Briefing for the Immigration Bill (Part 3, chapter 2 to end) House of Lords Report 3 April 2014 ff

The Immigration Law Practitioners' Association (ILPA) is a charity and a professional membership association the majority of whose members are barristers, solicitors and advocates practising in all aspects of immigration, asylum and nationality law. Academics, non-governmental organisations and individuals with an interest in the law are also members. Established over 25 years ago, ILPA exists to promote and improve advice and representation in immigration, asylum and nationality law through an extensive programme of training and disseminating information and by providing evidence-based research and opinion. ILPA is represented on numerous government committees, including Home Office, and other consultative and advisory groups and has provided briefing on immigration Bills to parliamentarians of all parties and none since its inception.

ILPA's briefings to date on this bill can be read at http://www.ilpa.org.uk/pages/immigration-bill-2013.html . ILPA is happy to comment on or assist with ideas for other amendments and will provide further briefing on the final selection of amendments tabled. All references are to HL Bill 96. We include briefings to all amendments printed at the time of writing. Inclusion does not imply that ILPA supports the amendment; this should be clear from the briefing.

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PART 3 ACCESS TO SERVICES

Chapter 2 Other Services Etc.

Health

Clause 38 Related provision: charges for health services

AMENDMENT 51 Lord Ramsbotham, Baroness Finlay of Llanduff, Baroness Masham of Ilton

Purpose

Provides that a person cannot be charges for services provided while s/he is detained or for services provided in continuation of treatment commenced while the person was detained.

Briefing

ἀσκέειν, περὶ τὰ νουσήματα, δύο, ὠφελέειν, ἢ μὴ βλάπτειν[1]

ILPA supports this amendment. We are concerned about both the physical and mental health of immigration detainees; including children held in what he Bill rechristens "pre departure accommodation".

On 11 October 2010 ILPA wrote to the Home Office expressing concerns about amendments made to para 55.10 of the Enforcement Instructions and Guidance. The change was to the

[1] Hippocrates, ἐπιδήμιος (*Epidemics*), c. 430 BC.

definition of those " normally considered suitable for detention in only very exceptional circumstances. The definition changed from "those suffering from serious medical conditions" to "those suffering from serious medical conditions which cannot be satisfactorily managed within detention". The definition changed from " "those suffering serious mental illness" to those suffering serious mental illness which cannot be satisfactorily managed within detention…In exceptional cases it may be necessary for detention at a removal centre or prison to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the Mental Health Act". The definition changed from "people with serious disabilities" to "people with serious disabilities which cannot be satisfactorily managed within detention". In its response to questions from ILPA the UK Border Agency said[2] that the qualifier 'satisfactorily managed'

> *"Is not defined, nor to we consider it necessary to do so. The phrase is intended to cover the broad basis on which a person's healthcare, mental health or physical needs might need to be met if they were to be detained, with the expectation being that where these needs cannot be met the persons concerned would not normally be suitable for detention."*

In no less than five cases in the last three years the High Court has made unprecedented findings that the Home Office has by detaining mentally ill people subjected them to inhuman or degrading treatment in breach of the absolute prohibition in article 3 of the European Convention on Human Rights.[3] There are further reported cases where the Home Office has unlawfully detained members of this group and ILPA members have been involved in other similar cases where out of court settlements have been agreed with the Home Office.

On 16 January 2014 Her Majesty's Inspectorate of Prisons report on Harmondsworth[4] found (we quote from the press release)

- *a lack of individual risk assessment meant that most detainees were handcuffed on escort and on at least two occasions, elderly, vulnerable and incapacitated detainees, one of whom was terminally ill, were handcuffed in an unacceptable manner;*
- *one man died shortly after his handcuffs were removed and the other, an 84-year-old man, died while still in restraints;*
- *the Rule 35 procedure that identified victims of torture and others with special conditions was failing to safeguard possible victims;*

…

- *some significant gaps in health care remained and the continuing uncertainty and disruption likely with the imminent change of health care provider meant there was potential for deterioration in this service.*

The Home Office has shown an unwillingness to acknowledge that there is a problem and has only done so as a result of litigation or the threat of litigation and even then there has been a refusal or reluctance to acknowledge the scale of the problem. The changes that have followed have focused on Rule 35(3) (the duty to report on survivors of torture) with the result that there has been too little attention paid to Rules 35(1) and 35(2) (the duty to report on those

[2] Written response from Alan Kittle, Director of UK Border Agency Detention Services to ILPA, 20th December 2010.

