House of Lords
House of Commons
Joint Committee on
Human Rights

Legislative Scrutiny:
Health Bill; Marine and Coastal Access Bill

Eleventh Report of Session 2008-09

Report, together with formal minutes and Written Evidence

Ordered by The House of Lords to be printed 31 March 2009
Ordered by The House of Commons to be printed 31 March 2009
Joint Committee on Human Rights

The Joint Committee on Human Rights is appointed by the House of Lords and the House of Commons to consider matters relating to human rights in the United Kingdom (but excluding consideration of individual cases); proposals for remedial orders, draft remedial orders and remedial orders.

The Joint Committee has a maximum of six Members appointed by each House, of whom the quorum for any formal proceedings is two from each House.

Current membership

HOUSE OF LORDS
- Lord Bowness
- Lord Dubs
- Lord Lester of Herne Hill
- Lord Morris of Handsworth OJ
- The Earl of Onslow
- Baroness Prashar

HOUSE OF COMMONS
- John Austin MP (Labour, Erith & Thamesmead)
- Mr Andrew Dismore MP (Labour, Hendon) (Chairman)
- Dr Evan Harris MP (Liberal Democrat, Oxford West & Abingdon)
- Mr Virendra Sharma MP (Labour, Ealing, Southall)
- Mr Richard Shepherd MP (Conservative, Aldridge-Brownhills)
- Mr Edward Timpson MP (Conservative, Crewe & Nantwich)

Powers

The Committee has the power to require the submission of written evidence and documents, to examine witnesses, to meet at any time (except when Parliament is prorogued or dissolved), to adjourn from place to place, to appoint specialist advisers, and to make Reports to both Houses. The Lords Committee has power to agree with the Commons in the appointment of a Chairman.

Publications

The Reports and evidence of the Joint Committee are published by The Stationery Office by Order of the two Houses. All publications of the Committee (including press notices) are on the internet at www.parliament.uk/commons/selcom/hrhome.htm.

Current Staff

The current staff of the Committee are: Mark Egan (Commons Clerk), Rebecca Neal (Lords Clerk), Murray Hunt (Legal Adviser), Angela Patrick and Joanne Sawyer (Assistant Legal Advisers), James Clarke (Senior Committee Assistant), Emily Gregory and John Porter (Committee Assistants), Joanna Griffin (Lords Committee Assistant) and Keith Pryke (Office Support Assistant).

Contacts

All correspondence should be addressed to The Clerk of the Joint Committee on Human Rights, Committee Office, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general inquiries is: 020 7219 2467; the Committee’s e-mail address is jchr@parliament.uk
## Contents

### Report

<table>
<thead>
<tr>
<th>Summary</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government Bills</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>1 Health Bill</strong></td>
<td>5</td>
</tr>
<tr>
<td>Background</td>
<td>5</td>
</tr>
<tr>
<td>Explanatory Notes</td>
<td>5</td>
</tr>
<tr>
<td>The effect of the Bill</td>
<td>6</td>
</tr>
<tr>
<td>Significant human rights issues</td>
<td>7</td>
</tr>
<tr>
<td>NHS Constitution</td>
<td>7</td>
</tr>
<tr>
<td><em>Human rights and the NHS Constitution</em></td>
<td>7</td>
</tr>
<tr>
<td><em>Freedom of religion, non-discrimination and the NHS Constitution</em></td>
<td>8</td>
</tr>
<tr>
<td>Direct payments</td>
<td>9</td>
</tr>
<tr>
<td>Adult social care: complaints</td>
<td>12</td>
</tr>
<tr>
<td><strong>2 Marine and Coastal Access Bill</strong></td>
<td>16</td>
</tr>
<tr>
<td>Background</td>
<td>16</td>
</tr>
<tr>
<td>Significant human rights issue</td>
<td>16</td>
</tr>
</tbody>
</table>

**Bills not requiring to be brought to the attention of either House on human rights grounds** 19

**Annex: Proposed Committee Amendments** 20

**Conclusions and recommendations** 21

**Formal Minutes** 23

**List of written evidence** 24

**Written Evidence** 25

**List of Reports from the Committee during the current Parliament**
Summary

We report here on our scrutiny of five Government Bills.

**Marine and Coastal Access Bill**

The Bill is, at present, incompatible with the right to a fair hearing (under the common law and Article 6 of the European Convention on Human Rights). The Bill needs to be amended to provide a right of appeal to an independent body. This would make the Bill compatible with the right to a fair hearing, and would bring it in line with comparable legislation.

**Health Bill**

We welcome the Government’s explicit reference to human rights in the NHS Constitution.

We make a number of recommendations to amend the Bill and guidance. These amendments relate to:

- Preventing discrimination in the provision of services to NHS patients;
- Clarifying that NHS services funded by direct payments and provided by independent bodies are functions of a public nature under the Human Rights Act 1998; and
- Improving rights in cases where a Local Commissioner investigates complaints.

**Industry and Exports (Financial Support); Northern Ireland; Postal Services Bills**

These Bills do not raise human rights issues of sufficient significant to warrant us undertaking further scrutiny of them.
Government Bills

**Bills drawn to the special attention of each House**

## 1 Health Bill

<table>
<thead>
<tr>
<th>Date introduced to first House</th>
<th>15 January 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date introduced to second House</td>
<td></td>
</tr>
<tr>
<td>Current Bill Number</td>
<td>HL Bill 31</td>
</tr>
</tbody>
</table>

### Background

1.1 The Bill was introduced in the House of Lords on 15 January 2009. Professor the Lord Darzi of Denham, the Parliamentary Under Secretary of State for Health, has made a statement of compatibility under s.19(1)(a) of the Human Rights Act 1998 (HRA). The Explanatory Notes accompanying the Bill set out the Government’s view of the Bill’s compatibility with human rights at paragraphs 364 to 385. The Bill had its Second Reading on 4 February 2009. It concluded Grand Committee on 17 March 2009. Report stage is due to commence on 28 April 2009.

1.2 Lord Darzi wrote to us on 28 January 2009 to provide us with information on the implication of the provisions of the Health Bill for human rights. **We are grateful to the Minister for his letter, which assisted our scrutiny of the Bill at an early stage.** We wrote to Lord Darzi on 12 February 2009 asking for a fuller explanation of the Government’s view of the human rights compatibility of some aspects of the Bill. We received the Minister’s response on 3 March 2009. **We welcome the full and prompt responses provided by the Minister.**

1.3 Following our recent practice, we published our correspondence with the Minister on our website and invited further submissions on the human rights implications of the Bill. We publish the submissions received together with this Report. **We welcome the engagement of the public and interested organisations in our legislative scrutiny work.**

### Explanatory Notes

1.4 The Government’s attempts to explain how, in its view, the Bill complies with human rights, have been mixed. On the one hand, the Explanatory Notes to the Bill dealing with human rights compatibility run to just over 20 paragraphs. At first glance, they appear to offer a reasonably detailed analysis of the human rights compatibility of the Bill. However, on a number of points they are confused and provide only a superficial analysis, without further explanation. The human rights section of the Explanatory Notes is also difficult to read as it does not follow the structure of the Bill, contains no subheadings, and groups its

---

1. HL Bill 18-EN.
2. Ev 6.
3. Ev 8.
analysis around Articles of the European Convention on Human Rights rather than specific clauses.

1.5 On the other hand, Lord Darzi subsequently provided us with an unsolicited letter which, whilst replicating the human rights analysis, is helpfully structured, dealing clause by clause with the compatibility of all provisions of the Health Bill, whether or not, in the Government’s view, they give rise to issues of compatibility with the European Convention on Human Rights (ECHR). In our most recent Annual Report, we recommended that the Government should provide such letters as a matter of course. We welcome the Minister’s letter as an example of a Department giving effect to our previous recommendation. When such letters supplement the analysis in the Explanatory Notes, it would assist us greatly if the letter was made available at the time of the Bill’s publication in providing effective scrutiny of legislation.

The effect of the Bill

1.6 The Bill implements those parts of the NHS Next Stage Review which require primary legislation and covers a number of topics, principally:

a) A framework for an NHS Constitution;

b) Direct payments for health care;

c) Powers of health bodies;

d) Advertising, display and sale of tobacco products;

e) Complaints procedure for privately arranged or funded adult social care; and

f) Disclosure of information relating to general medical practitioners or dental practitioners by Her Majesty’s Revenue and Customs.

1.7 Speaking during the Second Reading debate Lord Darzi, said:

The key purpose of the Bill is to underpin the commitments set out in High Quality Care for All. My aim in that report was to set out a vision for an NHS sustainable in the 21st century—an NHS that gives people more information and choice, works effectively in partnership and has quality of care at its heart.

1.8 In his first letter to us, Lord Darzi summarised the effect of the Bill as follows:

The Health Bill proposes measures to improve the quality of NHS care, the performance of NHS services, to improve public health and two miscellaneous measures concerning the remit of the Local Government Ombudsman and the processing of information by HM Revenue and Customs.

---

5 Ev 1.
7 HL, 4 February 2009, col 671-672.
8 Ev 1.
Significant human rights issues

1.9 There are a number of significant human rights issues that arise in the context of this Bill which relate to:

- g) the NHS Constitution;
- h) direct payments;
- i) complaints by recipients of privately funded adult social care; and
- j) access to healthcare for asylum seekers.

NHS Constitution

1.10 The Bill provides the framework for a NHS Constitution to which certain health bodies, contractors and sub-contractors are required to “have regard”.9 The Explanatory Notes do not cover the human rights compatibility of the NHS Constitution. Lord Darzi’s letter suggests that the provisions do not raise Convention issues.10

Human rights and the NHS Constitution

1.11 In our Reports on Older People in Healthcare and Adults with Learning Disabilities, we recommended that any Constitution or statement of values for the NHS should include “a statement about the importance of human rights to the provision of health services.” On 20 October 2008, we wrote to the Health Secretary, Rt Hon Alan Johnson MP, welcoming various aspects of the draft NHS Constitution but expressing our concern that there was no clear statement within the draft Constitution placing a human rights approach at the heart of service provision. We called on the Government to place, in the main body of the NHS Constitution, clear guidance for service providers in the NHS on the rights of patients and service users and specifically, the service providers’ obligations under the Human Rights Act.11 The Parliamentary Under Secretary of State, Ann Keen MP, replied, noting that the Government would consider our letter as part of its consultation on the draft Constitution and would set out any action it was going to take in the Government response, which would be followed with a revised and final NHS Constitution.12

1.12 The Government published the NHS Constitution, accompanying Handbook (of 144 pages) and its response to the consultation on 21 January 2009. On the basis of recommendations from the Constitutional Advisory Forum and consultation respondents, the Constitution contains three explicit references to human rights as follows:

Principle 1: The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where

---

9 Clause 2.
10 Ev 1.
11 See below.
12 See below.
improvements in health and life expectancy are not keeping pace with the rest of the population.

**Patient rights:** You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age.

**Staff duties:** You have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

1.13 In their joint submission to us, Age Concern and Help the Aged welcome the acknowledgement of the link between human rights and the concepts of dignity and respect but express disappointment that no explicit connection is made between the values set out in the Constitution and human rights.\(^{13}\)

1.14 We welcome the inclusion of express references to human rights in the NHS Constitution. We hope that this will help place a human rights approach at the heart of service provision and will be monitoring the effect of the Constitution.

**Freedom of religion, non-discrimination and the NHS Constitution**

1.15 The NHS Constitution requires staff not to discriminate and to adhere to equality and human rights legislation. Although not in the context of NHS staff, the courts have recently considered the interplay between public sector employees’ right to freedom of religion (Article 9 ECHR), their contractual duties and their duties not to discriminate. The European Court of Human Rights has adopted a very narrow protection for employees seeking to rely on their Article 9 rights. Cases in the UK have instead focussed on domestic equality legislation.

1.16 In *Chondol v Liverpool City Council*, the most recent case on the subject, the Employment Appeal Tribunal held that a Christian social worker employed by a local authority had not been unfairly dismissed or suffered religious discrimination as he had been improperly imposing his religion on services users.\(^{15}\) In *Ladele v London Borough of Islington*, the Employment Appeal Tribunal considered whether a Christian registrar who refused to participate in registering civil partnerships on the basis of her religious beliefs had been discriminated against by the Council, which insisted that she undertake at least some of these duties. Overturning the decision of the Employment Tribunal that the registrar had suffered discrimination, the Employment Appeal Tribunal held:

> Once it is accepted that the aim of providing the service on a non-discriminatory basis was legitimate – and in truth it was bound to be – then in our view it must follow that the council were entitled to require all registrars to perform the full range of services. They were entitled in these circumstances to say that the claimant could not pick and choose what duties she would perform depending upon whether they were in accordance with her religious views, at least in circumstances where her personal stance involved discrimination on grounds of sexual orientation. That

---

14 Ev 11.
15 *Chondol v Liverpool City Council* [2009] All ER (D) 155 (Feb).
stance was inconsistent with the non-discriminatory objectives which the council thought it important to espouse both to their staff and the wider community. It would necessarily undermine the council’s clear commitment to that objective if it were to connive in allowing the claimant to manifest her belief by refusing to do civil partnership duties.\(^{16}\)

However, the Employment Appeal Tribunal also made clear that it was permissible for employers to seek pragmatic ways of accommodating beliefs and reconciling conflicts.

1.17 It was not clear to us how the duty of NHS staff not to discriminate and to adhere to equality and human rights legislation interacted with the rights of staff to freedom of religion. We particularly had in mind the recently reported case of a health worker who offered to pray with patients and the position of health workers who might, for religious reasons, refuse to treat patients or try to dissuade them from undergoing certain treatment. We therefore wrote to the Minister to seek clarification.\(^{17}\)

1.18 In reply, Lord Darzi stated that “the Constitution merely reflects the current legal position of staff” but “does not itself create policy or law”. Referring to the Department of Health’s guidance on proselytising, he noted that there may be circumstances in which offering faith-based services could constitute discrimination or harassment. The Minister also explained that staff are required to treat patients in accordance with the duty to provide health services without discrimination on the ground of religion or belief, but that where staff have a conscientious objection, they may, under the Human Fertilisation and Embryology Act 1990 or the Abortion Act 1967, refuse to participate in treating a patient. Whilst recognising that abortion and fertility services are areas of particular sensitivity, the Minister suggested that “there may be other areas where an employer might wish to respect the religion or beliefs of a member of staff”.\(^{18}\)

1.19 Section 38 of the Human Fertilisation and Embryology Act 1990 and section 4 of the Abortion Act 1967 permit health workers to conscientiously object to participating in activities under the Acts. However, they do not provide a right to object to participating in other health activities, nor is this enshrined in any other legislation.

1.20 We welcome the Minister’s statement that the Constitution enshrines current law. In our view, the law is clear that staff must not discriminate when providing services to patients. In addition, the only circumstances in which an individual may, on the grounds of religious or other conscientious belief, refuse to treat a patient are the specific circumstances set out in the Human Fertilisation and Embryology and Abortion Acts. We recommend that current guidance be updated to reflect the current legal position, taking into account recent court decisions.

**Direct payments**

1.21 Clauses 9 to 11 enable the Secretary of State to discharge various statutory functions under the National Health Service Act 2006 by making direct monetary payments to patients in appropriate cases, initially through pilot schemes. Patients receiving direct

---

16 Ladele v London Borough of Islington, Appeal No. UKEAT/0453/08/RN, para. 111; [2009] All ER (D) 100 (Jan).
17 Ev 6.
18 Ev 8.
payments may purchase health care services directly from a variety of providers, including private organisations and the voluntary sector. Clause 10 enables the Health Service Commissioner to hear complaints about services for which direct payments were made, including those provided by independent organisations. According to the Explanatory Notes:

This gives patients receiving direct payments for health care similar rights to those enjoyed by patients accessing services from NHS organisations or from private sector organisations commissioned by PCTs. 19

1.22 The Explanatory Notes and Lord Darzi’s initial letter to us focus on whether the provisions are compatible with the right to respect for private and family life (Article 8 ECHR) and the prohibition on discrimination (Article 14 ECHR). 20 However, they fail to address the effect on an individual of using public money to procure contracted-out services from a private provider and whether the provider of those services would constitute a public authority under the Human Rights Act 1998 (HRA).

1.23 We have a longstanding interest in the meaning of the term “public authority” in Section 6 of the HRA. 21 Section 6 requires public authorities to act in a way which is compatible with the Convention rights set out in the Schedule to the HRA. The term “public authority” includes “any person certain of whose functions are functions of a public nature.” 22 What constitutes a “function of a public nature” is not further defined in the HRA. In our second report on Meaning of Public Authority, we recommended that:

… the Government should be prepared to acknowledge that the position in law is currently uncertain. This uncertainty should inform parliamentary debate on whether delegation or contracting out is an appropriate means of dealing with the provision of relevant services, and whether it is desirable to make clear on the face of a Bill that a body is a public authority for the purposes of the HRA. 23

1.24 A series of court cases, culminating in the judgment by the House of Lords in the YL v Birmingham City Council and others 24 case in June 2007, has subsequently narrowed what was widely understood to be the scope of the HRA. By a majority of 3 to 2, the Law Lords ruled that the person concerned could not bring a claim against her private sector care home under the HRA, in relation to the infringement of her right to respect for her private life and home under Article 8 ECHR. Her human rights claim lay solely against the local authority which funded her care.

1.25 The Government introduced an amendment to the Health and Social Care Bill in the last Session to ensure that publicly funded residents in private sector care homes come within the ambit of the HRA: but as we pointed out at the time, this particular solution leaves unclear the position in relation to other contracted-out services, including health, is not clear. A Government consultation paper on the subject has been promised but has not

---

19 EN, para. 106.
20 Ev 1.
24 [2008] 1 AC 95.
yet appeared. We note that, beyond referring to the fact that the Government is considering the definition of public authority, the Green Paper on a Bill of Rights and Responsibilities is silent on the issue. This is despite repeated assurances that the Green Paper would address it.

1.26 We wrote to the Minister to ask whether the Government considers that private providers of health services funded through direct payments are to be treated as public authorities under the HRA and if it does, why it did not make this clear on the face of the Bill. If it does not consider that such providers should be treated as functional public authorities, we also asked the Minister to explain how (and against whom) it proposes that individuals will be able to seek redress for breaches of their human rights.

