effort has been devoted to this analysis but no more than that required given the scale of costs and benefits involved. Similarly, the analysis has been tested with sensitivity analysis and was subject to proportionate analytical quality assurance. The resource devoted to the analysis is proportionate to the complexity of the analysis and the associated risks.

## H. Risks

### H.1 Baseline volumes

The baseline volume estimates outlined in this impact assessment are subject to significant uncertainty. The Covid-19 Pandemic, any NHS policy responses to maintain doctor and nursing recruitment, and the introduction of the Points Based System from January 2021 will each affect the volume of potential NHS-visa eligible inflows into the UK over the appraisal period.

However, no further adjustment has been made to the baseline volumes in this impact assessment. This is because it is not possible at this stage to isolate the impact of each to make a reasonable adjustment. As such, these baseline figures represent a reasonable approximation of the volume of inflows that might be expected under the Health and Care Visa but are subject to especially high levels of uncertainty.

The impact of Covid-19 on immigration to the UK remains uncertain. No adjustment has been made to volumes or the estimated impact of the policy as the potential impact of Covid-19 remains highly uncertain over the entirety of the appraisal period. See F.4 for further detail on the potential effect of Covid-19.

### H.2 Elasticity Assumptions

The application of elasticities in this impact assessment has not been tested in relation to the reduction of these specific visa fees and is unlikely to perfectly reflect the real-world elasticity in the specific circumstances considered, but it is believed that these represent the best available proxy measures.

As the Government is committed to introducing a route to attract qualified health and care professionals to the UK due to the non-quantifiable benefits that result, despite the quantified negative NPSV, break-even analysis has not been considered in this case.

### H.3 Displacement from Priority Service

The standard service level agreement to process Health and Care Visa applications within two weeks will reduce the relative benefit for an applicant in paying a premium for the Priority or Super Priority Service. In the absence of evidence on the magnitude of this behavioural response, the central scenario assumes a 50 per cent reduction in the number of applicants opting to pay for the premium services. Section F.3 outlines two sensitivity scenarios to outline an indicative range in the cost of displacement from the premium service routes.

## I. Summary and Recommendations

Table 9 outlines the costs and benefits of the proposed policy in the central scenario. **The Government's preferred option is Option 1** as it better meets its policy objectives. Despite the negative NPSV, the Government recognises that medical professionals play a vital role in supporting the health and well-being of the United Kingdom.

**Table 9: Cost and benefits of proposed policy (£m)**

| Option | Present Values – Five-year appraisal period (2020/21 prices) | | |
|---|---|---|---|
| | Benefit | Cost | NPSV |
| 1 | **23.3** | **-149.3** | **-126.0** |

Source: Home Office internal analysis, 2020.

## J. Wider impacts

Given the relatively small change in the estimated volume of applications over the appraisal period resulting from the policy, no wider impacts are considered in this IA.

The policy is not considered in scope of The Family Test[13]; there will be no change in the ability of depdenants to accompany main applicants and there will be no impact at the level of the family.

The policy is not considered to be in scope of a Health Impact Assessment of Government Policy as the impact on the health and wellbeing of the UK population is likely to be low. It is not anticipated that the number of people coming under the Health and Care Visa will have a significant impact on

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/368894/family-test-guidance.pdf

the wider health of the UK. The policy will primarily benefit health and care professionals who would have otherwise applied for the Tier 2 (General) route.

## K. Trade

This policy is unlikely to have any significant impact on trade.

## L. Implementation, monitoring, feedback, enforcement and evaluation

The policy is expected to be implemented from August 2020, following the introduction of secondary legislation.

The Home Office will continue to work closely with the Department of Health and Social Care and will engage with other Government departments as required. The impact of the introduction of the Health and Care Visa will be monitored by the Home Office, with support, as appropriate, from the Department of Health and Social Care and the devolved health ministries.

The Home Office will maintain open lines of communication with migrants via a dedicated email address and may also receive feedback as part of its normal visa issuing processes, through its public enquiry lines, and through formal correspondence with interested parties.