[3] *R (S) v Secretary of State for the Home Department* [2011] EWHC 2120; *R (BA) v Secretary of State for the Home Department* [2011] EWHC 2748; *R (D) v Secretary of State for the Home Department* [2012] EWHC 2501; *R (HA (Nigeria)) v Secretary of State for the Home Department* [2012] EWHC 979; *R (S) v Secretary of State for the Home Department* [2014] EWHC 50 (Admin).

[4] http://www.justice.gov.uk/news/press-releases/hmi-prisons/harmondsworth-immigration-removal-centre-not-making-progress-and-some-aspects-poorly-managed

whose health is likely to be injuriously affected by detention and those who are suicidal). We continue to see poor quality decisions by those tasked with authorising detention; even when presented with cogent medical evidence caseworkers demonstrate a fundamental misunderstanding of clinical information.

A significant number of respected national and international governmental and non-governmental organisations have highlighted failures in the Home Office's decision making in this context. We highlight:

The Independent Monitoring Board for Harmondsworth annual report for 2011 (published March 2012). The Board expressed concern about the detention of the mentally ill and the practice of managing them by placing them in segregation, as well as expressing concern about the operation of the Rule 35 process:

> "***4.2.5 Accommodation for those who are mentally ill***
> *Detainees with mental health or behavioural problems have see-sawed between a healthcare ward and being in segregated accommodation, removed from association. If those who are mentally ill are to be detained appropriate accommodation should be provided. (see Sections 5.3.6 and 5.4.6)*
>
> ***4.2.6 Unfit for detention***
> *We consider that an independent review is required of the application of Rule 35 of .The Detention Centre Rules. (See Section 5.3.7)"*

The effectiveness and impact of immigration detention casework, a joint thematic review by HM Chief Inspector of Prisoners and the Independent Chief Inspect of Borders and Immigration (December 2012). This found that "[t]he Rule 35 process did not provide the necessary safeguards for vulnerable detainees" (para 41).

The Home Affairs Select Committee, Eighth Report of Session 2012-13 *The work of the UK Border Agency* (April-June 2012) published on 31 October 2012:

> *13. … If medical practitioners have advised that detainees should be accommodated in hospital or other institutions that care for the mentally ill then that guidance should be acted upon by the Agency and not ignored.*
> …
> *15. We are concerned that the cases outlined above may not be isolated incidents but may reflect more systemic failures in relation to the treatment of mentally ill immigration detainees.*

The Committee recommended that the Home Office "immediately carry out an independent review of the application of Rule 35 at Harmondsworth and at its other immigration removal centres across the country." The Committee reiterated this recommendation in its Fourteenth Report of Session 2012-13 published on 19 March 2013, expressing concern "at the enormous gap between the number of reports received and the number of individuals released", stating that the Home Office should "tell Parliament the reasons for which its caseworkers overrule the advice of medical practitioners" and warning that "[f]urther intransigence will continue to pose a risk to individuals, as mental health issues may not be properly identified".

The United Nations Committee Against Torture, Concluding observations on the fifth periodic report of the UK dated 24 June 2013:

> ..
> *(b) Take necessary measures to ensure that vulnerable people and torture survivors are not routed into the Detained Fast Track System, including by: (i) reviewing the screening process for administrative detention of asylum seekers upon entry; (ii) lowering the evidential threshold for torture survivors; (iii) conducting an immediate independent review of the application of Rule 35 of the Detention Centre Rules in immigration detention, in line with the Home Affairs Committee's recommendation and ensure that similar rules apply to short-term holding facilities and (iv) amending the 2010 United Kingdom Border Agency, Enforcement Instructions and Guidance, which allows for the detention of people with mental illness unless their mental illness is so serious that it cannot be managed in detention;*
> *(c) Introduce a limit for immigration detention and take all necessary steps to prevent cases of de facto indefinite detention.*

The ability to get treatment on release may be highly relevant to whether a person can be released at all, and thus to respect for the right to liberty. Decisions regarding hospitalisation or community treatment for people in immigration detention with serious mental illness should be driven by clinical considerations. The full range of release options available to the former UK Border Agency are not being deployed where mentally ill detainees are identified and where release is clinically indicated.