1.27 Lord Darzi replied that the NHS is a core public function:

Independent providers of health care when they are providing services as part of the health service under the NHS Act 2006 are public authorities for the purposes of section 6 of the Human Rights Act 1998.

The introduction of direct payments for health care … by the Bill does not alter the Government’s view that independent providers of NHS care are public authorities. Services provided by private providers under a direct payment arrangement will still be services provided in fulfilment of the Secretary of State’s duty to provide or secure the provision of a national health service in accordance with … the NHS Act 2006.

1.28 He stated that there was no need to make this clear on the face of the Bill as “to do so would cast light on whether any independent provider of health services acting under another relevant section of the National Health Service Act 2006 was exercising a function of a public nature” and there was no case law which suggested to the Government that independent providers of national health services are not public authorities under the HRA.

1.29 In their joint evidence to us, Help the Aged and Age Concern argued that private bodies providing health services funded by direct payments should be considered as providing public functions, but “it is not clear whether in practice they will be”. They recommended that legislation should clarify the position, given “the overall uncertainty about the HRA status of private healthcare providers”.

1.30 We welcome the Government’s unequivocal statement that it considers private providers of health services funded by direct payments to be public authorities for the purposes of section 6 of the Human Rights Act. However, we do not share the Government’s confidence that the courts will take the same view, in the light of the reasoning of the House of Lords in YL. We therefore disagree that it was unnecessary to make this clear on the face of the Bill. We accept that it is arguable that doing so could raise the question of whether any private provider of NHS health services was acting as a public authority. However, given the legal uncertainty which continues to

---

25 Ministry of Justice, Rights and Responsibilities: developing our constitutional framework, Cm 7577, para. 4.23.
26 Ev 8.
27 Ev 8.
28 Ev 11, para. 20.
29 Ev 11, para. 25.
surround section 6 of the HRA, the potential for disagreement in the future and the undesirability of requiring patients to bring legal proceedings to clarify any such dispute, we recommend that the Bill be amended to make it absolutely clear that it is intended that NHS services funded by direct payments and provided by independent bodies are functions of a public nature for the purposes of the HRA 1998. Service users, Primary Care Trusts, service providers and the courts would then be left in no doubt about the application of the HRA and the availability of a direct remedy under the Act. In our view, this desirable outcome can be achieved by a simple amendment. We suggest the following amendment:

Page 6, line 36, [Clause 9] at end insert -

“(7) Health care provided in accordance with this section constitute functions of a public nature for the purposes of Section 6 of the Human Rights Act 1998.”

**Adult social care: complaints**

1.31 The Bill will extend the remit of the Local Commissioner for Administration (which runs the three Local Government Ombudsmen) to enable it to consider complaints about privately arranged or funded adult social care.\(^30\) The Local Commissioner may investigate action taken by an adult social care provider or particular complaints it receives.\(^31\) It may not investigate an action or matter listed in Schedule 5A.\(^32\) Schedule 5A may be amended by Order in Council, which is subject to annulment by a resolution of either House.\(^33\) As to the procedure to be followed, complaints to the Local Commissioner must be made in writing within 12 months of the person affected having notice of the matter.\(^34\) The Local Commissioner must give the adult social care provider and others alleged to have taken or authorised the action complained about an opportunity to comment on the matter.\(^35\) The Local Commissioner may determine whether individuals may be represented, require the production of certain documents or the attendance or examination of witnesses.\(^36\) Investigations are conducted in private.\(^37\) If the Local Commissioner decides not to investigate a matter or discontinue an investigation, he must provide written reasons. If he completes an investigation, he must set out in writing his conclusions and any recommendations which he considers to be appropriate. In all cases, the Local Commissioner must provide a copy of his written statement to each of the persons concerned.\(^38\) It does not appear that the Local Commissioner is required to provide the complainant with a copy of any of the representations that he receives, or provide the complainant with an opportunity to comment on them.

---

\(^30\) Clause 31 incorporates Schedule 5 into the Bill which itself inserts a new Part 3A into the Local Government Act 1974.

\(^31\) Schedule 5, inserting new section 34B into the Local Government Act 1974.

\(^32\) Matters not subject to investigation are where the matter could be investigated by the Local Commissioner under Part 3 or by the Health Service Commissioner, the commencement or conduct of civil or criminal proceedings, or action taken in respect of appointments or removals, pay, discipline, superannuation or other personnel matters (Schedule 5A).

\(^33\) Schedule 5, inserting new section 34B(10) and (11) into the Local Government Act 1974.

\(^34\) The Bill also contains provisions on the procedure and time for making complaints where the person affected has died – Schedule 5 inserting new section 34D(2)(b) into the Local Government Act 1974.

\(^35\) Schedule 5 inserting new section 34F into the Local Government Act 1974.

\(^36\) Schedule 5 inserting new section 34F-G into the Local Government Act 1974.

\(^37\) Schedule 5 inserting new section 34F(2) into the Local Government Act 1974.

\(^38\) Schedule 5 inserting new section 34H into the Local Government Act 1974.
In his initial letter to us, Lord Darzi explained the Government’s rationale for the proposal to extend the Local Commissioner’s powers to hear complaints by privately funded adults in receipt of social care as follows:

The purpose of these provisions is to give individuals who fund or arrange their own social care an independent body to which to complain. As well as obtaining redress for individuals who have suffered injustice as a result of failures in social care provision, it is hoped that the involvement of the Local Commissioner will contribute to ensuring provision of high quality adult social care.39

His letter and the Explanatory Notes concluded that the investigation of complaints may interfere with the rights to respect for private life of the service provider (Article 8 ECHR) but that any interference would aim to protect health and the rights and freedoms of others, and be proportionate to those aims.40

In our Report on Older People in Healthcare, we criticised Government proposals to create a merged inspectorate of health and social care providers which would not have the power to consider individual complaints.41 We followed this up in our first Report on the Health and Social Care Bill, which created the new inspectorate (the Care Quality Commission (CQC)).42 We recommended that the CQC should be able to deal with individual complaints and proposed a new clause and an amendment to the Bill to achieve this.43 In addition, we recommended that the CQC should have a role in overseeing the adequacy of complaints procedures throughout the health and social care sectors and proposed an amendment.44 This would be in tune with the Government’s reply to our Report on Older People in Healthcare that the process of making a complaint should be “easier, more user-friendly, more transparent, and much more responsive to people’s needs.”45

In the Explanatory Notes and the Minister’s correspondence with us, the Government does not deal with the human rights implications of the new provisions for a service user. It is surprising that the Government fails to consider the human rights implications of its proposals for service users, given that they are the beneficiaries of the proposed changes.

In principle, we welcome the proposal to empower a body to consider complaints about privately arranged or funded adult social care. This potentially gives effect to our previous recommendations and has the possibility to enhance human rights for service users. However, further scrutiny of how the body will operate in practice is required to determine whether the proposals are compatible with human rights. This accords with the evidence we received from Age Concern and Help the Aged. Whilst welcoming “the broad thrust of the provisions in the Health Bill that would give access to redress for complaints by those who fund their own social care”,46 they queried whether the Local Commissioner
was the appropriate body to deal with such complaints and raised a number of questions about whether or not the procedures envisaged would comply with the right to a fair hearing (Article 6 ECHR).  

1.36 We wrote to the Minister seeking further information and clarification. We asked the Minister to explain why the Government does not propose to extend the powers of the CQC to enable it to consider individual complaints by users of privately funded and arranged adult social care and why it considers the Local Commissioner to be better suited to this role. We also asked the Minister to explain how the complaints procedure complies with Article 6 ECHR and the common law principle of fairness, given that the complainant is unable to comment on the representations made in response to his or her allegation.

1.37 Lord Darzi replied that, in the Government’s view, the investigation of individual complaints does not fit with the CQC’s role as a service regulator but that the CQC would be able to act on information which comes to its attention via complaints. He also noted that the Local Commissioner already has a role in investigating complaints by users whose care is arranged or funded by local authorities and that the new responsibility would “sit logically” with its existing duties. On the question of the fairness of the procedure to be followed by the Local Commissioner, Lord Darzi pointed to the fact that the new scheme is modelled on the existing procedure for dealing with complaints about local authorities and that the procedure would largely be a matter for the Local Commissioner to determine. It noted that the usual procedure followed was for the complainant to be provided with the local authority’s representations and the Local Commissioner’s provisional conclusions so that the complainant’s views might be taken into account before a final decision was made and that the Local Commissioner intended to adopt a similar procedure in relation to its enlarged function. However, Lord Darzi also stated:

The Government does not consider that Article 6 is engaged in relation to investigations by the Local Commissioner. The Local Commissioner will not determine any civil right or obligation under the provisions in the Bill. The Local Commissioner will have discretion whether to investigate or not. Where the Commissioner finds that something has gone wrong, and recommends a remedy the adult social care provider is not obliged under the Bill to comply with that recommendation.

1.38 A decision of the Local Commissioner is subject to judicial review.

1.39 We welcome as a human rights measure the proposal to permit the Local Commissioner to investigate complaints by privately funded social care users. However, we believe that the scheme can be improved to make it more likely that in practice complainants will be treated fairly. Whether or not Article 6 ECHR applies, an individual retains due process rights under the common law of procedural fairness which UK courts have held are no less extensive than those in Article 6. Whilst the Minister refers to the intention of the Local Commissioner to provide complainants

---

47 Ev 11, paras 31-35.
48 Ev 6.
49 Ev 6.
50 Ev 8.
51 Ev 8.
with the representations made to it by the provider and an opportunity to respond, this is not required by the Bill. We recommend that the Bill be amended to make it clear that, except where other legislation prevents it, an individual should be provided with and allowed to comment on the providers’ representations and the Local Commissioner’s provisional conclusions before a decision on his complaint is concluded. We suggest an amendment below:

Page 55, line 13, [Schedule 5], at the end insert:

“(1A) Unless otherwise prohibited under the terms of another Act, comments made under subsection (1) must be provided to the person who made the complaint and that person must be provided with an opportunity to comment on them.”.

Page 57, [Schedule 5], leave out lines 10 and 11 and insert:

“(5) The Local Commissioner must send a draft copy of a statement prepared under this section to each of the persons concerned and must provide an opportunity for those persons to comment on it.

(5A) The Local Commissioner must have regard to any comments on a draft copy of a statement under subsection (5) before preparing a final copy of a statement and sending it to each of the persons concerned.”.
2 Marine and Coastal Access Bill

<table>
<thead>
<tr>
<th>Date introduced to first House</th>
<th>4 December 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date introduced to second House</td>
<td>HL Bill 1</td>
</tr>
<tr>
<td>Current Bill Number</td>
<td></td>
</tr>
</tbody>
</table>

Background

2.1 The Marine and Coastal Access Bill was introduced in the House of Lords on 4 December 2008. It is currently in Committee and will be considered further in Committee on 21 April 2009.

Significant human rights issue

2.2 In our view the Bill raises one significant human rights issue: whether the provisions in Part 9 of the Bill concerning the creation of a coastal footpath are compatible with the right of affected people to a fair hearing, both under Article 6 ECHR and the common law of procedural fairness.

2.3 The Bill provides an administrative regime for the designation of land for this purpose but makes no provision for a right of appeal to an independent court or tribunal by those with an interest in the land affected. Those affected will have a right to make representations to Natural England before it submits its scheme to the Secretary of State for approval, and again to the Secretary of State before he decides whether or not to approve the scheme. There is no provision, however, for any right of appeal to an independent court or tribunal, either against Natural England’s submitted scheme, or the Secretary of State’s final decision approving the scheme, with or without modifications.

2.4 The Secretary of State’s decision approving the coastal access scheme will amount to the determination of the “civil rights” of those with an interest in the land affected, within the meaning of Article 6(1) ECHR (the right to a fair hearing). As interpreted by the European Court of Human Rights, that Article requires there to be access to a court of full jurisdiction to challenge administrative determinations of civil rights. The availability of judicial review, in conjunction with other opportunities to challenge the determination, is capable of satisfying that requirement in some cases. However, where the determination of the civil right requires the determination of prior factual questions, the decision of the European Court of Human Rights in Tsfayo v UK makes clear that the availability of judicial review alone is not sufficient: there must be an independent court or tribunal with jurisdiction to determine the factual question in issue.

2.5 The Government appears to accept in the Explanatory Notes to the Bill that the Secretary of State’s decision approving the coastal access scheme will determine civil rights, so that Article 6(1) ECHR applies. It also accepts that the Secretary of State’s decision will be “a mixed decision of fact and policy”. However, it argues that “the procedures … set out in the Bill contain a high policy content, and will comply with Article 6 through the availability of judicial review”. This, taken together with the inclusion of other procedural

52 Clauses 286-300.
53 App. No. 60860/00, 14 November 2006
54 EN, para. 1027.
55 EN, para 1027.
safeguards in Part 9 (the opportunity to make representations before the making of the decision by the Secretary of State), renders the provisions compatible with Article 6 ECHR in the Government’s view.\textsuperscript{56}

2.6 We wrote to the Minister explaining that we had difficulty understanding how the provisions in the Bill can be compatible with Article 6 ECHR in the light of the decision in \textit{Tsfaya}.\textsuperscript{57} We asked if the Government would consider amending the Bill to ensure that those affected by the coastal access scheme have an opportunity to make arguments about factual questions to an independent court or tribunal, preferably the Planning Inspectorate. If, after such consideration, the Government decided not to amend the Bill, we asked the Minister to provide a detailed explanation as to why existing rights of access to the Planning Inspectorate in other contexts, such as the National Parks and Countryside Act 1949 and the Countryside and Rights of Way Act 2000, are not possible or appropriate in the context of coastal access.

2.7 The Minister’s reply maintains the Government’s position that Part 9 of the Bill is compatible with the right to a fair hearing in Article 6(1) ECHR.\textsuperscript{58} The Government’s argument is that the approval decision of the Secretary of State in relation to proposals for a coastal route is essentially one of “policy” and a “classic exercise of administrative discretion.” It accepts that the decision is one predicated on an assessment of the facts, which in some cases is likely to be reached by the determination of certain disputed questions of fact, but considers those findings of fact to be only “staging posts” on the way to much broader judgments of policy or expediency. The factual assessments are “merely incidental” to reaching those broader judgments, and the approval decision itself is therefore a policy decision which is the final stage of a complex process of consideration. On the Government’s reading of the Strasbourg case-law interpreting the requirements of Article 6(1) ECHR, in such cases judicial review is likely to be adequate to supply the necessary access to a court, even if there is no jurisdiction to examine the factual merits of the case, provided there are sufficient safeguards to ensure that the decision-making procedure itself is in fact both fair and impartial. The Government considers that the availability of judicial review of the Secretary of State’s decision is sufficient to achieve compliance with Article 6 ECHR, in view of the procedural safeguards in the Bill providing for representations by affected persons to be considered by Natural England and the Secretary of State.

2.8 We have considered the Government’s argument carefully but we are not persuaded by its reasoning. The breadth of the Government’s argument has alarming implications. Its characterization of the Secretary of State’s decision as a “policy” decision, a classic exercise of administrative discretion to which all prior factual findings are merely incidental staging posts, would seem to apply to all planning decisions, in which case the Government would be entitled to abolish the entire Planning Inspectorate without breaching Article 6. We read the requirements of Article 6(1) differently. The Government’s response overlooks the fact that in the planning cases\textsuperscript{59} on which the Government relies in support of its view that judicial review is adequate, the affected individuals had a right of appeal to the

\textsuperscript{56} EN, para 1027.
\textsuperscript{57} Ev 24.
\textsuperscript{58} Ev 25.
Planning Inspectorate before their further right of recourse to the High Court. The availability of this first tier of appeal was crucial in the courts’ reasoning that the High Court’s subsequent judicial review jurisdiction was sufficient to satisfy the right of access to court. Under the current Bill, there is no such prior right of appeal: the only avenue of recourse against the Secretary of State’s decision is to the High Court on judicial review.

2.9 A person with an interest in the land affected may wish to dispute any number of factual questions on which the Secretary of State’s determination rests but, as the Bill is currently drafted, such a person has no opportunity to do so before an independent decision-maker. If, for example, the person with the interest in land wished to dispute Natural England’s and the Secretary of State’s views on whether the land in question was unstable due to erosion, perhaps with their own expert’s report, they would have no opportunity to do so before an independent party. The High Court on judicial review would not enter into such factual questions. This is the role played by the Planning Inspectorate in many other comparable areas of decision-making, but in the Bill as drafted there is no role for the Planning Inspectorate.

2.10 In all comparable legislation providing for the designation of public rights of access over private land there is provision for a right of appeal by those affected to an independent court or tribunal. We recognise that there may be an argument that the existing appeal mechanism in the Countryside and Rights of Way Act 2000 may not be appropriate, because the Bill is concerned with a national path. We also accept that there may be a need for any right of appeal to the Planning Inspectorate in relation to a particular piece of land to take place prior to the Secretary of State’s decision on the national scheme as a whole. However we do not consider this to be an insuperable obstacle to providing a meaningful right of access to an independent body. We note that there is provision for inquiries by the Planning Inspectorate in relation to proposed ministerial orders in other contexts, such as that in Schedule 1 to the National Parks and Countryside Act 1949 (requiring the Minister to cause a local inquiry to be held where there are objections to certain draft orders such as orders designating a National Park).

2.11 We recommend that the Bill be amended in order to provide a right of appeal to an independent body. We consider the Planning Inspectorate to be the most appropriate existing body in view of the nature of the decision in question. We note that an amendment which would insert such a right of appeal into the Bill has already been proposed in the House of Lords by Lord Taylor of Holbeach and Earl Cathcart. In our view this amendment would remove the incompatibility with Article 6 ECHR that we have identified and we recommend that the Government accept it.