After five years there will be an evaluation of this policy.

## ANNEX 1 – A list of Health and Care Visa eligible Shortage Occupation Codes

Applications from visa liable medical staff who are applying to work in one of the following professions, with a job offer from the NHS, a social care provider or an organisation which provides services to the NHS, who have been trained to a recognised standard and who have good working English, will be eligible for the Health and Care Visa.

- 2112 – Biological scientists and biochemists
- 2113 – Physical Scientists
- 2211 – Medical Practitioners
- 2212 – Psychologists
- 2213 – Pharmacists
- 2214 – Ophthalmic Opticians
- 2215 – Dental practitioners
- 2217 – Medical Radiographers
- 2218 – Podiatrists
- 2219 – Health Professionals not elsewhere classified
- 2221 – Physiotherapists
- 2222 – Occupational Therapists
- 2223 – Speech and Language Therapists
- 2229 – Therapy professionals not elsewhere classified
- 2231 – Nurses
- 2232 – Midwives
- 2442 – Social Workers
- 3213 – Paramedics

## ANNEX 2 – Visa fee and Unit Costs

**Table A2.1 – The visa fee and unit cost for Out of Country Health and Care Visa applications, £.**

| OUT OF COUNTRY - Visa Products | Estimated 2020/21 Unit Cost (£) | 2020/21 Fee (£) |
|---|---|---|
| Health and Care Visa Up to 3 years- Main applicant | 127 | 232 |
| Health and Care Visa Up to 3 years- Dependant | 127 | 232 |
| Health and Care Visa Over 3 years- Main applicant | 127 | 464 |
| Health and Care Visa Over 3 years- Dependant | 127 | 464 |

Source: Home Office internal analysis, 2020

**Table A2.2 – The visa fee and unit cost for In Country Health and Care Visa applications, £.**

| IN COUNTRY - Visa Products | Estimated 2020/21 Unit Cost (£) | 2020/21 Fee (£) |
|---|---|---|
| Health and Care Visa Up to 3 years- Main applicant | 317 | 232 |
| Health and Care Visa Up to 3 years- Dependant | 317 | 232 |
| Health and Care Visa Over 3 years- Main applicant | 317 | 464 |
| Health and Care Visa Over 3 years- Dependant | 317 | 464 |

Source: Home Office internal analysis, 2020

## ANNEX 3 – Elasticity Assumptions

The following table sets out the elasticities used to analyse the impact of a change in visa fee on demand for the Health and Care Visa. Elasticities used for dependent applications are not included in Table A3.1 as these were not derived from academic literature; rather, they were derived from Home Office analysis on the likely response by dependents from changes to dependent fees. Such responses were deemed to yield an elasticity in the central case of 0.3 for out of country applicants and zero for In-Country applicants.

The term 'elasticity' measures the responsiveness of demand for a product after a change in a product's own price. The elasticity assumption used here should be interpreted as the proportional increase in visa applications (the demand) for a 1 per cent increase in expected income over the total duration of the visa due to the decrease in visa fee (the price). For example, if the decrease in visa fee represents a 2 per cent increase in total expected income and elasticity is assumed to be -0.5, volumes would increase by -0.5 x 2 per cent = 1 per cent.

