Neutral Citation Number: [2018] EWHC 3392 (Admin)

Case No: CO/4870/2017

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/12/2018

Before :

The Honourable Mr Justice Lewis

- -

Between :

The Queen (on the application of MP)	**Claimant**
- and -	
Secretary of State for Health and Social Care	**Defendant**
Equality and Human Rights Commission	**Intervener**

- -
- -

Jason Coppel Q.C. and Christopher Knight (instructed by **Deighton Pierce Glynn**) for the **Claimant**
Andrew Henshaw Q.C., Joe Barrett and Daniel Isenberg (instructed by **Government Legal Department**) for the **Defendant**

Hearing dates: 10 and 11 July 2018

Approved Judgment

THE HONOURABLE MR JUSTICE LEWIS:

INTRODUCTION

1. This is a claim for judicial review of the National Health Service (Charges to Overseas Visitors) Amendment Regulations 2017 ("the 2017 Regulations"). By those regulations, amendments were made to the regulations governing the charging of those not ordinarily resident in the United Kingdom for certain treatment. In brief, for present purposes, the 2017 Regulations provided that (1) charges would need to be paid in advance of the provision of treatment which was not urgent or immediately necessary (2) NHS trusts were required to record the fact that a person was an overseas visitor liable to be charged and (3) liability to pay charges was extended to cover certain NHS-funded services provided in the community (whereas charging previously related to services provided by NHS bodies in or under the direction of a hospital).

2. The claimant contends that the first two changes were introduced without public consultation and were unlawful for that reason. The claimant also contends that the defendant failed to discharge his duties under section 149 of the Equality Act 2010 ("the 2010 Act"), or his duties under section 1B and 1C of the National Health Service Act 2006 ("the 2006 Act") to have due regard to certain matters before making the 2017 Regulations.

3. Permission to bring a claim on a third ground, namely that the defendant had failed to make sufficient enquiries about the alleged deterrent effect of the changes as required by common law or section 1A of the 2006 Act, was refused. The claimant applied at the hearing for that refusal to be reconsidered and for permission to be granted on that third ground.

4. The claimant is a 58 year-old man who, sadly, suffers from a form of blood cancer and required medical treatment. Fortunately, it transpired at the hearing on 10 July 2018 that the claimant had had the necessary treatment prior to the hearing and the urgency had been removed. Furthermore, I was informed at the hearing that the First-tier Tribunal (Immigration and Asylum Chamber) had allowed an appeal against a decision by the Secretary of State for the Home Department that the claimant did not have leave to enter or remain in the United Kingdom and had determined that the claimant had a right of abode in the United Kingdom. I was told in written submissions dated 31 October 2018 that indefinite leave to remain had not been granted at that date but was expected to be granted by the end of November 2018. The consequence of that would be, it seems, that the claimant would not in future be liable to be charged for NHS-funded services in any event. It has not been suggested that the actual provision of medical treatment or the imminent grant of indefinite leave to remain rendered this challenge academic.

5. It also transpired at the hearing of the claim in July 2018 that the defendant had not provided all the relevant facts relating to the claim that the making of certain changes involved a breach of a legitimate expectation arising from a past practice of public consultation. Permission having been granted, the defendant is under an obligation to provide sufficient information to enable the court to assess the challenge. That obligation has been recognised since at least 1986, see *R v Lancashire County Council ex p. Huddleston* [1986] 2 All E.R. 941. The defendant had, it seems, understood, or

decided to treat, the claim as a claim that an expectation arose out of a practice of consultation based on consultations conducted in 2010, 2013 and 2015. I doubt, on a fair reading of the claim form, that the claim was so limited. In any event, if a defendant understands, or chooses to read, the claim in a limited way, and thereafter limits the information provided pursuant to its duty of candour accordingly, it is appropriate for a defendant to tell the court in its evidence what it has done. Ideally, that will enable any issues in relation to disclosure to be dealt with in advance of the hearing. In the present case, the course taken by the defendant only emerged at the hearing itself and was not apparent from its evidence. In the event, that necessitated an adjournment to enable the defendant to provide relevant evidence. By a consent order dated 16 October 2018, a timetable was fixed to enable the parties to make submissions on that evidence by the end of October 2018. A hearing was fixed for 22 November 2018 to hear further oral submissions but the parties indicated that they considered that they had had sufficient opportunity to make submissions in writing and the hearing was, therefore, not required.

THE FACTUAL BACKGROUND – REGULATIONS MADE BETWEEN 1989 AND 2015

6. In view of the claim that there was a past practice of public consultation giving rise to an obligation to conduct a public consultation before making the changes relating to advance payment and record keeping, it is necessary to set out briefly the background relating to the way in which regulations providing for charging non-residents for NHS medical treatment have been made and amended. A fuller description is set out in the fourth witness statement of Ms Mia Snook.

7. Regulations introducing charging of overseas visitors were made in 1982. There was consultation with specific interested bodies on the details of the proposed scheme but there was no consultation with the public generally.

8. Between 1982 and 1989, amendments were made on various occasions to the 1982 Regulations. These amendments included, by way of example, increases in 1983 and 1984 in the prescribed charges for services. They also dealt with other matters.

9. The 1982 Regulations were replaced in 1989 with a new set of regulations. There was no public consultation on the proposed 1989 regulations which, it seems, largely consolidated the 1982 regulations and the amendments made to them.

10. Between 1989 and 2003, amendments were made to the 1989 regulations on various occasions. These included, by way of example, amendments in 1994 which, amongst other things, removed the exemption from charging for services provided in a dental or ophthalmic emergency department. There was no public consultation on the changes made between 1989 and 2003.

11. In 2003, the defendant undertook a public consultation for the first time. He consulted on seven proposed amendments to the category of persons exempt from charging. Amendments giving effect to the seven proposed changes were made by regulation in 2004. The amending regulations made in 2004 also made certain changes which had not been the subject of consultation in 2003. These were changes exempting accident and emergency services provided at walk-in centres from charges, providing power to exempt specified overseas visitors from charging on humanitarian grounds and adding one medical condition to the list of conditions exempt from charges.

12. There was intended to be a public consultation in 2004 on whether to exempt treatment for a particular medical condition (Severe Acute Respiratory Syndrome or SARS) from charging but, it seems, the consultation was never carried out although SARS was added to the list of conditions exempt from charges.

13. A public consultation was carried out in 2004 on, amongst other things, whether to charge non-residents for NHS primary medical services. Following consultation, the defendant decided not to make any changes to charging for primary care.

14. Amendments to the 1989 regulations were made in 2004. Some of these had been the subject of the public consultation in 2003. Some had not. Amendments were also made in 2006, 2008 and 2009. These were not the subject of a public consultation (although, on it seems one occasion, other government departments were consulted).

15. In 2010, the defendant carried out a public consultation on five main areas concerning charging non-residents. These included (but were not limited to) consolidating the 1989 regulations, whether new guidance should be issued on certain topics, exemptions, and the provision of personal information by overseas visitors. The departmental response to the consultation indicated that two further modifications, not the subject of public consultation, would be included in any amendments, namely to exempt participants in the 2012 Olympic Games from charges and redefining the circumstances in which the exemption for treatment provided in connection with pandemic flu arose. The 1989 regulations were replaced by regulations made in 2011. These regulations also included the matters which were the subject of public consultation in 2010 and the two matters (the changes relating to participants in the 2012 Olympic Games and pandemic flu) which had not been the subject of public consultation.

16. In 2013, the defendant undertook a public consultation on migrant access and their financial contribution to NHS provision in England. The consultation was entitled "Sustaining services, ensuring fairness". The response of the Department of Health to that consultation was published in December 2013. The National Health Service (Charges to Overseas Visitors) Regulations 2015 ("the 2015 Regulations") were made setting out the basic framework for charging overseas visitors described below.

THE LEGISLATIVE FRAMEWORK

The Statutory Provisions

17. The power to charge for services provided in England to non-residents is currently contained in section 175 of the 2006 Act which provides that:

> "175 Charges in respect of non-residents
>
> "(1) Regulations may provide for the making and recovery, in such manner as may be prescribed, of such charges as the Secretary of State may determine in respect of the services mentioned in subsection (2).
>
> "(2) The services are such services as may be prescribed which are–
>
> (a) provided under this Act, and

> (b) provided in respect of such persons not ordinarily resident in Great Britain as may be prescribed.
>
> (3) Regulations under this section may provide that the charges may be made only in such cases as may be determined in accordance with the regulations.
>
> "(4) The Secretary of State may calculate charges under this section on any basis that he considers to be the appropriate commercial basis."

18. Section 1A of the 2006 Act provides that the Secretary of State must exercise his functions in relation to the health service with a view to securing continuous improvement in the quality of services provided to individuals in connection with the prevention, diagnosis or treatment of illness or the protection or improvement of public health. Section 1B of the 2006 Act provides that the Secretary of State must have regard to the NHS Constitution when exercising functions. Section 1C of the 2006 Act provides:

> "1C Duty as to reducing inequalities
>
> "In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service."

The 2015 Regulations

19. The 2015 Regulations, as originally enacted prior to the amendments made by 2017 Regulations, provided as follows. First, the basic obligation to recover charges from overseas visitors is provided for in regulation 3(1) of the 2015 Regulations in the following terms:

> "3.— Obligation to make and recover charges
>
> " (1) Where the condition specified in paragraph (2) is met, a NHS relevant body must make and recover charges for any relevant services it provides to an overseas visitor from the person liable under regulation 4 (liability for payment of charges)."

20. The person liable to pay the charges was "the overseas visitor in respect of whom the services are provided" (subject to certain exceptions): see regulation 4 of the 2015 Regulations. An overseas visitor was defined as "a person not ordinarily resident in the United Kingdom": see regulation 2 of the 2015 Regulations. There were exemptions from charging for refugees, asylum-seekers and looked after children: see regulation 15 of the 2015 Regulations.

21. The relevant services, that is, the services for which an NHS body must levy charges, were accommodation, services or facilities provided under the 2006 Act (subject to exceptions for primary medical, dental, and ophthalmic services): see regulation 2 of the 2015 Regulations. There were further exceptions. Charges could not, for example, be made for accident or emergency services, or for services provided in connection with certain specified diseases set out in Schedule 1 to the 2015 Regulations: see regulation 9 of the 2015 Regulations. Other services could not be charged for including by virtue of regulation 2 of the 2015 Regulations:

> "(b) services provided otherwise than at, or by staff employed to work at, or under the direction of, a hospital."