Amendment A357A, 9th Marshalled List.
3 Bills not requiring to be brought to the attention of either House on human rights grounds

**Government Bills**

3.1 We consider that the following Government Bills do not raise human rights issues of sufficient significance to warrant us undertaking further scrutiny of them:

- Industry and Exports (Financial Support) Bill
- Northern Ireland Bill
- Postal Services Bill.
Conclusions and recommendations

Health Bill

1. We are grateful to the Minister for his letter, which assisted our scrutiny of the Bill at an early stage. We welcome the full and prompt responses provided by the Minister. (Paragraph 1.2)

2. We welcome the engagement of the public and interested organisations in our legislative scrutiny work. (Paragraph 1.3)

3. We welcome the Minister’s letter as an example of a Department giving effect to our previous recommendation. When such letters supplement the analysis in the Explanatory Notes, it would assist us greatly if the letter was made available at the time of the Bill’s publication in providing effective scrutiny of legislation. (Paragraph 1.5)

4. We welcome the inclusion of express references to human rights in the NHS Constitution. We hope that this will help place a human rights approach at the heart of service provision and will be monitoring the effect of the Constitution. (Paragraph 1.14)

5. We welcome the Minister’s statement that the Constitution enshrines current law. In our view, the law is clear that staff must not discriminate when providing services to patients. In addition, the only circumstances in which an individual may, on the grounds of religious or other conscientious belief, refuse to treat a patient are the specific circumstances set out in the Human Fertilisation and Embryology and Abortion Acts. We recommend that current guidance be updated to reflect the current legal position, taking into account recent court decisions. (Paragraph 1.20)

6. We welcome the Government’s unequivocal statement that it considers private providers of health services funded by direct payments to be public authorities for the purposes of section 6 of the Human Rights Act. However, we do not share the Government’s confidence that the courts will take the same view, in the light of the reasoning of the House of Lords in YL. We therefore disagree that it was unnecessary to make this clear on the face of the Bill. We accept that it is arguable that doing so could raise the question of whether any private provider of NHS health services was acting as a public authority. However, given the legal uncertainty which continues to surround section 6 of the HRA, the potential for disagreement in the future and the undesirability of requiring patients to bring legal proceedings to clarify any such dispute, we recommend that the Bill be amended to make it absolutely clear that it is intended that NHS services funded by direct payments and provided by independent bodies are functions of a public nature for the purposes of the HRA 1998. Service users, Primary Care Trusts, service providers and the courts would then be left in no doubt about the application of the HRA and the availability of a direct remedy under the Act. In our view, this desirable outcome can be achieved by a simple amendment. (Paragraph 1.30)
7. In principle, we welcome the proposal to empower a body to consider complaints about privately arranged or funded adult social care. This potentially gives effect to our previous recommendations and has the possibility to enhance human rights for service users. (Paragraph 1.35)

8. We welcome as a human rights measure the proposal to permit the Local Commissioner to investigate complaints by privately funded social care users. However, we believe that the scheme can be improved to make it more likely that in practice complainants will be treated fairly. Whether or not Article 6 ECHR applies, an individual retains due process rights under the common law of procedural fairness which UK courts have held are no less extensive than those in Article 6. Whilst the Minister refers to the intention of the Local Commissioner to provide complainants with the representations made to it by the provider and an opportunity to respond, this is not required by the Bill. We recommend that the Bill be amended to make it clear that, except where other legislation prevents it, an individual should be provided with and allowed to comment on the providers’ representations and the Local Commissioner’s provisional conclusions before a decision on his complaint is concluded. (Paragraph 1.39)

Marine and Coastal Access Bill

9. We recommend that the Bill be amended in order to provide a right of appeal to an independent body. We consider the Planning Inspectorate to be the most appropriate existing body in view of the nature of the decision in question. We note that an amendment which would insert such a right of appeal into the Bill has already been proposed in the House of Lords by Lord Taylor of Holbeach and Earl Cathcart. In our view this amendment would remove the incompatibility with Article 6 ECHR that we have identified and we recommend that the Government accept it. (Paragraph 2.11)
Annex: Proposed Committee Amendments

Health Bill

Direct Payments

Page 6, line 36, [Clause 9] at end insert -

“(7) Health care provided in accordance with this section constitute functions of a public nature for the purposes of Section 6 of the Human Rights Act 1998.”

Adult social care: complaints

Page 55, line 13, [Schedule 5], at end insert:

“(1A) Unless otherwise prohibited under the terms of another Act, comments made under subsection (1) must be provided to the person who made the complaint and that person must be provided with an opportunity to comment on them.”.

Page 57, [Schedule 5], leave out lines 10 and 11 and insert:

“(5) The Local Commissioner must send a draft copy of a statement prepared under this section to each of the persons concerned and must provide an opportunity for those persons to comment on it.

(5A) The Local Commissioner must have regard to any comments on a draft copy of a statement under subsection (5) before preparing a final copy of a statement and sending it to each of the persons concerned.”.
Formal Minutes

Tuesday 31 March 2009

Members present:

Mr Andrew Dismore MP, in the Chair

Lord Bowness  
Lord Lester of Herne Hill  
Lord Morris of Handsworth  
The Earl of Onslow  
Baroness Prashar

Dr Evan Harris MP  
Mr Edward Timpson MP

******

Draft Report (Legislative Scrutiny: Health Bill; Marine and Coastal Access Bill), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1.1 to 3.1 read and agreed to.

Annex read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Eleventh Report of the Committee to each House.

Ordered, That the Chairman make the Report to the House of Commons and that Lord Morris of Handsworth make the Report to the House of Lords.

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence reported and ordered to be published on 3 February and 3 and 10 March.

[Adjourned till Tuesday 21 April at 1.30pm.]
List of written evidence

<table>
<thead>
<tr>
<th></th>
<th>Letter</th>
<th>Page/Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Letter from the Chairman to Alan Johnson MP, Secretary of State for Health, dated 20 October 2008</td>
<td>Page 25</td>
</tr>
<tr>
<td>2</td>
<td>Letter from Anne Keen, Parliamentary Under-Secretary of State, Department of Health, to the Chairman, dated 19 November 2008</td>
<td>Page 26</td>
</tr>
<tr>
<td>3</td>
<td>Letter from Lord Darzi of Denham, Parliamentary Under-Secretary of State, Department of Health to the Chairman, dated 28 January 2009</td>
<td>Ev 1</td>
</tr>
<tr>
<td>4</td>
<td>Letter from the Chairman to Lord Darzi of Denham, dated 12 February 2009</td>
<td>Ev 6</td>
</tr>
<tr>
<td>5</td>
<td>Letter from Lord Darzi of Denham to the Chairman, dated 3 March 2009</td>
<td>Ev 8</td>
</tr>
<tr>
<td>6</td>
<td>Age Concern and Help the Aged</td>
<td>Ev 11</td>
</tr>
<tr>
<td>7</td>
<td>British Medical Association</td>
<td>Ev 15</td>
</tr>
<tr>
<td>8</td>
<td>Global Health Advocacy Project</td>
<td>Ev 17</td>
</tr>
<tr>
<td>9</td>
<td>National Aids Trust</td>
<td>Ev 20</td>
</tr>
<tr>
<td>10</td>
<td>Royal College of General Practitioners</td>
<td>Ev 21</td>
</tr>
<tr>
<td>11</td>
<td>Still Human Still Here</td>
<td>Ev 22</td>
</tr>
<tr>
<td>12</td>
<td>Letter from the Chairman to Lord Hunt of Kings Heath, dated 10 February 2009</td>
<td>Ev 24</td>
</tr>
<tr>
<td>13</td>
<td>Letter from Lord Hunt of Kings Heath, Minister for Sustainable Development and Energy Innovation, dated 27 February 2009</td>
<td>Ev 25</td>
</tr>
</tbody>
</table>
Written Evidence

Letter from the Chairman to Alan Johnson MP, Secretary of State for Health, dated 20 October 2008

Consultation on the Draft NHS Constitution

I am writing to convey some concerns of the Joint Committee on Human Rights about the draft NHS Constitution.

The JCHR has recommended in two recent reports that any Constitution or statement of values for the NHS should include “a statement about the importance of human rights to the provision of health services”. We recently heard similar views from representatives of service providers and non-governmental organisations, at a conference we held about human rights and health care for older people.

The former care services Minister, Ivan Lewis, has said that the Human Rights Act 1998 forms the basis for the Constitution. However, we are concerned that there is no clear statement within the draft Constitution placing a human rights approach at the heart of service provision.

We welcome the fact that the draft Constitution refers to patients’ rights to access services without discrimination; the right to be treated with respect and dignity; and the right to privacy and confidentiality. We also note that the Handbook to the Constitution mentions “human rights”, and explains that rights to equal treatment, respect and dignity, privacy and confidentiality have their basis in the Human Rights Act 1998 and the ECHR. We are pleased that the Handbook explains how patients might complain or seek compensation for the breach of those rights.

However, we believe that the current approach of placing most of the references to human rights in the Handbook to the Constitution fails to make it clear to patients that a human-rights-based approach should at the heart of service provision in the NHS. In addition, we note that this approach appears to be inconsistent with the Government’s pilot project Human Rights in Healthcare – A Framework for Local Action.

We call on the Government to place, in the main body of the NHS Constitution, clear guidance for service providers in the NHS on the rights of patients and service users and specifically, the service providers’ obligations under the Human Rights Act 1998.

I am copying this letter to Ann Keen MP, who I understand will be taking forward the consultation on the NHS Constitution. I am also copying this letter to Phil Hope MP, care services Minister, who was invited, but did not attend, our conference. I would be grateful for a response by 14 November 2008, and would ask for a copy in Word format to be provided.

Letter from Anne Keen, Parliamentary Under-Secretary of State, Department of Health, to the Chairman, dated 19 November 2008

Thank you for your letter of 20 October to Alan Johnson about human rights and the draft NHS Constitution.

As you point out, the Human Rights Act of 1998 formed the basis for the draft NHS Constitution, and there are various references in the body of the text that reflect this. These include the right not to be unlawfully discriminated against in the provision of NHS services; the right to be treated with respect and dignity; and the right to privacy and confidentiality.

The accompanying handbook to the Constitution explains more fully what each right means and how patients, public and staff can seek redress if their rights are not met. Under each right, the relevant sections of the European Convention on Human Rights and the Human Rights Act are set out.

We note that in your letter you acknowledge, and welcome, these references. However, we note your concern that the Constitution should make explicit reference to human rights, so that it is clear that a human rights based approach should be at the heart of service provision in the NHS.

Consultation on the draft NHS Constitution closed on 17 October. This was a locally led initiative, overseen by the Constitution Advisory Forum (CAF), a group made up of leading figures in the health policy world and chaired by David Nicholson, the NHS Chief Executive. The CAF will present a report of its findings to the Secretary of State. The Government will consider this report along with the consultation responses. We will consider your letter as part of the consultation and will set out any action we are going to take in the Government response: this will follow with a revised and final NHS Constitution in January 2009.

I hope this reply is helpful.
Written evidence

Memorandum submitted by Lord Darzi of Denham, Parliamentary Under-Secretary of State, Department of Health, dated 28 January 2009

COMPATIBILITY OF THE HEALTH BILL 2009 WITH HUMAN RIGHTS

1. The Health Bill was introduced in the House of Lords on 15 January 2009. I am writing to provide the Committee with information on the implications of the provisions of the Health Bill for human rights. I hope this will assist the Committee in its scrutiny of the Bill.

2. We have considered the provisions in the Health Bill and whether they engage any of the rights set out in the European Convention on Human Rights (the Convention) and if they do, whether they breach any such rights. A summary of each set of provisions as regards the various matters covered by the Bill and how they relate to human rights is outlined below.

3. Our view is that the provisions of the Health Bill are compatible with the Convention rights defined in section 1 of the Human Rights Act 1998.

4. I enclose with this letter a copy of the Bill and a copy of the Explanatory Notes for the Bill.

Overview of the structure of the Health Bill

5. The Health Bill proposes measures to improve the quality of NHS care, the performance of NHS services, to improve public health and two miscellaneous measures concerning the remit of the Local Government Ombudsman and the processing of information by HM Revenue and Customs (HMRC).

6. Part 1 of the Bill covers:
   — procedures relating to the NHS Constitution;
   — duties of NHS providers to publish annual reports about the quality of NHS services,
   — piloting of direct payments for NHS services under personal health budget plans and further provision for direct payments; and
   — power for the Secretary of State to make payments as prizes to promote innovation in the NHS in England.

7. Part 2 of the Bill contains:
   — the regime for unsustainable NHS providers; and
   — suspension powers in respect of non-executives of health bodies.

8. The measures in Part 3 of the Bill:
   — control and include regulation making powers for the control of the advertising and promotion of tobacco;
   — improve the provision of pharmacy services;
   — enable the Local Government Ombudsman to investigate complaints about privately arranged or funded social care; and
   — allow anonymised information collected on doctors’ and dentists’ pay to be shared by HMRC, to be used for the purposes of NHS financial planning.

Further detail about provisions of the Bill and their implications for human rights

PART 1 OF THE BILL

NHS Constitution

9. Clauses 1 to 5 of the Bill concern the NHS Constitution and Explanatory Guide, which was published by the Department on 21 January 2009. The Constitution sets out principles that guide the NHS, NHS values, and rights and pledges for patients, the public and staff. The Bill will place a duty on NHS bodies, primary medical services and private and voluntary sector providers supplying NHS services to have regard to the NHS Constitution. It will also require the Secretary of State to consult on, to review and to re-publish the Constitution at least every ten years; to review and to republish the explanatory guide at least every three years and to report on its impact.

10. We do not consider that these provisions give rise to any Convention issues.
Quality Accounts

11. Clauses 6 to 8 require a provider of NHS services to publish information on the quality of NHS services provided by it in England. The clauses define “the provider” and “NHS services” and include regulation making powers that enable the Secretary of State to prescribe providers and services to which the duty does not apply.

12. The clauses also provide for the reporting period and for publication of the document containing the information, and contain regulation making powers enabling the Secretary of State to make further provision relating to the document.

13. We do not consider that these provisions give rise to any Convention issues.

Direct Payments

14. The provisions about direct payments for health care in clauses 9 to 11 enable the Secretary of State to discharge his functions under section 2(1) or 3(1) of or paragraph 8 or 9 of Schedule 1 to the National Health Service Act 2006 (the NHS Act) (broadly, to provide such NHS services as he considers necessary to meet all reasonable requirements) by making monetary payments to patients in appropriate cases, initially through pilot schemes. They include regulation making powers to provide for a PCT to be able to provide after-care services under section 117 of the Mental Health Act 1983 by means of direct payments. We anticipate that pilot schemes will provide the necessary evidence base to allow decisions to be made about whether and how to implement direct payments more widely.

15. The power for the Secretary of State or a PCT to make direct payments for health care to patients might be argued to confer an advantage on a citizen within the ambit of the Article 8 right to respect for private and family life. As initially the power may be exercised only in the context of a pilot scheme, there might be an issue as to whether any difference in treatment of patients with similar characteristics could arise between a patient within a pilot scheme and one outside the scheme who continues to receive NHS treatment by the traditional route, contrary to Article 14 (which prohibits discrimination in the enjoyment of rights under the Convention).

16. However, we consider that even if Article 8 were engaged, and if there were a difference in treatment, that difference in treatment would be justified and would be proportionate for the protection of health and in the interests of the economic well-being of the country. The anticipated benefits in learning from schemes would outweigh the risks of not operating such schemes in advance of possible national implementation. Piloting is expected to demonstrate, for example, which care groups are likely to benefit from health care direct payments (in terms of improved health and well-being outcomes), the types of support needed to ensure best use and management of direct payments and how best to operate a scheme. The risks associated with national implementation without piloting include waste of resources, lack of cogent guidance on administering and monitoring health care direct payments and imposing unnecessary burdens on patients.

17. The powers to provide for pilot schemes would be exercised compatibly with Convention rights. The legislation requires that a pilot scheme must have a specified period. In the regulations governing a scheme there must be provision for review of a pilot scheme. We consider that the provisions for pilot schemes are justified and proportionate and are compatible with the Convention rights.

18. The changes to the jurisdiction of the Health Service Commissioner made by the provision at clause 10 of the Bill expand the Commissioner’s powers for obtaining and disclosing information. These have the potential to interfere with the Article 8 rights of a provider of direct payment services. The analysis would be similar to that in respect of the changes made by clause 31 and Schedule 5 to the powers of a Local Commissioner (paragraph 46).

19. The changes would enable the Commissioner to properly investigate complaints about the provision of services procured by a recipient of direct payments and publication may encourage providers to carry out recommended action. The powers will pursue a number of legitimate aims including the protection of health and of the rights and freedoms of others and would be proportionate so that any interference would be justified.

Innovation prizes

20. Clause 12 enables the Secretary of State to give prizes to promote innovation in the provision of health services. Subsection (2) of the clause provides that prizes may be awarded in respect of work done at any time, including work done before commencement of the provisions. Subsection (3) provides that the Secretary of State may establish a committee to advise him on the exercise of the power. The Secretary of State may make payments to members of the Committee in respect of remuneration, allowances and expenses.

21. The Department does not consider that these provisions give rise to any Convention issues.
PART 2

Trust Special Administrators for NHS bodies in England

22. The purpose of the provisions on Trust Special Administrators in clauses 13 to 16 is to introduce new powers and procedures for dealing with unsustainable NHS trusts, NHS foundation trusts and “provider” Primary Care Trusts.

23. The provision for suspension of directors when a Trust Special Administrator is appointed and for termination of office of directors when a trust is coming out of administration might arguably engage Article 6, although we consider that Article 6 is not engaged by the provisions.

24. Article 6 applies to a civil right, which may include rights arising from service as a civil servant, a right to continue to exercise a profession, or rights arising from an allowance payable to an office holder. However, appointees to the public office appointments to which the unsustainable provider provisions relate are not civil servants. Where such appointees are professionals the suspension or termination of office would not generally prevent them from exercising their profession. And generally, a suspended person would continue to hold office so would be unlikely by suspension to suffer pecuniary loss. A loss potentially arising from the effect of suspension or termination of office on a person’s reputation would not be actionable by way of enforcement as a civil right, as there is no general civil right to a good reputation.

25. In addition, there would be consultation of the NHS Trust or foundation trust before a decision to trigger the Trust Special Administrator regime (which will result in suspension of the directors), and a fair procedure would apply before a decision to terminate the office of a particular director when a trust is coming out of administration. These decisions would also be subject to judicial review. The right of appeal provided by judicial review in these circumstances would be a right which satisfies the requirements for appeal of Article 6. Therefore, we consider that the provisions are compliant with Article 6.

26. The provisions for suspension of the directors when a Trust Special Administrator is appointed and for termination of the office of directors when a trust is coming out of administration may also engage Article 8. We consider that suspension or termination of office in those circumstances would be unlikely to have consequences which would affect the private life of the person suspended or removed from office and therefore the rights would be unlikely to be engaged. If the rights were engaged, the procedures which would apply and the availability of a remedy by way of judicial review would be fair. The interaction between the elements involved in suspension or termination, including the procedures, criterion for suspension or termination and the consequences would not be incompatible with Articles 6 or 8. In particular, we consider that interference with any rights under Article 8 would be justified to ensure that proper steps could be taken to deal with failing trusts and therefore in the interests of running a safe and effective health service.