The Department of Health guidance contained in Good *Practice Procedure Guide: The transfer and remission of adult prisoners under s 47 and s 48 of the Mental Health Act*, (revised 2011),[5] offers guidance for the use of s 48of the Mental Health Act 1983 to transfer immigration detainees for treatment. In April 2011 Department of Health amended this guidance as it dealt with the implementation of s 48(2)(d) for people held in immigration removal centres. At 4.42 the guidance now says

> *"The aim is to return detainees to the IRC when inpatient treatment is no longer required".*

In our view this is not correct. Where a person has been held in immigration detention there are a number of options at the end of a period in hospital following a transfer under the Mental Health Act 1983, including release to the community with reporting conditions
The previous version of the Department of Health guidance[6] did suggest that for immigration detainees

> *"Caseworkers will need to be approached by the Healthcare Manager initially for a decision on whether Temporary Admission is appropriate. Admission may be by Sections 2 / 3 if the case-worker decides on Temporary Admission. Where continued detention is required transfer will be by Section 48."*

This version of the guidance correctly clarified that release from detention should be properly considered at the point when admission to hospital is being considered.
The Department of Health guidance covers the use of s 47 and s 48 of the Mental Health Act in both the prison estate and the detention estate. A Mental Health Act transfer will not always be clinically indicated; rather the patient simply needs to no longer be in a custodial environment. A detainee may not require a Mental Health Act transfer for compulsory

[5] Available at http://bit.ly/Rx16zk
[6] Issued in October 2007, available at http://webarchive.nationalarchives.gov.uk/20110603043925/http://psi.hmprisonservice.gov.uk/PSI_2007_50_mental_health_transfer.doc

treatment, but it may be clinically indicated that he or she be released from a custodial environment for treatment in the community or in hospital. In our view this is not only desirable but entirely possible given the range of powers both of detention and release – with conditions – that are available to the Home Office.
Those released from immigration detention may be released because of their health. It cannot make sense that in those circumstances treatment would cease at point of release.

After Clause 48

AMENDMENT 52 Baroness Masham of Ilton, Lord Rogers of Riverside, the Lord Bishop of Leicester

Purpose
Provides for exemptions from charging both where it poses a risk to public health and where it is not cost effective. Sets out a *de minimus* provision but also gives the provider discretion to waive the charge where s/he considers that it is not economical to collect it or where it would pose a risk to public health.

Briefing

> "*…no society can legitimately call itself civilized if a sick person is denied medical aid because of lack of means.*" Aneurin Bevan [7]

ILPA supports this amendment which was laid at Committee as Amendment 66A.
Health professionals who gave evidence to the Public Bill Committee in the House of Commons drew particular attention to the risks of the costs of such charges outweighing the benefits. Professor Terence Stephenson, Academy Chair of the Academy of Medical Royal Colleges, giving evidence on Tuesday 29th October during the morning session[8] said

> ***Professor Stephenson:*** *Clearly, as a UK taxpayer I do not want to fund the health care of people who do not contribute to my system. I quite accept that principle. What we are talking about is the difficulty in proportionality of implementing it. If it costs more in time and money to recover those costs, the NHS has much bigger fish to fry at the moment. If you can recover substantial costs without putting much in, then that is wholly desirable. However, I see emergencies; I spent all last week seeing emergencies. I do not want to be a citizen in a health care system where someone has to show their credit card before I attend to their immediate needs. To me, that would be wholly unacceptable and would not be becoming of the profession of which I am a member.* (col 22)
> **…**
>
> ***Professor Stephenson:*** *… there needs to be far more detailed economic analysis of the costs required to recover, vis-à-vis the income one will get. The figure of £2 billion was quoted, but my reading of that quantity of analysis is that it was hedged by caveats and wide confidence limits. Indeed, much of that £2 billion could be recovered without any change in legislation; it just was not being chased up. From the Department of Health's document, it seems that the additional sums of money that will come in owing to the new legislation will be much less than £2 billion. That is not a particularly easy document to understand, but that was my take on it.* (col 25)

