

Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services



A summary of submissions to a Department of Health consultation whose findings were never published

Global Health Advocacy Project
August 2008



"Freedom of Information...can be inconvenient, at times frustrating and indeed embarrassing for governments. But Freedom of Information is the right course because government belongs to the people, not the politicians [...] Public information does not belong to Government, it belongs to the public on whose behalf government is conducted. Wherever possible that should be the guiding principle behind the implementation of our Freedom of Information Act."

Gordon Brown, 27 October 2007

"[T]here is much that we simply do not know. We don't know how many people in the UK fall - intentionally or not - into the groups that would be most affected by the proposed changes to primary care; nor do we know how many have already been refused secondary care and what has happened to this group. Perhaps more importantly it is not clear how we will provide alternative care for those who will be excluded from both secondary and primary care. It is perhaps not unreasonable to suggest that the Government answers these questions before taking such a drastic measure."

Medact, 2007

The following individuals helped with the collection of data or with the writing of this document:

Jonny Currie, James Chan, Dr Jienchi Dorward, Sophie Epstein, Dr Rob Hughes, Vanessa Jessop, Natalie King, Sarah Legrand, Dr Fred Martineau, Lizzie Moore, Helen Preston, Jennifer Riches, Nick Riches, Catherine Sikorski, Claire Shaftoe, Abi Smith, Tom Yates, Maryam Zaky.

The Global Health Advocacy Project is a group of students and young healthcare professionals, affiliated to the student group Medsin. Our aim is to challenge health inequalities in the UK and overseas.

www.wheretheconsultation.org
www.medsin.org/defendprimaryhealthcare

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If you would like to contact the authors of this report, please email access@medsin.org or write to us at...

Global Health Advocacy Project
C/o Tom Yates
105 Millington Lane
Cambridge
CB3 9HA

Please address any media enquiries to...

Tom Yates +44 (0)7809 600 784
Rob Hughes +44 (0)7714 214 182

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Full copies of the submissions summarised
in this report can be accessed via
www.wherestheconsultation.org

Preface

I warmly congratulate my young colleagues for the time and trouble they have taken to produce this compelling evidence. The proposals it relates to would undoubtedly have intolerable unintended consequences. The moral and ethical issues which arise for desperate individuals, the cohesion of minority communities and alienated health professionals should suffice to inspire wiser counsel.

Any policy maker who remains unmoved by humanitarian obligations might be impressed by the challenges posed by the logistical nightmare of seeking to impose charges on patients who are clearly unable to pay.

Finally, if those factors fail to register, there is our time-honoured public health appeal to enlightened self-interest. At its lowest, this argues for the precautionary principle - for preventing disease and treating needy sick people in primary care if only to minimise demands on more expensive hospital care when their condition has deteriorated. At its best, there is the imperative of protecting healthy people from contracting preventable communicable diseases from untreated individuals.

Overall, this document highlights the many dangers in using health policy as a lever of immigration policy, and we should be grateful that these arguments are now being published.

Sir Alexander Macara
Chairman of Council 1993-98
British Medical Association



Executive Summary

In 2004, the Department of Health carried out a public consultation exploring proposals to deny access to primary healthcare to failed asylum seekers and undocumented migrants. The results of this consultation were never published and the department have resisted our attempts to bring them into the public domain. They now claim submissions to the consultation will be made public in October 2008.

This document, which has been **written by medical students and doctors** working with the Global Health Advocacy Project, summarises the content of submissions we have been able to obtain. It is regrettable that this important body of opinion has not been available to guide and inform public debate on this issue over the last four years.

Submissions were received from doctors, primary care trusts and non-governmental organisations working with migrant communities. **Ninety seven percent raised at least one concern about the proposals** with eighty two percent raising three or more. Only thirteen percent broadly supported the proposals.

Notable concerns raised were as follows:

1. **Seventy five percent of submissions from healthcare providers expressed concern that denying care would place them in breach of professional codes of conduct.** Many were concerned that questioning patients about their immigration status could damage the doctor patient relationship.
2. Sixty eight percent of submissions expressed concerns regarding the public health impact of the proposals, particularly the risk that the **delayed detection and treatment of infectious diseases would constitute a risk to public health.**
3. It was stressed that certain groups were particularly vulnerable and concerns were raised about the potential impact of the proposals on children and pregnant women. The majority of respondents felt **refused asylum seekers, settled in the UK, were not 'overseas visitors'**, rather they were a vulnerable group who should not fall within the scope of the proposals.
4. **Eighty seven percent raised concerns about the workability of the proposals.** These included the challenge of requiring front-line healthcare workers or NHS administrators to determine immigration status.
5. Fifty five percent of respondents were concerned about the cost effectiveness of the proposals. Many felt that administrative costs incurred, as well as the costs associated with an inevitable increase in the uptake of expensive emergency services, would exceed any savings made in primary care. Some highlighted **the Government's failure to undertake a cost-benefit analysis of the proposals.**

6. A number of respondents thought the implementation of these proposals would lead to discrimination, social marginalisation and damage to the public perception of migrant communities. Some called for a full race impact assessment prior to any implementation of the proposals.

7. Twenty nine percent of submissions expressed concerns that the proposals would violate several international human rights agreements and therefore be open to legal challenge.

8. Whilst **five submissions were broadly supportive of the proposals**, seeing the current situation as lacking clarity, these submissions all contained concerns. One of these respondents contacted us to inform us that their organisation no longer held the views expressed in their submission; another submission called for vulnerable migrant groups to be excluded from the proposals. Others were concerned about the practicality of the proposals.

Whilst we acknowledge our sample may be biased, the **concerns raised are valid and important**. It is vital that the Department of Health address these points before moving ahead with further policy change. We call upon them to release the remaining two hundred and thirty six submissions in order that these valuable expert opinions are available to inform public debate and policy.

Our full conclusions and recommendations can be found towards the end of the document. Our recommendations include:

1. We suggest **denial of healthcare should not be used as a means of enforcing immigration policy**.
2. We recommend the Government reconsider leaving any community unable to access primary care as this could undermine efforts to tackle infectious diseases.
3. **We recommend refused asylum seekers fall outside the remit of these proposals.**
4. Front line healthcare workers and administrative staff have **insufficient knowledge** of the asylum process to implement these proposals.
5. Government must recognise that **administering a charging** regime would place a **significant burden on front line NHS services**.
6. We recommend the Government undertake a full cost benefit analysis of both proposed and existing NHS charging regulations.

Introduction

In April 2004, 'Statutory Instrument 614' was enacted by the Department of Health¹. This meant that those classed as 'not lawfully resident' in the UK, including vulnerable migrant groups such as victims of trafficking and other undocumented migrants, were no longer, with a number of important exemptions, eligible for free NHS hospital care. Until April 2008, asylum seekers whose claims had been refused were also being denied hospital care. However, a judicial review by Mr Justice Mitting found this group to be ordinarily resident and thus eligible for free NHS care. The Government has appealed this decision, with the hearing scheduled for mid-November. However, for now, failed asylum seekers should be able to access these services.

The 2004 changes in access to secondary care were soon followed by a consultation examining proposals to extend the new rules to limit access to primary care². The stated intention of the proposed regulations was to reduce 'health tourism' - overseas visitors arriving in the UK with the sole purpose of exploiting NHS services. The results of this consultation were never released.

In March 2007, a Home Office paper 'Enforcing the Rules' was released.³ It examined access to public services by 'overseas visitors'. The document stated 'Illegal migrants are unlikely to place a great strain on the NHS as most are thought to be young and therefore relatively healthy' (page 13). However, it suggested the denial of services could be used to deter undocumented migrants from entering the country and to encourage refused asylum seekers to leave.

The issue of charging foreign nationals for care is currently being revisited by the Government. A review of their findings is expected soon. It is expected that this will lead to changes in the regulations governing entitlement to NHS primary healthcare services.⁴

¹Department Health. 'Statutory Instrument 2004 No614.The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004. Available at:

<http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Statutoryinstruments/index.htm>

²Department of Health Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services. London 2004. Available at:

http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4087618

³Home Office. Enforcing the rules. A strategy to ensure and enforce compliance with our immigration laws. London. March 2007. Available at: <http://www.ind.homeoffice.gov.uk/aboutus/ourplans/enforcementstrategy>

⁴Medact. Medact briefing: proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services. October 2007. Available at

<http://www.medact.org/content/refugees/Briefing%20V1%20agreed.pdf>.

The opinions of a variety of primary care trusts (PCTs), healthcare providers and non-governmental organisations (NGOs) were collected by the government in the 2004 consultation on charging in primary care; opinions on which future legislation is likely to be based and that have never been made public. This lack of information means that we cannot know if those who will have to implement any changes support them, or have any concerns.

This document represents a summary of the responses which we have been able to obtain directly from respondents. We hope it will help to guide the debate surrounding access to healthcare for 'overseas visitors'.

These submissions come from people working with vulnerable migrant communities every day. Most of the submissions are only now entering the public domain. These are people whose opinions should be taken very seriously. Their concerns, detailed in the following chapters, must be raised in the public debate and must be addressed before the Government proceeds with policy change.

Methodology

On 13 September 2007 we submitted a request under the Freedom of Information Act (2000) to the Department of Health. We requested...

'Information concerning the Department of Health Consultation, Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services, which closed on 13 August 2004. Specifically, [...]

- 1. Complete copies of all the submissions to this consultation.*
- 2. A complete list of all the organisations and individuals who made submissions to the consultation.'*

Whilst the department agreed to our second request they refused to supply us with copies of the submissions to the consultation. We are currently appealing this decision with the Information Commissioner. Copies of the appeals and letters we have received from the department are enclosed in the appendices to this report.

Between October 2007 and April 2008, we began to contact individuals and organisations on the list. The template letter which we used can be found in Appendix C. This was not simple as the spreadsheet provided by the department did not contain contact details. In a number of instances the affiliations of individuals were not made clear. Some people had changed employer since making their submission. Of the 274 individuals and organisations who made submissions to the enquiry, we were able to make contact with 125 and received full submissions from 38. The vast majority of those who did not send submissions either never responded to our message or no longer had a copy of their submission.

Members of our team summarised the responses to the questions in the consultation document. However, many of the responses explored broader issues and there were a number of common themes. Therefore, in addition they answered the following questions...

1. Does the submission broadly support or broadly oppose the proposals?
2. Does the submission include concerns about the public health impact of the proposals?
3. Does the submission express concern that administering a charging regime is not the role of healthcare professionals or that to do so would require them to violate professional codes of conduct or duties?
4. Does the submission raise humanitarian objections to the proposals?
5. Does the submission suggest the proposals might violate human rights laws or conventions?
6. Does the submission suggest that implementing the proposed charging regime would be impractical or create significant extra administrative work?

7. Does the submission argue that vulnerable groups (such as failed asylum seekers) should be excluded from any charging regimen?
8. Does the submission suggest it would not be cost effective to implement these proposals?

These summaries were subsequently reviewed by a second member of the team. To reduce our workload, the second member of the team was not blinded to the opinions of the first. However, we are confident about the quality of our summaries. We have placed the vast majority of submissions we received in the public domain and would be happy to supply a detailed breakdown of our summaries to interested parties.

The 38 submissions we received were...

Healthcare Providers (12)	Dr Adam Sandell (GP), Dr Brian Fine (GP), Dr Carol Cheal (GP), Dr Christina Cock (GP), Dr Helen Sykes (GP), Kent Local Medical Committee, Dr Kevin Vaughan (GP), Dr Paul Williams (GP), Dr Phillip Matthews (GP), Dr Silke Bannuscher (GP), The Whitehouse Practice and Dr Wendy Ross (GP)
Primary Care Trusts (5)	Lewisham PCT, Morecambe Bay PCT, Newark and Sherwood PCT, South Birmingham PCT and Lambeth PCT's Refugee Health Team
Non-Governmental Organisations (12)	Age Concern, African HIV Policy Network, Asylum Aid, The Breastfeeding Network, Médecins du Monde, Médecins Sans Frontières, Migration Watch, National AIDS Trust, Refugee Action, Refugee and Asylum Seekers Action Group, Refugee Council and the Terrence Higgins Trust
Other (9)	Christian Medical Fellowship, Churches Commission for Racial Justice, The Haven, Immigration Law Practitioners Association, Joint Council for the Welfare of Immigrants, Mayor of London (Ken Livingstone), Royal Society for the Promotion of Health, Stanley Platt (advisor on immigration and asylum to the Methodist Church) and the Suffolk Practitioners Services Unit

This sample is likely to be biased for two reasons. Firstly, as members of the Entitlement Working Group, a coalition of groups opposed to charging vulnerable migrants for NHS services, we naturally have stronger connections with individuals and groups opposed to the consultation proposals. Secondly, we will undoubtedly have had greater success making contact with larger organisations with an online presence than with individuals and smaller groups. We suggest the quantitative aspects of the report be considered with this in mind.