27. Article 1 of the First Protocol may be engaged also by the provisions for appointing Trust Special Administrators to deal with unsustainable NHS trusts and foundation trusts. NHS foundation trusts have greater freedoms than NHS trusts for example to invest, borrow, and generate income. When a foundation trust is de-authorised, to avoid potential interference with rights to the peaceful enjoyment of possessions or not to be deprived of possessions protected by Article 1 of the First Protocol, clause 14 of and Schedule 2 to the Bill (inserting new Schedule 10A) contain provision to enable a de-authorised foundation trust to continue to act in accordance with arrangements previously made between the trust and a third party. The Secretary of State also has power to disapply relevant directions or guidance to de-authorised foundation trusts where necessary to protect third party rights. We consider that these provisions will ensure that there is no interference with third party rights under Article 1 of Protocol 1 to the Convention.

28. It might be argued that the provisions for suspension of the directors when a Trust Special Administrator is appointed, and for termination of the office of directors when a trust is coming out of administration engage Article 1 of Protocol 1. We do not believe that they do. Even if the rights were engaged, we consider that the proposed measures would be proportionate and would strike a fair balance between the general interests of the community as regards the need to take effective steps to intervene in failing trusts and the protection of an individual’s fundamental rights.

Suspension

29. Clause 17 incorporates a schedule of amendments, Schedule 3, into the Bill. The amendments in the Schedule provide for new powers of suspension of non-executive members of NHS and other health bodies and for consequential amendments and transitional arrangements.

30. The provisions might be thought to engage Article 6 of the Convention. Article 6 applies to a civil right, which may include rights arising from service as a civil servant, a right to continue to exercise a profession, or rights arising from an allowance payable to an office holder. However, as discussed in relation to the unsustainable provider provisions, we do not think that Article 6 is engaged. Appointees to the public office appointments to which the suspension provisions relate are not civil servants. Where such appointees are professionals the suspension or termination of office would not generally prevent them from exercising their profession. And generally, a suspended person would continue to hold office so would be unlikely by
suspension to suffer pecuniary loss. A loss potentially arising from the effect of suspension or termination of office on a person’s reputation would be unlikely to be actionable by way of enforcement as a civil right, as there is no general civil right to a good reputation.

31. If Article 6 were engaged in relation to these provisions we consider that the procedures for suspension, including in cases not governed by regulations provision for review of suspension after three months, would be fair. The procedures for suspension form part of a procedure which includes the procedures that apply to termination. Where suspension powers of the Secretary of State or ministers in the devolved administrations were delegated to the Appointments Commission, if an appointee were to allege that a decision by the Appointments Commission to suspend him was not sufficiently independent, the appointee would be able to judicially review the decision. The right of appeal provided by judicial review in these circumstances would be a right which satisfies the requirements for appeal of Article 6. Therefore, we consider that the provisions are compliant with Article 6.

32. The suspension powers may similarly be thought to engage Article 8. As indicated, an appointee to a health body suspended under the provisions incorporated by clause 17 would continue to receive benefits to which they were entitled by virtue of their office. Therefore, the Article 8 rights that might be affected by loss of employment would be unlikely to be engaged. Suspension would be unlikely otherwise to have consequences which would affect the private life of a person suspended. If the rights were engaged, the procedures which the legislation provides for and the availability of appeal by way of judicial review would be fair. The interaction between the elements involved in suspension and termination, including the procedures, criterion for suspension or termination and the consequences would not be incompatible with Articles 6 or 8. The public interest in preventing a person against whom serious allegations have been made from exercising public office would be balanced against the requirement for protection of the fundamental rights of the suspended person in a proportionate way so that any interference with Article 8 rights would be justified.

33. It may be argued with regard to the provisions for suspension that there is property in the right to exercise the functions of office from which an appointee might be suspended, and therefore that Article 1 of the First Protocol may be engaged. The right to quiet enjoyment of such a possession might be said to be engaged in the imposition of the suspension provisions on existing appointees. However, we consider that the imposition of suspension measures for control of any such right would be proportionate and strike a fair balance between the general interest of the community as regards the standards of conduct and competence of public office holders and the protection of an individual’s fundamental rights.

PART 3

Tobacco

34. Clauses 18 to 22 relating to tobacco products provide powers for prohibition or regulation of the display of tobacco products in places where such products are offered to consumers for purchase. The provisions also give the Secretary of State powers by regulations:

— to grant exceptions to such a prohibition;
— to regulate the display of the prices of tobacco products in places where such products are offered for sale to consumers;
— to impose requirements on the sale of tobacco products from vending machines; and
— to prohibit the sale of tobacco products from vending machine.

35. The provisions at clause 19 for prohibiting the display of tobacco products, regulating the display of their prices and regulating the display of such products and their prices on websites may engage Article 10 (freedom of expression) of the Convention, which protects freedom of commercial expression. We are however satisfied that these provisions are compatible with the Convention. The main purpose of these provisions is to protect public health by protecting children and young people from the promotion of tobacco, with the aim of reducing the take up of smoking by them, and to provide an environment that supports smokers who are trying to quit. The protection of public health is an important counter-balance to unrestricted commercial expression. The proposed restrictions are within the margin of appreciation accorded to a state, justified by the considerable evidence as to the efficacy of the proposed restrictions and proportionate. Evidence from other countries which have introduced display bans show that the potential costs for retail outlets in complying with a display ban need not be high. Such potential costs and loss of profitability of the tobacco industry would be outweighed by potential public health gains in reductions in smoking, particularly among young people.

36. The provisions for prohibiting or imposing requirements in relation to the sale of tobacco from vending machines at clauses 20 and 21 of the Bill may engage rights to the peaceful enjoyment of possessions or for possessions not to be subject to unnecessary controls protected by Article 1 of the First Protocol. The powers for prohibition of or imposition of requirements in relation to the sale of tobacco products from vending machines will not deprive owners of their machines or products. The use of such powers could however be expected to give rise to an interference with the right to peaceful enjoyment of the machines, and any goodwill in the business of supplying the machines, or amount to control on the use of the machines
and tobacco products. Nonetheless, a state is entitled to enforce such laws as it deems necessary to control the use of property in accordance with the general interest, provided that the restrictions are not disproportionate.

37. These provisions are aimed at protecting public health. The policy objective is to reduce smoking take-up, prevalence and the number of cigarettes smoked by under 18s, as well as to support smokers seeking to stop smoking. While tobacco vending machines account for only 1% of the overall UK market in tobacco sales, evidence shows that a disproportionate number of young people under the minimum legal age for sale of tobacco obtain cigarettes from this source. Whilst a prohibition on the sale of tobacco from vending machines would impact on the business stability of tobacco vending machine companies, or the imposition of requirements would have a cost impact on them, these measures would be a proportionate means of protecting public health (with a net benefit in life years gained by smokers as against the costs of implementing requirements or a prohibition on the sale of tobacco products from vending machines).

38. However, we consider that prohibiting the display of tobacco products, or regulating the display of their prices, is unlikely to engage Article 1 of the First Protocol in respect of such products. Although the restrictions might make it harder for retailers to sell such products, the European Court of Human Rights has consistently held that a loss of future income does not engage Article 1 of the First Protocol. Such prohibition or requirements could however engage rights to the peaceful enjoyment of the premises from which such products are sold, or of the equipment used by manufacturers for producing gantries for the display of tobacco products. Nonetheless, any such interference would be justified and proportionate for the reasons given above.

Pharmaceutical services

39. The purposes of the pharmacy provisions at clauses 23 to 30 of the Bill are threefold:

— **Market Entry**—The first purpose of the pharmacy provisions is to replace the current “control of entry” test which is applied to pharmaceutical contractors seeking to enter onto a pharmaceutical list. The pharmacy provisions replace the current “control of entry” test with a more robust assessment determined by reference to local pharmaceutical needs assessments conducted by Primary Care Trusts rather than by reference to the overall adequacy of the pharmaceutical services in the neighbourhood in which they are located.

— **Market Exit**—The second purpose of the pharmacy provisions is to give explicit powers to Primary Care Trusts to take appropriate action where there are concerns about the quality or performance of services provided by pharmacy contractors.

— **Local Pharmaceutical Services (LPS)**—The third purpose of the pharmacy provisions is to enable Primary Care Trusts to provide local pharmaceutical services themselves in certain prescribed circumstances.

40. We consider that some aspects of the pharmacy provisions may arguably engage some of the rights set out in the Convention, but we conclude that the pharmacy provisions are compatible with the Convention rights.

41. Some of the pharmaceutical services provisions may engage Article 6 of the Convention. These include the market entry provisions which revise the “control of entry” test for practitioners who provide pharmaceutical services seeking to enter onto a pharmaceutical list at clauses 23 and 24 and the market exit provisions which provide Primary Care Trusts or Local Health Boards with explicit powers to act where there are concerns about the quality of services provided by a practitioner who provides pharmaceutical services in England or Wales, or, in Wales, a practitioner who provides ophthalmic services in clauses 26 and 29 respectively.

42. Similarly, with regard to the pharmaceutical services provisions at Part 3 of the Bill, a decision by a Primary Care Trust to refuse to admit a practitioner who provides pharmaceutical services to a pharmaceutical list and decisions taken by a Primary Care Trust or Local Health Board to impose a notice or withhold payments from pharmacy practitioners may arguably engage Article 6. However, such decisions would be subject to rights of appeal so satisfying the requirements of Article 6. In the case of a practitioner in England, a right of appeal against a decision of a Primary Care Trust refusing admission to the pharmaceutical list is conferred by section 130 of the NHS Act. The regulation-making power in new section 150A inserted into the NHS Act by clause 26 requires that provision be made in the regulations for rights of appeal against decisions of Primary Care Trusts to impose sanctions or withhold payments under that section. In the case of practitioners in Wales, the regulation-making power in new section 106A of the NHS (Wales) Act inserted by clause 29 requires that provision be made in the regulations for rights of appeal.

43. Provision for pharmaceutical services in England at clause 26 and for pharmaceutical and ophthalmic services in Wales at clause 29 may indirectly impose restrictions in relation to the practice of a profession by placing conditions on the ability of pharmacists or ophthalmologists to provide services. Primary Care Trusts in England or Local Health Boards in Wales will have powers to impose sanctions on or withhold funds from underperforming pharmacies, (or, providers of ophthalmic services in Wales) leading ultimately

---

1 See, for example, judgment of 19 December 1989, Mellacher and Others, A. 169, p. 25, (1990) 12 EHRR 391.
Ev 6  Health Bill on Human Rights Committee: Evidence

to their removal from pharmaceutical lists or arrangements with Local Health Boards. However, in exercising the powers a fair balance would be struck between the protection of any rights of pharmacists or ophthalmologists and the benefit to the general interest in monitoring the performance of pharmacies or ophthalmic services. We consider that the proposed measures would be proportionate and strike a fair balance between the general interest of the community and the protection of an individual’s property rights.

Adult social care

44. The provisions on adult social care in Schedule 5 incorporated into the Bill by clause 31 insert a new Part 3A into the Local Government Act 1974 to extend the remit of the Local Commissioner for Administration to enable the Local Commissioner to consider complaints about privately arranged or funded adult social care. The Local Commissioner will be able to consider matters in connection with the provision of adult social care (which is regulated by the Care Quality Commission) by providers that are not local authorities. Many of these providers will be companies but there may be some individuals who are registered with the Care Quality Commission as service providers.

45. The purpose of these provisions is to give individuals who fund or arrange their own social care an independent body to which to complain. As well as obtaining redress for individuals who have suffered injustice as a result of failures in social care provision, it is hoped that the involvement of the Local Commissioner will contribute to ensuring provision of high quality adult social care.

46. The provisions for complaints about adult social care contain powers for obtaining and disclosing information and for publication of an adverse finding by a Local Commissioner, which may engage rights to respect for private life protected by Article 8. If a Local Commissioner exercising powers under the provision interferes with the Article 8 rights of a provider, we consider that any interference is compatible with Article 8. The powers of a Local Commissioner will enable the Commissioner to properly investigate complaints and encourage providers to carry out recommended action. We consider that the powers will pursue a number of legitimate aims including the protection of health and of the rights and freedoms of others and would be proportionate so that any interference would be justified.

Disclosure of information

47. Clause 32 of the Bill will allow Her Majesty’s Revenue and Customs (HMRC) to disclose certain information relating to the income and expenses of General Practitioners (GPs) and dental practitioners to the Secretary of State and to the devolved administrations or to persons providing services to, or exercising functions on behalf of, the Secretary of State or the Devolved Administrations. The information disclosed will be an anonymised summary of the earnings and expenses of GP and dental practitioners and will not extend to other details disclosed to HMRC as part of the tax assessment process, such as matters unconnected with the professional activities of GPs or dental practitioners.

48. We consider that the provisions for disclosure by HMRC would be unlikely to impinge on an individual’s right to respect for privacy protected by Article 8. The disclosure of the information only in an anonymised, summarised form for which the provisions provide would not lead to the identification of any individual. A point could be raised that the initial provision of information to HMRC to enable identification of relevant tax records, although not covered by clause 32, engages Article 8. It might also be argued that further analysis by HMRC of tax information for a non tax-related purpose also engages Article 8. Even if it was considered that these actions interfered with the rights of individuals to respect for their privacy, these actions would be proportionate and justified in the interests of the economic well-being of the country as they are essential for financial planning for the delivery of primary medical and dental care in the NHS.

49. I hope this letter is helpful and I am happy to provide any further information.

Letter from the Chairman to Lord Darzi, dated 12 February 2009

HEALTH BILL

Thank you for your letter of 28 January 2009 explaining your views on the implications of the Bill for human rights.

The Joint Committee on Human Rights is considering the human rights compatibility of the Health Bill. Having carried out an initial examination of the Bill, the Committee would be grateful if you could provide answers to the following questions concerning the human rights compatibility of some of the Bill’s provisions. The Committee may have further questions in due course, should the Government bring forward amendments to the Bill.
NHS Constitution

Part 1 creates the framework for the NHS Constitution. We welcome the fact that the Constitution now makes explicit reference to human rights in relation to the principles that guide the NHS and the responsibilities of staff including:

[The NHS] has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides [. .].

[Staff] have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

I note the recent case involving a healthcare worker who offered to pray with patients.

Q1. Does the duty of NHS staff not to discriminate and to adhere to equality and human rights legislation prevent staff from proselytising or offering faith-based services without the specific request of service users?

Section 38 of the Human Fertilisation and Embryology Act 1990 and section 4 of the Abortion Act 1967 permit healthcare workers to conscientiously object to participating in activities under the Acts.

Q2. Does the duty also prevent healthcare staff from refusing to treat people or trying to dissuade them from undergoing certain treatment, on the grounds of the staff member’s religious beliefs, except for services specified in the statutory provisions on conscientious objection?

Direct Payments

Clauses 9 to 11 enable the Secretary of State to discharge various statutory functions under the National Health Service Act 2006 by making direct monetary payments to patients in appropriate cases, initially through pilot schemes, to enable them to purchase health care services directly from a variety of providers, including private organisations and the voluntary sector. Clause 10 enables the Health Service Commissioner to hear complaints about services for which direct payments were made, including those provided by independent organisations. The Explanatory Notes and your letter focus on the compatibility of these provisions with Articles 8 and 14 ECHR, but do not deal with the effect on an individual of using public money to procure contracted-out services from a private provider and whether or not that provider would be a public authority for the purposes of section 6 of the Human Rights Act.

As you will be aware, my Committee has a longstanding interest in the meaning of the term “public authority”. What constitutes a “function of a public nature” is not further defined in the HRA. In the Committee’s second report on Meaning of Public Authority, it recommended that the Government acknowledge that the legal position is uncertain and that this uncertainty should inform parliamentary debate on whether it should be made clear on the face of a Bill if a body is a public authority for the purposes of the HRA.

The Government introduced an amendment to the Health and Social Care Bill in the last Session to ensure that publicly funded residents in private sector care homes come within the ambit of the Human Rights Act: but the position in relation to other contracted-out services, including health, is not clear.

Q3. Does the Government consider that private providers of health services funded through direct payments are to be treated as public authorities under the Human Rights Act?

Q4. If yes, why was this not made clear on the face of the Bill?

Q5. If no, how (and against whom) will individuals be able to seek redress for breaches of their human rights?

Suspension and Dismissal of NHS Trust Directors

Clause 13 provides that once NHS Trusts come out of administration, the Secretary of State may, by order, terminate the office of any executive or non-executive director of the Trust. Terminating the employment of officer holders may raise issues about the fairness of their dismissal under Article 6 ECHR.

The Explanatory Notes and Lord Darzi’s letter suggest that Article 6 is not engaged and that even if it is a “fair procedure” would apply and the decisions would be subject to judicial review, which would satisfy the requirements of Article 6(1).


Q6. Will an individual whose employment is terminated be entitled to bring a claim before the Employment Tribunal for unfair dismissal?

Q7. On what grounds will an individual who is dismissed be able to seek judicial review of the decision? Would the High Court, on judicial review, have jurisdiction to hear evidence or substitute its own view on the factual questions?

ADULT SOCIAL CARE

Clause 31 of the Bill extends the remit of the Local Commissioner for Administration to enable the Local Commissioner to consider complaints about privately arranged or funded adult social care. The Local Commissioner may investigate action taken by an adult social care provider or particular complaints it receives.

Your letter concludes that the investigation of complaints may interfere with the rights to respect for private life of the service provider (Article 8 ECHR) but does not address the human rights implications for a service user. As you will know, we were concerned at the time that the Care Quality Commission was created that it would not be able to deal with individual complaints, as we had advocated in our report on Older People in Healthcare and proposed a new clause and an amendment to the Health and Social Care Bill.²

Whilst the proposals are potentially human rights enhancing, it is not entirely clear why the Government has chosen to extend the Local Commissioner’s remit rather than the Care Quality Commission’s powers.

Q8. Why does the Government consider the Local Commissioner, rather than the Care Quality Commission, to be better suited to investigating individual complaints by users of privately funded and arranged adult social care?