**Table A3.1: Empirical studies of the wage elasticity of labour supply**

| Source | Estimate of wage elasticity of labour supply | Measure |
|---|---|---|
| Bargain, O., Orsini, K. & Peichl, A. (2012) *Comparing Labor Supply Elasticities in Europe and the US: New Results (December 2012)*. SOEP paper No. 525. | Men: between 0 and 0.4<br>Women: between 0.1 and 0.6 | Elasticity of labour supply based on total hours in response to changes in tax-benefit policies. Uses data from Europe and the US from 1998 to 2005. |
| Blundell, R., Bozio, A. & Laroque, G. (2011) *Extensive and intensive margins of labour supply: working hours in the US, UK and France,* IFS Working Papers W11/01, Institute for Fiscal Studies. | Between 0.3 and 0.44 | Aggregate elasticity estimate for total hours of the 30 to 54 age group for UK men and women from 1968 to 2008. |
| Evers, M., Mooij, R. & Vuuren, D. (2008) 'The Wage Elasticity of Labour Supply: A Synthesis of Empirical Estimates', *De Economist,* Springer, vol. 156(1), pp. 25-43. | Men: 0.07<br>Women: 0.43 (0.34 excluding outliers) | Mean estimates for a sample of 209 uncompensated labour supply elasticities in different developed countries. Average year of data sample in each study ranges from 1966 to 2000. |
| Jäntti, M., Pirttilä, J. & Selin, H. (2015) 'Estimating labour supply elasticities based on cross-country micro data: A bridge between micro and macro estimates?' *Journal of Public Economics*, vol. 127, pp. 87-99. | Between 0.23 and 0.64 | Range is based on point estimates of average 'micro' and 'macro' elasticity estimates. Uses data from 13 countries, including from OECD. Data ranges from early 1970s to 2010s. |

## ANNEX 4 – Fiscal Impact of migration

Changes in the volume of migrants coming to live in the UK can be analysed in terms of their fiscal impacts, by considering the fiscal revenue that one additional migrant contributes to the economy and the portion of government spending on public services that s/he consumes. The Home Office has developed modelling to assess the fiscal impact of migration on fiscal spend and fiscal revenue.

- Fiscal spend is estimated by calculating costs per head for different types of public services accessible by non-UK nationals who visit and live in the UK.

- Fiscal revenue considers the contributions to tax revenue, such as income tax, National Insurance, council tax and indirect tax of foreign nationals.

The following sections outline in more detail the methodology used for the two components of the analysis.

### 4.1 Fiscal spend analysis

The analysis is largely based on the same methodology used for the IA for the Fee Order 2016[14], although it has been reviewed and updated where relevant. The analysis uses a top down approach to apportion total expenditure on public services at the individual level and derive unit costs per migrant status. The unit costs are then applied to the volume of applicants deterred from applying for a visa due to the price elasticity of demand for visa effect, and ultimately estimate the saving in public expenditure due to fewer people using public services.

#### Data

Data on expenditure on public services is obtained from Public Expenditure Statistical Analysis (PESA) published by HM Treasury, which provides data on public sector expenditure broken down by functions. The analysis is based on data for 2017/18[15] up rated with inflation and reported in 2020/21 prices[16].

Public sector expenditure in PESA is broken down into the following functions:

- General public services.
- Defence.
- Public order and safety.
- Economic affairs.
- Environment protection.
- Housing and community amenities.
- Health.
- Recreation, culture and religion.
- Education.
- Social protection.
- EU transactions.

Data on migrant population characteristics is obtained from the Annual Population Survey (APS) produced by the Office for National Statistics. APS data for 2017/18 is used to derive population characteristics such as volumes of existing residents by nationality and age distribution. When using estimates of total UK population, the analysis uses ONS 2017[17] data which is considered more accurate than APS data.

[14] http://www.legislation.gov.uk/uksi/2016/177/impacts

[15] See Chapter 5 at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/726871/PESA_2018_Accessible.pdf

[16] https://www.gov.uk/government/statistics/gdp-deflators-at-market-prices-and-money-gdp-march-2020-budget

[17] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

**Methodology**

There are a number of different approaches to calculating fiscal impacts. The methodology attempts to represent a 'marginal' approach to measuring the impact of migration and therefore makes a distinction between costs that do not vary with additional individuals moving to the UK or extending their stay, and costs that do vary when one additional individual decides to move to the UK.

The fiscal impacts included here are also those attributable from migrants – any transfers between for example between UK companies and the Exchequer are excluded, according to Green Book guidance and MAC recommendations on appraisal of migration policies.