[7] ***I****n Place of Fear*, Bevan, A., 1952, chapter 5.
[8] See http://www.publications.parliament.uk/pa/cm201314/cmpublic/immigration/131029/am/131029s01.htm

…

Professor Stephenson: *I think we are dancing around three separate things here, which are getting conflated. First, I have absolutely no doubt that you could introduce a system to recover these costs, and I am sure that GPs could introduce a credit card. If you wish to do it, it can be done. It is not beyond the wit of man, but it has a cost.*

Secondly, as a doctor, I am a good samaritan. My preference is to treat people without fear or favour, irrespective of colour, creed or religion. Faced with a young child who is ill, I would prefer not to be drawn into discussions about what country they came from and why they are here. I recognise, however, that that is a personal preference.

Thirdly, I recognise, as a citizen in a democracy, that there will be taxpayers and others, and readers of certain newspapers, who are absolutely incensed by my view that I would be very happy to treat people irrespective of where they come from, their religion or their colour. I recognise that such people believe that we should absolutely bottom out why those patients are here. Are they fit to pay? Are they here fraudulently? Are they here on holiday? If those are the rules you want, I will live with that. The three are related. The cost of getting that money from those patients will be a cost to that same British taxpayer. A detailed analysis of the weighing of the scales as to whether taxpayers will really benefit from this would be wise. If it shows that we would be £2 million better off, that would be £2 million that we could be spending on the care of UK children, on treating cancer or on doing hip operations, which would be fantastic. But if it costs £4 million to get it out, I think that is probably a mistake. (col 31)

It was stated in the *2012 Review of overseas visitors charging policy*, that the majority of migrants charged by the National Health Service are persons without the required immigration clearance or documentation.[9] They include refused asylum seekers (some, but not all, of whom would benefit from an exemption for those receiving support under section 4 of the Immigration and Asylum Act 1999) and overstayers. Many will be unable to pay the charges for healthcare they receive. Charges levied are likely never to be recouped. See the conclusion in the evidence document accompanying the consultation: debt recovery is difficult and "in most cases the burden falls on the state."[10]

We reproduce the table 3 from the Department of Health evidence annexe.[11] It is a rough and ready calculation but raises questions. The justification for treating migrants differently from the resident population is stated to be the latter's long term connection with the UK. But if that is correct then over the course of a lifetime the British citizen or settled person will make the greater demands on the National Health Service associated with increasing age.

Those who remain in the UK long enough to make these demands will remain in the UK long enough to make contributions akin to those made by a British citizen or settled person. The figures for each age bracket are averages and include persons making very heavy demands on the National Health Service because of disability or chronic conditions. We suggest that such persons are under-represented among 'temporary' migrants and that a consideration of the demographic evidence as to the health of migrants is required. Many migrants faced with, for example, a serious illness or an underlying health problem will chose to return to the country of

[9] *2012 review of overseas visitors charging policy: Summary Report,* International Policy Team, Department of Health, 2013.

[10] Department of Health, *Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment*, July 2013, page 11.

[11] *Sustaining services, ensuring fairness: Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment,* Department of Health, 3 July 2013.

origin to have it treated (as the Department of Health consultation paper identified in Part Six is the case for British citizens). Against the spectre of health tourism, unquantified and ill-defined in the consultation and challenged by other careful studies,[12] is the question of the circumstances in which migrants draw less heavily on the National Health Service than they are entitled to do.

Table 3: 2011-12 age- health care costs summary

Common Age Bands	Average HCHS[1] Cost / head 2011-12	Average Prescribing[2] Cost / head 2011-12	Average PMS[3] Cost / head 2011-12	HCHS + Mental Health + Prescribing + PMS £s/head	ONS 2011 Census based population (000s)	2011-12 Spend by Ageband (£000s)
0_4	489	24	210	722	3,329	2,403,519
5_14	457	28	56	540	6,058	3,274,101
15_44	559	66	88	714	21,511	15,348,081
45_64	1,213	193	152	1,558	13,480	21,006,649
65_74	2,993	401	253	3,647	4,592	16,748,065
75+	5,377	517	388	6,281	4,137	25,988,460
Total	**1,295**	**155**	**146**	**1,596**	**53,107**	**84,768,874**

Source: Estimates based on Nuffield G&A and Mental Health age cost indices and scaled to 2011 ONS Census population and spend from the 2011-12 DH Annual Report & Accounts.