Schedule 5 sets out the procedure to be followed by the Local Commissioner in investigating complaints. These include that the adult social care provider and others must be given an opportunity to comment on the complaint, the Local Commissioner may determine whether individuals may be represented and s/he must produce written reasons for his decisions. It does not appear that the Local Commissioner is required to provide the complainant with a copy of any of the representations that s/he receives, or provide the complainant with an opportunity to comment on them.

Q9. Please explain how the complaints procedure complies with fairness requirements under Article 6(1) and the common law (in particular, given that the complainant is unable to comment on the representations made in response to his or her allegation)

I would be grateful if you could reply by 26 February 2009 and if an electronic copy of your reply, in Word, could be emailed to jchr@parliament.uk.

Andrew Dismore MP
Chair, Joint Committee on Human Rights

Letter from Lord Darzi to the Chairman, dated 3 March 2009

Thank you for your letter of 12 February following the Committee’s initial examination of the Heath Bill.

I am pleased that the Committee welcomes the fact that the Constitution makes explicit reference to human rights in relation to the principles that guide the NHS.

NHS CONSTITUTION

Q1. Does the duty of NHS staff not to discriminate and to adhere to equality and human rights legislation prevent staff from proselytising or offering faith-based services without the specific request of service users?

An offer of a service based on a staff member’s own faith or beliefs could depending on the particular circumstances amount to discrimination and as such would be unlawful under the equalities legislation. However, in other circumstances and in particular where a patient requests a faith-based service, such an offer would not be unlawful. Similarly, in certain circumstances proselytising might be construed as harassment (though not as such necessarily unlawful), but in others it may not. The Committee may be interested in reading the Department’s guidance on proselytising at page 22 of the publication entitled “Religion or belief a practical guide for the NHS” which can be found at:

---

Under section 117 of the Mental Health Act 1983, Primary Care Trusts must provide after-care services on behalf of people who have been treated in hospital. The Government is not in a position to make the payment under new section 12A of the NHS Act 2006 as an alternative means of fulfilling its duty to provide after-care services on its behalf. Again the Primary Care Trust will be responsible for providing these services.

Q2. Does the duty also prevent healthcare staff from refusing to treat people or trying to dissuade them from undergoing certain treatment, on the grounds of the staff member’s religious beliefs, except for services specified in the statutory provisions on conscientious objection?

NHS bodies as public authorities are under a duty under section 52 of the Equality Act 2006 to provide health services without discrimination on the ground of religion or belief. Members of staff are expected to treat patients in accordance with that duty.

However, there are cases where staff who have a conscientious objection may be permitted (or have the right) not to be involved in the provision of a health service. It would not be appropriate for a member of staff who is treating a patient to act other than in the patient’s best interests and in particular, to dissuade a patient from one course of action rather than another on the basis of that member of staff’s religion or belief.

The conscientious objection provisions in the Human Fertilisation and Embryology Act 1990 and the Abortion Act 1967 permit a health care professional to refuse to participate in treating a patient. They do not permit them once they are treating a patient to dissuade the patient from treatment which would be in the patient’s best interest. Abortion and fertility services are areas of particular sensitivity but there may be other areas where an employer might wish to respect the religion or beliefs of a member of staff.

DIRECT PAYMENTS

Q3. Does the government consider that private providers of health services funded through direct payments are to be treated as public authorities under the Human Rights Act?

The Secretary of State must under section 1 of the National Health Service Act 2006 provide or secure the provision of a comprehensive and free health service in accordance with the Act. The NHS is a core public function. It is essentially a universal and free service which touches on many fundamental aspects of the Convention rights. The Government considers that independent providers of health care when they are providing services as part of the health service under the NHS Act 2006 are public authorities for the purposes of section 6 of the Human Rights Act 1998.

The introduction of direct payments for health care under new provisions inserted into the NHS Act 2006 by the Bill does not alter the Government’s view that independent providers of NHS care are public authorities. Services provided by private providers under a direct payment arrangement will still be services provided in fulfilment of the Secretary of State’s duty to provide or secure the provision of a national health service in accordance with sections 1, 2 and 3 of the NHS Act 2006.

It is significant in this regard that direct payments are set out in new section 12A of the NHS Act 2006 and are therefore firmly established within the framework of the National Health Service. Secondly, new subsection (2) of section 12A ties direct payments directly to sections 2 and 3 of the 2006 Act. Section 3 requires the Secretary of State to provide throughout England to such extent as he considers necessary to meet all reasonable requirements hospital and other medical services.

The Government does not consider that a distinction should be drawn between independent providers of health services under section 12 of the NHS Act 2006 (which allows the Secretary of State to enter into contracts with independent providers) and section 12A (which will allow patients to enter into contracts with independent providers). In both cases services will be provided as part of the National Health Service pursuant to the Secretary of State’s duties under the NHS Act 2006. Nor, does the Government consider that a distinction should be drawn between, on the one hand, NHS bodies providing services under the delegation of functions under sections 3 and 7 of the NHS Act 2006 or NHS contracts under section 9 of the NHS Act 2006 and on the other hand, independent contractors providing services under section 12 or 12A of the NHS Act 2006. Again, all providers will be providing services under the NHS Act 2006.

It will of course be the case that not all of a patient’s health care needs will be met through direct payments. Rather they will continue to receive health services under the Act, for example GP and other primary care services. If the patient’s condition in relation to which they are receiving a direct payment deteriorates or they otherwise need additional care for their condition which was not envisaged in the making of the direct payment, the Secretary of State’s duty to provide services remains in place in respect of that need.

Under section 117 of the Mental Health Act 1983, Primary Care Trusts must provide after-care services for any person to whom the section applies subject to the provisions of section 117. The Government is similarly of the view that independent providers of after-care services commissioned by a Primary Care Trust to provide after-care services on its behalf are covered by the Human Rights Act. The same will be true if they are providing such services under a direct payment arrangement. Again the Primary Care Trust will make the payment under new section 12A of the NHS Act 2006 as an alternative means of fulfilling its duty under section 117 of 1983 Act.
It is also to be noted that the Secretary of State or Primary Care Trust has to agree that a direct payment would be appropriate in each case. Secondly, it is to be noted that regulations under new section 12B of the NHS Act 2006 may provide for conditions that the patient or payee must comply with, before, after or at the time of making a direct payment. Those regulations may also set out the circumstances in which the Secretary of State or the Primary Care Trust may or must stop making direct payments. Accordingly, the Secretary of State will be able to ensure there is a robust framework for the making of direct payments and how they are used by patients.

Q4. If yes, why was this not made clear on the face of the Bill?

There is no need to make provision on the face of the Bill. To do so would cast doubt on whether any independent provider of health services acting under another relevant section of the National Health Service Act 2006 was exercising a function of a public nature.

Provision was made at section 145 of the Health and Social Care Act 2008 in order to make it clear that notwithstanding the judgment of the House of Lords in the case of YL v Birmingham City Council and others [2007] UKHL 27, provision of certain social care under arrangements described at section 145 is subject to the Human Rights Act. The House of Lords held in the cases mentioned that a private care home when accommodating residents under arrangements made with a local authority for the implementation of the authority’s obligations under section 21 of the National Assistance Act 1948 was not exercising a public function for the purposes of section 6(3)(b) of the Human Rights Act. However as indicated by the House of Lords, the judgment applies to the facts of those cases. There has been no subsequent court judgment that leads the Government to consider that independent providers of national health services are not public authorities for the purposes of the Human Rights Act.

Q5. If no, how (and against whom) will individuals be able to seek redress for breaches of their human rights?

In the Government’s view, the answer to question 3 is yes.

Suspension and dismissal of NHS Trust Directors

Q6. Will an individual whose employment is terminated be entitled to bring a claim before the Employment Tribunal for unfair dismissal?

An individual will not have their employment terminated by virtue of clause 13, when an NHS trust comes out of administration. Non-executive directors are office holders appointed by the Secretary of State (or, by virtue of directions under section 58 of the Health Act 2006, the Appointments Commission) and are not employees of the trust. Non-executive directors are therefore not entitled to bring a claim before an Employment Tribunal in respect of their removal from office.

An individual may however bring a claim for judicial review. In the case of removal under new section 65L, however, the removal from office is to ensure that the constitution of the board of directors of a trust which is a “deauthorised” NHS foundation trust is compliant with the legislation governing NHS trusts. This is necessary as some NHS foundation trusts may have a board of directors whose numbers exceed what permitted for NHS trusts, and so it may be necessary to reduce the number of directors. An individual would be able to challenge their selection for removal, for example, if they alleged they were selected over another as a result of bias or prejudice. But the reduction in the number of directors could not itself be subject to challenge (other than an argument that the Secretary of State was in error when concluding that the reduction in numbers was necessary, for example, as a result of misinterpretation of the relevant statutory provisions), as it would be necessary for the board of directors to be so constituted in accordance with the statutory requirements.

The Government considers that removal in these circumstances is similar to removal in the case of dissolution and merger of NHS trusts, where some members will have their office terminated, while others may be re-appointed to the new body.

In relation to executive directors, clause 13 provides only for their removal from office as a member of the board of directors; that decision could be the subject of a claim for judicial review as set out in the previous paragraph. In relation to their employment, however, they would remain an employee of the trust; if the trust terminated that individual’s employment, the individual would be entitled to challenge that dismissal by means of a claim for unfair dismissal in the usual way.
Q7. On what grounds will an individual who is dismissed be able to seek judicial review of the decision? Would the High Court, on judicial review, have jurisdiction to hear evidence or substitute its own view on the factual questions?

As indicated in the answer to the previous question the individual would be able to seek judicial review of the decision to select them, rather than another board member, on the usual grounds—for example, that the decision was irrational or had been reached without a fair procedure. The member may also be able to challenge a decision to terminate on the basis that termination was not in fact necessary in order to comply with the statutory provisions regarding membership of NHS trust boards (see new section 65L(5)).

The Government’s view is that the usual position on judicial review would apply eg that it would not be for the Administrative Court to substitute its own view on the factual questions.

ADULT SOCIAL CARE

Q8. Why does the Government consider the Local Commissioner, rather than the Care Quality Commission, to be better suited to investigating individual complaints by users of privately funded and arranged adult social care?

The Care Quality Commission will be a service regulator and in the Government’s view the investigation of individual complaints does not fit with the Care Quality Commission’s regulatory role. The Care Quality Commission will, however, be able to act on information that comes to their attention via complaints. This will include reports by the Local Commissioner about complaints the Local Commissioner has investigated from users of privately funded and arranged adult social care. The Government considers this to be a more appropriate role in relation to complaints for the Care Quality Commission.

The Local Commissioner already has a role in investigating complaints by users whose care is arranged or funded by local authorities. The proposed new responsibility will sit logically with these existing duties, and the Commissioner’s staff have the advantage of already understanding the types of issues that arise in adult social care.

Q9. Please explain how the complaints procedure complies with fairness requirements under Article 6(1) and the common law (in particular, given that the complainant is unable to comment on the representations made in response to his or her allegation)

The complaints procedure for the new scheme is modelled on the existing procedure for dealing with complaints about local authorities. As with the existing scheme, the procedure for conducting the investigation of each complaint will be largely for the Local Commissioner to determine—see new section 34F(3). When investigating complaints about local authorities, the Commissioner’s usual procedure is to provide the complainant with the local authority’s representations and the Local Commissioner’s provisional conclusions on the complaint so that the complainant’s views may be taken into account before a final decision is made. There may be some information gathered in the course of an investigation, or contained in the authority’s comments, which is not shared with the complainant, such as sensitive personal data about third parties or information that is protected from disclosure under other legislation. But whenever possible the Commissioner will share information with the complainant.

The Government understands that the Local Commissioner intends to follow similar procedures for the new scheme so will in general share with the complainant the provider’s representations made in response to the complainant’s allegations and allow complainants to comment on the Commissioner’s provisional conclusions. The Government does not consider that Article 6 is engaged in relation to investigations by the Local Commissioner. The Local Commissioner will not determine any civil right or obligation under the provisions in the Bill. The Local Commissioner will have discretion whether to investigate or not. Where the Commissioner finds that something has gone wrong, and recommends a remedy the adult social care provider is not obliged under the Bill to comply with that recommendation.

Decisions of the Local Commissioner are subject to judicial review. So a complainant who felt that their complaint had not been handled fairly would be able to seek a remedy through the Courts.

Memorandum submitted by Age Concern and Help the Aged

KEY POINTS

1. Age Concern and Help the Aged welcome the inclusion in the NHS Constitution of the right not to be discriminated against on the grounds of age and the confirmation that patients can expect to be treated in accordance with their human rights.

2. However we are concerned that the NHS Constitution does not go far enough in making an express connection between human rights and healthcare.
3. We are worried that direct payments made to private bodies providing healthcare, including mental health services, will lead to more patients falling outside of the protection of the Human Rights Act (HRA); we call for the legislation to be clarified.

4. We are also concerned about the lack of clarity in the HRA status of a person funding their own care who is deprived of their liberty under the Mental Capacity Act.

5. While we broadly welcome provisions that will give access to redress for complaints by those who fund their own social care, we remain unconvinced that the Local Government Ombudsman (LGO) is best placed to be investigating complaints against adult social care providers.

6. We also have a number of concerns about the proposed process for redress, as we believe it falls short of standards of fairness required under Article 6 of the European Convention on Human Rights. A particular worry is that insufficient additional funding for the LGO will cause delays in resolving complaints.

INTRODUCTION

7. Age Concern and Help the Aged welcome the opportunity to comment on aspects of the Health Bill that raise significant human rights issues.

8. Older people are the main adult users of the National Health Service. For instance, people over the age of 65 occupy 65% of acute beds and account for 63% of finished consultant episodes in acute hospitals. The Health Bill will therefore have a significant effect on older people and their experiences of the NHS.

9. Many aspects of healthcare engage rights guaranteed by the European Convention of Human Rights (ECHR). While the most stark example is Article 2, there are clear cases where Articles 3, 5 and 8 are engaged. Above and beyond this the right to good health, necessitating a high standard of healthcare, is a fundamental human right and is also reflected in the United Nations Principles for Older Persons.

10. Although the majority of older people experience care from dedicated staff which protects and promotes their human rights, there is ample evidence to demonstrate that their human rights are sometimes breached.

11. As requested by the JCHR this submission will concentrate on:

---

- The duty in the NHS Constitution on healthcare staff not to discriminate and to adhere to equality and human rights legislation;
- Whether private bodies providing health services funded by direct payments are public authorities for the purposes of section 6 of the Human Rights Act 1998 and, if not, how individuals receiving such services may seek redress for breaches of their human rights;
- Whether the procedure for investigating a complaint against a NHS Trust complies with procedural fairness requirements (Article 6(1) ECHR); and
- The role of the Local Commissioner in investigating complaints by users of privately funded and arranged adult social care, and whether the procedure satisfies the common law and the requirements of Article 6(1) ECHR for procedural fairness.

NHS CONSTITUTION

12. Clause 2 of the Health Bill introduces a duty for listed NHS bodies to have regard to the NHS Constitution in the performance of NHS functions. The NHS Constitution requires staff not to discriminate against patients or other staff members and to adhere to equal opportunities and equality and human rights legislation. It also contains two connected “rights” for patients and staff alike not to be discriminated against.

13. Age Concern and Help the Aged welcome the inclusion of the right not to be unlawfully discriminated against in the NHS Constitution. We have long campaigned for an end to age discrimination in the provision of healthcare and we therefore wholeheartedly supported the JCHR’s earlier recommendations that there should be a positive duty on providers of health and residential care to promote equality for older people and that the prohibition on age discrimination should be extended to cover goods, facilities and services including healthcare.

14. We are, however, concerned that age discrimination is being left behind when compared to the other discrimination “strands”. We welcomed the Government’s announcement that the Equality Bill will introduce protection from age discrimination in goods, facilities and services; however the timetable for drafting and implementing Regulations will leave older people vulnerable to discriminatory treatment for

---

7 See Principle 11 on older people’s access to health care.
many years to come, with clear implications for their enjoyment of human rights. The JCHR should press Ministers and the Department for Health to bind themselves to a timetable for rapid implementation of the Regulations, including in the field of healthcare.

15. The NHS Constitution states that patients have the right to be treated with dignity and respect, in accordance with their human rights. We welcome the acknowledgment of the express link between human rights and the concepts of dignity and respect, which are of course core human rights principles; this link was conspicuously missing from the earlier draft of the NHS Constitution. However, the link could have been elaborated further to ensure that NHS patients understand that their expectation of being treated with “dignity” and “respect” is underpinned by the Human Rights Act.

16. Six values are described in the NHS Constitution as providing common ground for co-operation to achieve shared aspirations. We consider all of these values to be central elements of an approach to healthcare that is based on human rights. The values are consistent with the core principles underlying the ECHR and are also reflected in other human rights instruments, for example the UN Principles on Older Persons (independence, participation, care, self-fulfillment and dignity). It is therefore disappointing that an explicit connection between these values and human rights has not been made in the NHS Constitution.

17. In summary, Help the Aged and Age Concern believe that the NHS Constitution has only gone part-way in making the connection between human rights and healthcare.

PRIVATE BODIES PROVIDING HEALTH SERVICES

18. Clause 9 of the Health Bill would amend the National Health Service Act 2006 by inserting sections 12A–12D to allow the Secretary of State to make direct payments in healthcare.

19. Age Concern and Help the Aged believe that direct payments in healthcare may in some circumstances be an appropriate way for people to personally direct their care. However, we will not support the widespread roll out of direct payments unless evaluation of pilots demonstrate clear benefits for older people (in the field of social care the government announced the national roll-out of personal budgets before negative evaluation was published). We also seek clarity about how they would work in practice. For example a robust safety net should be put in place to support those individuals who choose to accept a direct payment only to later find themselves without funds and unmet health needs. In the IBSEN review of individual budget pilots in social care, older people did not experience the same benefits in terms of flexibility and increased control that younger people did.\(^{10}\) It is therefore questionable whether direct payments for health services will bring benefits for older people, except in narrowly defined fields such as NHS continuing care.

20. Age Concern and Help the Aged believe that private bodies that are providing health services funded by direct payments should be considered as providing functions of a public nature for the purposes of section 6 of the Human Rights Act 1998 (HRA). However, it is not clear that in practice they will be.