22. This last exemption (together with the provision that only NHS bodies could charge) meant, in effect, that facilities or services provided in the community were not liable to be charged for as, usually, services provided in the community (by way of example only, services such as those connected with treatment of drug or alcohol addiction) would not be provided by staff employed to work at a hospital or under the direction of such staff.

23. Section 2 of the 2006 Act provides for the Secretary of State to do anything which is calculated to facilitate or is conducive or incidental to the discharge of any function conferred by that Act. That includes a power to give guidance. In general terms, a person exercising functions would have to have regard to the guidance and would be expected to give good reasons for departing from any relevant applicable guidance: see *R (Fisher) v North Derbyshire Health Authority* [1997] EWHC 675 (Admin).

24. Relevant bodies have an implied power to require payment in advance for services which are chargeable under regulations made under section 175 of the 2006 Act: see *R v Hammersmith Hospitals NHS Trust ex p. Reffell* (2001) 4 C.C.L.R. 159. The Secretary of State has given guidance since 1989 indicating that health authorities should seek deposits, or payments, from overseas visitors of the likely amount of the hospital charges for which would be liable before non-urgent treatment is provided. The 2011 Charging Guidance provided that:

> "Non-urgent treatment should not be provided unless the estimated full charge is received in advance of payment".

THE 2017 REGULATIONS

25. The 2017 Regulations which are the subject of this challenge amend the 2015 Regulations. In view of the grounds of challenge, it is necessary to set out in detail the process by which they came to be made.

The Consultation Paper

26. In December 2015, the government undertook a public consultation on the extension of charging overseas visitors and migrants using the NHS in England. The consultation document was entitled "Making a fair contribution". The paper noted that the aim was to extend charging of overseas visitors and migrants. It indicated that it was consulting on how best to do that, including exploring changes in primary medical care, secondary care, community healthcare and residency requirements. The consultation paper noted that the government intended to:

> "continue to mitigate any adverse impact these proposals might have on public health protection and health inequalities. This includes consideration of those who may not be able to provide evidence of residency and might therefore be assumed to be chargeable, or might fail to seek necessary care. The most important mitigations are that GP consultations will remain free to all, and immediately

> necessary and urgent treatment must always be provided. We will also provide clear guidance on implementation to NHS staff".

27. The overarching principles underlying the system were described, in summary, as ensuring (1) access for all in need including access to immediately necessary treatment (2) that everybody made a fair contribution (3) that the system was workable and efficient and (4) that the system did not increase inequalities. One of the areas which was consulted upon was the provision of services by non-NHS providers of NHS-funded treatment outside a hospital. Section 11 of the consultation document explained that the 2015 Regulations (as then in force) only required NHS bodies to make charges and noted that non-NHS bodies providing NHS-funded services were not entitled to charge. Further, it noted that there was an exemption so that services provided otherwise than by staff employed to work at or under the direction of a hospital could not be charged for. The consultation paper noted that the proposal was that NHS-funded services provided by non-NHS providers and those providing out of hospital care (irrespective of who provided treatment or care) would be chargeable.

28. The consultation paper did not include consultation on requiring payment in advance for services which were chargeable under the 2015 Regulations nor on any requirement to record a person's status as an overseas visitor against that person's NHS number.

Additional Material

The Impact Assessment

29. An impact assessment prepared in November 2015 had also referred to the need to identify any potential for worsening access to healthcare in a way which could affect some groups of individuals disproportionately. It noted that the proposals largely mitigated that risk in three main ways, namely, retaining free access to GP and nurse consultations, providing that no person should be denied timely treatment necessary to prevent risks to their life or permanent health, and ensuring exemptions from charging for vulnerable groups.

The Prederi Review

30. The Department commissioned a review by a company called Prederi Ltd. of the evidence submitted by those who responded to the consultation paper. A report on the review was submitted in April 2016. The report should be read fairly and in its entirety. There is an executive summary. That sets out the limitations on the conclusions it was able to draw and, under a heading "findings", the report contained the following:

> "Despite these limitations some general findings have emerged.
>
> "There was no evidence to suggest that protected groups in the ordinarily resident UK population covered by the Public Sector Equality Duty are expected to be adversely affected by the proposals, with the exception that people who may be perceived to be 'foreign' may experience greater challenges to their right to use NHS services, depending on how the proposals are implemented

> "Visitor health (as distinct from migrant health) was not an issue raised in the consultation responses; there was only one report in the literature searches.
>
> "There were few, if any, issues raised about the impact of the proposals on the protected groups in the 'mainstream' migrant population in the consultation and these did not feature significantly in the literature searches.
>
> "Among the other vulnerable groups, there is evidence of health inequalities for 'undocumented migrants' and the challenges faced accessing services in a residence-based system, including access for gypsy and traveller people.
>
> "In relation to 'irregular' or 'undocumented' migrants, there were particular issues found relating to children, pregnancy and maternity.
>
> "In relation to 'irregular' or 'undocumented' migrants, there was considerable evidence about access to primary care, the gatekeeper to most NHS services, and the extra barriers that the proposals could present in practice, even though some groups would be technically exempt from charges.
>
> "Some 'irregular' migrants may suffer from the cumulative effect of deprivation, homelessness, poor English, illiteracy and discrimination creating a further barrier to accessing health services. Although potentially marginal, and possibly perceived rather than real, these changes could be the 'straw that breaks the camel's back'".

31. The Prederi review noted other concerns. The report then sets out the proposals and the evidence found about their general impact in a chart and described the detailed results in the main body of the report.

Other material

32. Other material was generated during the review. These included an evaluation of the costs recovery programme by IPSOS. At various stages, equality impact assessments were prepared (and two of these are discussed below). It is not necessary and would be disproportionate to discuss in this judgment each document produced, or referred to, as part of the process resulting in the changes which are the subject of this claim.

The Department's Response to the Consultation Responses

33. The Department's response to the consultation responses indicated that the defendant proposed to amend the 2015 Regulations to provide, amongst other things, that overseas visitors who were liable to be charged for medical treatment provided in hospitals would also be charged for primary medical care, that is medical care provided in the community (except GP and nurse consultations). The consultation response noted that:

> "There were also concerns across all proposals from those who disagreed with them due to the possible negative impact on the health of those individuals who might decide not to take up NHS care, the impact on the public's health if people did not receive treatment for infectious diseases and the impact on NHS staff of having to operate charging rules in areas of care not used to doing so".

34. The consultation said that, in response, it proposed to extend charging in a staged way. The government was still considering the points raised in relation to accident and emergency services and was exploring the feasibility of implementing that

proposal and would respond to those points later. The response indicated that it was intended to amend the law with effect from 2 April 2017 in the following ways:

> "NHS secondary and community care services provided outside hospitals, and
>
> NHS-funded secondary care delivered by non-NHS bodies, where these are funded in their entirety by NHS commissioners
>
> unless the service provide is one that will remain free to all, e.g. the diagnosis and treatment of specified infectious diseases".

35. The response noted that additional changes would be made from April 2017 and said, so far as material, that:

> "In addition to the proposals set out in our consultation we intend to place the following new statutory requirements on all providers of NHS-funded services:
>
> - to charge overseas visitors upfront and in full for any care not deemed by a clinician to be "immediately necessary" or "urgent" and/or cease providing such non-urgent care where payment is not received in advance of treatment beginning
>
> - require relevant NHS bodies to identify and flag an overseas visitor's chargeable status, starting with NHS trusts….".

36. The document set out a summary of responses made by those who responded to the consultation. These included responses indicating that many respondents considered that not charging overseas visitors for NHS care was unfair to residents in the UK and providing free health care to overseas visitors had an impact on funding available for services. The responses from several respondents, including those from professional organisations, raising concerns about the potential impact of the proposals on the health of the patient and the public were summarised. These included concerns that people in need of services would not access them or would wait until their condition worsened and when they would need possibly more costly emergency treatment. Concerns were expressed about unsupported failed asylum-seekers or other undocumented migrants who were not within the exemptions from charging and would be likely to have little money available for treatment and/or would be wary of engaging with public bodies who asked about their immigration status. Concerns were also recorded in relation to public health and some respondents considered that discouraging people from taking up healthcare by charging or requiring the provision of information might mean that opportunities to detect infectious diseases were lost. Many said that providing free GP and nurse consultations were not enough and exemptions should be made from charges for diagnostic and other investigations.

The Making of the 2017 Regulations

37. The minister who decided to make the 2017 Regulations was provided with the following documentation:

> (1) a submission dated 12 July 2017, together with a checklist of points;
>
> (2) a draft of the 2017 Regulations and an explanatory memorandum;
>
> (3) a draft impact assessment;

(4) an equality analysis completed in July 2017 and the equality analysis completed in December 2016;

(5) a document dealing with consideration of the Secretary of State's duties under the 2006 Act;

(6) an analysis undertaken in July 2017 described as the family test analysis together with a similar analysis completed in December 2016.

The Submission

38. The submission explained that the minister's approval was being sought to make amendments to the 2015 Regulations following publication of the government's response to the consultation on extending charges for visitors and migrants. It explained that the regulations would, amongst other things, (1) require payment in advance (referred to as up-front charging) for all non-urgent care, and for immediately necessary/urgent care unless doing so would prevent or delay the provision of treatment (2) bring non-NHS providers of NHS-funded secondary and community care services within the scope of the charging regulations for the first time (3) remove the exemption for secondary and community care NHS services provided outside the hospital setting and (4) require specified bodies to flag a person's record when the person had been assessed as an overseas visitor. The submission referred to the duties under various enactments and asked the minister to read the equality analysis provided with the submission. The submission said that:

> "Whilst we acknowledge that there may be some impact on some groups as a result of the Regulations, for example the impact upfront charging may have on those with a lower income, we consider it to be low and in any event justified by the need to preserve free NHS services for those with a sufficient connection to the UK."

The Explanatory Memorandum

39. The explanatory memorandum explained the changes being made by the proposed amending regulations. It set out what was being done and why. It explained that requiring advance payment would require the full estimated amount of charges to be paid by a chargeable overseas visitor in advance of the provision of the treatment save that this requirement would not apply if it prevented or delayed the provision of immediately necessary or urgent services. It explained the obligation to record against a person's NHS record the fact that a person has been determined to be an overseas visitor. It also explained the changes made in relation to services provided outside a hospital or otherwise than by staff employed to work at or under the direction of a hospital. The explanatory memorandum dealt with a number of other matters.