The estimates in the Department of Health's response following its consultation on charging evidenced that its estimates of the costs to the National Health Service of persons under immigration control using the National Health Service are little more than guesses.

At second reading, Baroness Barker (cols. 460-1) argued that the existing research which the government has used does not provide evidence to justify the change: '…the conclusion that can be drawn from them is that there is currently no systematic data collection whatever on NHS use by migrants, chargeable or otherwise. ... the much publicized figure of £1.76 billion, which has been bandied around, is about 50% likely to be wrong.' (col. 461).

The Government has long been on notice of the need to undertake a cost benefit analysis of charging for health care. The House of Commons Health Select Committee said back in 2006 that its members:

> …*were astonished that by the Department's own admission, these changes* [were] *introduced without any attempt at a cost-benefit analysis*[13]

Such cost benefit analysis as has been carried out does not appear to support charging. The evidence paper that accompanies the Department of Health consultation says that the effect of the charges deterring persons from coming to the UK is unlikely to exceed 0.5% of Gross Domestic Product in a given year.[14] But 0.5% of Gross Domestic Product in 2012 was eight billion pounds.[15] If, as per the consultation document, charges levied will total about one billion and will not all be collected, then it would appear that the costs look set starkly to outweigh the

[12] See, e.g. *The Myth of HIV Health Tourism*, National AIDS Trust, 2008.
[13] House of Commons Health Select Committee (2006) 'NHS Charges: Third Report of Session 2005-2006', HC 815-I, London: The Stationary Office. See also *Early Action: Landscape Review*, National Audit Office 2013.
[14] Department of Health, *Evidence to support review 2012 policy recommendations and a strategy for the development of an Impact Assessment*, July 2013, page 20.
[15] Gross Domestic Product for 2012 was £1,623.48 billion.

financial benefits. What is the point of spending funds the National Health Service does not have in levying charges that it cannot recover?

The spectre of health tourism is often invoked to justify concerns about costs. In the case below the Home Office had at the outset accused the appellant of health tourism.

***[…] (health claim: ECHR Article 8)* [2013] UKUT 00400 (IAC), 24 July 2013**

[…][16]… lived alone in Nigeria after being widowed … She was able to come to the United Kingdom in 2004 having secured, in the face of fierce competition, a scholarship … Soon after arriving in the United Kingdom to commence her studies… the appellant was diagnosed with end stage kidney failure. It is now accepted and no longer in dispute that she was unaware of this potentially fatal illness, or even that she was unwell at all, until after her arrival. The evidence establishes that to be unsurprising as the nature of that condition is such that a person in the claimant's position would most likely not have noticed any symptoms. …The claimant required dialysis…to remain alive … Her leave was progressively extended and, despite having to undergo dialysis several times each week, she graduated in 2008. Although granted a final extension of leave… so that she could attend her graduation ceremony, thereafter the respondent has refused all subsequent applications for further leave to remain…

In July 2009 the claimant received a kidney transplant and thereafter required carefully monitored medication to ensure that the level of that medication in her body is maintained at an appropriate level so that the transplanted organ is not rejected. Quite apart from that, monitoring is essential as too high a level of that medication in the body can prove fatal. She will always remain particularly at risk of infection, … While the claimant remains in the United Kingdom her life expectancy and her quality of life will be normal. It is, now at least, accepted by the respondent that she would not be able to access treatment in Nigeria and so would die within weeks. That is not because appropriate treatment and living conditions are not available in Nigeria but because she would not be able to afford to pay for them…

The issue at that appeal was a simple one but it was also a stark one: Was the refusal to grant leave, with the accepted consequence that the claimant would die soon after removal, such as to breach the claimant's right to respect for her private life, as protected by article 8 of the ECHR, or was it a proportionate interference with that right, given that the claimant is not a national of this country and had been admitted for a temporary purpose which has now been concluded?...