In considering the extent of the bias it is important to consider that we contacted 46% of all those who made submissions to the consultation. The vast majority of those we contacted were unknown to us prior to us making contact. Secondly, the scale of opposition to the proposals in our sample is overwhelming.

Chapter One: The Role and Duty of Healthcare Professionals

'To ask any clinician to not continue to treat an illness which can often be easily controlled is to ask them to compromise their professional standards and as such is wholly unacceptable.'

Dr Helen Sykes, General Practitioner, Middlesborough

'The British Medical Council and British Council of Midwives have issued statements indicating that they do not wish to assume roles, which will involve 'policing' the immigration system...Although it has been suggested that all discussions for eligibility will be referred to Primary Care Trusts the pressure on front line staff will be unavoidable.'

African HIV Policy Network

Fifty five percent of submissions and seventy five percent of submissions from healthcare workers expressed concern that healthcare providers would be asked to administer the proposed charging regime. These concerns came both from organisations and individuals broadly opposed to the proposals and from organisations who felt a charging regime was needed.

These concerns were broadly divided into concerns about ethics and breaching professional codes of conduct; a feeling that the policing of immigration was the responsibility of the Home Office and not healthcare workers; and more practical concerns, regarding discrimination, confidentiality and the limited knowledge healthcare workers have of immigration regulations. We deal with the latter group of concerns in chapter four.

Ethics and Professional Codes of Conduct

'The first line of the [General Medical Council's] Duties of a Doctor is 'make the care of your patient your first concern'...This is an important statement, and in accord with the Hippocratic Oath that, 'I will apply measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.' The 1948 Declaration of Geneva Physicians Oath reiterates, 'I will practice my profession with conscience and dignity; the health of my patient will be my first consideration... And I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.'

Christian Medical Fellowship

The Christian Medical Fellowship point out that everyone attending the general practice will need to be seen by a healthcare worker:

'Paragraph 2.22 [of the consultation document] is incorrect to claim that a doctor would not be drawn into discussions about eligibility – especially in the area of general practice. Certain categories of treatment will remain free for everyone attending a general practice. Thus, a clinically trained person will have to make a decision regarding the eligibility of patient's for treatment. (Deciding which category the patient falls into, and whether treatment is 'immediately necessary'). Clinical staff will therefore inevitably be drawn into arguments about entitlement.'

Christian Medical Fellowship

Healthcare workers are bound by a number of codes of conduct. Some, such as the Hippocratic Oath, are no longer legally binding but continue to be widely respected. There are also codes of conduct produced by professional bodies to which healthcare workers must adhere to remain registered. For example, doctors must adhere to the rules contained within the General Medical Council publication *Good Medical Practice* when interacting with patients. The first rule in the code is to 'make the care of the patient your first concern'. A number of respondents expressed concern that doctors could not administer a charging regime or assess eligibility without contravening this rule:

'The GMC's guidelines for the duties of a doctor state 'make the care of your patient your first concern'. There is no reference to determining eligibility and if this proposal is enacted, general practitioners and their staff may be placed in the invidious and ethically compromised position of withholding treatment while a person's 'eligibility' is determined. This eligibility would also need to be checked on every subsequent contact with the primary care team as a person's status might change either way at any time.'

Dr Kevin Vaughan, General Practitioner, Smethwick

'Policing Role'

Concerns about healthcare professionals being involved in the policing of immigration policy were of two types. Some healthcare workers simply did not see this as part of their role:

'GPs should not be asked to become policemen. Many GPs would refuse to take on this role. GPs should be left to use their discretion as they do now'

Kent Local Medical Committee

'My job is to do the best I can for my patients, who are the people who come to see me. I do not see my job as deciding which of them are entitled to care...'

Dr Wendy Ross, General Practitioner, Newcastle upon Tyne

'...I cannot see how general practice can operate within its existing ethos, if it has to have interrogative police-style functions. That is simply not the way we work, and it would be impractical to implement...I would add that I think it is a damaging idea to withdraw the right of GPs to exercise their discretion in being able to register people who may be technically ineligible. This right enables GPs to keep within the law, when the regulations and rules are in conflict with other medico-legal and ethical considerations.'

Dr Brian Fine, General Practitioner, London

Other submissions thought it was inappropriate that denial of healthcare be used as a lever of immigration policy:

'While we welcome the Government's commitment to an effective immigration policy, we do not believe that exclusion from basic services such as primary medical care should be used as a way of enforcing immigration policy.'

Morecambe Bay PCT

'They should be considered as ordinarily resident in the UK until they have left the country ... It is the responsibility of the Home Office to see that they leave the country appropriately...'

Dr Kevin Vaughan, General Practitioner, Smethwick

'The BMA has queried why doctors should be policing this system, and we reiterate that concern. It is the government's responsibility to deal with failed asylum seekers and to generate the necessary routes for deportation where that is deemed appropriate, rather than trying to force them out by making their lives here as unhappy and unhealthy as possible in the interim.'

Christian Medical Fellowship

The British Medical Association policy the Christian Medical Fellowship refer to was passed at their Annual Representative Meeting in 2005 and states 'this Meeting believes that it is not appropriate for medical staff to act as proxy immigration officers in seeking to determine the immigration status of people presenting for care and treatment.'

Both the consultation document and the submission from MigrationWatch UK suggest these problems could be avoided. They suggest this could happen either by having eligibility assessed on entry to the country or by devolving responsibility for assessing eligibility to the Primary Care Trust or to an independent body. However, other submissions argue that these suggestions are impractical because migration status can change, documentation can be lost and doctors would not know, without seeing patients, whether they were suffering from a condition which was exempt from charging. These ideas are explored further in chapter four.

The Doctor-Patient Relationship

Numerous submissions were concerned that requiring healthcare providers to question patients about their immigration status could affect the patient-provider relationship:

'The general practice reception area is not the place to determine the asylum status. This will not only cause administrative problems, but more importantly will put a strain on the patient-doctor relationship which should be a trusting and caring one. We will not take on policing roles to determine the asylum status but will continue to provide primary medical care to those in need, urgent, immediate or routine needs without discriminating the most vulnerable and destitute patients on our list.'

Dr Silke Bannuscher, General Practitioner, Glasgow

'[I]t will ... create a climate of suspicion. This is contrary to the relationship of trust that needs to be established between patient and clinician for effective health care.'

Christian Medical Fellowship

There was particular concern that any breakdown in trust or doubt as to where loyalties lay, could adversely affect practitioners' ability to care for migrants who had experienced torture or abuse:

'We object to the NHS being made a tool for national anti asylum and migrant policies ... Such a future obligation to record [Immigration and Nationality Directorate] identification to justify right of access to medical care will undoubtedly gravely damage trust between patient and practitioner. That trust is the essential and absolute ethical premise of the profession, and is crucial for effective treatment, especially of the problems so often associated with trauma victims.'

Churches Commission for Racial Justice

Key Points: The Role and Duty of Healthcare Professionals

Fifty five percent of submissions and seventy five percent of submissions from healthcare workers expressed concern that healthcare providers would be asked to administer the proposed charging regime.

Some felt the proposals placed healthcare workers in violation of professional codes of conduct.

Some felt it was inappropriate for the denial of healthcare to be used as a means to enforce immigration policy.

Others felt that if healthcare professionals were to take on a policing role, it could damage relationship between healthcare professionals and the communities they serve.

Chapter Two: Infectious Diseases

Sixty eight percent of submissions we analysed expressed concerns about the public health impact of the proposals.

Primary healthcare plays a central role in an effective healthcare system ⁵. As well as treating minor illnesses effectively and economically, it acts as a gateway to secondary healthcare services. It has a strong role in disease prevention and health promotion, including the monitoring of chronic diseases to prevent disease progression and reduce complications. Primary Healthcare is a key contributor to reductions in health inequalities.

In this chapter we consider the effects of denying access to primary care on the spread of infectious diseases. The following chapter will look at the wider implications for public health.

Effects on the Health of Vulnerable Migrants

Migrant groups are at increased risk of many serious infectious diseases, due to both their geographical background and poor social and environmental conditions while living in the UK. Important factors identified in reversing the increasing incidence of many infectious diseases include timely diagnosis and treatment. A common concern raised by those consulted was that without access to primary health care, diagnosis is likely to be delayed until the disease is serious enough to warrant presentation to emergency services, increasing the length of time that patients are contagious.

The proposed bill does include provisions to exempt some infectious diseases from the general ban, in particular TB and sexually transmitted infections (excluding HIV). However, there were concerns that even when entitled to some free healthcare, undocumented migrants may be unaware of these distinctions and therefore will not seek healthcare. A number of case studies of asylum seekers being unaware of their entitlement to free primary health care were described by respondents, in particular with regard to antenatal services, as discussed in the following chapter.

The practicalities of allowing selective access to health services may further hinder access. Patients present with symptoms rather than diagnoses. The Royal Society of the Promotion of Health raise the point that as an undocumented migrant:

“would be fairly unlikely to self-diagnose tuberculosis, it is possible that he would both fail to secure appropriate treatment for himself and subject those around him to prolonged exposure to a deadly communicable disease”

⁵ Martin Rowland. Assessing the options available to Lord Darzi. BMJ 2008;336:625-6.

The symptoms of many infectious diseases covered by the exemptions are often non-specific, and according to Dr Bannuscher, a GP working in Glasgow:

'How should the screening for Tuberculosis or STIs [...] happen if the patients are not coming for routine consultations any more? It is in these routine consultations that the suspicion of TB [...] is raised and the necessary tests are ordered to confirm the diagnosis. I understand that once the diagnosis is made the treatment for TB or STIs would be free, but under your proposals you would not be able to make the diagnosis any more.'

Respondents were unclear how GPs are expected to decide that a patient has an infectious disease covered by the exemptions before they have even seen the patient, let alone investigated them. As Médecins Du Monde ask:

'Although treatment for TB, hepatitis and other communicable diseases are still free to all, how are people infected by them going to be detected if they do not have access to primary care? It is very likely that they can only be detected in A&E department at a later stage of their medical condition. Such a system of detection implies high risks in terms of public health.'

The submissions raise further concerns as to whether GPs are liable for the cost of investigating a patient for an infectious disease if these tests yield negative results. This confusion is likely to deter many GPs from investigating patients who may be entitled to free care.

Effects on the health of those allowed access to NHS care

All people and communities are at risk of infectious diseases, regardless of their immigration status. A change in policy that increases the incidence of infectious diseases or the duration of contagion in a selected group of patients will increase the risk to all. As discussed above, respondents were concerned that exemptions provided in the proposed changes in access cannot be assumed to prevent infectious diseases going undetected and untreated. Such changes can therefore be assumed to increase the risk of everyone to infectious diseases.

Submissions expressed additional concerns regarding vaccine coverage:

'If [vaccines] are not continued, there will be further erosion of the herd immunity with the resultant risk of a recurrence of epidemics of measles, diphtheria and pertussis in particular.'

Dr Helen Sykes, General Practitioner, Middlesborough

Key Points: Infectious Diseases

Sixty eight percent of submissions analysed expressed concerns about the public health implications of the proposals on both vulnerable 'overseas visitors' and the wider UK population.

Some highlighted that the proposals would be likely to lead to delayed diagnosis of communicable diseases, increasing the contagious period.

Some were concerned that the proposed exemptions for various infectious diseases (e.g. STIs and TB) would be confusing to patients and impossible to implement.

Others highlighted that falling vaccine coverage rates would place individuals and the wider community at increased risk from communicable disease.

Chapter Three: Vulnerable Migrant Groups

Seventy one percent of the submissions we summarised expressed concerns about the use of the blanket term 'overseas visitors' and called for the exclusion of certain vulnerable groups of individuals from the remit of the regulations, recommending that they be given separate consideration.

The majority of the submissions expressing concern regarding vulnerable groups recommended that failed asylum seekers should not be classified as overseas visitors and should be exempt from any charging rules.