The Impact Assessment

40. The impact assessment dated 29 March 2017 explained that the 2015 Regulations were the first stage of a national programme to increase cost recovery from visitors and migrants who access NHS-funded treatment when in the United Kingdom. It noted that the ultimate aim of the proposed amendments to the 2015 Regulations was further to improve cost recovery across the NHS in England and thereby contribute to the financial sustainability of the NHS. It summarised how that would be done.

The Equality Analyses

41. The minister was provided with copies of two documents entitled equality analyses, one dated December 2016 and the second dated July 2017. Both should be read in their entirety. Each document began by setting out the public sector equality duty. Each explained, in different terms, the proposals being considered. Each set out the sources of evidence to which regard had been paid in preparing the analysis. These included, but were not limited to, papers prepared by, amongst other organisations, the Doctors of the World organisation.

The 2016 Equality Analysis

42. The 2016 equality analysis referred amongst other things to the Equality and Human Rights Commission triennial review and supporting paper noting that there were particular health concerns for migrants, refugees and asylum seekers and confusion over entitlement. That review also noted other particular concerns relating to particular migrant groups and the difficulties they faced. The 2016 equality analysis referred to a report from the National Inclusion Health Board in England which identified vulnerable migrants as a group with poor health, focussing on low paid or unemployed migrant workers, asylum seekers, refused asylum seekers, refugees, unaccompanied asylum-seeking children, undocumented migrants and trafficked persons. That report said, amongst other things, that certain GP practices were refusing to register vulnerable populations and advised steps to be taken to address that.

43. The 2016 equality analysis also discussed the Prederi report and set out a summary of its findings and its recommendations. It considered specifically the proposal for providers to identify and record those overseas visitors and migrants (i.e. those not ordinarily resident in the United Kingdom) who were chargeable. It noted that identifying and recording patients who were chargeable may have an impact on those groups with lower incomes and who were more likely to need health care, such as older people, children and disabled people. In relation to race, it noted that stakeholders had raised concerns that non-white people and those whose first language was not English may be targeted and asked questions on the assumption that they were not resident in the United Kingdom. It also noted that any measure to increase co-operation and compliance by specified bodies within the NHS charging rules would have a particular impact on failed asylum seekers and undocumented migrants as, unless otherwise exempt, they would be more likely to be charged for their healthcare treatment. It also noted that there could be an adverse impact on groups who had more difficulty in establishing their non-chargeable status such as homeless people and those from gypsy and traveller communities. The 2016 equality analysis noted on this issue that:

> "This proposal will improve the identification of people who are eligible for charge, and therefore will have some impact on protected characteristics as more people will be charged for treatment.
>
> "We believe that any potential impacts are justified as we consider that ensuring the long term sustainability of the NHS is a legitimate aim and that those who are required to pay for NHS healthcare are identified and charged correctly, this is a proportionate way of achieving this aim. However, immediately necessary or urgent treatment, including maternity services, will not be withheld due to payment".

44. The 2016 equality analysis also considered specifically the proposal to charge overseas visitors in advance and in full for any care not deemed immediately necessary or urgent. It noted that low income groups which were likely to include older, and disabled, people could face a disproportionately greater impact. However, the authors of the 2016 equality analysis did not consider that requiring payment in advance would have a significant impact as the charges were already made at some point during the treatment process. Further, it considered that the current policy was for upfront charging so that there should be no change in effect. The 2016 equality analysis considered whether certain races were more susceptible to certain conditions but considered that these were likely to be for conditions that would generally be within the scope of immediately necessary or urgent treatment and would not be charged for in advance. The document noted that some stakeholders had raised concerns that black or ethnic minority persons might have a greater susceptibility to certain health conditions (such as diabetes and glaucoma) which would not fall within the exemption but the document noted that it had not found evidence of this. It noted that current policy was for upfront charging and there had been no change in policy. The authors of the document stated that they considered that this particular proposal remained justified and proportionate. The document concluded on the issue of advance payment that:

> "We do not believe this proposal makes a significant impact on all these characteristics as upfront charging would seek payment for a charge that is already applicable at an earlier point in the process, further there has not been a change in policy as the guidance already requires upfront charging. In addition, treatment that is immediately necessary or urgent would not be denied due to any form of charging. We therefore believe any potential impacts of this proposal are justified as we consider that ensuring the long term sustainability of the NHS is a legitimate aim and that those who are required to pay for NHS healthcare are identified and charged correctly, this is a proportionate way of achieving this aim. The proposal will also be an important element in discouraging overseas visitors from failing to ensure that they have insurance or sufficient resources to fund their healthcare whilst in the UK and discourage misuse/abuse of the NHS by potential 'health tourists'.
>
> "We are providing information to visitors and migrants about health services on NHS and other websites and are working with the Home Office to ensure people who apply for a visa are fully informed about health insurance requirements or the surcharge. We are also working with OGDs to communicate to prospective visitors in their home countries about health insurance prior to any travel they undertake. We will build on our communications activity during the development and implementation of this proposal."

45. The 2016 equality analysis also considered who else would be affected. It noted, amongst other things, that the general public might be affected as they would be more likely to be asked questions about their residency. It also noted that it would be more likely that undocumented migrants would be identified as chargeable for NHS treatment. It noted that if they did not pay, the information would be passed on to the Home Office, and that information could inform future decisions regarding their entitlement to stay in, or return to, the United Kingdom.

46. Chapter 8 of the 2016 equality analysis considered the extension of charging for services provided beyond those provided upon admission to hospital and noted that

that would affect some groups more than others. However, the authors concluded that the potential impact of those proposals was justified to ensure the long -term sustainability of the NHS, ensuring everyone made a fair contribution to the NHS, ensuring that the NHS was no more generous to overseas visitors and migrants than services provided in comparable countries, and to deter overseas visitors from failing to have insurance and to discourage abuse of misuse of the NHS. The document also set out a number of ways of minimising the impact of the proposals, including providing free GP and nurse consultation, free diagnosis for infections and other diseases, free childhood immunisation, the provision of immediately necessary and urgent treatment without delay and exemptions from charge for the most vulnerable. The analysis noted that it was not possible to mitigate against all the potential consequences or impacts of the proposals but it was intended to ensure that there was not a disproportionate or negative impact on anyone other than visitors and migrants.

The 2017 Equality Analysis

47. The 2017 equality analysis document noted that the overarching aim of the costs recovery programme was to improve identification and cost recovery from overseas visitors and migrants and to ensure that the NHS in England received a fair contribution for the cost of healthcare it provided to visitors who needed treatment from the NHS. It summarised the proposals. It noted that the equality analysis built on earlier work. In a section considering who would be affected it noted that charging was in place for care in hospitals but "as charging is extended further, visitors may find that they now may no longer be eligible for free NHS services or exemptions and may be subject to further charges". It noted that there would be an impact on the general public as they were more likely, especially at the outset of treatment, to be asked questions about their residency to identify those who were not eligible for free NHS care.

48. The 2017 equality analysis noted, on advance payment, that the consultation response published in February 2017 had concluded that there would not be a significant impact on protected groups as this was the policy set out in guidance and charging was made at some point in the process so making charges at an earlier stage in the process would not have a significant effect. It also noted that immediately necessary and urgent treatment would not be delayed pending identification and charging. It then considered specific groups, noting that lower income groups who included older persons and the disabled might refuse treatment because the cost would now be apparent upfront. The authors of the 2017 equality analysis considered that "[to] the extent that there is an impact on any particular group the impact is justified". The 2017 equality analysis repeated, in essence, the justification considered in the earlier 2016 equality analysis, namely the need to ensure the sustainability of the NHS and considered that it was proportionate to ensure that those required to pay for services were identified, and that those overseas visitors who had a non-urgent need for treatment which could await their return home were required to pay in advance for treatment. It noted the authors' view that there was not likely to be any impact on persons with the protected characteristics of sex, race, religion or belief or sexual orientation in relation to upfront charging, noted the current policy strongly recommended upfront charging and considered that reflecting this in regulations was justified and proportionate.

49. The 2017 equality analysis considered the impact of charging for NHS secondary care outside hospitals. It noted that the definition of a hospital was broad and the exemption from charging did not apply when staff were employed by or under the direction of a hospital. The 2017 equality analysis considered that the change would not be wide-ranging but went on to consider the potential impacts. It noted the impact on older persons and on children who may require services such as speech and language therapy provided outside a hospital and which would now be chargeable. It concluded that the impacts were justified for the reasons already explained in this judgment. Similarly, in relation to persons with a disability there would be an impact as they may require out of hospital services such as physiotherapy, occupational or speech therapy or mental health services. The authors took the view that services of this nature were already chargeable if provided by hospital employed or directed staff and so charging would not, in their view, amount to a change of policy. In any event, the authors considered that "any impact is justified on the grounds that NHS resources are limited where people do not have a sufficient and permanent connection to the UK". The authors considered that there would not be any specific adverse impact on a person with the protected characteristic of race or, similarly, on homeless people, gypsy and traveller communities save that lower income groups may be more greatly affected by charging.

50. In a section entitled summary of analysis, the 2017 equality analysis noted that concerns had been expressed that questions about residency may be more frequently asked of persons with a black, or ethnic minority background. The document noted that this was an unacceptable practice and guidance would make it clear that decisions about eligibility and chargeability should be made systematically and that all new patients, regardless of who they are or where they are from, should be asked the same questions. The section also noted that the need to establish sufficient connection with the UK to obtain free services meant persons in this group would be asked to answer questions and provide evidence more often and that this would inevitably be challenging for those without documentation. The 2017 equality analysis noted that those involved would work to ensure that this group did not face discrimination, harassment or victimisation as they tried to access services.