21. The leading case on the definition of “public function” is \textit{YL v Birmingham}.\(^ {11}\) The House of Lords judgment focused on the status of independent care homes providing residential care services under contract to local authorities. The status of private bodies providing health care under contract with the NHS was not directly at issue. The obiter remarks of the Law Lords on this point suggest that their views were divided. For example, Lord Neuberger suggested that:

\begin{quote}
The state provides education and health to everyone, and indeed it is obliged by the Convention to provide education. However, that certainly does not mean that the provision of health or education services in a private school or hospital is a function of a public nature, and, at least as at present advised, that would apply, in my view, even where the costs of the recipient of the service happens to be paid for by a core public authority.\(^ {12}\)
\end{quote}

On the other hand, Baroness Hale argued [at paragraph 67] that “It cannot be doubted that the provision of health care [by the care home] was a public function”. Lord Mance was undecided on this point [paragraph 123]: “I would leave entirely open the position of those operating in the different areas of health and education services”. It should be noted, however, that their Lordships did not even consider the question of private bodies providing health services funded by direct payments—arguably a more remote relationship with the originating public authority.

22. One area of particular concern is the status of people who are placed in care homes under section 117 Mental Health Act 1983, as they are not covered by the amendment to the HRA introduced by the Health and Social Care Act 2008. Most people whose accommodation is provided under section 117 are funded by Social Services although some are funded jointly by the NHS and social services. The Health Bill would be a good opportunity to bring residents funded under section 117 under the protection of the HRA.


\(^{11}\) \textit{YL v Birmingham City Council} [2007] UKHL 27; [2008] 1 AC 95; [2007] 3 WLR 112.

\(^{12}\) \textit{YL v Birmingham}, [164].
23. The Health Bill is proposing that direct payments may be made for services under section 117 Mental Health Act, which includes provision of residential accommodation. These are often funded entirely by social services, or jointly funded by health and social services. One difficulty that needs to be addressed is that direct payments by social services are only available for non-residential services. If the local authority funds a section 117 placement, it would not be able to do so through direct payments. If the package is jointly funded by the local authority and—via direct payments—the NHS, this could cause difficulties as part of the package could be met by direct payment and part would have to be funded in the traditional way to the care home under a local authority contract. It will create an inequitable system in that a direct payment will be possible if the package is funded by the NHS, but not if it is funded by social services.

24. We are also concerned that there is no clarity about whether someone whose care is funded under section 117 Mental Health Act falls within the scope of the Human Rights Act. Similarly the Health Bill says nothing about the HRA status of a person who is funding their own care and is subject to an authorisation of deprivation of liberty under the Mental Capacity Act. It seems self evident that where the state is depriving someone of their liberty, the care home concerned should be considered as performing a public function, even if the individual is funding their own care.

25. Given the overall uncertainty about the HRA status of private healthcare providers, we believe that legislation should clarify the position, confirming that they are performing a public function under the Act. This would be in keeping with legislative action subsequent to the YL decision. Otherwise there is a real risk that another HRA loophole will be opened up. This would create a two-tier system within the NHS and could act as a disincentive to take up direct payments. Alternatively, and perhaps more likely, people might remain in ignorance of their lack of legal protection under the HRA.

26. In theory, individuals who receive healthcare from a private body paid for by direct payments should still be able to rely on standard private law causes of action, such as in tort or contract, if their rights under common law are breached. However, as the case of YL v Birmingham demonstrated those options may not always be available to assist individuals seeking redress and cannot be relied on to deal with all human rights breaches. People using private healthcare commissioned by NHS would be able to make a complaint to the Health Service Ombudsman. However, it is not clear what the position will be for those paying for care through a personal health budget, as the initial guidance is silent on the matter.

EMPLOYMENT OF TRUST DIRECTORS

27. The JCHR has questioned whether the procedure allowing the Secretary of State to terminate the employment of NHS Trust Directors complies with procedural fairness requirements contained in Article 6(1) of the ECHR. Age Concern and Help the Aged have no view on this matter.

LOCAL COMMISSIONER AND ADULT SOCIAL CARE COMPLAINTS

28. Age Concern and Help the Aged welcome the broad thrust of the provisions in the Health Bill that would give access to redress for complaints by those who fund their own social care. We have previously called for this loophole to be remedied, and are pleased that the Government has used the opportunity presented by the current Bill to address this. Clause 31 of the Health Bill, taken together with Part 5, would insert a new Part 3A into the Local Government Act 1974. This would make provision for the investigation of complaints about privately arranged and funded adult social care to be investigated by a Local Commissioner (Local Government Ombudsman (LGO)). Clearly, it is important to ensure that this procedure complies with Article 6 of the ECHR as it must be regarded as affecting people's civil rights. On this basis, we have a number of concerns about this proposal.

29. While we welcome the principle behind these proposals, we remain unconvinced that the LGO is best placed to be investigating complaints against adult social care providers. There is an argument that legislation should provide for the Care Quality Commission (CQC) to have responsibility for complaints for privately funded and arranged adult social care as well as for publicly funded care. An alternative approach would be to consider expanding the remit of one of the existing tribunals, such as the Care Standards Tribunal.

30. We have a major concern about the apparent lack of assurance that the budget of the LGO is going to be increased appropriately to cover the additional work involved in handling adult social care complaints. We are concerned that this will lead to excessive delays in the conclusion of complaints, breaching the Article 6 right to the determination of a complaint within a reasonable time.

31. The LGO will retain discretion whether to investigate complaints referred to it. Effectively, the complaint could be “struck out” without the complainant’s case being investigated. This may leave some complainants without any redress, and would be in breach of Article 6.

32. It is also unclear how far the LGO will deal with complaints that are about contracts. Age Concern and Help the Aged receive many complaints about the fact that “self-funders” are charged considerably more for the same services than local authority funded residents. Often self-funders are told openly that because the

13 YL v Birmingham, [171]; Health and Social Care Act 2008, section 145.
local authority fee level is so low, homes are forced to charge a much higher price to those who fund their own care, thus bringing in an element of cross subsidy. The Commission for Social Care Inspection has not felt able to intervene in the past on what is a matter of contract, and while the Office of Fair Trading has investigated the problem,\textsuperscript{14} it has taken no subsequent action to address it. We hope that the Government will explore the option of the LGO having the power to investigate such complaints given that they work with local authorities and so could investigate the fees that they pay.

33. We are concerned that the LGO will not have to state reasons for its decision where it completes an investigation, although it will need to publish its conclusions and, if it has any, its recommendations. Once again, we would suggest that this would be in breach of the principles of fairness established under Article 6.

34. It is not clear whether the LGO has a discretion to pay legal expenses of a complainant if they instruct a solicitor, or whether complainants could get legal aid. If complainants do not have access to funding for legal representation there is a risk that this procedure will not satisfy the Article 6 requirements of fairness, where the case is particularly complex or the complainant is very vulnerable.

35. Although an adult social care provider would be required by the new section 34I(3) to publish an adverse findings notice if they do not comply with recommendations made by the LGO, there is no requirement on them to follow the LGO’s recommendations. Once again, this suggests that Article 6 requirements could be breached; it is an important principle under this Article that the court or tribunal should be able to take binding decisions.

36. A further and related concern is that the role of the Healthcare Commission in providing a system for the independent review of complaints will not be taken over by the CQC. The CQC will simply have a role in “ensuring that NHS trusts deal with complaints properly”. The revised NHS complaints system is predicated on excellent local handling of complaints. However, the most recent report by the Healthcare Commission, \textit{Spotlight on Complaints},\textsuperscript{15} expresses disappointment that far too many complaints about the NHS do not receive an appropriate response locally and that the same issues continue to be complained about year after year. People who make complaints cannot be confident that these will be thoroughly investigated or that they will receive an appropriate response. Without a role in the independent review of complaints the CQC is unlikely to be in a position to provide effective oversight of local complaints handling.

\textit{February 2009}

Memorandum submitted by the British Medical Association

\textbf{EXECUTIVE SUMMARY}

1. The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine throughout the UK. It has a membership of over 141,000 doctors.

2. This response highlights the BMA’s perspective on the compatibility of the Health Bill 2009 with Human Rights legislation particularly in respect of restricting some population groups, such as failed asylum seekers, from access to primary healthcare, in the event that the Government pursues previously stated policy objectives. In particular the BMA would like to highlight the humanitarian considerations of preventing access to care, the health inequalities that may result from such policies and the additional burden that may be placed on doctors in determining eligibility for services.

\textbf{BACKGROUND INFORMATION}

3. Although the Health Bill does not contain any clauses proposing the introduction of restrictions on access to healthcare, this policy objective has been clearly stated in the 2004 consultation document “Proposals to Exclude Overseas Visitors from Eligibility to Free NHS Primary Medical Services” particularly in relation to restricting failed asylum seekers from access to free primary healthcare.\textsuperscript{16} The 2008 document “Making Change Stick: An Introduction to the Immigration and Citizenship Bill”\textsuperscript{17} stated that access to healthcare will be restricted to those who “earn it”. The BMA understands that the Immigration Simplification Bill due in late 2009 may be used as a means of introducing clauses restricting access to healthcare through the redefinition of terms such as “ordinarily resident”, “lawfully present” and “habitually resident”, a process which could have a serious impact on the health and well-being of failed asylum seekers and other vulnerable groups within the UK.

\textsuperscript{14} Office of Fair Trading. \textit{Care homes for older people in the UK}, May 2005.


\textsuperscript{16} http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4087618

\textsuperscript{17} http://www.ukba.homeoffice.gov.uk/sitecontent/documents/managingourborders/makingchangestick.pdf
4. The BMA has previously highlighted the individual health, public health, economic and humanitarian implications of restricting access to primary care for failed asylum seekers. These concerns were emphasised recently in written and oral evidence to the Home Affairs Select Committee inquiry on Managing Migration: Draft Immigration and Citizenship Bill.\(^{18}\)

**NHS Constitution**

5. The BMA welcomes the Health Bill’s introduction of an NHS Constitution which sets out the rights to which patients, public and staff are entitled and to which all NHS bodies and providers supplying NHS services must be required to take account of by law. The NHS Constitution states “[The NHS] has a duty to each and every individual that it serves and must respect their human rights.” The BMA has concerns related to the possible introduction of restrictions on access to primary care for failed asylum seekers and how such restrictions will be balanced with the principles and values of the NHS Constitution.

6. The BMA would like to take this opportunity to highlight to the Joint Committee for Human Rights, general concerns with proposals to restrict access to care not simply in a human rights context but in relation to health inequalities and the values stated within the NHS Constitution.

**Human Rights Legislation**

7. The NHS Constitution, states that “access to NHS services is based on clinical need, not an individual’s ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament”.

8. The BMA has significant concerns that future legislation may impose charges on failed asylum seekers accessing primary care and this may lead to individuals being refused access to care for which they are unable to pay, even where there is a genuine medical need. The BMA would assert that the failure to treat individuals in these circumstances contravenes Article 3 of the European Convention on Human Rights (ECHR) which determines that “no one shall be subject to . . .inhumane or degrading treatment”.\(^{19}\)

12. There are considerable humanitarian considerations in restricting access to primary care not least the possibility of individuals being unable to access simple primary care treatment to manage a particular condition to the point where their health deteriorates and emergency intervention is required. In addition, a failure to manage a condition at an earlier stage may lead to unnecessary suffering which would contravene Article 3 of the ECHR. A policy in which healthcare is restricted may well have a wider impact on an individual’s family life which would breach Article 8 of the ECHR, “everyone has the right to respect for his private and family life”.\(^{20}\)

13. Such a policy not only impacts upon the individual’s wellbeing but also appears to conflict with Principle 6 of the NHS Constitution which states that “the NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources”. In some circumstances restricting access to healthcare may lead to individuals requiring far more intensive and costly treatment as their condition will deteriorate as a result of them being unable to access services at an early and more manageable stage. This in turn will place an additional burden on health services, when earlier intervention would have been cheaper and more effective. Early treatment is the right way to manage health conditions economically as well as from a humanitarian view.

**Health Inequalities**

14. The first guiding principle of the NHS Constitution is that the NHS has “a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population”. Any future restrictions on access to healthcare particularly in relation to failed asylum seekers are likely to have a detrimental effect on those individuals unable to access primary care and may potentially cause greater inequalities between those deemed eligible for free primary care and those who are deemed ineligible but who remain in the UK and are unable to return home. This would appear to be at odds with the guiding principles set out in the NHS Constitution.

15. A BMA report “Asylum seekers: meeting their healthcare needs” documented the complex health needs of asylum seekers and highlighted that threats to their health were mostly posed by diseases linked to poverty and overcrowding. There are other health problems specific to asylum seekers originating from physical or mental torture in their country of origin.\(^{21}\) There is also some evidence to suggest that the health of many asylum seekers may worsen in the two or three years after entry to the UK.\(^{22}\) Those individuals


\(^{19}\) http://www.hri.org/docs/ECHR50.html

\(^{20}\) http://www.bma.org.uk/asp.nsf/content/Asylumseekers

whose asylum applications have been rejected, but who remain unable to return to their country of origin\(^{23}\) may see a decline in their health as a result of being restricted from accessing primary care treatment or being made to pay for treatment which they cannot afford.

16. The BMA has concerns that a policy of restricting access to primary care for a group of individuals who have no alternative healthcare available to them will not promote equality within this section of society nor will it positively facilitate improvements in their health and life expectancy. This contravenes the guiding principles set out in the NHS Constitution.

17. There are considerable public health implications of restricting access to healthcare. Failure to allow free access to primary care for this group of vulnerable individuals will mean a delay in diagnosis, including of infectious diseases. This will damage the NHS’s ability to manage potential epidemics and increased risk to the whole population. Those in our most vulnerable groups, including those who do have access to primary care, are likely to be most severely affected further increasing the health inequalities they face.

**ROLE OF DOCTORS**

18. Doctors have a duty to care for patients as documented in the General Medical Council’s “Good Medical Practice” (2006).\(^{24}\) A system in which Parliament has sanctioned charges for NHS services or restrictions on accessing services to be imposed upon failed asylum seekers may place an unnecessary burden on doctors in providing care. This is particularly salient in those cases where a failed asylum seeker may have a genuine medical need but may not possess the funds to pay for accessing NHS services or meet the proposed eligibility criteria for free primary care. A doctor’s overriding duty is to provide treatment to those who genuinely need it and the refusing of care to failed asylum seekers is at odds with this principal and principled, obligation.

**CONCLUSION**

19. Although the Health Bill does not contain specific clauses of concern to the BMA in respect of human rights, there are fears that future legislation may conflict with the principles set out in the NHS Constitution and have an adverse effect on the well-being of certain vulnerable groups, contrary to the European Convention on Human Rights.

*February 2009*

---

Memorandum submitted by the Global Health Advocacy Project

We are a group of students and young healthcare professionals affiliated to the student organisation Medsin. Our aim is to challenge health inequalities in the UK and overseas.

**EXECUTIVE SUMMARY**

1. A policy of deliberate denial of healthcare, secondary or primary, to undocumented migrants and refused asylum seekers is inhumane and contravenes several international Human Rights agreements.

2. Such a policy would contribute to discrimination against and marginalisation of vulnerable groups with every right to remain in the UK which is entirely out of line with the current Health Bill and NHS Constitution.

3. This submission will argue that in order to bring the Health Bill and NHS Constitution in line with international Human Rights law, in particular General Comment 14 regarding Article 12 of International Covenant on Economic, Social and Cultural Rights, undocumented migrants and refused asylum seekers should be excluded from the remit of the charging regulations set out in Statutory Instrument 614.

1. The Health Bill\(^{25}\) establishes a framework for the NHS Constitution\(^{26}\) and places a duty on all providers of NHS services to have regard of the NHS Constitution.

2. The NHS Constitution outlines the “principles and values of the NHS in England” as well as “pledges which the NHS is committed to achieve”:

\(^{23}\) These individuals fall under Section 4 of the Immigration and Asylum Act 1999 where it has been determined that they are unable to return to their country of origin immediately due to circumstances beyond their control. http://www.ukba.homeoffice.gov.uk/asylum/support/apply/section4/

\(^{24}\) http://www.gmc-uk.org/guidance/good_medical_practice/index.asp


Ev 18  Health Bill on Human Rights Committee: Evidence

The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

Access to NHS services is based on clinical need, not an individual’s ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

[Staff] have a duty not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.

3. The Constitution document sets out that “everyone counts. We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken—and that when we waste resources we waste others’ opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier”.

4. In April 2004, Statutory Instrument 614\(^\text{27}\) limited access to NHS hospital services for undocumented migrants and refused asylum seekers. The declared purpose of these regulations was to crack down on health tourism. There is no evidence of significant levels of health tourism in the UK, a point which has been conceded by the Department of Health.\(^\text{28}\)

5. In summer 2004, the Department of Health consulted on “proposals to deny overseas visitors, including refused asylum seekers, free primary care treatment on the NHS”.\(^\text{29}\) 274 individuals and organisations made submissions to the enquiry but, unlike every other Department of Health consultation published that year, the department published no response.

6. To date, the government has still not published a response, nor has it made public the submissions to the initial consultation. A proportion of the submissions were released in August following requests made through the Freedom of Information Act. A group of medical students and doctors released a report in August detailing the contents of these submissions.\(^\text{30}\)

7. Twenty nine percent of submissions expressed concerns that the proposed changes in entitlement to primary care would breach International Human Rights agreements which the UK ratified. Secretary of State for Health, Alan Johnson, referred to the “sheer inhumanity of actually refusing to treat people that are ill in primary care”.\(^\text{31}\)

8. In withdrawing free access to secondary healthcare from undocumented migrants and asylum seekers whose refused asylum claim the UK is in breach of these in Human Rights agreements including Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR); General Comment 14 regarding Article 12 of the ICESCR; Article 25 of the Universal Declaration of Human Rights and Articles 2, 3 and 8 of the European Convention on Human Rights (ECHR).

9. This submission will argue that in order to bring the Health Bill and NHS Constitution in line with international Human Rights law undocumented migrants and asylum seekers whose refused asylum claim has failed should be excluded from the remit of the charging regulations set out in Statutory Instrument 614.

**HUMAN RIGHTS**

1. Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)\(^\text{32}\) states health is a fundamental human right. It describes “the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

2. Article 2 of the ICESCR puts states under the specific obligation “to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”.


3. In General Comment 14 related to Article 12 of the ICESCR, the right to the highest attainable standard of health, the UN Committee on Economic, Social and Cultural Rights specifically states that “states are under the obligation to respect the right to health by [. . .] refraining from denying or limiting equal access for all persons”.  