'This group of people are human beings and are amongst the most vulnerable people in our communities, being at risk of ill health, disease and death. It is simply inhumane to refuse to offer treatment to this group of people, and such a refusal would run counter to the ethical principles that underpin the practice of medicine. Many doctors will simply not be able to refuse to treat this group of patients, as they will have nowhere else to turn for help'

Dr Brian Fine, General Practitioner, London

'Charging should only be introduced if people have the means to pay. Most failed asylum seekers are destitute and homeless. They have lost the £38.96 weekly payment that they were getting and rely on charitable handouts even to get food. To expect them to have money to pay for healthcare is ludicrous. This proposal places barriers in the way of health care for some of the most needy people in the United Kingdom.'

Dr Paul Williams, General Practitioner, Stockton-on-Tees

The Mayor of London (Ken Livingstone) stressed that:

'failed asylum seekers should not be equated with health tourists'.

Dr Helen Sykes also stated that there is a need for careful evaluation of what is meant by the term 'overseas visitor'. Within the population of overseas visitors there are several subgroups, rendering use of a blanket approach to the vulnerable people within this group unjust and potentially harmful.

The Refugee Council highlight the many legitimate reasons for asylum seekers to remain in the UK. Specifically, they call on the Department of Health to clarify whether these groups would be eligible for treatment:

'[T]here are some categories of unsuccessful asylum seekers who have good reasons for remaining in the UK. Could the DH provide clarification on whether the following groups will be eligible for primary health care, and provide reasons where a particular category is excluded:

- *Asylum seekers applying for a judicial review of the decision to refuse asylum*
- *Asylum seekers who have exhausted their appeals but that have submitted further representations to the Home Office*
- *Asylum seekers who cannot be removed on grounds of ill health*
- *Asylum seekers who cannot be removed from the UK for other reasons*
- *Asylum seekers in receipt of section support under Section 4 of the Immigration and Asylum Act 1999'*⁶

Similarly, Médecins Sans Frontières point out that it is often difficult to determine whether a failed asylum seeker is one who has exhausted all their appeal rights, as defined in the consultation, or merely had their initial claim refused and is going on to appeal. They suggest that all asylum seekers should be entitled to universal care under the NHS.

At the end of an asylum process the individual concerned is often not quickly removed from the UK and can wait months, and even years for removal to be effected. Dr Kevin Vaughan suggests that failed asylum seekers should not be included in the proposals and should instead be considered ordinarily resident in the UK until they have left the country, particularly as individuals are able to appeal if new evidence comes to light or the situation in their home country deteriorates. The fact that failed asylum seekers are not entitled to employment or benefits means that they are likely to become increasingly destitute and their health is likely to deteriorate.

⁶ Section 4 recipients are people whose asylum claims have been refused but whom the Home Office acknowledge are unable to safely travel home either because they are too unwell or because the journey would be too dangerous. They receive housing and minimal financial support from the National Asylum Support Service.

Despite not being recognised as a refugee under international conventions, individuals whose asylum claims have failed may still have suffered traumatic events in their home country and remain vulnerable. Sally Hargreaves and Judith Cook from Médecins Sans Frontières highlight the additional healthcare needs of failed asylum seekers during their time in the UK:

“Health problems may be compounded by traumatic events experienced in the individual’s home country and health concerns exacerbated by their experience in the UK”.

Asylum seekers frequently have:

“physical and mental health needs caused by experiences of war, imprisonment, torture, rape and the journey into exile”

Asylum Aid

The Christian Medical Fellowship note that asylum seekers, who are entitled to register with GPs, and failed asylum seekers, who are currently entitled to register with a GP at the discretion of the practice, already experience significant barriers in accessing care. They worry that the proposed charging regulations could make accessing healthcare harder for both groups of people:

“Asylum seekers already face multiple barriers to accessing health care. This has been acknowledged by the Department of Health through their funding of dedicated asylum seeker primary care services across the country. Requiring asylum seekers to prove their entitlement to primary health care will accentuate problems with access.”

Christian Medical Fellowship

Hargreaves and Cook point out that the Home Office is widely criticised for inaccuracy in determining asylum claims and there are many cases where initial refusals are consequently overturned. Moreover, Dr Kevin Vaughan states that asylum is often refused on technical grounds despite a history of torture and maltreatment.

The African HIV Policy Network (AHPN) submission questions whether the proposed measures are solely concerned with saving NHS funds, rather than acting as support to the Home Office in clamping down on immigration. They go on to say that the proposals ‘inhumanely target people from developing countries’. Statistics provided in the AHPN submission show that the overseas visitors to the UK who currently access the NHS most regularly are tourists, students and visitors from the developed world. They suggest that it is these groups who should be the legitimate focus of any charging regime as this is where reimbursements are most likely to be secured.

Many submissions expressed concerns about other potentially vulnerable groups including children and pregnant women.

Maternal and Newborn Health

Access to effective ante- and perinatal services is crucial to reducing maternal and neonatal mortality.⁷ Primary care is:

'generally the first port of call for any pregnant woman. If she is denied access to her GP as a result of her immigration status she will be unable to access other primary care services such as midwives and will not be monitored during her pregnancy. Any health issues will not be spotted unless an emergency arises.'

Joint Committee for the Welfare of Immigrants

Antenatal services are not exempt from charging, although they do qualify as immediately necessary. This means that, whilst they should be provided immediately without upfront payment and regardless of ability to pay, they are chargeable. Bills can be chased as far as is considered 'reasonable'. It is likely that the threat of charging will lead to decreased use of antenatal services.⁸

Without antenatal care, mothers will not be screened for infectious diseases that would benefit from intervention to prevent vertical transmission of, for example, HIV. Identification of complications of pregnancy such as pre-eclampsia will be delayed, precluding early treatment and thus increasing the risk of emergency caesarean section, premature delivery and serious harm to both the mother and her baby.⁹

Impact on children

Some identified the fact that the expected proposals make no allowances for minors who are the children of failed asylum seekers or victims of trafficking.

The AHPN calls for unaccompanied minors and young people to be excluded from the scope of the proposals, stating that to classify them as overseas visitors and consequently deny them treatment contradicts the Children's Act 1989 (Lord Laming's recommendations following the Victoria Climbié Inquiry) and the current Children's Bill.

The Refugee and Asylum Seeker Action group in Newcastle identified the 'immense' suffering which would ensue for children from refused asylum seeker families should the proposals go ahead.

7 Health Inequalities Unit, Department of Health. Review of the Health Inequalities Infant Mortality PSA Target. Feb 2007.

8 Medact. Maternal and infant health of vulnerable migrants. January 2008. Available from http://medact.org/content/reaching_out/maternal%20and%20infant%20health%20briefing.doc.

9 Confidential Enquiry into Maternal and Child Health. Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer - 2003-2005. Dec 2007.

Asylum Aid meanwhile described the fact that many of their clients who will be affected are parents and carers of children. They believe the effect of withdrawing healthcare would be that these parents were significantly less able to care for their children.

Continuity of care and regular review by community healthcare teams is particularly important in the diagnosis of chronic conditions in children. As infants and young children are unable to communicate their symptoms as adults would, diseases often present insidiously and non-specifically. Regular monitoring of basic health indicators such as children's weight is often the only way that such conditions are identified¹⁰. This will not be possible if children do not have access to primary care services. Failure to identify medical conditions during infancy or early childhood may have a permanent effect on the child's physical and intellectual development. Under the proposed policies:

'Babies will not have access to the services of a health visitor and therefore developmental issues (eg problems with vision, hearing, feeding, autism, slow physical growth) will not be detected. This will impact on a child's future quality of life if not addressed.'

Joint Committee for the Welfare of Immigrants

Woody Caan, Professor of Public Health at Anglia Ruskin University, was unable to locate the submission he made to the consultation. However, he sent us a number of letters and articles summarising his opinions. A key role of child health services is child protection. A significant number of children come to the UK unaccompanied and may be forced into work that is physically or sexually exploitative. Professor Caan's letters and articles have not been included in our analysis but in one, he points out that for unaccompanied children:

'Access to a GP, say for treatment of a minor injury, may be their first opportunity for contact with a responsible, law-abiding UK citizen.'

All children, regardless of their race or immigration status, are at risk of neglect and abuse. However, many of the societal and mental health risk factors for child abuse, such as depression, poverty and social isolation¹¹, may unfortunately be more prevalent in undocumented migrant families and communities due, at least in part, to the denial of state support and the right to work. Child abuse is often first identified by primary health services¹². The Joint Committee for the Welfare of Immigrants states that:

'Research also shows that domestic violence often starts/escalates during pregnancy and after birth - prohibition on using a GP will mean that health professionals will be unable to detect danger signs and risk to unborn/new born child and mother at the earliest stages.'

10 Health Inequalities Unit, Department of Health. Review of the Health Inequalities Infant Mortality PSA Target. Feb 2007.

11 Dubowitz H, Bennett S. Physical abuse and neglect of children. Lancet. 2007 Jun 2;369(9576):1891-9.

12 Royal College of General Practitioners; The Role of Primary Care in the Protection of Children from Abuse and Neglect. September 2005.

Denying access to healthcare may mean abuse goes undetected, leaving these children at risk of continuing harm for longer. It will also prevent the identification of children in need, and therefore impede access to early intervention aimed at preventing abuse from happening.

Key Points: Vulnerable Migrant Groups

Seventy one percent of submissions analysed expressed concern about the blanket approach to all 'overseas visitors' and called for specific vulnerable groups to be considered separately.

Many felt failed asylum seekers should be exempted from charging as:

- They are some of the most vulnerable people in our communities.
- They may legitimately remain in the UK for extended periods after being refused asylum (e.g. on Section 4 support).
- They may have been subjected to traumatic and harmful experiences before or after arrival in the UK.

Some were concerned that the proposals would limit access to important maternal and newborn care.

Others suggested the proposals would unjustly impact on trafficked children and the children of failed asylum seekers.

Chapter Four: Practicalities and the Administrative Burden

Eighty seven percent of the submissions we reviewed suggest that implementing the proposed charging regime would be impractical or create significant extra administrative work. In this chapter we seek to outline some of these concerns. These fall under 3 broad categories: the process of determining immigration status, clinical assessment of eligibility for exceptions to payment and the additional administration required to process payments.

Determining Immigration Status

'The Refugee Council noted in a survey of 81 NHS trusts carried out in 1997 in Manchester and London that 67 per cent of the respondents (NHS staff) wrongly believed that refugees and asylum seekers were not entitled to free health care [...] The survey also revealed that the respondents used the terms 'immigrants', 'illegal', and 'refugee' interchangeably. These findings are worrying. The Refugee Council believes that the proposed amendment will exacerbate this lack of awareness, and will result in asylum seekers and refugees not only being questioned about their immigration status inappropriately but also being refused services to which they are entitled. Other NHS customer groups including those from settled minority communities are also likely to be affected.'

Refugee Council

A common theme running throughout the responses was a concern that primary care services did not have the time or the technical expertise to accurately determine a potential patient's immigration status. Primary care centres do not employ specialists in immigration law; the decision regarding eligibility will therefore rest with either the receptionists, practice manager or clinical staff. Their ability to assess eligibility was repeatedly questioned by respondents. For example, Refugee Action noted that:

'[establishing a person's immigration status] is a specialist area where many different forms of documentation are used (e.g. ARC cards, IS96s, EU travel documents, passports, vignettes, IND status letters etc). Healthcare staff would have to have a very wide knowledge of the fast-changing documentation used both by IND staff, the EEA and various other countries who may or may not have mutual health agreements with the UK.'

The proposed changes to accessing the NHS apply principally to those classified as undocumented migrants and those whom have exhausted the asylum process. Refugees and those with asylum claims pending would still theoretically be able to freely access all NHS services. However, there is evidence that under current provisions asylum seekers are often unaware of their entitlements, therefore do not access the health care services to which they are entitled.¹³

'Voluntary organisations have many examples of people being denied treatment improperly and a recent letter to The Guardian from 10 doctors states that "Some healthcare providers have already misunderstood and anticipated changes and there have been cases of 'non-failed' asylum seekers being refused hospital, GP or dental care to which they were entitled".'

National AIDS Trust

'We have had experience of clients who have been turned away from GP surgeries by receptionists because they do not believe that they have an entitlement to free health care, despite the fact that they have ongoing asylum claims.'

Asylum Aid

Some respondents argued that placing the responsibility of proving eligibility for treatment on the patient would decrease the administrative burden on practice staff. Others felt that such a system would only work effectively if staff asked every patient in the practice about their eligibility for treatment before each appointment, prescription or immunisation. If unable to produce the requisite documentation, the appointments would need to be cancelled and rearranged, lengthening waiting times for appointments. Lesley Hedges, a public health specialist from Barnsley PCT, could not locate the Barnsley PCT submissions but sent us some comments. These were not included in our analysis. She pointed out the unequal burden this will place on GPs depending on the population they serve:

'The system is likely to put more pressure on GPs in more deprived areas, where people without permanent homes or incomes are more likely to be living. People who are homeless, are travellers, or have left home under difficult circumstances (domestic violence or abuse, or their own poor mental health, for example), may, under the proposed system, be denied treatment to which they are entitled because they do not have the relevant proof of their identity.'