*Treatment of public goods*

Goods and services that do not vary with an additional individual are known as public goods and are defined as 'non-rival' and 'non-excludable'. Non-rival means that the consumption of the good or service by one individual does not exhaust the opportunity for another person to consume the good or service. Non-excludable means that once the good or service is provided, it is impossible to prevent individuals from consuming it. For example, once street lighting is provided, it is impossible to prevent individuals walking past from benefitting from the light provided, regardless of whether they have contributed to that provision of that street lighting.

This IA makes a further distinction between pure and congestible public goods or services. The classification of public goods and services as pure and congestible is uncertain and open to debate. The definition and classification used in this IA is based on Dustman & Frattini 2014[18]. Pure public goods are non-rival and non-excludable, and the additional cost of providing such a good or service to an individual is considered to be zero. This category includes for example expenditure on basic research, or on defence. Congestible public goods are to some extent rival in consumption, but the additional cost of providing such goods and services is unknown and expected to be smaller than average costs. This category includes for example expenditure on transport and waste management.

Based on the Dustman and Frattini 2014 classification of pure and congestible public goods, Home Office analysts estimated the unit cost per person of such goods and services using PESA 2017/18 data for public expenditure divided by total population estimates. ONS total population estimates for 2017[19] are used to estimate the total population. Table A4.1 presents the results. In the short term, whilst expenditure on pure public goods is not expected to vary with additional individuals, expenditure on congestible public goods is more likely to vary.

For the scenario analysis, the central and low scenarios include only the unit cost for congestible public goods, to reflect the fact that these costs are more likely to vary in the short term with one additional individual. The high scenario includes estimates of both pure and congestible public goods and services to reflect the possibility that over time a large increase in the population due to migration may lead to an increase in expenditure on these goods and services.

**Table A4.1 Public good and services estimates, 2020/21 prices, £.**

| **Public good and services estimates** | |
|---|---|
| Pure | 1,700 |
| Congestible | 1,600 |

Source: Home Office analysis using PESA 2017/18 and APS 2017/18 data. Data uprated with inflation. Figures are rounded to the nearest 100.

*Treatment of all other public services*

[18] http://www.cream-migration.org/files/FiscalEJ.pdf

[19] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates

For those categories of expenditure where costs would change when one additional individual moves or stays in the country, with costs shared equally across the population, public expenditure is apportioned to the total UK population to derive a unit cost estimate using ONS 2017 population estimates. Examples include public expenditure on policy or housing development. The Home Office estimate of the unit cost for providing these public services is estimated at £560[20] per person in 2020/21 prices.

*Treatment of public services: Health, Education and Social Services*

In some cases, the consumption of public services is likely to vary by age, gender, family composition and other factors such as income and ethnicity. Migrants and the native population may therefore have different characteristics in relation to the consumption of public services.

APS 2017/18 data shows that around 50 per cent of non-EEA nationals living in the UK are aged between 20 and 44, compared to 25 per cent of UK nationals. Following a similar approach to the one used in the 2016 Fee Order IA[21], this analysis estimates public service expenditure on health, education and social services by migrant status, adjusting for the age distribution of the migrant group.

Unit costs are calculated by apportioning PESA 2017/18 spend on education, health and social services by the proportion of each age group made up by non-EEA nationals. This uses APS 2017/18 data to identify the migrant population by migrant status such as worker, student or dependant.

For health estimates, unit costs are calculated based on OBR data on the proportion of total health spend by age group[22] and weighted by the proportion of non-EEA nationals in each age group by migrant status. It is important to note that the estimates used in the central and high scenario only adjust for the age distribution of the non-EEA population, and do not make any further adjustments. For example, no adjustment is made in the central and high scenario for use of the service, which can be different between migrants and the native population. A further reduction of 72 per cent has been made to health unit costs in the low scenario, to reflect Department of Health & Social Care internal analysis on the lower use of health services by the migrant population compared to the UK population as a whole[23].