4. The committee explicitly mentions that this obligation extends to “all persons, including [. . .] asylum seekers and illegal immigrants, to preventive, curative and palliative health services”.

5. Article 25 of the Universal Declaration of Human Rights outlines that everyone has a right to health which shall be “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”.

6. Charging refused asylum seekers and undocumented migrants for NHS care effectively prevents access to any healthcare as there are high levels of destitution in both populations, meaning they cannot access private healthcare. Charging for NHS care discourages engagement with healthcare services. Research in Sweden suggests there is a risk that policies which link healthcare providers with immigration agencies in the minds of migrants can lead them to disengage with services.

7. Evidence of vulnerability and inequitable access to healthcare of migrant populations is given in the latest report from the Confidential Enquiry into Maternal and Child Health. Refugee and asylum-seeking women accounted for 12% of maternal deaths in 2003–05. Barriers to accessing care for these women are already significant.

8. A King’s Fund survey of organisations providing services for asylum seekers concluded that asylum seekers and refugees in the UK “are subjected to a system that leaves them insecure, impoverished and unhealthy”. Further restricting access to care could worsen the situation.

9. Removing access to healthcare from a vulnerable section of the population has further huge implications for the physical and mental health of individuals concerned. Case studies show that, since NHS regulations were amended in 2004, both those not entitled to care as well as those entitled to care, but with limited understanding or ability to communicate their rights, have come to harm.

10. Lack of alternative healthcare provision to some individuals may constitute a breach of articles 2, 3 and 8 of the European Convention on Human Rights (ECHR), which guarantee the right to life and prohibit inhumane or degrading treatment.

11. Article 14 of the ECHR 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 ECHR is instituted into UK law through the Human Rights Act. Currently, the only free healthcare services available outside the NHS are those provided by organisations such as Project London and the Helen Bamber Foundation, with limited capacity.


DISCRIMINATION

1. The current charging regulations give rise to a risk of race discrimination. No race equality impact assessment was carried out before introducing the 2004 charging regulations or with regard to the current discretionary arrangements for GP registration. The Health Minister told the JCHR that she had “looked at issues regarding public health”.44

2. The Joint Council for the Welfare of Immigrants (JCWI) told the JCHR that a race equality impact assessment was particularly important given the nationalities of people who are being refused or charged for treatment, and stated that “there are race implications which have to be tackled by the Department for Health”.45

3. Denial of care to vulnerable migrants may lead to illegal discrimination against asylum seekers through refusing to provide them with healthcare services or by providing lower standards of care.46

4. Healthcare professionals lack skills needed to accurately determine immigration status.47 Identifying those eligible for treatment is difficult and may result in or exacerbate existing discrimination, even against those who are entitled to care.47,48

5. In their tenth report The Treatment of Asylum Seekers, the JCHR reported that “the 2004 Charging Regulations have caused confusion about entitlement, that interpretation of them appears to be inconsistent and that in some cases people who are entitled to free treatment have been charged in error. The threat of incurring high charges has resulted in some people with life-threatening illnesses or disturbing mental health conditions being denied, or failing to seek, treatment. We have heard of many extremely shocking examples.”44

CONCLUSION

A policy of deliberate denial of healthcare, secondary or primary, to undocumented migrants and refused asylum seekers is inhumane and contravenes several international Human Rights agreements. Such a policy would contribute to discrimination against and marginalisation of vulnerable groups with every right to remain in the UK which is entirely out of line with the current Health Bill and NHS Constitution.

February 2009

Memorandum from National Aids Trust

SUMMARY OF RECOMMENDATIONS

Recommendation: The duty of NHS staff not to discriminate and to adhere to equality and human rights legislation should prevent staff from proselytising or offering faith-based services without the specific request of service users.

Recommendation: The duty should prevent healthcare staff from refusing to treat people or trying to dissuade them from undergoing certain treatment, on the grounds of the staff member’s religious beliefs, except for services specified in the statutory provisions on conscientious objection.

INTRODUCTION

1. NAT (National AIDS Trust) is the UK’s leading independent policy and campaigning charity on HIV. NAT develops policies and campaigns to halt the spread of HIV and improve the quality of life of people affected by HIV, both in the UK and internationally.

2. NAT welcomes the chance to submit evidence to the Joint Committee on Human Right’s scrutiny of the Health Bill.

3. NAT’s submission focuses on the duty in the NHS Constitution on healthcare staff not to discriminate and to adhere to equality and human rights legislation in relation to proselytising.

4. NAT notes the JCHR’s questions to Lord Darzi in their letter of 12 February:

Q1. Does the duty of NHS staff not to discriminate and to adhere to equality and human rights legislation prevent staff from proselytising or offering faith-based services without the specific request of service users?

Q2. Does the duty also prevent healthcare staff from refusing to treat people or trying to dissuade them from undergoing certain treatment, on the grounds of the staff member’s religious beliefs, except for services specified in the statutory provisions on conscientious objection?

5. This submission draws attention to relevant experiences of people living with HIV around religion and health service provision, and makes related recommendations.

HIV AND PROSELYTISING

6. Proselytising was raised as an issue of concern in November 2007 by attendees at a workshop looking at stigma and discrimination (organised by NAT and THT for the Sexual Health Independent Advisory Group).

7. People living with HIV reported their experiences of being prayed for because of their status by healthcare staff. They noted that they found this a distressing experience.

8. As HIV can be transmitted sexually, and disproportionately affects gay and bisexual men, people living with HIV may be subject to proselytising from staff who believe either that homosexuality is “sinful” or that HIV is a “punishment” for certain sexual activities.

9. Workshop attendees recommended that the Department of Health should provide clear guidance on the conflict between personal belief and someone’s role as healthcare worker, underlining the importance of not imposing religious views on service users.

10. NAT recognises the importance of considering the rights of healthcare workers but would underline the importance of ensuring religious beliefs are not permitted to intrude on the professional relationship between healthcare worker and service user.

Recommendation: The duty of NHS staff not to discriminate and to adhere to equality and human rights legislation should prevent staff from proselytising or offering faith-based services without the specific request of service users.

11. NAT is not aware of a case where NHS staff have refused to treat people living with HIV because of religious beliefs, but sadly, for the reasons outlined above, this is not inconceivable. For that reason we would make the following recommendation:

Recommendation: The duty should prevent healthcare staff from refusing to treat people or trying to dissuade them from undergoing certain treatment, on the grounds of the staff member’s religious beliefs, except for services specified in the statutory provisions on conscientious objection.

February 2008

Memorandum submitted by the Royal College of General Practitioners

1. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the “voice” of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 36,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

2. The College welcomes the opportunity to comment on the compatibility of aspects of the 2009 Health Bill with the existing human rights framework. The College has identified one area of concern, as outlined below.

3. The provisions for direct payment to patients for purchasing health care services in Clauses 9 to 11 of the Bill give cause for concern as there is arguably potential for discrimination in the amount or quality of care available to different groups of patients. Article 14 of the Convention prohibits discrimination in the enjoyment of rights. Lord Darzi in his letter (paragraph 15) to Andrew Dismore, Chair of the Joint Committee on Human Rights, acknowledges this as an issue as between patients included and not included in pilot schemes for direct payments. But the problem would continue to arise in any continuation of such schemes unless these were nationally homogeneous in their availability. Even then the question would arise of why one group of patients and not another were to be offered this option. The possible implication of
such a scheme is that those patients availing themselves of it would be advantaged over those who did not. This would be particularly true if all the generic services available to patients with that condition remained freely available to them even if their budget for direct payments had been used up.

4. I gratefully acknowledge the significant contribution of Dr Duncan Keeley of the RCGP’s Medical Ethics Committee towards the above comments.

March 2009

Memorandum submitted by Stillhuman Still Here

1. Still Human, Still Here is a coalition of 29 organisations which are campaigning to end the destitution of refused and asylum seekers in the UK. We welcome the opportunity to comment on the human rights issues that relate to the duty in the NHS Constitution on healthcare staff to not discriminate and to adhere to equality and human rights legislation.

2. The NHS Constitution states that: “. . . it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population. Access to NHS services is based on clinical need, not an individual’s ability to pay. NHS services are free of charge, except in limited circumstances sanctioned by Parliament. . .”.

3. The Government’s current policy under which refused asylum seekers (including children, the elderly, victims of torture and other seriously ill and extremely vulnerable people) can be denied secondary healthcare unless they can pay for it is inhumane and is putting asylum seekers’ lives at risk.

4. This policy is, by its very nature, discriminatory and is burdensome for healthcare professionals to administer and enforce. It requires patients to be assessed on their immigration status rather than their clinical need and is resulting in one group (refused asylum seekers) not receiving the care they need to improve their health and life expectancy.

5. We do not consider this policy to be in line with the UK’s international commitments as stated in Articles 2 and 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

REFUSED ASYLUM SEEKERS AND ACCESS TO SECONDARY HEALTHCARE

6. Since April 2004, there has been no free healthcare for refused asylum seekers at hospitals except for emergencies. In practice this means that treatment in an Accident and Emergency department is free, but the costs of all other hospital and specialised medical care are chargeable.

7. This includes pregnant women, cancer patients, diabetics and those needing treatment for HIV/AIDS. Treatment for communicable diseases (except HIV/AIDS), and compulsory mental health care and family planning are the exceptions to this rule and can be provided free of charge, but still may be difficult to access (see below for more details).

8. NHS trusts providing secondary care have to assess whether a patient is liable to pay for treatment and charge accordingly. Only “immediately necessary treatment to save life or prevent a condition from becoming life-threatening” should be provided and even then all treatment is still chargeable later. Where urgent treatment “cannot wait until the patient returns home”, trusts are “strongly advised to seek deposits equivalent to the estimated full costs in advance of providing the treatment”. This is done by the trusts’ overseas visitors managers and trusts must take all reasonable measures to recover debts, including issuing invoices, demands for payment and referral of debts to recovery agencies.

9. In the vast majority of cases, refused asylum seekers will not have any means to pay these bills as they are destitute. In these circumstances, seeking recovery for the costs of treatment causes additional anxiety to vulnerable people and is a waste of NHS resources and taxpayers money.

10. In the first two years following the introduction of the regulations, the Refugee Council worked with dozens of refused asylum seekers who have been denied the healthcare they urgently needed. These cases included:

— Fifteen women and two girls who were charged more than £2,000 for maternity care and in some cases denied that care if they could not pay in advance.

49 As part of the NHS (Charges to Overseas Visitors) (Amendment) Regulations, 2004.
50 This policy is currently being challenged in the Courts. It was successfully challenged in April 2008 (see A v West Middlesex Ntis Trust [2008] EWHC 855), but this ruling has been appealed by the Government.
52 Refugee Council, First do no harm: denying healthcare to people whose asylum claims have failed, June 2006, page 7.
53 For more detail’s see Refugee Council, op cit 2006.
Four people with cancer who were denied treatment. One man with bowel cancer was admitted to A&E, but had an operation cancelled when they realised he could not pay for it. He was told to come back “when his condition deteriorates”.

**Asylum Seekers Access to Primary Healthcare**

11. The Department of Health says that “GP practices have the discretion to accept (refused asylum seekers) as registered NHS patients”. This has led to some confusion over entitlements and led to some GPs refusing to see, let alone treat refused asylum seekers.

12. There are also examples where GP practices have advised asylum seekers to attend the A&E department of the local hospital which is an additional and inappropriate demand on overstretched resources. A victim of rape from Uganda who had been refused asylum sought medical help for serious abdominal pain and bleeding, but was turned away by both her GP and her local trust.

13. Research carried out by Refugee Action found that some 40% of destitute asylum seekers had problems accessing a GP.

**Healthcare Needs of Asylum Seekers**

14. Refused asylum seekers face considerable obstacles in accessing care, including confusion over entitlement and language barriers, but they are a group which have very specific and acute healthcare needs.

15. Many asylum seekers experience mental health problems caused by detention, torture, persecution, witnessing extreme violence or the death of loved ones. Trying to adapt to life in the UK, isolated from friends and family, not speaking the language and living in poverty can cause or exacerbate existing mental health problems.

16. Women asylum seekers face additional health problems in relation to child birth. As a result, asylum seeking pregnant women are seven times more likely to develop complications during childbirth and three times more likely to die than the general population. The current policy increases the risks to this already vulnerable group.

17. NHS guidance states that “maternity services should not be withheld if the woman is unable to pay in advance”. This does not mean that the care is free, but rather that the woman should not be denied the care if she cannot pay for it, although a charge can still be made after treatment.

18. However, this is often not happening in practice. The Refugee Council documented eight cases in which women were told that they had to pay in advance to access maternity care. The Citizens Advice Bureau also documented women being charged £2,500 or more for maternity services (either in advance or for services provided).

19. Asylum seekers’ health needs may arise from trauma and deprivation in their country of origin, but they are being compounded by their isolation and destitution in the UK. Research by Refugee Action found that despite the fact that 80% of destitute asylum seekers were between 21 and 40, 83% of those surveyed said that they had serious health problems since arriving in the UK.

**International Human Rights Law and the Case for a Coherent Policy**

20. The International Covenant on Economic, Social and Cultural Rights (ICESCR), which is ratified by the UK, puts governments under a specific obligation not to limit equal access to healthcare.

21. Article 12 obliges State Parties to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and also obliges States to take the necessary step to: reduce infant mortality and promote the healthy development of children; prevent, treat and control diseases; and create conditions which will provide medical attention to all those in need.

22. Article 12 is not being applied to refused asylum seekers who are being charged or refused access to non-emergency healthcare despite being one of the most vulnerable groups in the UK.

23. The rationale for the current policy was to protect NHS resources from “health tourism”—where foreign nationals travel to the UK for the express purpose of benefiting from free NHS healthcare.

24. However, in 2009, the Royal College of General Practitioners concluded that “There is no evidence that asylum seekers enter the country because they wish to benefit from free healthcare”. It also stated that GPs have a “duty of care to all people seeking healthcare” and “should not be expected to police access to healthcare and turn people away when they are at their most vulnerable.”

54 Royal College of Obstetricians and Gynaecologists, *The 6th report of the confidential enquiry into maternity deaths in the UK: Quoted in Faculty for Public Health, The health needs of asylum seekers, 2008.*

25. The Royal College of Psychiatrists recommended that services should be improved and be available “throughout the asylum process, including those whose claims have failed, whilst they remain legally in the UK”.  

26. The policy to charge refused asylum seekers to access most secondary healthcare is not consistent with our obligations under the ICESCR and requires healthcare professionals to consider a person’s immigration status when their duty of care to their patient should be their only concern. The BMA described this policy as “utterly unacceptable”.  

27. Treatment that prevents or cures illnesses is obviously more efficient and effective than waiting for a condition to deteriorate until it requires emergency care. Restoring refused asylum seekers’ access to secondary healthcare will save lives and ensure efficient use of NHS resources. It is consistent with the ethos of the NHS Constitution and the UK’s international human rights commitments as well as other policy objectives in relation to health, social exclusion, combating HIV/AIDS and the every child matters agenda.

---

Letter from the Chairman to Lord Hunt of Kings Heath, Minister of State for Sustainable Development and Energy Innovation, dated 10 February 2009

The Joint Committee on Human Rights is considering the compatibility of the Marine and Coastal Access Bill with the requirements of human rights law. The issue we are particularly considering is whether the provisions in Part 9 of the Bill concerning the creation of a coastal footpath are compatible with the right of affected people to a fair hearing, both under Article 6 ECHR and the common law of procedural fairness.

The Bill provides an administrative regime for the designation of land for this purpose but makes no provision for a right of appeal to an independent court or tribunal by those with an interest in the land affected. Those affected will have a right to make representations to Natural England before it submits its scheme to the Secretary of State for approval, and again to the Secretary of State before he decides whether or not to approve the scheme. There is no provision, however, for any right of appeal to an independent court or tribunal, either against Natural England’s submitted scheme, or the Secretary of State’s final decision approving the scheme, with or without modifications.

The Secretary of State’s decision approving the coastal access scheme will amount to the determination of the “civil rights” of those with an interest in the land affected, within the meaning of Article 6(1) ECHR. As interpreted by the European Court of Human Rights, that Article requires there to be access to a court of full jurisdiction to challenge administrative determinations of civil rights. The availability of judicial review, in conjunction with other opportunities to challenge the determination, is capable of satisfying that requirement in some cases. However, where the determination of the civil right requires the determination of prior factual questions, the decision of the European Court of Human Rights in Tsfayo v UK makes clear that the availability of judicial review alone is not sufficient: there must be an independent court or tribunal with jurisdiction to determine the factual question in issue.

The Government appears to accept in the Explanatory Notes to the Bill (para. 1027) that the Secretary of State’s decision approving the coastal access scheme will determine civil rights, so that Article 6(1) ECHR applies. It also accepts that the Secretary of State’s decision will be “a mixed decision of fact and policy”. However, it argues that “the procedures . . . set out in the Bill contain a high policy content, and will comply with Article 6 through the availability of judicial review”. This, taken together with the inclusion of other procedural safeguards in Part 9 (the opportunity to make representations before the making of the decision by the Secretary of State), renders the provisions compatible with Article 6 ECHR in the Government’s view.

We have difficulty at present understanding how the provisions in the Bill can be compatible with Article 6 ECHR in the light of the decision in Tsfayo. A person with an interest in the land affected may wish to dispute any number of factual questions on which the Secretary of State’s determination rests but has no opportunity to do so before an independent decision-maker. If, for example, the person with the interest in land wished to dispute Natural England’s and the Secretary of State’s views on whether the land in question was unstable due to erosion, perhaps with their own expert’s report, they would have no opportunity to do so before an independent party. The High Court of judicial review would not enter into such factual questions. This is the role played by the Planning Inspectorate in many other comparable areas of decision-making, but in the Bill as drafted there is no role for the Planning Inspectorate.