13 Nancy Kelley and Juliette Stevenson. First do no harm: denying healthcare to people whose asylum claims have failed. Refugee Council, June 2006

The practicality of using external advisors to clarify entitlement was questioned by several respondents. One suggestion made by the original consultation was that the PCT itself could be used in cases where immigration status was unclear:

'When the patient is at the practice reception desk insisting they need to see a doctor how on earth is the PCT going to be any help? PCTs do not have the capacity or the responsiveness to undertake this. It fails to recognise the demand led nature of general practices and the fact that we are expected to offer appointments within 24-48 hours of request.'

Dr Wendy Ross, General Practitioner, Newcastle upon Tyne

'The patient often does not understand the situation themselves and their solicitor may be difficult to contact and may be unwilling to provide such details. On the one occasion that we contacted the Home Office to clarify a patient's status, we were kept waiting for an hour, and then were told that we could not get an answer as the computer was down.'

Dr Phillip Matthews, General Practitioner, Newcastle upon Tyne

Even when a patient's entitlement has been established, several submissions made the point that the process would need to be repeated for each encounter with primary care as immigration status does not remain static. This would necessitate the continuous monitoring of every non-UK national in case their immigration status changes and they become eligible or ineligible for care.

'There is considerable ambiguity around the point at which these proposals would apply to failed asylum seekers - and what exactly constitutes such a 'failure.' Where new evidence emerges, or the political situation deteriorates in a particular country, a person is entitled to mount a fresh claim [...] Are practices to be expected to grasp the finer nuances of this when deciding if a person is eligible for free primary care?'

Christian Medical Fellowship

'As mentioned earlier Asylum seekers generally have some form of Home Office identification. This is not automatically removed from them once they are refused. GPs therefore have no simple way of establishing entitlement - short of making a telephone call to the National Asylum Support Service (NASS) or immigration every time a patient is seen. The proposed measures will involve a lot of policing and this will be expensive to resource. The immigration system is also constantly changing and GPs may find it hard to ascertain when someone is no longer entitled.'

African HIV Policy Network

Assessing clinical eligibility to exceptions

Under the proposed new regulations treatment for a number of specified infectious diseases important to public health would remain free. As is currently the case in NHS hospitals, treatment deemed 'immediately necessary' probably would be chargeable but should not be denied if payment could not be provided up front. In secondary care, 'immediately necessary' care includes antenatal care, but is otherwise poorly defined.

Many submissions questioned the ability of non-clinical staff to assess a patient's entitlement to treatment under one of the exemptions

'How on earth are we meant to establish who needs emergency or immediately necessary treatment without holding a consultation with the person? Do you expect our receptionists to make this decision?'

Dr Wendy Ross, General Practitioner, Newcastle upon Tyne

Even if a potential patient is assessed by a healthcare professional, it still may not be easy to confidently rule out an urgent or infectious cause without a full medical consultation.

'It is often very difficult to determine whether a medical problem is an emergency or requires immediately necessary treatment, particularly if the patient has poor English, without carrying out a consultation. It would often not be possible to tell the patient whether a consultation would be chargeable until after the consultation has taken place.'

Dr Phillip Matthews, General Practitioner, Newcastle upon Tyne

'General Practitioners are already facing a rising number of complaints and increasing litigation against them. They are obliged to practice very defensive medicine. Thus to refuse to treat a non-eligible patient based on a few brief words at the reception desk would be extremely unwise [...] The only way a GP could determine whether a non-eligible patient had a routine or minor condition that did not require immediately necessary treatment would be by seeing and examining him. By this stage the work would have been done.'

Migration Watch

Payment structures and other related costs

The introduction of a new charging regime would necessitate an administrative structure to process these payments. The consultation document outlines two proposed options for charging:

'1. GPs would hold a separate list for overseas visitors. The charges made would be NHS charges and would be considered to be NHS income. The practice would account for them as such.

2. Any services provided to overseas visitors would be provided on a private basis by GPs. In this case the practice would be responsible for agreeing and recovering charges from individuals.'

Opinions regarding the relative merits of these options varied. Whilst many opposed both methods, a handful agreed with the introduction of a charging mechanism and were in favour of implementing option two. However, none of the submissions argued that there would be benefits to implementing option one. Newark and Sherwood PCT stated:

'The recovery mechanism for NHS charging would put more pressure on PCTs and general practice. The administration of separate lists for overseas visitors could lead to confusion and duplication, i.e. ghost patients. Overall we feel the system would be too bureaucratic.'

In addition, some respondents felt it would hinder their performance in the Quality and Outcomes Framework (QOF), the system by which general practices are financially rewarded for achieving performance targets.

Those in favour of option two felt that it would be less bureaucratic and enable practices to fully recover any charges made by patients, providing greater freedom and flexibility. However, others felt that such a system would create variation in the quality of care delivered by each practice. Practices located in affluent areas with richer 'overseas visitors' would reap the benefits of a private charging system. In contrast, practices located in less affluent areas serving more refused asylum seekers would experience difficulties in obtaining payment for treatments given.

'The suggestion that leaving practices to be responsible for making and recovering charges in some way reduces bureaucracy and gives us "local freedom" seems disingenuous to me. It is likely to lead to the pre-NHS situation where practices in affluent areas treating those who may really be "overseas visitors" are able to recover charges, and those of us in poor areas dealing with dispersed asylum seekers at the end of the line are left with the choice of refusing people in need or working for nothing.'

Dr Wendy Ross, General Practitioner, Newcastle upon Tyne

Overall, however, those in favour of either option were in the minority, with most respondents opposing the implementation of any charging regime and the additional administrative burden it would entail:

'Many of our patients speak very little or no English, which would make obtaining this information from them difficult without additional time and finance for interpreters'

The Whitehouse Practice

'[T]he proposed charges would clearly entail overhead costs. Chasing patients in the event of non-payment would clearly involve further costs, not only where the patient is overseas but also in the case of the failed asylum seeker whose housing arrangements will often be highly insecure and therefore hard to track.'

Mayor of London (Ken Livingstone)

This echoes some existing research. In June 2006, Sally Hargreaves and colleagues undertook the only health impact assessment of charging in primary care and concluded:

*"In light of the broad scope of the organisational and procedural changes required for the effective implementation of the primary care proposals in Newham, and the limited financial burden that Overseas Visitors appear to be having on primary medical services in the borough, we conclude that the current proposals to streamline charging procedures at primary medical services with those in place at hospitals should be reconsidered."*¹⁴

14 Hargreaves S, Friedland J S, Holmes A. The Identification and charging of Overseas Visitors at the NHS Services in Newham: a Consultation. London. 2006. Available from: <http://www.newhampct.nhs.uk/docs/publications/IHUEntitlementReport06.pdf>.

Key Points: Practicalities and the Administrative Burden

Eighty seven percent of submissions reviewed suggest that implementing the proposed charging regime would be impractical or create significant extra administrative work.

Many submissions highlighted current and potential problems ascertaining the immigration status of patients. Concerns were expressed about the complexity of the immigration process, patient confidentiality and that responsibility was to be placed on staff with limited legal and medical expertise.

Submissions questioned the practicality of both proposed cost recovery systems, emphasising the likely difficulty in recovering charges from vulnerable migrants who may not speak English as a first language and may have insecure housing arrangements.

Chapter Five: Cost Effectiveness

Fifty five percent were concerned that the charging proposals might not prove cost effective.

'The planned measures have [...] been proposed without any attempt to cost the implementation. There is as yet no evidence to substantiate the claim that these measures will save funds.'

African HIV Policy Network

'Measured in gross terms, the maximum amount of NHS resources saved by the DH proposals is likely to be:

- small compared to the annual cost of emergency care for tourists or other foreign visitors deemed 'legitimate' by the Government*
- trivial compared to total expenditure by London region NHS.'*

Mayor of London (Ken Livingstone)

Diverting Care and Delaying Treatment

At present, care received in accident and emergency departments is not chargeable. One possible consequence of the proposed regulations, which was repeatedly raised by respondents, was that patients would stop attending general practices and increasingly utilise hospital services, particularly emergency departments.

'We are concerned that the withdrawal of primary care will result in a greater pressure on Accident and Emergency (A&E) departments and secondary care services, as those denied treatment and assistance at the primary care stage become seriously ill and approach A&E departments directly.'

Refugee Council

'Inevitably, faced with the new charging regime, many will either go immediately to A&E instead of primary care – or will wait until they are so ill that hospital admission is the only option'

Mayor of London (Ken Livingstone)

Primary care services are significantly cheaper than secondary care. Indeed, the consultation document explicitly recognises this:

'You state that "we must avoid the possibility that people will chose instead to visit A&E". It seems to me inevitable that this is exactly what will happen. Already many consultations take place in Casualty which are really about primary care problems, for a whole variety of reasons. People who cannot get treatment in primary care are bound to go to casualty instead.'

Dr Wendy Ross, General Practitioner, Newcastle upon Tyne

'Like the British Medical Association (and other healthcare professional bodies), we question whether treating patients only in emergency situations is cost effective in the longer term.'

Mayor of London (Ken Livingstone)

Many of the consultations pointed out that without access to primary care, undocumented migrants would be more likely to develop chronic diseases due to a lack of primary preventative interventions. Furthermore, those with chronic conditions would be subjected to greater long-term complications and require more frequent emergency admissions to hospital. For example, the Joint Committee for the Welfare of Immigrants notes that:

'These groups who are therefore more likely to suffer illnesses and poor health associated with poor diet and poor living conditions (such as heart disease and diabetes) will be denied all medical services until it reaches crisis point and they are admitted to hospital as an emergency.'

The Royal Society of Promotion of Health voices an additional concern:

'if ineligible patients are to be charged, market forces will begin to operate and there will be an incentive for unscrupulous and unlicensed practitioners of one sort or another to offer 'reduced rate' services [...] Not only would this be risky for the health of the individual involved, but it is likely that the NHS will be expected to pick up the problem at a later, acute stage if the condition develops into an emergency.'

The likely effect that reducing access to primary care will have on the spread of infectious diseases is discussed in greater detail in a separate chapter. However, in their submission, African HIV Policy Network point out that any increase in the spread of infectious disease would also have cost implications:

'Africans living in the UK tend to present later for HIV/AIDS testing and we feel that the proposed measures would further deter people from taking up testing services. This has evident repercussions for the spread of the epidemic which will have further and weightier social and economic cost implications.'

Care under the Mental Health Act (involuntary inpatient care for seriously ill patients) is exempt from charging under the 2004 regulations which govern access to secondary care. However, some submissions pointed out that there is no provision in the primary care proposals to provide free access to early interventions aimed at preventing the progression of mental illness. Traumatic experiences in countries of origin that prompted migration to the UK, compounded by the difficulty and uncertainty of the UK asylum process, place asylum seekers and undocumented migrants at greater risk of mental health problems. Primary care is again the most common point of access for mental health services in the UK.

'To deny primary care to victims of torture, rape and war-related crimes will result in many people being unable to access mental health care including counselling and anti-depressants, unless their condition becomes so bad that they fall to be treated under the Mental Health Act.'

Joint Committee for the Welfare of Immigrants

Inpatient admissions under the mental health act are expensive so this could have implications for NHS finances as well as the health of the individuals concerned.

Administrative and Practical Costs

A detailed summary of concerns about the administrative burden of implementing the proposals is contained in the previous chapter. However, any increase in administrative costs will clearly influence the cost effectiveness of the proposals.

'The knock-on costs of creating additional financial and practical hurdles to their accessing health care, both within the NHS and elsewhere, are likely to be considerable.'

Dr Adam Sandell, General Practitioner, Newcastle upon Tyne

Costs Recovered

Many respondents felt that there was insufficient evidence to suggest that large numbers of 'overseas visitors' are currently accessing NHS primary healthcare services. There were concerns that the amount of money recuperated from these patients would be insufficient to justify the proposals. For example, the Whitehouse Practice stated that:

'We believe that it would probably entail a huge administration effort from our team to identify the small number of our patients who are overseas visitors or "failed asylum seekers."'

In addition, many felt that the cost-effectiveness of the proposed policy was undermined by including so many groups under the blanket term of 'overseas visitor'. Whilst many respondents agreed that non-residents genuinely able to pay for healthcare should be charged for non-emergency care given, the practicality of asking for payment from more vulnerable groups was questioned:

'Seeking funds from those who are unlikely to possess them is neither cost effective nor productive.'