51. The 2017 equality analysis also set out the authors' views on how the proposals would advance equality of opportunity. They considered that consistency in charging would advance that aim as all patients would face the same questions and same residency requirements rather than certain groups with particular characteristics facing greater scrutiny. They considered that ensuring the fair application of systematic questions to everyone would reduce the dangers of discrimination. The considered that advance payment would ensure that everyone would know at the same stage in the treatment process what the costs would be. The authors expressed their view that the proposals would make cost recovery more efficient and effective and help ensure that everyone makes a fair contribution. They said that they believed that extending charging as proposed would make the situation fairer for all groups. Everyone who accessed these NHS services would all make a contribution in some way to the NHS (unless exempt for valid reasons) and considered this would reduce hostility or misconception about what visitors and migrants could expect to receive at the expense of the UK taxpayer. The authors considered that this would promote good relations between groups. Under a heading "what is the overall impact" the 2017 equality analysis said this:

> "There is some evidence that overseas visitors with a protected characteristic may be adversely impacted by the Regulations, as set out in the analysis above. In particular those who lack resources to pay or who are more likely to require healthcare will be more impacted by the changes.
>
> "However, it is believed that any such impacts should be considered in the context of ensuring the long term sustainability of the NHS. This is a legitimate aim and the policies being implemented by these Regulations are a proportionate way of achieving this aim.
>
> "Overall, the Regulations should have a positive impact on the NHS by ensuring consistency with how charging is implemented for relevant NHS services provided in hospitals and by other non NHS providers. The introduction of upfront charging may have some negative effects on overseas visitors with low or no income or who are undocumented migrants and they may be unable to pay, however, immediately necessary and urgent treatment will not be denied or delayed regardless of the patient's ability to pay and exemptions remain for certain groups of people.
>
> "Charging rules will be applied irrespective of disability, age, race, sex, sexual orientation, gender reassignment, pregnancy and maternity, religion or belief, or marriage or civil partnership status. Improved identification of patients will also benefit those who are entitled to free NHS care but who may struggle to understand the healthcare system currently and will assist in the reduction of questioning to establish the chargeable status of a patient."

52. For completeness, I note that there were two documents entitled "Family Test Analysis" before the minister. They considered the impact of the proposals primarily on families.

Statement on the duties in the 2006 Act

53. The material before the minister included a statement on the duties of the Secretary of State under sections 1, 1A, 1C and 1D of the 2006. Again, the document summarised the proposals. It compared those proposals against the duty in section 1 of the 2006 Act to promote a comprehensive health service and said this:

> "The NHS is under increasing financial pressure. In order to sustain it for the future it is vital that resources are protected. Charging those who are not ordinarily resident in the UK is, we believe, therefore justified. This is because NHS resources are finite, so cannot be spent on those outside the UK without diminishing, perhaps significantly, the resources that are available to UK residents."

54. Similar conclusions were reached in relation to the duty under section 1A of the 2006 Act. The document also considered the duty under section 1C of the 2006 Act to have regard to the need to reduce health inequalities which the document recognised might be particularly relevant to visitors and migrants. The document noted that those in lower socio-economic groups and with no or low income may suffer from health inequalities which may be exacerbated by charging in advance for services or being charged for treatment provided outside hospital settings for which they had not previously been charged. This included overseas visitors, the ordinarily resident population in particular gypsies, travellers, the homeless and undocumented migrants. The document noted the particular difficulties of many people in this group. It noted

that persons who are ordinarily resident may have difficult proving their entitlement to free NHS services due to being unable to prove identity or residency in the United Kingdom. The document continued by considering educational issues, gender, age and vulnerable groups. It also considered race and noted that one potential impact was in relation to care provided outside a hospital setting which was aimed at facilitating access to timely and appropriate care for migrant groups. Those services may now be chargeable although the document noted that there were exemptions for certain vulnerable groups and that would mitigate the impact for those groups. The document also considered the mitigating actions available more generally. It concluded that:

> "29. Where we have identified a potential detrimental impact, we consider that appropriate steps have been taken to seek to mitigate the effect to the extent possible. We also consider that where it is not possible to fully mitigate the potential detrimental impact, the approach is justified as the policy has the legitimate and important aim at [sic] of protecting the limited resources of the NHS for those with a sufficient connection to Great Britain and to discourage health tourism, which is detrimental to the NHS. This is necessary to ensure the long term sustainability of the NHS.
>
> "30. We consider that the policy is consistent with your duty to have regard to the need to reduce inequalities".

55. The document considered the duties imposed under sections 1D and 1G, 1F, and 2A of the 2006 Act.

THE 2017 REGULATIONS

56. The 2017 Regulations were made by the minister on 17 July 2017 and laid before Parliament on 19 July 2017. Most of the material provisions came into force on 21 October 2017, save that the obligation to record information came into force on 21 August 2017.. The requirement for payment in advance was made by amending regulation 3 of the 2015 Regulations by inserting a new Regulation 3(1A) and making consequential amendments. Regulation 3 of the 2015 Regulations as amended by the 2017 Regulations provides, so far as material, that:

> "3.— Obligation to make and recover charges
>
> "(1) Where the condition specified in paragraph (2) is met, a relevant body[1] must make and recover charges for any relevant services it provides to an overseas visitor from the person liable under regulation 4 (liability for payment of charges).
>
> (1A) Where the condition specified in paragraph (2) is met, before providing a relevant service in respect of an overseas visitor, a relevant body must secure payment for the estimated amount of charges to be made under paragraph (1) for that relevant service unless doing so would prevent or delay the provision of—
>
> (a) an immediately necessary service; or
>
> (b) an urgent service.
>
> "(1B) The person from whom payment is to be secured under paragraph (1A) in respect of a relevant service is the person who it appears to the relevant body, at the time that the request for that payment is made, will be the person to whom a charge will be made under paragraph (1) in respect of that relevant service at the time that it is provided.

"(2) The condition is that the relevant body, having made such enquiries as it is satisfied are reasonable in all the circumstances, including in relation to the state of health of that overseas visitor, determines that the case is not one in which these Regulations provide for no charge to be made.

"(3) Where more than one relevant body is to provide relevant services to an overseas visitor, each relevant body must secure the advance payment sum in respect of each relevant service that it is to provide.

"(3A) Where more than one relevant body provides relevant services to an overseas visitor, each relevant body must make and recover the actual charge in respect of each relevant service that it provides.

"(4) A relevant body that makes and recovers a charge in accordance with paragraph (1) or secures payment in accordance with paragraph (1A) must give or send to the person making the payment a receipt for the amount paid.

"(4A) In making and recovering an actual charge from a person in respect of a relevant service, a relevant body must—

` (a) deduct any advance payment sum secured by the relevant body from that person in respect of that relevant service; and

(b) refund any amount by which an advance payment sum secured by the relevant body from that person in respect of that relevant service exceeds the amount of the actual charge that person is liable to pay.

…..

"(7) In this regulation—

"actual charge" means a charge to be made under paragraph (1);

"advance payment sum" means a sum to be secured under paragraph (1A);

"immediately necessary service" means—

(a) antenatal services provided in respect of a person who is pregnant;

(b) intrapartum and postnatal services provided in respect of—

(i) a person who is pregnant;

(ii) a person who has recently given birth; or

(iii) a baby; and

(c) any other relevant service that the treating clinician determines the recipient needs promptly—

(i) to save the recipient's life;

(ii) to prevent a condition becoming immediately life-threatening; or

(iii) to prevent permanent serious damage to the recipient from occurring;

> *"urgent service"* means a service that the treating clinician determines is not an immediately necessary service but which should not wait until the recipient can be reasonably expected to leave the United Kingdom."

57. The obligation to record information is provided for by the insertion of regulation 3A into the 2015 Regulations which is in the following terms:

> **"3A.— Obligation to record information against an overseas visitor's consistent identifier**
>
> "(1) An NHS foundation trust or an NHS trust that, in meeting its obligations under regulation 2, determines that a person is an overseas visitor must, as soon as it is practicable to do so, record against the overseas visitor's consistent identifier—
>
> (a) the fact that the person has been determined to be an overseas visitor;
>
> (b) the date on which that determination was made; and
>
> (c) whether Part 4 (overseas visitors exempt from charges) provides for no charge to be made.
>
> "(2) In this regulation, *"consistent identifier"* means a consistent identifier specified in regulation 2 of the Health and Social Care Act 2012 (Consistent Identifier) Regulations 2015). "

58. The extension of charging for NHS funded services provided outside a hospital was achieved by two means. First, regulation 9 of the 2015 Regulations was amended by removing the exemption from charges previously available in respect of "services provided otherwise than at, or by staff employed to work at, or under the direction of a hospital" (see regulation 10 of the 2017 Regulations). Secondly, regulation 2(3) of the 2017 Regulations amended the definition of "a relevant body" (i.e. the body liable to make the charges) to include "any other person providing relevant services". Relevant services were already defined in regulation 2 of the 2015 Regulations as "accommodation, services or facilities which are provided, or whose provision is arranged under the 2000 Act" other than certain specified services. The effect is that any person providing relevant services under the 2006 Act, whether at a hospital or in the community, will be required to charge an overseas visitor for those services (unless an exemption applies).

SUBSEQUENT EVENTS

59. Following the enactment of the 2017 Regulations, the defendant undertook a review of the impact of those regulations in respect of the advance payment and record keeping requirements and the extension of charging to NHS-funded services in the community on those with protected characteristics. The outcome of the review, together with an updated equality analysis and a document dealing with the defendant's duties under the 2006 Act was finalised and submitted to the minister on 18 June 2018.

THE ISSUES

60. Against that background, the issues that arise having regard to the claim form, and written and oral submissions are:

(1) did the defendant act unlawfully by failing to carry out the consultation exercise properly by not including within the consultation two proposals, namely the requirement of advance payment and recording of information, as part of the consultation process it undertook in 2015; and/or did the claimant have a legitimate expectation, arising out of a past practice of public consultation, that there was would be a public consultation on any significant amendments imposing charges including these two proposals?

(2) did the defendant fail to comply with (1) his public sector equality duty under section 149 of the 2010 Act or (2) his duties under sections 1B or 1C of the 2006 Act:

(3) should permission be granted to allow the claimant to contend that the defendant failed to take reasonable steps to acquire relevant information?

THE FIRST ISSUE – CONSULTATION

The First Contention – The Way In Which The Consultation Was Carried Out

61. Mr Coppel Q.C. on behalf of the claimant puts the case that the defendant failed to consult on the introduction of the requirement for advance payment and record-keeping in two ways. First, he submits that whether or not there was an obligation to consult on changes to the charging regulations, where a defendant chooses to consult, he must do so fairly. That requires the defendant to set out in clear terms what is proposed and provide sufficient information to make an intelligent response: see *R v North and East Devon Health ex p. Coughlan* [2001] Q.B. 213 at paragraphs 108 and 112 and *R (Eisai Ltd.) v National Institute for Health and Clinical Excellence* [2008] EWCA Civ 438 at paragraph 24.