Unit costs for education and social services are calculated by apportioning PESA 2017/18 spend to the proportion of non-EEA nationals in each age category. A unit cost is estimated by migrant status, which seeks to reflect the characteristics of the different segments of the non-EEA population. Note that no education costs are assigned to workers and students. Non-EEA workers are by definition in the UK for employment reasons and therefore no spend on education services is apportioned to them. Non-EEA students pay tuition fees set at a higher level than for UK and EEA students, which are assumed to cover the cost of their studies. The estimates used for education, health and social services unit costs are summarised in the Table A4.2 below.

**Table A4.2 Education, health and social services unit costs, 2020/21 prices, £.**

| Health, Education, Social Services | Central and High Scenarios | Low Scenario |
|---|---|---|
| All migrants | 3,100 | 1,900 |
| All non-EEA migrants | 3,100 | 1,800 |
| Non-EEA More than 5 years | 2,500 | 1,200 |
| Non-EEA Less than 5 years | 2,700 | 1,600 |
| Non-EEA Economic migrant | 1,800 | 700 |
| Non-EEA Student | 600 | 200 |
| Non-EEA Dependant | 3,600 | 2,400 |

Source: Home Office internal analysis. Figures are rounded to the nearest 100.

[20] Rounded to the nearest £10

[21] The methodology used in the 2016 Fee Order impact assessment was based on work by the National Institute for Economic and Social research 2011, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257236/impact-of-migration.pdf

[22] OBR 2016; http://budgetresponsibility.org.uk/fsr/fiscal-sustainability-analytical-papers-july-2016/

[23] Department of Health & Social Care estimate of the use of service is based on data on use of primary and secondary care by immigration health surcharge payers.

The estimates are based on the age distribution of non-EEA migrants using APS data on nationality. They do not therefore include those long-term migrants who have obtained British nationality as they are considered part of the resident population. It should be noted that the age distribution used in the analysis may therefore be skewed towards younger and working age individuals.

*Treatment of public services: Welfare*

Individuals subject to visa requirements are not eligible to access the welfare system for the first five years lived in the UK[24]. As the appraisal period of the analysis covers five years, welfare costs are only applied in the high scenario as sensitivity, as it is unlikely that the majority of migrants considered in the analysis would be eligible for welfare payments.

The central scenario assigns half of welfare expenditure to all migrant categories except those who have been in the country for less than five years[25]. This reflects the fact that the visa categories considered cover both new applicants and extensions and therefore it is possible that those who extend their visa may have been in the country long enough to be eligible for welfare payments.

The estimate used for welfare costs per person is based on PESA 2017/18 expenditure, weighted to reflect the working-age and pension-age splits of non-EEA nationals using APS 2017/18 data. The Home Office estimates this cost to be £2,500[26] per person in 2020/21 prices (2017/18 data has been uprated with inflation). It is important to note that this only takes into account the age distribution of the non-EEA population, and does not make any further adjustments.

The estimate is also based on the age distribution of non-EEA migrants using APS data by nationality and not by country of birth; it does not therefore include those long-term migrants who have obtained British nationality as they are considered part of the resident population. The age distribution used in the analysis may therefore be skewed towards younger and working age individuals.

**Results**

In summary, the impact assessment makes the following assumptions in the low, central and high scenarios, as set out in Table A4.3.

**Table A4.3 Summary assumptions used in the IA, 20120/21 prices, £.**

| Unit cost | 2020/21 prices, £ | Scenario | | |
|---|---|---|---|---|
| | | Low | Central | High |
| Pure public good | 1,700 | - | - | Included |
| Congestible public good | 1,600 | - | Included | Included |
| Other public services | 600 | Included | Included | Included |
| Health, Education, Social Services | Varies | Included | Included | Included |
| Welfare | 2,500 | - | Included (half) | Included (full) |

Source: Home Office internal analysis. Figures are rounded to the nearest 100.

Table 4.4 shows the total unit cost used by migrant status in each scenario.

[24] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/639597/analysis-of-migrants-access-to-income-related-benefits.pdf

[25] In the absence of further evidence on the migrants' use of the welfare system over time, 50% of estimated welfare expenditure has been selected as an indicative assumptions, and it may not accurately reflect reality.