African HIV Policy Network

Some submissions expressed surprise that the Government had not undertaken a cost-benefit analysis before proposing these changes to the charging regulations:

'I am not aware of any convincing evidence that "overseas visitors" are a significant problem for the NHS. Could this not be established before introducing a whole new set of regulations? It is certainly not an issue for us as a practice and I have no doubt at all that the new proposals would create far more work for us than they will save.'

Dr Wendy Ross, General Practitioner, Newcastle upon Tyne

Key Points: Cost Effectiveness

Fifty five percent of submissions expressed concern that the charging proposals might not prove cost effective. Some noted the government had not produced a cost benefit analysis of the proposals.

Submissions suggested any costs recovered would be offset by the costs of increased utilisation of Accident and Emergency Departments and treating more advanced illness in secondary care.

Many submissions felt there is insufficient evidence of significant use of NHS services by 'overseas visitors' to justify the proposals and the costs entailed.

Chapter Six: Racism and Social Cohesion

'Improving access to primary health care for people from ethnic minorities, including asylum seekers and refugees, is a key aspect of current government policy to reduce health inequalities and to modernise the NHS. In the Mayor's view, the DH proposals in this consultation document cut across this objective.'

Mayor of London (Ken Livingstone)

Sixty six percent of available submissions took issue with the denial of care from a number of humanitarian viewpoints. A number of these submissions addressed racism, social exclusion and the impact these proposals could have upon marginalised communities.

'We believe that these proposals are inhumane, impractical and amount to a public health risk. They are likely to leave the most vulnerable in our society without essential health treatment and push them even further into a socially excluded underclass. These proposals will affect children and pregnant women. They risk turning our health service into an extension of the immigration service with serious implications for our community relations.'

Asylum Aid

'The proposals would further marginalise some of the most vulnerable groups in society, particularly refugees and asylum seekers. While we welcome the Government's commitment to an effective immigration policy, we do not believe that exclusion from basic services such as primary medical care should be used as a way of enforcing immigration policy. Everyone living in Britain should be able to access primary health care irrespective of their social and economic standing.'

Morecambe Bay PCT

Submissions that raised concerns that the proposals could have an adverse affect upon race relations and community cohesion fell into a number of groups. Some were concerned the regulations would be implemented in a discriminatory manner. Others were concerned that they would increase the social exclusion experienced by migrants, damage community relations and or worsen the way in which migrant communities are depicted in the media. There were also concerns that denying care to refused asylum seekers or undocumented migrants could harm both their dependants and the communities in which they are living.

Respondents noted that migrants already experience significant levels of discrimination when attempting to access the NHS, and suggest the proposals may be open to legal challenge:

'There is no acknowledgement that at present there is evidence of discrimination in the provision of health care to those entitled to it. More needs to be done from a humanitarian and a public health perspective to ensure that those in need of medical care, and entitled to receive it, are not denied it. This experience of NHS provision makes many of our members doubt whether the proposed restrictions to NHS Primary Care can be delivered in a manner which is not inherently discriminatory and which does not breach race relations legislation.'

Immigration Law Practitioners Association

'Although the National Health Service currently makes HIV treatments widely available, a range of barriers exist to equitable treatment access for some, particularly for overseas visitors. These include limited availability of information about treatment options, lack of patient support services for adherence to complex treatments, the discriminatory attitudes of health care workers, and regulatory restrictions affecting groups such as asylum seekers. Research indicates that the most common form of discrimination experienced by people with HIV in the UK is discrimination by health care providers.'

African HIV Policy Network

'The common misuse amongst the media of terms such as 'illegal immigrant', 'refugee' and 'asylum seeker' reflect a wider confusion in society a whole about immigration statuses. We do not expect healthcare workers to be exempt from this and are very concerned that this lack of awareness will result in asylum seekers and refugees, as well as settled BME [Black and Minority Ethnic] communities being asked inappropriate questions about their immigration status. Such questioning is likely to have a negative impact on race relations.'

Asylum Aid

A range of submissions expressed concern that the proposals were designed in such a way that their implementation would risk exacerbating existing racial discrimination and discrimination against people for whom English is not a first language:

'It is not difficult to imagine that an ineligible white native speaker of English would not find it hard to register without being challenged. Conversely an elderly UK citizen of Bangladeshi origin whose command of English was limited might find themselves required to produce evidence that they were entitled to register. This would amount to targeting individuals on the basis of race, language or accent and this could have serious implications for the NHS staff in question as it might potentially expose them to criminal prosecution for racial discrimination.'

Royal Society for the Promotion of Health

'Patients with poor English often find it difficult to access services, even without having to show eligibility. Ethnic minority patients will be assumed to be overseas visitors, and so will be subject to checks that white patients wouldn't.'

Dr Phillip Matthews, General Practitioner, Newcastle upon Tyne

'It is important that self certification does not disadvantage patients who are potentially entitled to NHS primary medical services but who may lack the necessary linguistic, legal or social skills to prove their entitlement. It is equally important that those who have lived in the United Kingdom for years but who are confused about their entitlement are not discouraged from seeking treatment.'

Immigration Law Practitioners Association

Lewisham Primary Care Trust consulted general practices in their borough:

'Many felt that the proposals were taking services backward in that they were feeding into institutional racism and taking the debate away from delivering effective and appropriate services to marginalised communities. There are concerns that once again black faces and people with 'foreign' accents will be singled out for scrutiny and excessive checks.'

Lewisham PCT

Asylum Aid suggested that women and dependants might be particularly vulnerable to discrimination:

'Women asylum seekers are likely to be the hardest hit by these proposals as they are often dependants on their partners' asylum claims. This means that they often have less awareness of the stage of the claim. They are also likely to have a lower level of English than their male counterparts and find it more difficult to explain their immigration status.'

Asylum Aid

The submission from the former Mayor of London (Ken Livingstone) explored these issues in some detail suggesting that discriminatory screening procedures would lead to inequalities in access to healthcare:

'The GLA's Access to Primary Care Scrutiny, as well as other studies and enquiries have raised concerns about unequal access to the NHS and perceived racism within the Health Services. Moreover, NHS staff at every level work in a climate of media and political discussion which is strongly hostile to immigrants and – in particular – asylum seekers and refugees.'

Against this background and in the London demographic context (see appendix note), the Mayor considers current DH proposals on charging for primary care carry significant risks of:

- *fostering real and perceived racial discrimination within the NHS, and*
- *impeding access to health care for many Black and ethnic minority Londoners, whether visitors, asylum seekers, or first or second generation UK citizens.*

The DH's own account of the operation of its charging proposals acknowledges that issues about eligibility could obstruct access to primary care for ethnic minority Londoners, whether or not they are in the DH 'ineligible' groups: '... if there is some doubt about a person's eligibility he or she should be referred to the PCT ... to ensure that the practice is not drawn into protracted discussions ...' (p.p.8-9).'

Mayor of London (Ken Livingstone)

The Mayor also suggested that, even in the event that everyone was screened in the same fashion, the regulations might still exacerbate health inequalities:

'Extra fears about immigration control: The present DH proposals require NHS staff in effect to check the immigration status of people seeking primary care. Besides asking about UK residence, staff would (if self-certification is used) administer a questionnaire that asks 'Can you show you have the right to live here?' (Annex C). Given the pervasive anxiety about exchange of personal information between public bodies on immigrant service users, the likely result is that many of London's more recent immigrants will choose to go without primary care – even in an emergency - rather than face this scrutiny at a GP practice.'

Mayor of London (Ken Livingstone)

Some submissions went further, suggesting that the proposals might affect community relations:

'Public health does not just mean communicable disease. It would be unhealthy for a society to contain a marginalized group of people denied access to Primary Health Care services. This would lead to a breakdown in social cohesion and increased levels of racial tension and violence. It would increase prejudice and assumptions about people's behavior within the NHS, placing more barriers to accessing health services in the path of people who did not conform to the stereotype of a British national.'

Dr Paul Williams

Many submissions pointed out how socially marginalised members of migrant communities can already be:

'Regardless of the reasons for them being 'failed' asylum seekers, the vast majority of them are highly vulnerable people, with poor health, little social contact or support, minimal financial resources, and communication difficulties due to poor English. They are truly deprived and have very significant rates of ill health, disability and premature death. Often they only survive as a result of the charity of voluntary groups such as churches or refugee community organisations. It could easily be argued that the vast majority of failed asylum seekers require "immediately necessary treatment" by virtue of their particularly vulnerable situation. More importantly there is also a moral issue - this group of people are human beings and are amongst the most vulnerable people in our communities, being at risk of ill health, disease and death.'

Dr Brian Fine, General Practitioner, London

'At Asylum Aid, we have worked with many asylum seekers who have had refusals on their asylum claim. At this point, they are often denied any further state benefits or accommodation and are not permitted to work despite the fact that, in many cases, the government cannot return them to their country of origin because there is no safe route back or because of bureaucratic difficulties. Already marginalised in our society, they become further excluded and are in even greater danger of experiencing poor mental and physical health. At the moment, they can still access GP services and receive essential treatment that may prevent serious deterioration of their medical conditions.'

Asylum Aid

There was very widespread concern that the proposals risked further marginalising vulnerable migrant communities:

'To deny free health care to people who effectively, if illegally, live here is to use the health system punitively rather than on the basis of need. The actual public health outcome will not be either to deter new migrants nor encourage those illegally here to leave. It will be to create a pool of poor, marginalised, exploited and increasingly sick people, with adverse social consequences both for themselves and for those amongst whom they live and work.'

National AIDS Trust

Concern was expressed that, regardless of any impact on the spread of infectious disease, the proposals could cause harm to the settled communities in which 'overseas visitors' live and the health of dependent partners or children:

'The Mayor cannot agree that failed asylum seekers should be denied access to free NHS care and believes that to do so would be manifestly unjust. It would increase the risk of ill-health within London's refugee communities and make it harder to tackle key areas of social exclusion in London.'

Mayor of London (Ken Livingstone)

'Our members believe that denying proper medical care will seriously impede some clients from exercising their rights to enjoy a reasonable family or private life. Denial of treatment to one family member, for example the husband of a British-born wife and father of British children, who is applying for leave to remain with his family, will impact on others. They also doubt whether a court would find it proportionate to deny treatment which for instance would enable a child to walk with assistance in order to attend school and be part of the community when he or she had been born in this country and had played no part in his or her parent's illegal entry to the UK.'

Immigration Law Practitioners Association

'[B]urden may be placed on members of their family/extended family, who may be members of the settled communities and who will need to find the finance to pay for these services. Ethnic minorities are already statistically more likely to be unemployed or in poor paid employment than the white population. We see this would place further burden on some members of these groups.'

Joint Council for the Welfare of Immigrants

Furthermore, some groups expressed concern that the regulations would damage the public perception of migrant communities:

'The lack of clear guidelines about NHS entitlement and the lack of political determination to inform about the legislation is likely to encourage discrimination against refugees, asylum seekers, ethnic minorities or any person (from the British citizen to the legal migrant worker) assimilated as a potential 'health tourist'. Wrong images against asylum seekers and refugees will be even more exacerbated by the regulations.'

Médecins Du Monde

'As an umbrella African organisation we are concerned that the tone with which the proposed measures are introduced, will serve to stigmatise African communities compounding existing experiences of racial discrimination and social exclusion with that of stigmatisation as the 'bearers' of disease within the British public mind.'

African HIV Policy Network

In light of the above concerns, many groups expressed concern that a Race Impact Assessment of the proposals had not yet been carried out:

'Under the amended Race Relations Act 1976, public authorities have a duty to promote good relations. The Refugee Council urges that a race impact assessment be carried out prior to this proposal being taken any further.'

Refugee Council

Some submissions suggested that by amending the proposals it might be possible to charge rich overseas visitors for NHS care whilst minimising the risk of racial discrimination and social exclusion:

'Our main comment is that we cannot support the proposals that are outlined because they would not adequately protect the health and wellbeing of marginalised groups in society. We believe that any policy on introduction of charges for primary medical services must take account of the fundamental difference between those who are able to pay such charges and those for whom payment would reduce or abolish access to basic health care.'

Morecambe Bay PCT

'[M]y main objection to the proposed changes is the inclusion of failed asylum seekers in the category of overseas visitors. If an asylum seeker's claim has legitimately been rejected at all stages, he or she should be removed from the country by the proper procedures. However, until they are removed, they should continue to have access to NHS treatment without charge. Many of these people will be destitute, having by this stage no recourse to public funds, and may be relying on charity. They will have no means of paying for treatment. If these changes go ahead they will become 'socially excluded' quite contrary to the Government's previously stated policies.'