62. Mr Coppel contends that the defendant decided to consult upon a large number of proposals concerning charging overseas visitors for health services but then sought to implement two further changes, the requirement for advance payment and record keeping, which he had not consulted upon at all. He submitted, in effect, that these two proposals were intrinsically linked with the proposals on changes to the charging regime, and indeed, were announced in the document setting out the defendant's response to the consultation exercise. Consequently, the failure to consult on these two proposals meant that he had failed properly to carry out the consultation exercise that he himself undertook.

63. Mr Henshaw Q.C. for the defendant submits that the fact that a defendant chooses voluntarily to consult on one proposal in a particular policy area does not mean that he must also consult on other proposals in the same area. In the present case, the defendant chose to consult on a number of changes to the charging regime. He chose not to consult, for the reasons given in the evidence, on two particular matters, namely, the proposal to require advance payment of treatment and record keeping. Those were distinct, separate issues. Those changes were not intrinsically connected with other changes and the decision to make those two changes did not arise out of, and did not form a response to issues raised in, the consultation exercise.

Discussion

64. In my judgment, the defendant is correct on this issue. If a public body chooses to consult upon a particular proposal, then it must do fairly and in accordance with well-established principles. If a public body chooses to consult on one set of proposals, but not to consult on another, different set of proposals, then, unless it can be shown that there is a legal obligation to consult upon the second set of proposals, it is not obliged to do so because it is consulting on the first set of proposals. Indeed, the claimant recognises that in paragraph 56 of his skeleton argument where he accepts that the fact that a public authority consults on one issue does not of itself mean that it is unfair not to consult upon a completely separate issue which it later decides upon.

65. The fact that the defendant chose to consult upon a very large number of proposals relating to the charging regulations does not alter the position. The two issues upon which he chose not to consult (advance payment and record keeping requirements) were discrete, self-contained issues. The fact that notice of the decision to make those two changes was contained in the document setting out the response to the consultation exercise does not mean that the proposals were part of, or were linked in some way to the proposals that were consulted upon. The defendant did not fail to carry out the consultation exercise properly. The key question, therefore, is whether there was an obligation to consult upon these two changes.

The second contention – whether there was a legitimate expectation

66. In the claim form, the claimant contended that there was a legitimate expectation based on prior practice that there would be a public consultation on any significant amendments made imposing charges under section 175 of the 2006 Act. In his written responses, following disclosure of the number of changes to charging regulations made by the defendant, Mr Coppel contends that there was a practice of public consultation upon changes which were disadvantageous to individual recipients of NHS services and which had continued unbroken for at least over 20 years between 1995 and 2017.

67. Mr Coppel relied upon the approach derived from *R (Bhatt Murphy) v Independent Assessor* [2008] EWCA Civ 755, especially at paragraphs 29 to 30, and *R (Davies) v HM Revenue & Customs* [2011] 1 W.L.R. 2625 at paragraph 49. That approach was summarised recently by the Divisional Court in *R* (*Brooke Energy Limited) v Secretary of State for Business, Energy and Industrial Strategy* [2018] EWHC 2012 (Admin) at paragraph 53 that there had to be a "sufficiently settled and uniform practice" of consultation. Mr Coppel further relied upon the observations of Sedley L.J. at paragraph 39 of his judgment in *R (BAPIO) v Secretary of State for the Home Department* [2007] EWCA Civ 1139 that while "a practice does not have to be unbroken, it has to be sufficiently consistent to be regarded as more than an occasional voluntary act".

68. Mr Coppel submits that the evidence here, properly analysed, does show a sufficiently settled practice since 1989 or at least 1995 of public consultation upon changes which would be disadvantageous to individuals. In so far as there were changes which were not the subject of public consultation, he submits that these were changes which were what he described as technical, that is to reflect wider legal developments, or were

beneficial and operated to the advantage of individuals such as extending the scope of exemptions from charges.

69. Mr Henshaw for the defendant submitted that there was no sufficiently settled practice, and certainly not one that was unequivocal, of public consultation on changes to the charging regime. Further, he submitted it was artificial to separate out those changes to the charging regime where there had been consultation from those changes where there had not been. Rather, the position was as explained in the evidence of Ms Snook, namely that the practice was to decide whether to consult with specific bodies, or the public at large, on a case-by-case basis taking into account the nature and purpose of the proposed changes and the benefits that consultation might be expected to yield.

Discussion

70. This case concerns the exercise of a statutory power to make regulations. Parliament has not imposed a statutory duty to consult. Nonetheless, there may be circumstances where the common law will impose a duty to consult before such a power is exercised. That may arise where there is a legitimate expectation of consultation. As Laws L.J. expressed in in *Bhatt Murphy* at paragraph 29:

> "The paradigm case arises where a public authority has provided an unequivocal assurance, whether by means of an express promise or an established practice, that it will give notice or embark upon consultation before it changes an existing substantive policy…"

71. As Lord Wilson explained in *Davies* at paragraph 49 there is a need for evidence that:

> "the practice was so unambiguous, so widespread, so well-established and so well-recognised as to carry within it a commitment to …. treatment in accordance with it".

72. The current approach is helpfully summarised by Flaux L.J. at paragraph 53 of his judgment in *Brooke Energy* in the following terms:

> "The alleged practice must be clear, unequivocal and unconditional: see per Laws LJ in *Bhatt Murphy* at [29]; per Mostyn J in *L* at [17]. The practice must be sufficiently settled and uniform to give rise to an expectation that the claimant would be consulted: see per Stanley Burnton J in *R on the application of BAPIO Action Ltd. v Secretary of State for the Home Department* [2007] EWHC 199 (Admin) at [53]. It is also clear from [17] of *L* and from [28] of *Bhatt Murphy* that there must be unfairness amounting to an abuse of power for the public authority not to be held to the practice."

73. Analysing the evidence in the present case, there is not a settled and uniform practice of public consultation before exercising the power to make regulations relating to the making and recovery of charges for services provided to persons not ordinarily resident in the United Kingdom. There was certainly no unequivocal practice of public consultation.

74. There was no public consultation on the making of the regulations in 1982 or the replacement regulations in 1989. The claimant accepts that there was no practice of public consultation between 1982 and 1989 but contends that a sufficiently settled and uniform practice did emerge either since 1989, or at least since 1995, that changes

imposing disadvantages for individuals were the subject of consultation. I accept that, in principle, a sufficiently settled practice could emerge from either 1989 or 1995 or some later date even though there was no consultation earlier. The question is whether it did.

75. First, it is right to note that other changes to the regulations in force were made between 1989 and 2003. There was no public consultation on the making of any those amendments (just as there had been no consultations on the regulations or amendments made between 1982 and 1989). One of the changes, in 1994, involved removing an exemption for certain services, meaning that they would be charged for. Given the absence of any consultation prior to 2003, there is no basis upon which it can said that any past practice of consultation began in 1989 or 1995.

76. Secondly, there was a public consultation on seven proposed changes to the regulations in 2003. That was the first public consultation on matters to do with the charging regime. Furthermore, the amendments made to the regulations then in force included not only those seven proposals on which there was public consultation but also two other proposals on which there was no public consultation. The claimant seeks to separate out those two proposals because he regards them as beneficial to the individual whereas the seven that were consulted on were not. It is, however, artificial to treat the period from 1989 (or 1995) to 2003 in that way.

77. Any person looking at the position in 2003 would not have seen a settled practice of public consultation on making amendments to the regulations. There was no consultation on the amendments that were made in the period prior to 2003. The consultation in 2003 would not, of itself, amount to a settled practice. It was the first time that a public consultation was undertaken. It would, furthermore, be equivocal as it would be uncertain, viewed at the time, as to why certain amendments to the regulations were the subject of public consultation and some were not. A reasonable person would not regard the position in 2003 as being one where an unequivocal assurance, arising out of a practice, had been made that there would be public consultation on any other changes in future.

78. Mr Coppel relies upon a ministerial submission made in 2003 in which the official said the proposals that were not consulted upon were different in nature from other proposals as they would extend exemptions not restrict them. That, he submits, emphasises the consistency of the distinction that he draws. That comment was made in 2003 when public consultation was undertaken for the first time. It would not be a fair or proper reading of that submission as amounting to a recognition in 2003 that there was a practice of consulting on changes which were disadvantageous but no such practice or obligation of consulting on changes seen as beneficial. At the time that that ministerial submission was written, there had been no public consultation on any change. It can at most be a reflection of what the official thought it appropriate to consult upon in 2003 not a definition of what the practice was. Furthermore, it is, ultimately, a matter for the court, considering the evidence of what was done, to determine whether a past practice had given rise to an unequivocal assurance to the public that there would be a public consultation in future. The observations in the 2003 ministerial submission do not assist in that task.

79. Thirdly, there was a public consultation exercise on certain proposals in 2004. That was the second time that a public consultation had been undertaken. Amendments

were made to the regulations in 2006, 2008 and 2009. Again, there was no public consultation on the proposals leading to these amendments. As at 2009, therefore, there had been two occasions when proposed amendments were the subject of consultation. There were other occasions when amendments were not consulted upon. Even when there had been a public consultation on some proposed amendments in 2003, other amendments were made at the same time as those consulted upon. It is not possible to regard the position as at 2009 as establishing a settled and uniform practice, still less one giving rise to an unequivocal assurance, that future amendments of any sort would be the subject of public consultation.

80. Fourthly, there was public consultation on five areas in 2010. The departmental response to the consultation indicated that two further modifications, not consulted upon, would also be made. The claimant seeks to contend that these were, in effect, relatively minor changes (exempting participants in the 2012 Olympic Games from charges and refining the circumstances for exemption in cases involving pandemic flu) and, more significantly he submits, these were situations where individuals benefited from, and were not disadvantaged by, the changes.

81. In my judgment, it is artificial to seek to separate out the changes in this way. Viewed objectively, the power that is being exercised is the statutory power to make regulations. In some cases, the defendant is consulting upon whether to exercise the power to make changes. In other cases, the defendant is exercising the power and making amendments to the regulations without public consultation. It cannot realistically be said in 2010 that the defendant had, by its practice in recent years, given an unequivocal assurance that it would not exercise its power to make regulations, or to make particular types of changes to the regulations, without there first being a public consultation.