The appeal came before First-tier Tribunal Judge […] on 21 November 2012….the judge… allowed the appeal. Our task is to examine the challenge brought by the respondent to that decision…The judge summarised the respondent's case as it was argued before him as follows: "…. [The respondent's representative] *conceded that she could not afford the treatment in Nigeria and would therefore inevitably die… It was however proportionate to remove her"*[17]

The evidence demonstrated that the Home Office was wrong to accuse the appellant of health tourism. The Home Office then resisted the conclusion that were the appellant returned to Nigeria she would die within weeks from kidney failure. The evidence showed that the Home

[16] We have omitted the name in this public submission.
[17] See endnote.

Office was wrong. For cases started after 1 April 2013, there has been no legal aid for immigration, as opposed to asylum, cases and thus it is very likely that there would have been no successful challenge to the accusation of health tourism. The Home Office then argued that the appellant's death was a proportionate price to pay for immigration control. This is a question that falls to be answered by reference to the law on Article 8 of the European Convention on Human Rights. Again, for cases started after 1 April 2013 there is no legal aid to assist an appellant in putting a case and this appellant, given her straitened circumstances, would have had to represent herself and herself make the case as to why she should be allowed to live.

Public health concerns have costs implications as well as implications for the lives of individuals and families. In 2011 over 60 per cent of African-born men and women were diagnosed with HIV "late", i.e. after treatment should have started.[18] Research suggests that more than half of new HIV infections are passed on by people who are undiagnosed.[19]

The Government is committed to an effective programme of immunisation programme to try to reduce the incidence of childhood infections[20]. The Healthy Child Programme is based in General Practitioners' surgeries[21]. The National Institute for Clinical Excellence has identified:

> *…those from some minority ethnic groups, those from non-English speaking families, and vulnerable children, such as those whose families are travellers, asylum seekers or are homeless*"[22]

as being at particular risk of not being immunised and has emphasised the potential attendant effect on herd immunity[23].

In Northern Ireland there is a considerable confusion about migrants' entitlement to free primary health care, stemming from the policy circular Family Health Services for Persons not Ordinarily Resident in Northern Ireland[24] and its relationship to the Provision of Health Services to Persons not Ordinarily Resident Regulations (NI) 2005[25]. Links between this confusion and shortfalls in vaccination resulting in outbreaks of infectious disease have been documented[26].

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[18] Health Protection Agency, *HIV in the United Kingdom*, 2011.

[19] Hall HI et al. *HIV transmissions from persons with HIV who are aware and unaware of their infection, United States*. AIDS 26, online edition. DOI: 10.1097/QAD013e328351f73f, 2012.

[20] *Improving Children and Young People's Health Outcomes: a system wide response*, Department of Health with the Care Quality Commission, Department for Education, Health Education England, Healthwatch England, Medicines and Healthcare products Regulatory Authority, 33 Monitor, NHS Commissioning Board, NHS Information Centre, NHS Trust Development Authority, National Institute for Health and Clinical Excellence, Public Health England, Royal College of General Practitioners, Royal College of Nursing, Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists, 2013.

[21] Department of Health (2013) *Healthy Child programme: pregnancy and the first five years of life* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf (accessed 22 August 2013).

[22] NICE (2009) Reducing differences in the uptake of immunisations (including targeted vaccines) among children and young people aged under 19 years http://www.nice.org.uk/nicemedia/pdf/ph21guidance.pdf

[23] *Ibid.*

[24] HSS (PCD) 10/2000, 23 June 2000.

[25] SRNI 2005/551. See Access to free primary (GP) and secondary (hospital) health care for migrants, Law Centre (NI) Community Care Information Briefing No. 29, July 2013.

[26] Accessing healthcare for migrants in Northern Ireland: problems and solutions, Law Centre (NI) Policy Briefing, 2013 available at : http://www.lawcentreni.org/Publications/Policy-Briefings/Policy-Briefing-Migrants-and-health-care-Law-Centre-NI-2013.pdf (accessed 22 August 2013). This records 15 cases of measles among members of a migrant community in 2012-2013, necessitating hospital treatment in several cases.