Dr Carol Cheal, General Practitioner, London

However, other respondents felt that the existing regulations adequately dealt with the problem:

'A great strength of the current almost universal access (in practice if not in principle) is that it is very simple and extremely cheap to administer. Many overseas patients speak little or no English and struggle greatly in their dealings with services. The knock-on costs of creating additional financial and practical hurdles to their accessing health care, both within the NHS and elsewhere, are likely to be considerable.'

Dr Adam Sandell, General Practitioner, Newcastle upon Tyne

Key Points: Racism and Social Cohesion

Sixty six percent of available submissions had humanitarian concerns about the proposals.

Submissions raised concerns that the proposals could have an adverse affect upon race relations and community cohesion.

Some were concerned the regulations would be implemented in a discriminatory manner.

Some were concerned that they would increase the social exclusion experienced by migrants, damage community relations and or worsen the way in which migrant communities are depicted in the media.

Respondents noted that migrants already experience significant levels of discrimination when attempting to access the NHS, and suggest the proposals may be open to legal challenge.

Chapter Seven: Human Rights

Twenty nine percent of submissions to the consultation expressed concerns that the proposed changes in entitlement would breach international Human Rights agreements which the UK has ratified.

Universal Declaration of Human Rights

The African HIV Policy Network point out that the UK is bound by Article 25 of the Universal Declaration of Human Rights, which recognises migrant communities have a right to health, and would be in breach of this legislation should the proposals be implemented. Article 25 states that the right to health 'shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, *association with a national minority*, property, birth or other status' (emphasis added).

International Covenant on Economic, Social and Cultural Rights

Several submissions highlighted that Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) states health is a fundamental human right. Article 12 describes "the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health". The UN Committee on Economic, Social and Cultural Rights have stated that under the ICESCR:

'States are under the obligation to respect the right to health by...refraining from denying or limiting equal access for all persons, including...asylum seekers and illegal immigrants, to preventive, curative and palliative health services'

Some submissions argued that restricting access to healthcare for refused asylum seekers and vulnerable migrants would therefore contravene the ICESCR. Whilst the ICESCR is not justiciable in the UK, it is no less binding on governments than international agreements that have been incorporated into domestic legislation.

The European Convention on Human Rights (ECHR)

Refugee Action and other groups expressed concern that the lack of alternative healthcare provision available to some individuals affected by the proposals constitutes a breach of Articles 2, 3 and 8 of the ECHR. Currently, the only free healthcare provision available outside the NHS are those services provided by organisations such as Project London and the Helen Bamber Foundation, which do not have the capacity to treat many more people.

Articles 2 and 3 of the ECHR guarantee the right to life and prohibit inhumane or degrading treatment. The ECHR is instituted into UK law through the Human Rights Act, meaning that:

'the proposed changes will be open to legal challenge unless general practices and other primary care services are permitted to provide free NHS treatment in circumstances which would otherwise give rise to a breach of the European Convention on Human Rights'

Immigration Law Practitioner's Association

Discrimination

There was concern that the proposals may lead to illegal discrimination by health service providers against vulnerable migrants. For example:

'Health professionals must also be careful not to breach section 20 of the Race Relations Act by discriminating against asylum seekers (by refusing to provide them with health care services, for example, or by providing lower standards of care.)'

African HIV Policy Network

Identifying who is illegible for treatment is difficult and may also lead to discrimination, even against those who are entitled. Any form of discrimination would breach Article 14 of the ECHR which states that *'The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.'* The UK has also ratified the 1969 International Convention on the Elimination of all Forms of Racial Discrimination, which:

'also accords minority ethnic communities the right to access public health, medical care, social security and social services.'

African HIV Policy Network

Rights of the Child

The UN Convention of the Rights of the Child also recognises health as a fundamental human right. Refugee Action argued the government must ensure *'the proposals do not exclude children from their provisions which would run contrary to the Children Act and various Government initiatives supporting the rights of children.'*

The significance of Human Rights

Many submissions highlighted the conflict between the proposed changes and both existing government initiatives and Human Rights legislation. As one well known charity said,

'We fully support the Government in their work towards improving the rights of children, those with HIV and other vulnerable groups, and hope that they scrutinize these proposals to ensure that they do not mistakenly contravene their commitments or duties.'

Refugee Action

These submissions suggest that if the government do not take these considerations into account, the proposals may face legal challenge on a number of fronts.

Key Points: Human Rights

Twenty nine percent of submissions expressed concerns that the proposed changes in entitlement would breach international Human Rights agreements which the UK has ratified.

Submissions expressed concern about the lack of alternative healthcare provision to some individuals affected by the proposals.

Some were concerned that the proposals may lead to systematic discrimination which would be open to legal challenge.

Some highlighted the conflict between the proposals and both government initiatives and Human Rights legislation.

Chapter Eight: A Summary of those ‘broadly supportive’ of the proposals

Out of the thirty eight submissions to the consultation that we summarised, there were five that our reviewers considered 'broadly supportive' of these proposals to 'exclude overseas visitors from eligibility to free NHS primary medical services'. These submissions came from South Birmingham PCT, Newark and Sherwood PCT, Suffolk Practitioners Services Unit, MigrationWatch UK and an organisation that requested anonymity.

This organisation stated in their submission that they believed there was a need for a charging regime. However, they also stated vulnerable migrants should be exempt from charging. In an email to us on 24 July 2008, they clarified their position:

'The only charging we may support is for those choosing to visit from countries where there is not a reciprocal agreement for health care and who seek non urgent/immediate care'

Interestingly, South Birmingham PCT also requested that we did not make public their submission as they feel it no longer reflects their position.

Here we outline the reasons the other three organisations gave for supporting the proposals as well as outlining some concerns they had about the proposals.

Newark and Sherwood PCT

Newark and Sherwood PCT state the main reason for their support is also the need to 'bring clarity to the charging for NHS treatment for overseas visitors, both for secondary and primary care treatment'. They argue 'The resulting changes should ensure consistency and prevent confusion for frontline staff'. However, they later go on to list a number of 'practical difficulties envisaged for practices in operating the proposals outlined in the document.'

Suffolk Practitioners' Services Unit

Suffolk Practitioners Services Unit 'manages the GP patient register on behalf of the five Suffolk Primary Care Trusts'. They 'are responsible for processing GP patient registrations and for allocating patients to GP practice lists when they have failed to gain voluntary registration anywhere'. They state that their response to the consultation therefore 'reflect[s] both our experiences of dealing with 'overseas visitors' and associated queries and those of [...] colleagues in similar agencies across the Eastern region'. Suffolk Practitioners Services Unit suggests the introduction of 'some form of identity or smart card which confirms that the holder is entitled to free NHS primary medical services'. They support the need for 'a new set of rules regarding overseas visitors as the current system, based on guidance only, is subject to wide variances in interpretation and is therefore perceived as inconsistent and unfair'.

MigrationWatch UK

MigrationWatch UK is an independent think-tank who:

'wish to ensure that the arguments adduced in favour of the current large-scale immigration are thoroughly examined as we believe them to be unsound. We also believe that such massive immigration is contrary to the interests of all sections of our community, adding to the problems of both overcrowding and integration.'

migrationwatchuk.com/whoweare.asp

They believe that 'The present rules are completely ineffective' in preventing overseas visitors accessing NHS treatment.

MigrationWatch UK suggest that their main reason for supporting the proposals is to give GPs the ability to refuse treatment without facing serious complaints – 'the absence of proof of entitlement should become a full defence for a GP who refused treatment.'

They support separating 'the administrative problem of entitlement from the work of the medical profession', proposing that a system of 'Local Entitlement Offices' are established to take on the responsibility of establishing entitlement.

Concerns

Despite being broadly supportive of the proposals to introduce a system of charging, these submissions also raise a number of concerns about the consequences of implementing them as described in the consultation document.

Suffolk Practitioners Services Unit have concerns over the position that GPs would likely find themselves in 'being both gatekeepers and providers' and worry that this could lead to possible conflicts of interest.

All the submissions in broad support of the proposals highlight a number of services they feel should be except from any charging regime either on public health or human rights grounds:

"Family Planning services should continue to be freely available"

Newark and Sherwood PCT

"The existing arrangements for communicable diseases [sh]ould remain in place."

MigrationWatch UK

“The treatment of communicable diseases [should be exempted from charging]. However, there are logistical difficulties with this. A general practitioner would not necessarily know that an overseas visitor was suffering from a communicable disease until the patient had actually been examined. Therefore, a service would have been provided before a decision could be taken as to whether or not the patient should be charged for treatment. Is this moral? Would we want to put GPs in the position of having to refuse free NHS treatment in the confines of an examination room with its inherent security problems and the possible adverse effects on the patient?”

Suffolk Practitioners’ Services Unit

In summary, whilst five submissions are supportive of the proposals, the situation in reality is more complex. Firstly, this is no longer the position of one of the organisations. Secondly, with the exception of MigrationWatch UK, which would like to see fewer 'overseas visitors' using NHS services, the other organisations are mostly seeking regulations that provide greater clarity. Many of these submissions express concerns about the practicalities of implementing the proposed charging regime and feel that a number of conditions or patient groups should be eligible for free NHS treatment.

Key Points: Broadly Supportive Submissions

Five of the submissions analysed were considered to be broadly supportive of the proposals, although one has indicated the views in their submissions no longer reflect those of the organisation.

Rationale for support includes: the need to clarify existing guidelines; the current 'inconsistent and unfair' variation in interpretation of government guidance; and the failure of current regulations to prevent 'overseas visitors' from accessing NHS services.

Many of these submissions express concerns about the practicalities of implementing the proposed charging regime and feel that a number of conditions or patient groups should be eligible for free NHS treatment.

Conclusion and Recommendations

The public consultation that prompted the creation of this report is important. It proposed removing entitlement to healthcare from some of the most vulnerable people in our community. It is clear from reviewing the available submissions that a large number of organisations and individuals responded with detailed and thoughtful answers to the questions posed by the Department of Health. We are disappointed that it has taken the Freedom of Information Act and a group of volunteer medical students and doctors to bring at least some of these into the public domain.

The following are recommendations that we have drawn from this – albeit limited – data set:

1. Considering a large majority of healthcare providers express concern that denying care would place them in breach of professional codes of conduct, we suggest that denial of healthcare should not be used as a means of enforcing immigration policy.
2. Given widespread concerns about the public health implications of these proposals, we recommend the government reconsider leaving any community unable to access primary care, as this could seriously undermine efforts to tackle infectious diseases.
3. Given most respondents felt settled refused asylum seekers were a distinct population to overseas visitors we recommend that these persons fall outside the remit of these proposals. In the event that Government wishes to proceed with implementing these recommendations, we suggest special consideration be given to vulnerable groups including children and pregnant women.
4. Eighty seven percent suggested there would be significant practical problems associated with these proposals. Front line healthcare workers and administrative staff have insufficient knowledge of the asylum process to implement these proposals. Government must recognise that administering a charging regime would place a significant burden on front line NHS services.
5. Given the majority of submissions questioned the overall cost-effectiveness of implementing such a charging regime, we recommend the government undertake a full cost benefit analysis of both the existing charging regime in secondary care as well as any planned new regulations before they are introduced.
6. As the proposed regulations disproportionately affect particular ethnic groups, the Government must honour their commitment to conduct a full race impact assessment prior to implementation.
7. Given concern that the proposals may contravene several international human rights agreements, we suggest independent legal opinion is obtained and published.

8. Very few of the submissions we obtained were supportive of the proposed changes and some organisations have informed us they no longer hold these views. Taking this into account, we call upon the Department of Health to: (i) substantiate their claim that opinions expressed in submissions to the consultation were divided by publishing all submissions in full; and (ii) carry out further public consultation prior to implementation of the proposals.

Appendix A: Correspondence with the Department of Health

On the 13th September 2007, we posted a Freedom of Information request to the Department of Health requesting the following...

'information concerning the Department of Health Consultation, Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services, which closed on 13 August 2004. Specifically, I am requesting two things.

1 Complete copies of all the submissions to this consultation.

2 A complete list of all the organisations and individuals who made submissions to the consultation.'

On the 2nd October 2007, we received the following response...

'Thank you for your letter of 13 September requesting under the Freedom of Information (FOI) Act 2000, a list of all organisations and individuals who responded to the Department of Health 2004 Consultation, Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services and copies of their submissions.