82. Fifthly, the defendant did undertake a public consultation in 2013 on migrant access to healthcare and their financial contribution which resulted ultimately in the 2015 Regulations. Even in 2013, however, all that could be said was that on four occasions (2003, 2004, 2010 and 2013) there had been public consultations on some proposed changes to the regulations. On other occasions, there had not been public consultation. Even when there was consultation in 2003 and 2010, not all the changes made were ones that were consulted upon. That does not amount to the kind of settled and uniform practice giving rise to an unequivocal assurance of public consultation if amendments, or particular types of amendments, are to be made to the regulations in future.

83. It is not feasible to consider the 2015 consultation exercise itself as evidence of a practice of public consultation for two reasons. First, the question is whether there was a past practice of consultation established by December 2015 such that there was on obligation on the defendant to conduct a public consultation in 2015 on the advance repayment and record keeping requirements. Secondly, the 2015 consultation does not, on analysis, evidence a practice of consulting on any change to the regulations, or even any change such as the advance payment requirement which might be seen as disadvantageous to individuals. It does the opposite as the defendant did not consult upon those changes.

84. In substance, the claimant has analysed the material from the perspective of seeking to construct from the public consultation exercises that have taken place a practice. He

does so by redefining occasions when public consultation did not take place as ones involving "technical matters" or as involving changes which are to be regarded as beneficial to individuals. A more accurate analysis, in my judgment, would focus on the nature of the power being exercised, that is the power to make regulations relating to charging non-residents for NHS services. That analysis would take account of the fact that there have been occasions when that power has been exercised without consultation. In all the circumstances, therefore, there has not been a settled and uniform practice of public consultation on changes to the charging regime since 1989, 1995 or later.

85. Furthermore, and additionally, it would be difficult to regard any previous practice as giving rise to an unequivocal assurance that the two particular changes in issue in this case would be subject to public consultation. The requirement to record the fact that a person is a non-resident liable to charging, for example, does not of itself involve making any changes to the liability to pay charges (which is set out in the 2015 Regulations). It simply means that a person who is liable to pay charges is readily identifiable. It is difficult to see how the consultation exercises that were carried out in 2003, 2004, 2010 and 2013 gave rise to an unequivocal assurance that changes governing the recording of information would be the subject of consultation. The legitimate expectation that the claimant asserts in his claim form is an expectation, based on past practice, of consultation "on any significant amendments made imposing charges under the section 175 power". The recording of the fact that a person is liable to charges is not concerned with imposing charges. In his written submissions dated 14 September 2018, the claimant in effect reformulates the practice and expectation and describes it as "an established prior practice of consulting on significant changes to the charging scheme which operate to the disadvantage of affected patients". He then seeks to treat a requirement that liability to charging be recorded as such a change. It would be difficult, in my judgment, to treat the previous consultations as giving rise to an unequivocal assurance that changes relating to the recording of liability to pay charges is something that the defendant would consult upon. That indicates, more generally, that no unequivocal assurance arises out of any previous instances of consultation as to what might be the subject of any future consultation.

86. Similarly, it is it is difficult to see that that changes to the timing of payment for treatment is an amendment imposing charges, the expectation alleged in the claim form. It is only by recasting the practice as a practice of consulting on disadvantageous changes, and then classifying the imposition of a legal requirement to make advance payment as a disadvantageous change, that the second change is brought within the alleged past practice giving rise to a legitimate expectation. That, again, indicates the earlier instances of consultation did not give rise to a clear, unequivocal assurance that certain types of changes to the regulations would be the subject of consultation. In truth, the claimant can only seek to rely upon an alleged past practice both by ignoring instances where the exercise of the power to make regulations were not preceded by public consultation and by defining the consultations that did take place as instances where there was consultation on changes disadvantageous to the individual, and then classifying changes to record-keeping and the timing of payment as similarly disadvantageous. That is not, however, the type of situation which the courts have recognised as of a settled and unform practice, giving rise to an unequivocal assurance, which results in the imposition of an obligation to

consult before exercising a statutory power to make regulations. In the circumstances, therefore, the first ground of challenge, fails.

THE SECOND ISSUE – THE STATUTORY OBLIGATIONS

87. Mr Coppel contends that the defendant failed to have due regard to the matters specified in section 149 of the 2010 Act and so failed to discharge his public sector equality duty. In addition, he submits that that failure is reinforced by a failure to discharge the duties under section 1B and 1C of the 2006 Act. As part of the grounds, the claimant contends that the defendant proceeded on a mistaken basis as he assumed that the requirement for advance payment would not have a significant effect as it was already policy to charge whereas this was mistaken. Previously, relevant bodies had a discretion to charge in advance whereas the 2017 Regulations imposed a duty to do so. The grounds further contend that the defendant failed to have regard to what is described as the disproportionate impact of the three changes made by the 2017 Regulations on the disabled (which includes those with cancer and HIV), ethnic minorities and women (as the impact of charging for abortion services and community midwifery services were not considered). The grounds contend that there was no consideration of the impact on equality of opportunity of those affected. Mr Coppel developed those criticisms in his skeleton argument and oral submissions.

88. The Equality and Human Rights Commission intervened by way of written submissions. They adopted the criticisms made by the claimant. Their written submissions focussed on the extension of charging to services provided in the community. In summary, the Commission contends that the defendant failed to identify to a sufficient degree the range of NHS organisations providing services which would now be chargeable and failed to consider the impact of the change on those organisations. In particular, the Commission contends that the extension of charging for such services have big impacts on some of the most vulnerable groups. The Commission contends that the minister did not have sufficient information to assess the relevant impact and, if the arrangements were too difficult to apply or too burdensome, administrative staff might focus their attention on those who appeared for whatever reason to be from an ethnic minority. The Commission contends that the defendant did not, and was not in a position properly to assess the potential impacts of the proposals as required by the public sector equality duty.

89. Both the claimant and the Commission referred to a further review carried out after the 2017 Regulations had been made. It is submitted in summary that that review is flawed, was prepared after the 2017 Regulations were made, and was a rearguard action (in essence, an attempt to justify the regulations made, not an attempt to assess properly the potential impacts of the changes). In any event, it is submitted that consideration of impacts in the review in 2018 would not establish that the public sector duty had been complied with at the time the 2017 Regulations were made and, as a minimum, it is submitted that a declaration should be granted that the duty had not been complied with at the time the 2017 Regulations were made.

90. Mr Henshaw for the defendant contends that the defendant did discharge his duties under the 2010 Act, and sections 1B and 1C of the 2006 Act. He submitted that equality matters were addressed in the documents, including the equality analyses that were before the minister when he decided to make the 2017 Regulations. Further, the

matter had been kept under review after the 2017 Regulations had been made so that an assessment of the actual, as opposed to potential, impacts could be considered.

Discussion

91. The material provisions of section 149 of the 2010 Act are as follows:

> "(1) A public authority must, in the exercise of its functions, have due regard to the need to—
>
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
>
> …..
>
> "(3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
> (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
> (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
> (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
>
> "(4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.
>
> "(5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
>
> (a) tackle prejudice, and
> (b) promote understanding.
>
> …..
>
> " (7) The relevant protected characteristics are—
> age;
> disability;
> gender reassignment;
> pregnancy and maternity;
> race;
> religion or belief;
> sex;
> sexual orientation.

….."

92. The general approach to whether the public sector equality duty has been complied with is now well-established. The relevant principles are set out in the decision of the Court of Appeal in *R (Bracking) v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, especially at paragraph 26. There, the relevant government department decided to close a fund operated by an independent non-government body which, broadly, provided funding to assist disabled persons to lead independent lives. On the facts, the Court of Appeal concluded that the information provided to the relevant minister did not give her an adequate awareness that the proposals would place independent living in serious peril for a large number of people. The Court concluded that the minister had not complied with the public sector equality duty and quashed the decision.

93. The Court of Appeal in *R (Baker) v Secretary of State for Communities and Local Government* [2008] 2 P. & C.R. 6 has also given valuable guidance on assessing whether there had been compliance with section 71 of the Race Relations Act 1996Similar principles apply to the equivalent duty in section 149 of the 2010 Act: see *Hotak v London Borough of Southwark* [2016] A.C. 811 at paragraphs 73 to 74. In broad terms, the duty is a duty to have due regard to the specified matters not a duty to achieve a specific result. The duty is one of substance, not form, and the real issue is whether the relevant public authority has, in substance, had regard to the relevant matters, having regard to the substance of the decision and the authority's reasoning. The absence of a reference to the public sector equality duty will not, of itself, necessarily mean that the decision-maker failed to have regard to the relevant matters although it is good practice to make reference to the duty, and evidentially useful in demonstrating discharge of the duty (see, e.g., *Baker* at paragraphs 36 to 37, and *Bracking* at paragraph 26). As Lord Neuberger observed at paragraph 74 of his judgment in *Hotak v London Borough of Southwark* [2016] A.C. 811 "the weight and extent of the duty are highly fact-sensitive and dependent on individual judgment". It is also right to note the observations of the Court of Appeal in *R (West Berkshire District Council) v Secretary of State for Communities and Local Government* [2016] 1 W.L.R. 3923, especially at paragraphs 83 and 85, that what is important is to pay due regard to the equality impact of proposals and that does not require a precise mathematical exercise to be carried out in relation to particular affected groups and that, depending on the circumstances, a relatively broad brush-approach may be appropriate.

94. The duties imposed by section 1C and 1B of the 2006 Act are described above. In essence, the section 1C duty is a duty to have regard to the need to reduce inequalities between the people of England with respect to the benefits they can obtain from the health service. Section 1B is a duty to have regard to the NHS Constitution, the particular, principally material provision of which for present purposes provides 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 or life expectancy are not keeping pace with the rest of the population".

95. Against that background, it is necessary to consider the material before the minister at the time at which he took his decision to make the regulations (see paragraphs 37 to 55 above). From that material, the following is apparent.

96. First, the minister was expressly reminded of the duty under section 149 of the 2010 Act and, indeed, the material provisions were summarised in each equality analysis. Similarly, he was expressly reminded of his duties under section 1A and 1C (but not section 1B) of the 2006 Act.