[26] Rounded to the nearest £100.

**Table A4.4 Total unit cost used by migrant status in each scenario, 2020/21 prices, £.**

| Category | Low | Central | High |
|---|---|---|---|
| All migrants | 2,500 | 5,300 | 9,500 |
| All non-EEA migrants | 2,400 | 5,200 | 9,400 |
| Migrant in last 10 years | 1,700 | 4,600 | 8,900 |
| Migrant in last 5 years | 2,200 | 5,000 | 6,600 |
| Economic migrant | 1,300 | 4,100 | 8,200 |
| Student | 800 | 3,600 | 7,000 |
| Dependant | 3,900 | 5,800 | 9,900 |

Source: Home Office internal analysis. Figures are rounded to the nearest 100.

## 4.2 Fiscal revenue analysis

The analysis on fiscal revenue is based on a similar methodology to that used for the 2016 Fees Order impact assessment, although it has been reviewed and updated where relevant. The model uses a bottom up approach to calculate the expected contribution to direct and indirect taxes from visa applicants. The results are applied to the volume of visa applicants deterred from applying due to the price elasticity effect on visa demand, as a consequence of the increase in visa fees. This enables calculation of the total tax revenue forgone due to fewer migrants moving to the UK or extending their stay.

### Data

The analysis applies tax rates and assumptions on tax contributions to generate estimates of both the direct and indirect tax contributions associated with applicants applying to each visa category. These are used as proxies for the earnings of those applying.

The analysis uses data on gross income estimates from 2018/19 Home Office management information, with the figures subsequently inflated to 2020/21 prices. For dependants, the incomes of dependants across visa categories is proxied using an estimate of the annual wage of non-EEA dependents (spouse/partner/child under 18) living in the UK without indefinite leave to remain (ILTR) for non-settlement visas, and with ILTR for settlement visas.

### Methodology

The analysis considers the fiscal contribution of a migrant through direct and indirect taxation. For direct taxation the analysis applies income tax and National Insurance Contribution rates from 2017/18 to the income estimates for each visa category. The estimates are adjusted for inflation to generate estimates for 2020/21.

Council tax contributions are estimated based on ONS estimates of council tax contribution by income decile[27]. These estimates are adjusted by the number of economically active people per household to estimate an individual's council tax contribution. The amount spent on council tax for each income decile is then applied to income estimates for each visa category. The income deciles of the salaries for visa categories is based on the same distribution used in the ONS estimates.

Indirect taxes include VAT, duties on specific products such as alcohol and tobacco, licences such as television and intermediate taxes. Indirect tax contributions will depend upon tastes, preferences and characteristics. The lack of robust data on the expenditure of migrants results in uncertainty about their spending patterns. Therefore, for indirect tax contributions the analysis applies a similar approach as taken for council tax. ONS estimates[28] are used to calculate the proportion of income spent on indirect

[27] ONS publication on "The effect of taxes and benefits on household income 2017/18"; April 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/incomeandwealth/bulletins/theeffectsoftaxesandbenefitsonhouseholdincome/financialyearending2018

[30] https://www.gov.uk/government/statistics/family-resources-survey-financial-year-201718

tax for each earning decile, and these proportions are then applied to the estimated income for each visa category.

The analysis excludes intermediate taxes paid on employers' National Insurance Contributions, business rates and corporation taxes as these are considered transfers between businesses and the Exchequer. The analysis also does not make further adjustments to cover other taxes, for example environmental levies or capital gains tax or GOS revenue. It is therefore possible that the fiscal revenue estimates outlined in this IA do not align with estimates in other HO publications, as they are not intended to reflect total direct and indirect taxes.

The estimates of the fiscal contribution of migrants only include direct and indirect tax contributions from migrants themselves. The analysis does not account for any impact that migrants may have on the fiscal contributions of the resident population. For example, this may occur through the impact of migrants on the productivity and wages of resident workers or through the impact of any displacement of resident workers that may result from migration.