The list of respondents is attached.

I am sorry to advise you that the Department of Health is unable to disclose individual submissions in detail at this stage. The Department considers that this information is exempt from disclosure under section 35(1)(a) of the FOI Act. Section 35(1)(a) provides that information is exempt if it relates to the formulation or development of Government policy.

Section 35 is a 'qualified' exemption and we are therefore required to consider whether the public interest in disclosing the information outweighs the public interest in applying the exemption.

The purpose of the exemption at section 35 of the FOI Act is to protect the internal deliberative process as it relates to policy making. In other words, the exemption is intended to ensure that the possibility of public exposure does not deter from full, candid and proper deliberation of policy formulation and development, including the exploration of all options, the keeping of detailed records and the taking of difficult decisions. Premature disclosure of information protected under section 35 could prejudice good working relationships, the neutrality of civil servants and, ultimately, the quality of Government.

I can inform you, however, that the majority of responses to the Consultation showed strong support for clarifying the rules. Beyond that, the responses were divided. There was much support for tighter rules and much support for a more inclusive and public health-driven approach. There was particular support for allowing failed asylum seekers (and dependants)

to have access to primary medical services, taking account of their almost invariably poor economic position and their reasons for being in this country.

We acknowledge that the existing rules regarding eligibility for primary medical services are unclear and leave much to the individual discretion of GPs and practices. That is why we undertook the consultation in 2004. The responses received highlighted a range of difficult and sensitive issues.

These and other issues are now being considered as part of the joint Department of Health and Home Office review of the rules governing access to the NHS by foreign nationals which was announced in the 7 March Home Office publication, Enforcing the rules: A new strategy to ensure and enforce compliance with our immigration laws.

The review is due to be completed shortly and will then be followed by a public consultation as part of the wider migration strategy. Any changes resulting from the review and consultation are intended to be in place by September 2008 and will be clearly communicated to the NHS.

I hope this is helpful. If you are unhappy with the way the Department of Health has handled your request you may ask for an internal review. You should write to the Section Head of the Freedom of Information group at the Department of Health, quoting the reference number above:

*Freedom of Information Unit
Department of Health Room
334b Skipton House
80 London Road
SE1 6LH*

Email: FreedomofInformation@dh.gsi.gov.uk

If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner's Office (ICO) for a decision. Generally, the ICO cannot make a decision unless you have exhausted the complaints procedure provided by the Department.

The ICO can be contacted at:

*Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF*

Yours sincerely,

On the 15th November 2007, we requested an internal Department of Health review of the decision not to release the submissions...

'Dear Sir,

Re: Freedom of Information Request DE00000238979

I would like to appeal the Department of Health's decision not to release the submissions made to their 2004 consultation 'Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services'. In an email on 2 October 2007 (copied below), Stephen Fay of the department's Customer Service Centre cites an exemption under section 35(1)(a) of the Freedom of Information Act. I contest this on the following grounds...

1 In his email, Mr Fay kindly explains that section 35(1)(a) of the Freedom of Information Act "is intended to ensure that the possibility of public exposure does not deter from full, candid and proper deliberation of policy formulation and development, including the exploration of all options, the keeping of detailed records and the taking of difficult decisions." However, the original consultation document contained the following text...

"Your response will be used to inform the further development of this proposed policy and therefore responses, including the name and address of respondents, may be made public unless confidentiality is specifically requested. In accordance with the freedom of information legislation, individual responses will be made available to anyone who asks for them, unless one of the exceptions in the legislation applies, for example the information was provided in confidence, or its disclosure would prejudice third parties."

Thus, those responding to the consultation expected their submissions to be made public. Those who wished to respond in confidence will have notified the department. Those that did not do this could have done, had confidentiality been required for them to engage fully in debate and policy formulation. If people did not request confidentiality, it seems unlikely that concerns with their submissions being made public limited their ability to respond in a candid way to the consultation document. We therefore request all submissions from those individuals and organisations not requesting confidentiality - presumably the vast majority.

2 The Department of Health and Home Office are currently undertaking a joint review of access to NHS services by 'overseas visitors'. This review was announced in the Home Office document 'Enforcing the Rules' (March 2007). The consultation 'Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services' considered the same issues. I understand there will be another consultation on the same issue in the New Year, following the publication of the joint Department of Health and Home Office review. Therefore submissions to this new consultation rather than the 2004 consultation are likely to form the basis for future policy formulation. Furthermore, the submissions we are requesting are now three years old. Thus the submissions we are requesting are likely to play a lesser role in the formulation or development of government policy. This weakens the argu-

ment that it is in the public interest to apply the section 35(1)(a) exemption to allow "candid and proper deliberation of policy formulation and development".

3 The Department of Health and the Home Office are currently undertaking a review of access to NHS services by 'overseas visitors'. They have stated in the past their intention to align the regulations governing charging for primary care with those governing charging for secondary care (for example, in 'Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services' (2004)). If this occurred, a large population including undocumented migrants, failed asylum seekers awaiting deportation and failed asylum seekers receiving Section IV support from the National Asylum Support Service would lose the right to freely access many NHS primary care services.

The withdrawal of access to primary care from a large population of migrants living in the UK will have a significant impact upon not only the health of those denied care but also upon Accident and Emergency departments and charities who will find themselves dealing with the health needs of this population. There will be also be implications for public health. A summary of the many concerns about these proposals can be found at <http://www.medact.org/content/refugees/Briefing%20V1%20agreed.pdf>.

It is important to realise that very little is known about the likely impact of limiting access to primary care:

- Only one Primary Care Trust (Newham) has undertaken a health impact assessment of the proposals. This assessment raised significant concerns about the proposals (see <http://www.lho.org.uk/Download/Public/11948/1/IHU%20Entitlement%20Report%2006.pdf>).
- We don't know how many people in the UK fall into the groups that would be most affected by the proposed changes to primary care (see the minutes of the Health Select Committee meeting on 10 February 2005, particularly Melanie Johnson's response to question 210, available from

<http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/252/5021008.htm>).

- We also do not know how many people have already been refused secondary care and what has happened to this group. Freedom of Information requests we have made reveal that neither University College London Hospitals NHS Trust nor the United Bristol Healthcare NHS Trust monitor mortality in the population who were excluded from freely accessing many NHS hospital services when Department of Health, Statutory Instrument 2004 No614 came into force in April 2004.
- Perhaps more importantly, it is not clear how alternative care will be provided for those who may be excluded from most NHS secondary and primary care services.

Two hundred and seventy five people and organisations submitted evidence to the consultation 'Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services'. This group included tens of doctors and other healthcare professionals who would

be directly affected by any change in charging regulations. Their submissions thus form a hugely valuable source information that, if released, would allow healthcare providers, charities and policy makers to plan for the future. With the Government's response (<http://www.publications.parliament.uk/pa/jt200607/jtselect/jtright/134/134.pdf>) to 'The Treatment of Asylum Seekers' (2007), a report by the Joint Committee on Human Rights, suggesting that implementation of the proposals made in the Department of Health and Home Office review might occur as early as September 2008, there is an urgent need for more information on these issues. There is thus an overwhelming public interest in disclosing this information now.

I would be grateful if you could acknowledge receipt of this email and I look forward to hearing from you in due course.

Yours sincerely,'

On 31st December 2007, our appeal was turned down...

'Dear Mr Yates,

OUTCOME OF A REQUEST UNDER FREEDOM OF INFORMATION [FOI] ACT 2000 FOR INTERNAL REVIEW

Thank you for your email of 15 November seeking a review of the Department's decision to withhold part of the information requested by you under the Freedom of Information Act (FOIA).

Your original request (our ref: DE238979) was:

" I would like to make a request, under the Freedom of Information Act 2000, for information concerning the Department of Health Consultation, Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services, which closed on 13 August 2004. Specifically, I am requesting two things.

1 Complete copies of all the submissions to this consultation.

2 A complete list of all the organisations and individuals who made submissions to the consultation. "

The Department replied to you on 2 October to inform you that it was withholding the information you had requested in part 1, which it considered was exempt from disclosure under section 35(1)(a) of the FOI Act. You were provided with the list you asked for in part 2.

In your request for an internal review you referred to the text in the original consultation document which states that:

"Your response will be used to inform the further development of this proposed policy and therefore responses, including the name and address of respondents, may be made public un-

less confidentiality is specifically requested. In accordance with the freedom of information legislation, individual responses will be made available to anyone who asks for them, unless one of the exceptions in the legislation applies, for example the information was provided in confidence, or its disclosure would prejudice third parties."

The text stated that in accordance with the freedom of information legislation, individual responses will be made available to anyone who asks for them, unless one of the exemptions in the legislation applies. As explained in the Department's reply to you on 2 October, section 35(1)(a) applies to the responses submitted to the consultation.

The responses to the 2004 consultation, Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services were both extensive and inconclusive. They highlighted a range of difficult and sensitive issues.

As a result, all these issues are now being considered as part of the joint Department of Health and Home Office review of the rules governing access to the NHS by foreign nationals. The review was announced on 7 March in the Home Office publication, Enforcing the Rules: A new strategy to ensure and enforce compliance with our immigration laws.

The review is due to be completed shortly and will then be followed by a full public consultation. The responses to the 2004 consultation are being considered as part of this review, we will publish the responses to the 2004 consultation when the Review of Access to the NHS by foreign nationals goes out to public consultation in Spring 2008.

The aims of the review in relation to primary medical services are to establish clear rules which are, wherever possible, consistent with the rules relating to secondary care. Any new rules will take into account the key preventative and public health role of NHS primary medical care as well as international law and humanitarian principles.

The review will look at a range of issues regarding immigration and asylum particularly the eligibility of failed asylum seekers and their children. An equality impact assessment will also be carried out as part of this review process, in relation to both primary medical services and secondary care.

We have considered all the relevant issues and documents in this case and have concluded that the original request was handled systematically and appropriately.

It is our view that the Act was correctly applied, and the reasons for the decision were appropriate to the circumstances of the case. Section 35(1)(a) relates to the formulation or development of government policy. However, this exemption is a qualified exemption and the Department is required to assess as objectively as possible whether the balance of public interest favours disclosing or withholding this information.

The decision on the public interest is based on the following:

Factors in favour of disclosure:

The Department recognises that there is a general public interest in the transparency of the processes leading up to a decision being made.

Disclosure of information could result in the public being better informed about this subject and thus better placed to engage in debate on the issues associated with Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services.

Factors in favour of non-disclosure:

The purpose of the exemption at section 35 of the FOI Act is to protect the internal deliberative process as it relates to policy making. Premature disclosure of information protected under section 35 could prejudice good working relationships, the neutrality of civil servants and, ultimately, the quality of Government.

Information need not be released if release would inhibit the free and frank provision of advice or the free and frank exchange of views for the purposes of deliberation, or would otherwise prejudice the effective conduct of public affairs.

Ministers and Government officials need to be able to engage in free and frank discussion of all the policy options, to expose their merits and demerits and their possible implications as appropriate. Their candour in doing so will be affected by their assessment of whether the content of such discussion will be disclosed in the near future.

Premature reporting of information may deter civil servants and experts from providing comprehensive advice in the future.

Premature release of this information may result in misinterpretation.

The review is now complete. The Department is satisfied that section 35 of the FOI Act was correctly applied to your original request.

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at:

*Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF*

Yours sincerely,

On 10th January we submitted an appeal regarding this decision to the Information Commissioner, which can be found in Appendix B.

On 16th July we received a letter from the Department of Health:

'Dear Mr Yates,

UPDATE ON YOUR REQUEST UNDER FREEDOM OF INFORMATION [FOI] ACT 2000

We received a letter from the Information Commissioners Office, 5 February 2008 (ICO case reference FS50189099), regarding a complaint you have made to our Department concerning the replies to your original FOI request of 13 September 2007 (ref DE238979) and to your subsequent request for an internal review (ref 3810R).

Your original FOI request concerned the Department of Health's consultation, "Proposals to exclude overseas visitors from eligibility to free NHS primary medical services". You asked for complete copies of all submissions made in response to this consultation exercise and for a complete list of all organisations and individuals who made submissions.

As you are aware, this information is to be included in the published consultation response. I regret to inform you that there has been a further delay in the publication of the response to this consultation. The Department of Health is required to publish significant documents only when the House of Commons is sitting, unfortunately this will not be possible before the recess date of 22nd July, hence the need to delay until October 2008, once Parliament is back after the summer recess.

I would like to apologise for this further delay in publication of the consultation response - I have updated the Information Commissioner's Office with the new date.