97. Secondly, it was clear that the 2017 Regulations made changes which would affect overseas visitors and migrants wishing to access NHS services. That is clear from the text of the draft regulations, the explanatory memorandum and the equality analyses documents themselves.

98. Thirdly, in assessing the extent to which due regard was paid, it is relevant to bear in mind that it is the impact of the proposed changes to which the minister had to have due regard. The public sector duty applies to the exercise of a function (see section 149(1) of the 2010 Act). The function the minister was exercising in the present case was the making of the 2017 Regulations in the exercise of the power conferred by section 175 of the 2006 Act. It was the changes made in those 2017 Regulations which were the subject of the public sector equality duty. Charging for hospital-based NHS services was provided for by the 2015 Regulations and was not something that needed to be assessed when making the 2017 Regulations dealing with the advance payment for such services. In that context, the need was, in substance, to have due regard to the impact of requiring advance payment for those services. In the context of charging for NHS-funded services provided in the community, that was a change made by the 2017 Regulations and it was the impact of the extension of charging for those services to which due regard had to be paid. In assessing the impact of both of these changes, however, it is also necessary to bear in mind the exemptions from charging in advance (for example, for immediately needed or urgent treatment, or the exemptions for particular vulnerable groups). In relation to the requirement that information about a person's status and liability to charging be recorded, it was the impact of that requirement to which due regard had to be paid.

99. Considering all the material before the minister at the time he took his decision, it is clear that he was directed to have regard to the impact of each of the three proposals which were subsequently included in the 2017 Regulations. This was not a case therefore where the minister did not appreciate that the public sector equality applied to the decision that he was making.

100. Dealing with the requirement for advance payment, the claimant criticises the 2017 equality analysis for saying, amongst other things, that there is not likely to be any impact on protected characteristics such as race. He contends that the requirement will apply to overseas visitors and migrants and will be likely to have an impact. This, however, is to take one single sentence in a document out of context. Reading the material before the minister as a whole, it is clear that he would have known that this proposal affected overseas visitors and migrants. The 2016 and 2017 equality analyses focus on those groups who have lower income and are considered, therefore, to be more likely to refuse treatment if they are told the cost in advance and required to pay for it in advance. Those are likely to be the older and the disabled groups of overseas visitors and migrants liable to be charged. That is reflected in the conclusion, for example, to the 2017 equality analysis document, which says expressly that there was some evidence that overseas visitors with protected characteristics may be adversely affected, in particular those who lack resources to pay or who are more likely to require healthcare. The assessment was made, however, that the impacts should be

considered in the context of ensuring the long term sustainability of the NHS and the proposals were considered a proportionate way of achieving that aim.

101. That reflects earlier observations made in the 2016 equality analysis. That analysis set out the findings from the Prederi report which referred, amongst other things, to health inequalities for irregular or undocumented migrants. The 2016 equality analysis considered the difficulties faced by groups with low incomes (older people and the disabled). The document also considers if some races are more likely to suffer from conditions which would not fall within the immediately necessary or urgent treatment exception but found no evidence of that. It, too, expresses the view that the proposal will not make a significant impact. The conclusion is, however, that any potential impact is justified. In the circumstances, therefore, the relevant minister reading the material, including the 2016 and 2017 equality analyses, would have had due regard to the potential impact of advance payment on particular groups of overseas visitors and migrants and the view that the potential impact was justifiable.

102. Similarly in relation to the requirement for identifying and recording a person's chargeable status as not-ordinarily resident in the United Kingdom and so eligible to pay, the documents did draw attention to potential impacts on protected groups. The 2016 equality analysis, for example, noted that concerns had been raised that non-white people, or people for whom English was not their first language, might be more likely to be targeted. The document also noted that more people eligible for charging (i.e., those non-resident in the United Kingdom) would be identified and this would impact on persons with protected characteristics. But the document considered that that was justifiable as it was a proportionate means of achieving the legitimate aim of ensuring the sustainability of the NHS. The 2017 equality analysis noted that the earlier analysis had concluded that any potential impact on protected groups would be justified as a proportionate aim means of achieving that legitimate aim.

103. The documents before the minister also considered the impact of extending charging for the first time to NHS-funded services provided in the community. The 2017 equality analysis noted particular groups who would be likely to be affected by this requirement, for example, older people who were likely to require more out of hospital services, and children who tended to receive services such as speech and therapy services, and the disabled. It may well be that there are other groups which might be affected and other types of services for which charges will be made. The claimant refers, for example, to persons seeking treatment in connection with alcohol addiction and, in the case of women, abortions. The fact that other groups may be affected does not, of itself, mean that the defendant failed to have regard to the matters referred to in section 149 of the 2010. It is clear that the defendant would have known that the extension of charging would have a particular impact on certain groups. It is also obvious that if people were not liable to be charged for certain services before but are to be liable now, that there is an impact. But the thrust of the documentation is that, even giving due regard to that factor, it was justifiable to charge non-resident persons (i.e. overseas visitors and migrants) for NHS-funded services.

104. The matter had also been considered in the 2016 equality analysis which was supplied to the minister before he took his decision. Section 8 of that document recorded that the extension of charging for NHS-funded care outside of hospitals would affect some groups more than others. It said that having reflected on the issue, the potential impact

was justifiable for the reasons given (which are described above). It set out the steps taken to minimise the impact on the most vulnerable people, or the people in protected groups. These include exempting certain services, for example, GP and nurse consultations, free diagnosis and treatment for infections and sexually transmitted diseases, the provision of immediately necessary or urgent treatment regardless of ability to pay in advance, and exemptions for the most vulnerable. The claimant has adduced evidence from doctors indicating why they consider that those measures would not be effective for example in relation to infectious diseases (such as tuberculous) or particular diseases (such as HIV). They explain why they consider that that would not be enough to ensure that such diseases are detected and say that it would result in later detection, and so be deleterious for the health of the individual, the wider public health and potentially disadvantageous to the public purse if more expensive treatment had to be provided when it became urgent. That, however, is to argue about the substance of the decision taken by the minister. The issue in relation to section 149 of the 2010 Act is the procedure. Reading the material before the minister as a whole, and fairly, the defendant did have regard to the fact that the proposal would have an impact on vulnerable groups (and identified some of those) but considered that the proposals pursued a legitimate aim and that appropriate measures existed to minimise the impact.

105. The defendant did therefore have due regard to the need to eliminate discrimination, harassment and victimisation as required by section 149(1)(a) of the 2010 Act in relation to the proposals to require advance payment, record information, and extend charging to NHS-funded services provided in the community. The equality analyses also considered the promotion of good relations between groups (as required by section 149(1)(c) of the 2010 Act). It concluded that making cost-recovery more efficient and effective and helping ensure that everyone made a fair contribution, and extending charging to all NHS would make the situation fair for all. That was expected to reduce hostility towards overseas visitors and migrants.

106. The claimant criticised the conclusions in the various equality analysis documents on advancing equality of opportunity (section 149(1)(b) of the 2010 Act). The thrust of this conclusion is that, in the long-term consistency across all healthcare providers would advance equality of opportunity. It would, it was believed, lead to all patients facing the same questions about residency and having the criteria applied systematically. There is reference to the advance payment requirement increasing choice as overseas visitors and migrants would know what the costs of the treatment would be and could decide whether to have it.

107. I recognise that the substantive decision made on equality matters is for the decision maker subject to residual judicial control by way of irrationality or error of law. It is, however, difficult to understand how the matters referred to, particularly in relation to requiring payment in advance, do reflect the possibility of advancing equality of opportunity in the way envisaged by section 149(1)(b) of the 2010 Act. It may be more realistic to accept that the position of resident and non-resident persons in the United Kingdom is different and the extent to which a person has a sufficient connection to the United Kingdom to justify the provision of free health care differs between those groups. In those circumstances, proposals dealing with charging for non-residents are, perhaps, unlikely to advance equality of opportunity as between the non-resident and resident population. That would not mean that the defendant had

failed to have due regard to the matters referred to in section 149(1)(b) of the 2010 Act. Rather, it may be that, even having due regard to advancing equality of opportunity, that consideration will have a limited application in this context. It was, in any event, outweighed by other considerations. In reality, it is that last point which underlay the decision to make the 2017 Regulations. The repeated assessment was that even though the proposals would, in different ways, affect particular groups with particular protected characteristics more, that was justified as the measures contributed in a proportionate way to a legitimate aim, namely the sustainability of the NHS. In the circumstances, therefore, I do not consider that the defendant failed to have due regard to the matters referred to in section 149 of the 2010 Act.

108. For completeness, I deal, additionally, with some of the particular points of criticism made by the claimant about particular documents or parts of the documents. First, the claimant contends that the defendant erred in considering that the advance payment requirement would be unlikely to have any significant impact as it was already policy as set out in the guidance. The claimant submits that advance payment was not policy. Prior to the 2017 Regulations, there was a discretion to require overseas visitors to pay in advance and the legal position was changed by the 2017 Regulations so that it was required. Further, it is said that that change was made precisely because providers could in any event depart from the guidance for what they considered good reason and, additionally, the motivating factor in introducing this part of the 2017 Regulations was that providers were often not, in fact, requiring payment in advance and imposing a duty to do so would increase the recovery of charges. Consequently, it is said, the defendant erred in considering that the impact of this change would not be significant and, by implication, that the defendant failed to discharge his statutory duties when making regulations providing for advance payment.