We note that in all comparable legislation providing for the designation of public rights of access over private land there is provision for a right of appeal by those affected to an independent court or tribunal. We recognise that there may be an argument that the existing appeal mechanism in the Countryside and Rights of Way Act 2000 may not be appropriate, because the Bill is concerned with a national path. We accept that there may be a need for any right of appeal to the Planning Inspectorate in relation to a particular piece of land to take place prior to the Secretary of State’s decision on the national scheme as a whole. However we do not consider this to be an insuperable obstacle to providing a meaningful right of access to

---

56 The Royal College of Psychiatrists (RCP), Improving services for refugees and asylum seekers: position statement, 2007.
57 For more information contact: Mike Kaye, Advocacy Manager for Still Human Still Here on 020 7033 1600 or e-mail mike.kaye@amnesty.org.uk
an independent body. We note that there is provision for inquiries by the Planning Inspectorate in relation to proposed ministerial orders in other contexts, such as that in Schedule 1 to the National Parks and Countryside Act 1949 (requiring the Minister to cause a local inquiry to be held where there are objections to certain draft orders such as orders designating a National Park).

I would therefore be grateful if you would now consider amending the Bill to ensure that those affected by the coastal access scheme have an opportunity to make arguments about factual questions to an independent court or tribunal, preferably the Planning Inspectorate. If, after such consideration, you decide not to amend the Bill, please provide a detailed explanation as to why existing rights of access to the Planning Inspectorate in other contexts, such as the National Parks and Countryside Act 1949 and the Countryside and Rights of Way Act 2000, are not possible or appropriate in the context of coastal access.

I would be grateful for your response to the above questions by 24 February 2009.

Andrew Dismore MP
Chair, Joint Committee on Human Rights

---

Letter from Lord Hunt of Kings Heath, Minister for Sustainable Development and Energy Innovation, dated 27 February 2009

Thank you for your letter of 10 February concerning the compatibility of the Marine and Coastal Access Bill with the requirements of human rights law. The Committee indicated that the issue of particular concern to it is whether the provisions of Part 9 of the Bill are compatible with the right of affected people to a fair hearing under Article 6 ECHR and the common law of procedural fairness.

As the Committee notes, the Government agrees with the Committee that the Secretary of State’s decision approving the coastal access scheme will determine civil rights, and that Article 6 applies. The Government also recognises that the decision must be based on a proper appreciation of the factual circumstances, most particularly where objections have been received by a landowner in relation to a particular stretch of the route which affects his land, and that there may well be certain questions of fact to be determined as preliminary issues before a proper appreciation of the position is possible. The description of the decision as “a mixed decision of fact and policy” was intended as a shorthand way of referring to this, but as a paraphrase perhaps does not fully articulate the point that the approval decision is essentially one of policy, but one predicated on an assessment of the facts which in some cases is likely to be reached by the determination of certain disputed questions of fact. In other words, the approval decision is a policy decision which is the final stage of a complex process of consideration.

The Committee indicated that its concern in relation to Article 6 principally stems from the case of Tsfayo v UK in the European Court of Human Rights. The Court held in that case that, in relation to what it termed “a simple question of fact”, there was a breach of Article 6 where that issue was not determined at first instance by an independent tribunal and the only available mechanism for review was the power of the High Court on judicial review to quash a decision of the administrative decision-maker (in this instance, the Housing Benefit Review Board) on certain limited grounds such as the absence of evidence to support the factual findings of the decision-maker, that its findings were plainly untenable, or that it had misunderstood or been ignorant of an established and relevant fact. In particular the Court referred to an absence of jurisdiction to rehear the evidence or substitute its own views as to the applicant’s credibility.

The determination in question in Tsfayo was as to whether the applicant had “good cause” for delay in making a claim for housing and council tax benefits. This was an issue which the Court characterised as “a simple question of fact”. It turned on the credibility of evidence submitted by the applicant that the delay was the result of her lack of familiarity with the benefits system and her poor English, and that she had not realised that her housing benefit had ceased until she received notice from her landlord seeking repossession of her flat, and (not at first understanding the correspondence) had sought advice from the local authority’s advice office.

The Court contrasted this “simple question of fact” with a case of the kind considered by the House of Lords in Runa Begum v London Borough of Tower Hamlets (2003) UKHL 5 in which the findings of fact were “only staging posts on the way to the much broader judgements”, in Runa Begum judgements “concerning local conditions and the availability of alternative accommodation, which the housing officer had the specialist knowledge and experience to make”. The Court went on to distinguish cases such as Bryan and Runa Begum, where “the issues to be determined required a measure of professional knowledge or experience and the exercise of administrative discretion pursuant to wider policy aims” or where the factual findings were “merely incidental to the reaching of broader judgements of policy or expediency which it was for the democratically accountable authority to take”.

The Court made no criticism of the decisions in Bryan and Runa Begum, and the clear implication from the terms in which it distinguished those cases is that it did not disagree with their approach.

In Runa Begum Lord Bingham said (at paragraph 56):
“The key phrases in the judgments of the Strasbourg court which describe the cases in which a limited review of the facts is sufficient are “specialised areas of law” (Bryan v UK (1996) 21 EHRR 342 at 361 (para 47)) and “classic exercise of administrative discretion” (Kingsley v UK (2001) 33 EHRR 288 at 302 (para 53)). What kind of decisions are these phrases referring to? I think that one has to take them together. The notion of a specialised area of the law should not be taken too literally. ... And when the court in Kingsley spoke of the classic exercise of administrative discretion, it was referring to the ultimate decision as to whether Kingsley was a fit and proper person and not the particular findings of fact which had to be made on the way to arriving at that decision. In the same way, the decision as to whether the accommodation was suitable for Runa Begum was a classic exercise of administrative discretion, even though it involved preliminary findings of fact” (emphasis added).

In R (on the application of Wright and others) v Secretary of State for Health (2009) UKHL 3, Lady Hale, giving the leading speech, summarised the case law in the light of Tsieyo as follows:

“23. The difficult question is how the requirements of article 6(1) apply in cases such as this. It is a well-known principle that decisions which determine civil rights and obligations may be made by the administrative authorities, provided that there is access to an independent and impartial tribunal which exercises “full jurisdiction”. Bryan v United Kingdom (1995) 21 EHRR 342, applied domestically in R (Alconbury Developments Ltd) v Secretary of State for the Environment, Transport and the Regions [2003] 2 AC 295 and Runa Begum v Tower Hamlets London Borough Council 2003] 2 AC 430. What amounts to “full jurisdiction” varies according to the nature of the decision being made. It does not always require access to a court or tribunal even for the determination of disputed issues of fact. Much depends upon the subject-matter of the decision and the quality of the initial decision making process. If there is a “classic exercise of administrative discretion”, even though determinative of civil rights and obligations, and there are a number of safeguards to ensure that the procedure is in fact both fair and impartial, then judicial review may be adequate to supply the necessary access to a court, even if there is no jurisdiction to examine the factual merits of the case. The planning system is a classic example (Alconbury); so too, it has been held, is the allocation of “suitable” housing to the homeless (Runa Begum); but allowing councillors to decide whether there was a good excuse for a late claim to housing benefit was not (Tsieyo v United Kingdom (Application No 60860/00) (unreported) 14 November 2006.”

The principles which can be derived from these cases are as follows:

(a) If there is a “classic exercise of administrative discretion”, even though determinative of civil rights and obligations, and there are a number of safeguards to ensure that the procedure is in fact both fair and impartial, then judicial review may be adequate to supply the necessary access to a court, even if there is no jurisdiction to examine the factual merits of the case.

(b) Subject to the points below, the scope of judicial review, as it has traditionally been conceived, is unlikely to suffice for the purposes of compliance with Article 6 in relation to determinations on a simple question of fact.

(c) Where the findings of fact are “only staging posts on the way to much broader judgements” or “merely incidental to the reaching of broader judgements of policy or expediency” which it is “for the democratically accountable authority to take”, judicial review is likely to suffice in relation to a classic exercise of administrative discretion even though it involves preliminary findings of fact.

(d) Where the determinations of fact require “a measure of professional knowledge of experience and the exercise of administrative discretion pursuant to wider policy aims”, judicial review is again likely to suffice.

The Government considers that the approval decision of the Secretary of State in relation to proposals for a coastal route is of the type properly characterised as a classic exercise of administrative discretion, and that the findings of fact that contribute to the factual assessment which underlies the Secretary of State’s decision are only staging posts on the way to much broader judgements of policy or expediency, and are merely incidental to reaching these broader judgements. Judicial review of the approval decision will be available in the ordinary way.

The Government also considers that Part 9 of the Bill makes provision for certain procedural safeguards, in particular consultation by Natural England of persons with a relevant interest in affected land before preparing a report (new section 55D(4) of the 1949 Act), the giving of notice of reports to these persons, the consideration by Natural England of representations made by these persons and the consideration by the Secretary of State of those representations together with Natural England’s comments on them.

It is, however, now sufficiently clear that it is not the case that safeguards of the kind considered by the courts as attaching to the functions of inspectors are essential for the acceptance of a limited review of fact by the appellate tribunal: see the clarification provided by Lord Hoffman in Runa Begum at paragraph 40, and the discussion by Simon Brown LJ in R (on the application of Adlard and others) v Secretary of State for the Environment, Transport and the Regions (2002) AER 267 at paragraphs 18–31.

The Government has also noted that there have been a number of recent decisions of the Court of Appeal in which judicial review alone has been found to be adequate to secure compliance with Article 6, notwithstanding the decision in Tsieyo. In particular, in the case of Ali and others v Birmingham City
Council (2008) EWCA Civ 1228, the Court of Appeal held that the decision of the House of Lords in Runa Begum applied to a determination under Part VII of the Housing Act 1996, where the sale issue was a simple question of fact as to whether or not the appellants had received a letter, as distinct from an issue of fact which required the application of specialist knowledge or policy considerations. Thomas LJ stated in his judgment that the Strasbourg Court in Tsfayo had relied on the decision in Runa Begum in reaching its conclusion, and said nothing that cast doubt on that decision. He also made it clear that each of those two cases turned upon a careful examination of the whole of the statutory scheme relevant to the particular case.

For these reasons the Government considers that Part 9 of the Bill is compatible with Article 6. However, the Government has also had regard to certain domestic authorities which do not appear to be affected by the decision of the European Court of Human Rights in Tsfayo.

In particular, the Government has noted the decision of Forbes J in R (Friends of Provident Life Office) v Secretary of State for the Environment that judicial review may suffice in relation to a judgement by the decision-maker as to the progress or outcome of some future event or events, for example the impact of a particular development on a particular locality. This would appear to be of relevance where the issues of fact that arise for determination in relation to a proposed coastal route include questions as to the impact of the route on a particular landowner.

The Government has also noted authorities to the effect that, where judicial review would otherwise be insufficient, the court on judicial review is bound to exploit such fact-finding powers as it possesses (which may for example include disclosure of documents and cross-examination) to ensure compliance with Article 6 (see for example Wilkinson v Broadmoor Hospital (2002) 1WLR 419, cited with approval by the Court of Appeal in T-Mobile (UK) Ltd v Office of Communications (2008) AER 131, (2008) EWCA Civ 1373.

As regards the requirements of the common law of procedural fairness, the Government’s view is that these are satisfied in this case by the Bill’s provision for the consideration of representations by the Secretary of State (in addition to earlier consultation before the preparation of the report).

I hope that this is helpful.
## List of Reports from the Committee during the current Parliament

<table>
<thead>
<tr>
<th>First Report</th>
<th>The UN Convention on the Rights of Persons with Disabilities</th>
<th>HL Paper 9/HC 93</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fourth Report</td>
<td>Legislative Scrutiny: Political Parties and Elections Bill</td>
<td>HL Paper 23/ HC 204</td>
</tr>
<tr>
<td>Eighth Report</td>
<td>Legislative Scrutiny: Coroners and Justice Bill</td>
<td>HL Paper 57/HC 362</td>
</tr>
<tr>
<td>Tenth Report</td>
<td>Legislative Scrutiny: Policing and Crime Bill</td>
<td>HL Paper 68/HC 395</td>
</tr>
<tr>
<td>Eleventh Report</td>
<td>Legislative Scrutiny: 1) Health Bill and 2) Marine and Coastal Access Bill</td>
<td>HL Paper 69/HC 396</td>
</tr>
<tr>
<td>Twelfth Report</td>
<td>Disability Rights Convention</td>
<td>HL Paper 70/HC 397</td>
</tr>
<tr>
<td>Thirteenth Report</td>
<td>UK Libya Prisoner Transfer Treaty</td>
<td>HL Paper 71/HC 398</td>
</tr>
</tbody>
</table>

### Session 2007-08

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Report</td>
<td>Counter-Terrorism Policy and Human Rights: 42 days</td>
<td>HL Paper 23/HC 156</td>
</tr>
<tr>
<td>Third Report</td>
<td>Legislative Scrutiny: 1) Child Maintenance and Other Payments Bill; 2) Other Bills</td>
<td>HL Paper 28/ HC 198</td>
</tr>
<tr>
<td>Fifth Report</td>
<td>Legislative Scrutiny: Criminal Justice and Immigration Bill</td>
<td>HL Paper 37/HC 269</td>
</tr>
<tr>
<td>Sixth Report</td>
<td>The Work of the Committee in 2007 and the State of Human Rights in the UK</td>
<td>HL Paper 38/HC 270</td>
</tr>
<tr>
<td>Report Number</td>
<td>Title</td>
<td>Paper Reference</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Eighth Report</td>
<td>Legislative Scrutiny: Health and Social Care Bill</td>
<td>HL Paper 46/HC 303</td>
</tr>
<tr>
<td>Ninth Report</td>
<td>Counter-Terrorism Policy and Human Rights (Eighth Report): Counter-Terrorism Bill</td>
<td>HL Paper 50/HC 199</td>
</tr>
<tr>
<td>Eleventh Report</td>
<td>The Use of Restraint in Secure Training Centres</td>
<td>HL Paper 65/HC 378</td>
</tr>
<tr>
<td>Fourteenth Report</td>
<td>Data Protection and Human Rights</td>
<td>HL Paper 72/HC 132</td>
</tr>
<tr>
<td>Fifteenth Report</td>
<td>Legislative Scrutiny</td>
<td>HL Paper 81/HC 440</td>
</tr>
<tr>
<td>Sixteenth Report</td>
<td>Scrutiny of Mental Health Legislation: Follow Up</td>
<td>HL Paper 86/HC 455</td>
</tr>
<tr>
<td>Seventeenth Report</td>
<td>Legislative Scrutiny: 1) Employment Bill; 2) Housing and Regeneration Bill; 3) Other Bills</td>
<td>HL Paper 95/HC 501</td>
</tr>
<tr>
<td>Nineteenth Report</td>
<td>Legislative Scrutiny: Education and Skills Bill</td>
<td>HL Paper 107/HC 553</td>
</tr>
<tr>
<td>Twentieth Report</td>
<td>Counter-Terrorism Policy and Human Rights (Tenth Report): Counter-Terrorism Bill</td>
<td>HL Paper 108/HC 554</td>
</tr>
<tr>
<td>Twenty-First Report</td>
<td>Counter-Terrorism Policy and Human Rights (Eleventh Report): 42 days and Public Emergencies</td>
<td>HL Paper 116/HC 635</td>
</tr>
<tr>
<td>Twenty-Fourth Report</td>
<td>Counter-Terrorism Policy and Human Rights: Government Responses to the Committee’s Twentieth and Twenty-first Reports of Session 2007-08 and other correspondence</td>
<td>HL Paper 127/HC 756</td>
</tr>
<tr>
<td>Twenty-sixth Report</td>
<td>Legislative Scrutiny: Criminal Evidence (Witness Anonymity) Bill</td>
<td>HL Paper 153/HC 950</td>
</tr>
<tr>
<td>Twenty-seventh Report</td>
<td>The Use of Restraint in Secure Training Centres: Government Response to the Committee’s Eleventh Report</td>
<td>HL Paper 154/HC 979</td>
</tr>
<tr>
<td>Twenty-eighth Report</td>
<td>UN Convention against Torture: Discrepancies in Evidence given to the Committee About the Use of Prohibited Interrogation Techniques in Iraq</td>
<td>HL Paper 157/HC 527</td>
</tr>
<tr>
<td>Report</td>
<td>Title</td>
<td>Publication</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Twenty-ninth Report</td>
<td>A Bill of Rights for the UK?: Volume II Oral and Written Evidence</td>
<td>HL Paper 165-II/HC 150-II</td>
</tr>
</tbody>
</table>

**Session 2006–07**

<table>
<thead>
<tr>
<th>Report</th>
<th>Title</th>
<th>Publication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Report</td>
<td>Legislative Scrutiny: First Progress Report</td>
<td>HL Paper 34/HC 263</td>
</tr>
<tr>
<td>Fourth Report</td>
<td>Legislative Scrutiny: Mental Health Bill</td>
<td>HL Paper 40/HC 288</td>
</tr>
<tr>
<td>Fifth Report</td>
<td>Legislative Scrutiny: Third Progress Report</td>
<td>HL Paper 46/HC 303</td>
</tr>
<tr>
<td>Sixth Report</td>
<td>Legislative Scrutiny: Sexual Orientation Regulations</td>
<td>HL Paper 58/HC 350</td>
</tr>
<tr>
<td>Seventh Report</td>
<td>Deaths in Custody: Further Developments</td>
<td>HL Paper 59/HC 364</td>
</tr>
<tr>
<td>Tenth Report</td>
<td>The Treatment of Asylum Seekers: Volume II Oral and Written Evidence</td>
<td>HL Paper 81-II/HC 60-II</td>
</tr>
<tr>
<td>Twelfth Report</td>
<td>Legislative Scrutiny: Fifth Progress Report</td>
<td>HL Paper 91/HC 490</td>
</tr>
<tr>
<td>Thirteenth Report</td>
<td>Legislative Scrutiny: Sixth Progress Report</td>
<td>HL Paper 105/HC 538</td>
</tr>
<tr>
<td>Fifteenth Report</td>
<td>Legislative Scrutiny: Seventh Progress Report</td>
<td>HL Paper 112/HC 555</td>
</tr>
<tr>
<td>Seventeenth Report</td>
<td>Government Response to the Committee’s Tenth Report of this Session: The Treatment of Asylum Seekers</td>
<td>HL Paper 134/HC 790</td>
</tr>
<tr>
<td>Report</td>
<td>Description</td>
<td>Paper Number</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Twentieth Report</td>
<td>Highly Skilled Migrants: Changes to the Immigration Rules</td>
<td>HL Paper 173/HC 993</td>
</tr>
<tr>
<td>Twenty-first Report</td>
<td>Human Trafficking: Update</td>
<td>HL Paper 179/HC 1056</td>
</tr>
</tbody>
</table>