Yours sincerely,'

We have replied to this letter but as the Department have not had a reasonable opportunity to respond to us, we have opted not to print our reply here.

Appendix B: Appeal to the Information Commissioner

FOI Complaints Resolution
Information Commissioner's Office
Wycliffe House
Water Lane
WILMSLOW
Cheshire
SK9 5AF

10 January 2008

Department of Health's references: DE238979, 3810R

Dear Commissioner

Freedom of Information Act 2000: complaint by Mr Thomas Yates against the Department of Health

I write on behalf of Mr Thomas Yates to complain about a refusal by the Department of Health to release information requested under the Freedom of Information Act 2000 ('the Act').

Please find enclosed copies of the communications and other documents relating to this request and to the subsequent internal review, along with Mr Yates' authority for me to act for him (page 59). Page numbers referred to in this letter are the handwritten numbers in the enclosed bundle. I outline Mr Yates' grounds for complaint in the numbered paragraphs below.

As a courtesy I am copying this letter to the Department of Health's Freedom of Information Unit.

The request for information

1. On 14 May 2004 the Department of Health consulted the public about charging overseas visitors for the use of NHS primary care services. A copy of the consultation document is enclosed at page 15. A number of individuals and organisations responded to that consultation exercise; they are listed at pages 51-57.

2. At paragraph 4.4 of the consultation document (page 34) respondents were advised that:

'Your response will be used to inform the further development of this proposed policy and therefore responses, including the name and address of respondents, may be made public unless confidentiality is specifically requested. In accordance with the freedom of information legislation, individual responses will be made available to anyone who asks for them, unless one of the exceptions in the legislation applies, for example the information was provided in confidence, or its disclosure would prejudice third parties.'

3. In the consultation document the government, when inviting submissions, indicated that '[a] summary of the outcome of this consultation will be placed on the Department of Health's consultation website www.dh.gov.uk/consultation by 12 November 2004' (page 24, paragraph 1.9).

The government did not fulfil this commitment then, nor has it published the responses or a summary of the outcome of the consultation exercise since.

4. On 13 September 2007 Mr Yates wrote to the Department requesting, under the Freedom of Information Act 2000, two pieces of information relating to this consultation (page 1).

5. The information requested consisted of:

complete copies of all submissions made in response to the consultation exercise, and a complete list of all organisations and individuals who made submissions.

6. On 2 October 2007 the Department replied to Mr Yates by email (page 3). An Excel spreadsheet containing the list of respondents was attached (pages 51-57). The Department declined to provide Mr Yates with copies of the submissions, citing the s 35(1)(a) exemption (formulation or development of government policy), although it did make brief reference to the contents of the responses (page 4).

7. On 15 November 2007 Mr Yates requested by email an internal review of the refusal to provide copies of the submissions (page 7). The Department replied in an emailed letter dated 31 December 2007, upholding its original decision (page 11).

8. Mr Yates complains that this refusal to provide copies of the responses to the consultation violates s 1(1)(b) of the Act.

9. Specifically, Mr Yates complains that the Department has misapplied the s2(2)(b) test balancing the public interest in disclosure against the public interest in withholding information.

The public interest in non-disclosure

10. The Department has relied upon the s 35(1)(a) qualified exemption (pages 3 and 11-13). I submit that this exemption is not engaged.

11. The only court or Information Tribunal decision interpreting this exemption that I have been able to identify is *Department for Education and Skills v Information Commissioner and the Evening Standard* (EA/2006/0006), which related to the minutes of senior management meetings on a policy matter at a government department. It assists with this interpretative issue only tangentially. The Tribunal concludes, at [53], that 'relates to' and 'formulation and development of policy' can be given a 'reasonably broad interpretation' since the provision requires a further balancing test to be applied, but the Tribunal goes on (at [75]) to hold that, with regard to s 35(1):

- (i) The central question in every case is the content of the particular information in question. Every decision is specific to the particular facts and circumstances under consideration. Whether there may be significant indirect and wider consequences from the particular disclosure must be considered case by case.
- (ii) No information within s 35(1) is exempt from the duty of disclosure simply on account of its status [...omitted as irrelevant]

12. Running through the analysis of the interpretation of s 35(1)(a) in the *Evening Standard* case is an assumption that it relates to behind-closed-doors, *intra*-governmental policy discussion. This would accord with the obvious purpose of the clause.

13. In my submission the responses of the public to a public consultation exercise are not caught the s 35(1)(a) definition of information relating to the formulation or development of government policy at all. Following the *Evening Standard* case, the fact that the responses were solicited by a policy-making government department does not of itself subject them to the s 35(1) exemption. While clearly within that vast category of information that might helpfully guide government policy, the information requested consists of the views and observations of members of the public who expected their responses to be made public and their responses are as directly related to the formulation or development of government policy as is a letter to a newspaper on the same subject.

14. In considering the public interest in non-disclosure the Department has provided a list of what appear to be generic considerations that might, in certain circumstances, weigh against disclosure of information relating to policy-making (pages 12-13).

15. In the alternative to the argument that s 35(1)(a) is not engaged, I submit that none of the reasons given by the Department is relevant to comment provided by members of the public in a public consultation exercise. The Department appears to have given no thought to the application of these factors to Mr Yates' request. The factors the Department has listed, on page 13, as weighing against non-disclosure are, when read in this context, either irrelevant or of no more than slight and marginal importance.

16. When respondents to the consultation were expressly notified that their responses were likely to be made public, the irrelevance of the particular considerations to which the Department has given weight applies all the more strongly, and notably to the Department's second and fourth bullet points on page 13.

17. The Department's final bullet point on page 13 is simply nugatory.

18. In summary, the Department has identified no reasons, or no good reasons, that weigh significantly against the public interest being served by disclosure of the requested material.

The public interest in disclosure

19. In its review the Department has offered two generic considerations weighing in favour of disclosure. We agree that these are important considerations.

20. There is a, however, a more specific, weighty reason that disclosure is in the public interest.

21. The groups the government proposes to exclude from eligibility for free NHS primary care services includes those whose asylum applications have failed. This group encompasses some of the most vulnerable, marginalised and deprived people in the UK, many of whom have very serious and sometimes life-threatening mental and physical health problems.

22. Professionals and organisations who work with this group, including a number who responded to the consultation exercise, believe or suspect that the responses to the consultation exercise were not, as the Department claims at pages 4 and 12 respectively, 'divided' and 'inconclusive', but were in fact overwhelmingly opposed to the proposed policy change as it affects failed asylum-seekers. Rightly or wrongly, there is a perception that the consultation exercise was carried out for the sake of appearances and that the government intends to disregard (or has already disregarded) its results.

23. If this perception is wrong, it is clearly in the public interest for it to be corrected. If it is right, it is clearly in the public interest for such an approach to policy-making to be subject to public scrutiny prior to further consultation being carried out and further policy decisions being made. This is why Parliament enacted the Freedom of Information Act. The Department's refusal to disclose the material, without giving any coherent grounds for doing so, can only serve to fuel suspicions and so harm the interests of both the government and the public.

24. It is perhaps understandable that the Department would find it difficult to give this consideration its due weight. Assessed objectively, however, as the Act requires, this consideration weighs heavily in favour of disclosing the information requested.

The s 2(2)(b) public interest balancing test

25. The Department has erred in applying the s 2(2)(b) balancing test.

26. It has correctly identified two important but general factors favouring disclosure but disregarded the important, more specific factor identified at paragraph above. This is not internal deliberative information but simple public comment and is of obvious, direct, and legitimate interest to the public.

27. More importantly the Department has, for the reasons given at paragraphs to above, failed to identify any factors logically or legally weighing significantly, or at all, against disclosure.

28. The Department then appears not to have engaged in any actual weighing of these considerations against each other, as required by s 2(2)(b).

29. Even if, as is disputed, s 35(1)(a) is engaged then, as Mr Bartlett QC observes in the unanimous decision in *HM Treasury v Information Commissioner* (EA/2007/0001) at [57], 'the s 35(1)(a) exemption is qualified. Parliament has therefore recognised that the balance of public interest may favour disclosure of information relating to the formulation or development of government policy'.

30. In the *Evening Standard* case referred to at paragraph , notwithstanding s 35(1)(a) being engaged, the Tribunal required the disclosure of (in comparison, very much more sensitive) minutes of senior management meetings at the Department for Education and Skills relating to the setting of school budgets. In the *Treasury* case, notwithstanding the s 35(1)(a) exemption being engaged, the Tribunal required the disclosure of advice provided by the Treasury to the then Chancellor when he was considering reducing income tax by one penny in the pound.

31. Even if the s 35(1)(a) exemption is engaged, the s 2(2)(b) balancing test, correctly applied to

these facts, weighs heavily in favour of disclosing the requested information.

The expectations of the respondents and the 'confidence' exemption

32. It is clear from the statements in the consultation document quoted at paragraphs and above that Department anticipated publishing this information and that respondents have been made aware that their responses would, effectively, be in the public domain.

33. If any respondent has clearly requested that his or her response be treated as confidential, whether or not the s 41 'information provided in confidence' exemption is engaged, Mr Yates has no objection to the confidential material to that information being withheld to the minimum extent necessary to preserve individuals' confidentiality and keep the cost of compliance within the s 12 limit, for example by redacting or, if necessary, excluding responses containing personal information.

34. Objections founded upon respondents' expectations and the 'confidence' exemption cannot therefore justify refusal to disclose this information.

The Department of Health's future intentions

35. The Department has asserted at page 12 that it intends to publish the responses to the consultation exercise in 'Spring 2008'. The Department has not suggested that this assertion can impact upon the balancing test. We agree that it was correct not to do so. Given the period of time that has elapsed since the consultation exercise, this statement is no more relevant than the Department's unfulfilled commitment in the consultation document that a summary of responses would be published by 12 November 2004 (page 24, paragraph 1.9). A telephone conversation with the Department's Carole Griffiths today (10 January 2008) confirmed that the Department is "still deliberating" on whether to publish the full responses or merely its own summary of them. Either way, there is no material benefit to the public in withholding these responses now, particularly in the context of concerns about how this exercise has been handled (paragraph above), the delay, and the importance of open and transparent government.

The exemption for information intended for future publication

36. The Department of Health has not claimed that the qualified exemption under s 22(1) of the Act (information intended for future publication) applies.

37. If it were to do so I submit that this exemption fails the test in s 22(1)(c) in that, in all the circumstances and for the reasons given in paragraph above, it is now unreasonable for the Department to rely upon this exemption (if indeed it ever was reasonable) some three and a half years after the consultation period has ended, notwithstanding any current claims it makes about its plans to publish the information at some point in the future.

38. Alternatively I submit that, in the context of the concerns outlined at paragraph above and with the marked passage of time, the public interest in disclosure at this point greatly outweighs any public interest in maintaining its secrecy.

The exemption for personal information

39. The Department has not cited the s 40(2) exemption for personal data. If the material requested contains genuinely personal information, whether or not the s 40(2) exemption is engaged, Mr Yates has no objection to that information being withheld to the minimum extent necessary to preserve individuals' confidentiality and keep the cost of compliance within the s 12 limit, for example by redacting or, if necessary, excluding responses containing personal information.

40. This exemption cannot therefore justify the refusal to disclose this information.

Conclusions

41. I submit that the Department is obliged by s 1(1)(b) of the Act to disclose the requested information. The Commissioner is respectfully invited to make this finding and to require the Department to release the material promptly.

42. Alternatively, if there are relevant exemptions protecting some of the material from release, the Information Commissioner is respectfully invited to require prompt release of the remaining material.

Thank you for considering this complaint. Please do not hesitate to contact me by telephone, email or letter if I can assist with its speedy resolution in any way. I look forward to hearing back from you in due course.

Yours faithfully
Adam Sandell

cc. Ms Caroline Wyatt

Appendix C: Approaching those who made submissions

Dear,

My name is, a medical student at I am emailing to ask for your help.

I understand that in 2004, you made a submission to the Department of Health consultation, 'Proposals to exclude overseas visitors from eligibility to free NHS primary medical services'.

I am very interested in refugee health and am attempting to collate the submissions that were made to this enquiry as I feel they will help to inform any debate about the current proposals to bring the rules governing charging in primary care into line with those that govern secondary care.

I have asked the Department of Health for copies of the submissions made to the enquiry but they are unable to share this information, as they feel it was given in confidence. Would you be able to send me a copy of the evidence that you submitted to the enquiry? Also, would you object to our making this evidence available on the internet (contact details removed) and using it in a synopsis of submissions to the consultation which we plan to publish in the near future? I hope you will be able to assist me with this matter.

Many thanks,