109. The significance of this point has been over emphasised. The full context is that that section of the equality analysis was dealing with the impact of the requirement for services which the individual was already liable to pay (this section was not dealing with the extension of charges to NHS-funded services provided in the community which was dealt with later). The guidance provided that non-urgent treatment should not be provided unless the estimated full charge is received in advance. In other words, what the section was saying is that in assessing significance it should be borne in mind that people were already liable for the charge, and that the guidance (which should be followed unless there is good reason to depart from the guidance), provided that the discretion should be exercised to require that non-urgent treatment should be paid for in advance. The requirement for advance payment would not therefore apply to those particular services. In those circumstances, the authors of the equality analysis did not consider that the imposition of a legal requirement in the regulations to pay in advance would have a significant impact. The claimant claims that it was not policy to require advance payment prior to the 2017 Regulations, as that was only guidance, and there was a positive decision to impose a legal obligation in place of the discretionary power on the part of a provider to require payment in advance. Hence, there was a change in policy from conferring a discretion to imposing a duty. This is, largely, playing with words. The equality analysis is using the word "policy" in the sense of describing the underlying aims in relation to the charges for which non-residents were already liable. The underlying aim was that they should pay in advance for non-urgent treatment (as set out in guidance) and that underlying aim remained (and was now transformed into a legal obligation). The real difference, in terms of

assessing significance, was the fact that there would have been cases where a charge would not be made (either because of a proper decision to depart from the guidance) or from a failure to act in accordance with the guidance. Furthermore, the focus should be on what the minister took into account when deciding to make the 2017 Regulations not on one particular document viewed in isolation. It is clear from the other documents before the minister that he was told that requiring advance payment would reduce the amount of charges that are not subsequently recovered (for example, because they were not paid in advance and the recipients of the treatment had left the country). He was told that the scale was difficult to assess but was given an estimate of the likely financial gain (this was set out at paragraphs 60 to 64 of the impact assessment). The minister can have been in no doubt that the aim of the proposal was to increase the amount of costs recovered because those eligible for charging were, for whatever reason, receiving the treatment without paying the costs. He would have known that introducing the advance payment requirement would, and was intended to, improve costs recovery (i.e. more non-residents would pay for their NHS treatment).

110. More fundamentally, the advice to the minister was that there would be an impact but that this was justifiable as introducing a legal requirement for advance payment was seen as a proportionate means of achieving a legitimate aim, namely ensuring the sustainability of the NHS, as the equality analysis document itself sets out. In reality, therefore, the minister would have known that there would be an impact (particular for those overseas visitor and migrants who could not afford to pay the charges they were liable to pay) but considered that that impact was justifiable. There was no failure to have due regard to the matters referred to in section 149 of the 2010 Act and no material error in the consideration of those matters.

111. Secondly, the claimant contends that the defendant did not have regard to the impact on the disabled. That is not correct. The documentation evidences that this fact was drawn to his attention. Thirdly, it is said that he did not have regard to race. It was submitted that the 2017 Regulations applied to non-United Kingdom nationals and so directly affected persons on grounds of nationality and indirectly on grounds of race and ethnicity. (Technically, they applied to those non-resident in the United Kingdom, rather than non-nationals of the United Kingdom, but they would inevitably have a greater indirect, even if not direct, impact on non-United Kingdom nationals). The claim that the defendant did not have regard to race is not correct for the reasons given above. It was obvious from the material that the 2017 Regulations dealt with non-residents. The accompanying material made it clear that they applied to recover charges from overseas visitors and migrants. The impact of requiring advance payment and extending the charges on groups within the non-resident group (such as the old, children, the disabled, even race in terms of susceptibility of particular racial groups to conditions not likely to fall within the immediately necessary and urgent treatment exception) was considered.

112. Fourthly, is said that the documents before the minister did not refer to pregnancy termination services. That is correct. The fact that the medical services for one particular situation, associated with one protected characteristic (here, women) was not identified does not mean that the defendant failed to have due regard to the matters referred to in section 149 of the 2010 Act (see, e.g. the observations of Elias L.J. in *R (Hurley and Moore) v Secretary of State for Business and Skills* [2012] EWHC 201 (Admin) at paragraph 87; and of Sullivan L.J. in *R (Zacchaeus 2000*

Trust) v Secretary of State for Work and Pensions [2013] EWCA Civ 1202 at paragraph 60).

113. Fifthly, the claimant, and the Commission in its written submission, refer to an alleged failure to consider the complications arising out of charging for, and the burdens imposed on those providing, NHS-funded services in the community. The defendant was aware of this issue and considered it would be addressed by measures such as training and guidance. Even assuming, without deciding, that such matters fall within the scope of the matters to which due regard must be had under section 149 of the 2010 Act, due regard was had to them.

114. Similarly, the defendant did have regard to the need to reduce inequalities in accordance with section 1C of the 2006 Act. The minister was provided with an assessment of impact of the draft 2017 Regulations on health inequalities, particularly having regard to requiring advance payment or charging for treatment provided outside of hospitals. The document looked at the effect on persons in lower socio-economic groups and those with no or low income, who may include overseas visitors, undocumented migrants and travellers and gypsies. It looked at the impact on race and referred to the exemptions. It looked at vulnerable groups and those with special needs. It set out the mitigating actions. In the circumstances, it is clear that the minister who made the 2017 Regulations did have regard to health inequalities in reaching his decision. Mr Coppel makes specific complaints about this document too. He submits that it continues to make the error of regarding advance payment as current policy. I have already dealt with that above. So far as paragraph 7 of that document refers to charging for services provided outside a hospital setting, it is clear from the document read as a whole (see paragraph 14) and the documentation before the minister at the time that he made his decision that he was well aware that NHS-funded services provided outside hospitals would be chargeable (unless an exemption applies). The fact that the document does not refer to pregnancy termination services does not mean that the defendant failed to have regard to the need to reduce health inequalities. For completeness, I note that the claimant initially contended that the duty in section 1C of the 2006 Act had the effect that the need to reduce health inequalities meant that what was proposed did not in his view at least cause an increase in such inequalities, relying on the decision of Collins J. in *R (Pharmaceutical Services Negotiating Committee) v Secretary of State for Health* [2017] EWHC 1147 (Admin): see paragraph 49 of the grounds of claim. In his written submissions dated 14 September 2018, the claimant recognises that he can no longer advance that contention in the light of the decision of the Court of Appeal in that case which held that section 1C of the 2006 Act was concerned with the process by which decisions were taken not the substantive merits of those decisions: see [2018] EWCA Civ 1925, especially at paragraph 82.

115. It is correct that the material before the minister did not specifically refer to the duty in section 1B of the 2006 Act to have regard to the NHS Constitution or Article 1 of that constitution which refers, amongst other things, to the wider social duty to promote equality and to pay particular attention to groups or sections where improvements in health and life expectancy are not keeping pace with the rest of the population. In substance, however, on the facts of this case, that duty does not add to the duty in section 149 of the 2010 Act, and section 149(1)(b) in particular, or the duty to have regard to the need to reduce health inequalities in section 1C of the 2006

Act. For the reasons given, I consider that the defendant did have due regard to the matters referred to in section 149 of the 2010 Act and had regard to the need to reduce health inequalities. In substance, therefore, the defendant has had regard to the matters identified in the Constitution.

116. For completeness, I note that the defendant has carried out a further review of the impact of the 2017 Regulations. The case law deals with the question of how a court should consider a subsequent consideration of the matters referred to in section 149 of the 2010 Act, and whether it would be appropriate to quash a decision or subordinate legislation because of a failure to comply with section 149 before the measure was adopted if adequate consideration had been given later and it was decided to retain the measure in force: see, e.g. *R (West Berkshire District Council) v Secretary of State for Communities and Local Government* [2016] 1 W.L.R. 3923, especially at paragraphs 86 to 88. As I have concluded that there was no breach of the relevant statutory duties at the time that the minister made the 2017 Regulations, it is not necessary to consider whether or not the subsequent review complied with those duties and, if so, what the effect would be on the claim that the 2017 Regulations should be quashed or, at the least declaratory relief given in relation to the position prior to the review.

THE THIRD ISSUE – ADEQUACY OF THE INQUIRIES

117. Mr Coppel seeks permission to apply for judicial review on a third ground, permission having been refused on the papers. The claim refers to this ground as a breach of the duty of sufficient inquiry and says that the defendant did not comply with this duty or his duty under section 1A of the 2006 Act. The essence of this ground is that the defendant failed to make any, or any sufficient, inquiry into the risk of charging have a deterrent effect on sick people with consequent implications for public health if the disease is infectious and the NHS generally if conditions are not identified early and before they become urgent or life-threatening. This concern was elaborated in the written and oral submissions of Mr Coppel. He submitted, referring amongst other things to the witness statements submitted on behalf of the claimant (including, for example, the statements of Dr Yates, Dr Potter, Mr Azad and Dr Jones), that the greater the scope for charges and the more financial and other disincentives there are to seeking healthcare when an exemption is not applicable, the more likely it is that individuals will not seek healthcare. That, he submits, will be detrimental to the health of the individual, if conditions are not identified early but only when the need for treatment is immediately necessary or urgent and that may impose greater burdens on the NHS. Further, if the individual has an infectious disease and is deterred from seeking healthcare until symptoms are serious, that may pose a risk to public health. Mr Coppel takes issue with the decision of the judge refusing permission who considered that the risks of deterrence were obvious not scientifically or statistically measurable.

118. The issue is whether the defendant has taken reasonable steps to acquire the information relevant to any consideration which is relevant to his decision: see *Secretary of State for Education v Thameside* [1977] A.C. 1014 at 1065B-C . It is for the defendant to decide the manner and intensity of the inquiries: see *R (Khatun) v Newham London Borough Council* [2005] Q.B. 37 at paragraph 35. A court will not interfere unless the measures taken by the defendant to obtain information are irrational. In the present case, the defendant did undertake such inquiries as he considered relevant to, amongst other things, the potential deterrent effect of

amendments to the 2015 Regulations. As appears from the material referred to above, the defendant obtained information from a wide range of sources, including, but not limited to, those with a particular concern for vulnerable groups. These included, but were not limited to, briefings and papers from the Doctors of the World Organisation and others. There is no arguable basis for contending that the defendant's decision as to what inquiries to make is irrational. In these circumstances, there is no need to consider the specific point referred to in the judge's reasons for refusing permission (that deterrence was obvious but its effect could not be measured). Permission to argue this ground of challenge is therefore refused.

ANCILLARY MATTERS

119. For completeness, I note that the claimant and the defendant referred to a large number of documents, and each made a large number of points in the course of the pleadings, skeleton arguments, oral submissions, and written submissions filed after the conclusion of the hearing. It is neither necessary nor proportionate to identify each and every paragraph of each document referred to, or to identify each of the many points made. I have dealt in this judgment with those documents, and those points, that explain the principal arguments, and the reasons for my conclusions. The claimant and the defendant can be assured, however, I have considered every document referred to and every point made.

CONCLUSION

120. The defendant was not required to consult publicly before amending the relevant regulations and imposing a requirement that advance payment for treatment be made, or requiring that records be kept of chargeable individuals. The defendant complied with his duties under section 149 of the 2010 Act and the 2006 Act. The claim for judicial review of the 2017 Regulations is therefore dismissed.