### Results

The following table shows the expected contribution per year to direct and indirect tax for Tier 2 applicants, including those for the Health and Care Visa. Results are based on the estimated salary of an applicant.

**Table A4.5 Expected average annual salaries and contributions per year to direct and indirect tax for Tier 2 General/ Health and Care Visa applicants, 2020/21 prices, £.**

| Visa Product | Average income (£) | Estimated yearly contribution to direct and indirect taxes (£) |
|---|---|---|
| **Out of Country** | | |
| Tier 2/ Health and Care Visa- Main applicant: < 3 years | 38,700 | 17,700 |
| Tier 2/ Health and Care Visa- Main applicant: >3 years | 38,700 | 18,600 |
| Tier 2/ Health and Care Visa- Dependant: < 3 years | 7,200 | 2,400 |
| Tier 2/ Health and Care Visa- Dependant: >3 years | 7,200 | 2,400 |
| **In Country** | | |
| Tier 2/ Health and Care Visa- Main applicant: < 3 years | 39,000 | 4,900 |
| Tier 2/ Health and Care Visa- Main applicant: >3 years | 39,600 | 13,800 |
| Tier 2/ Health and Care Visa- Dependant: < 3 years | 7,200 | 2,400 |
| Tier 2/ Health and Care Visa- Dependant: >3 years | 7,200 | 2,400 |

Source: Home Office internal analysis. Figures are rounded to the nearest 100.

**Impact Assessment Checklist**

| Mandatory specific impact test - Statutory Equalities Duties | Complete |
|---|---|
| **Statutory Equalities Duties**<br>The Health and Care Visa will be available to anyone applying to enter the UK under the Tier 2 General route (or the equivalent skilled route under the Points Based System) who work for the NHS or an organisation which provides services for the NHS. The proposed changes would not directly discriminate as the route would be open to all persons who meet the relevant criteria regardless of age, disability, gender reassignment; pregnancy and maternity; race (including ethnic or national origins, colour or nationality); religion or belief; sex; and sexual orientation. There may be a risk of indirect discrimination. For example, the majority of applicants for a Tier 2 General visa are below the age of 39 so eligible overseas health professionals below this age are more likely to benefit from the introduction of an Health and Care Visa. In addition, early evidence suggests that more women than men in health professions apply for a Tier 2 visa. However, this is mitigated by all applicants having to meet the same requirements (such as skills level and salary). As with all policies the Health and Care Visa will be kept under review and there will be of consideration of further action if there are signs of discrimination. | **Yes** |

**Economic Impact Tests**

| Does your policy option/proposal consider…? | Yes/No (page) |
|---|---|
| **Business Impact Target**<br>The Small Business, Enterprise and Employment Act 2015 (s. 21-23) creates a requirement to assess the economic impacts of qualifying regulatory provisions on the activities of business and civil society organisations. [Better Regulation Framework Manual] or<br>[Check with the Home Office Better Regulation Unit] | No |

| | |
|---|---|
| **Small and Micro-business Assessment (SaMBA)**<br>The SaMBA is a Better Regulation requirement intended to ensure that all new regulatory proposals are designed and implemented so as to mitigate disproportionate burdens. The SaMBA must be applied to all domestic measures that regulate business and civil society organisations, unless they qualify for the fast track. [Better Regulation Framework Manual] or [Check with the Home Office Better Regulation Unit] | Yes- see page 17 |

**Social Impact Tests**

| | |
|---|---|
| **Family Test**<br>The objective of the test is to introduce a family perspective to the policy making process. It will ensure that policy makers recognise and make explicit the potential impacts on family relationships in the process of developing and agreeing new policy. [Family Test Guidance] | Yes- see page 19 |

| | |
|---|---|
| **Health Impact Assessment of Government Policy**<br>The Health Impact Assessment is a means of developing better, evidenced-based policy by careful consideration of the impact on the health of the population.<br>[Health Impact Assessment Guidance] | Yes- see page 19 |