Questions of public health are also relevant to the plight of British citizens who are unable to evidence their entitlement to health service, including the mentally ill and those leading chaotic lives. Aneurin Bevan said of access to the National Health Service:

> *However, there are a number of more potent reasons why it would be unwise as well as mean to withhold the free service from the visitor to Britain. How do we distinguish a visitor from anybody else? Are British citizens to carry means of identification everywhere to prove that they are not visitors? For if the sheep are to be separated from the goats both must be classified…*"[27]

Before Clause 43

AMENDMENT 53 NEW CLAUSE Recruitment agencies: local workforce Lord Rosser, Lord Monks, Baroness Smith of Basildon

Purpose

To prohibit recruitment agencies from including only those not ordinarily resident in the United Kingdom as their clients.

Briefing

Laid at Committee as amendment 67 (Vol 753, col 13ff). Lord Taylor of Holbeach rejected the amendment saying

> *"…while I am sympathetic…[the amendment] would not achieve its aims. An agency could evade its scope simply by signing up a single UK resident as part of a recruitment process. We agree however that more should be done to tackle these types of unfair recruitment practices. Ministers will actively consider how best to protect British workers from this type of discrimination and we will seek to bring forward proposals shortly.*

This statement appears confused. There is in law no separate category of "British workers", there is a resident labour market made up of British and settled persons and it would be unlawful to distinguish between them. It would be helpful to correct this for the record.

Lord Rosser made clear in moving the amendment that the practice of refusing to register an applicant on the grounds of nationality is unlawful (col 14). The amendment is thus best understood as a probing amendment about enforcement rather than a proposal for primary legislation. Greater enforcement is desirable: all members of the resident labour market are entitled to protection from discrimination on the grounds of nationality, in parliamentary debates as in recruitment.

After Clause 44

AMENDMENT 54 NEW CLAUSE Permiss*ion to work* Lord Roberts of Llandudno, Baroness Lister of Burtersett, the Lord Bishop of Leicester

Purpose

[27] *In Place of Fear*, Bevan, A., (1952), chapter 5.

To make provision for persons seeking asylum whose claim (including a fresh claim) has yet to be determined within six months to apply for permission to work after that time and to ensure that persons seeking asylum are not restricted in the work for which they can apply.

Briefing

Laid at Committee as amendment 71. We know the answer to this one before the Minister stands up: that it encourages people to put down roots and makes it less likely that they will leave; that it makes asylum a more attractive route for those without protection needs. There are two responses to this. We shall then be told that the system needs to speed up.

We have a hideous and punitive support system based on the idea that people do not want to work and will lounge around and claim any subsistence only support on offer for as long as possible. What difference would it make then to let them work.

Will decision-making speed up? Many may recall the vote on the Bishop of Southwark's amendment in 1999, supported by the Conservative and Liberal Democrat parties, which would have prevented the Government from bringing in the National Asylum Support System until it had got decision-making times down to less than six months. Numbers of asylum applicants have fallen since then and this is the sixth Bill exclusively about immigration since the 1999 Act. We think we are entitled to conclude that what can be done by the UK Border Agency and its successors to speed up initial making has been done. We also recall the words of the Home Secretary when she abolished the UK Border Agency[28]

…it will take many years to clear the backlogs and fix the system."

Does being allowed to work make it less likely that people will leave?

Return from the UK having nothing to show for it may be harder than going back with skills to show for a stay and it may be harder to return when one has no hope of making a living on return. The government's Assisted Voluntary Return scheme is based on this principle. It may give out money or material support. Skills may be just as valuable.

Does being allowed to work make it more likely that people with economic reasons for coming to the UK to claim asylum?

What would you do if you were coming to the UK for economic reasons? If you could, presumably you would get a visa and work lawfully. If you could not get a visa would you
A)

- Make yourself known to the authorities
- Draw subsistence levels of support
- Risk being detained and removed

Or

B)

- Hide
- Work in the informal economy
- Try to escape detection for as long as you could?

[28] Hansard HC Deb 6 Mar 2013 : Column 1500.

The rudiments of that choice would not be affected by a grant of permission to work. The informal economy is very far from populated solely by foreign nationals unlawfully present. Many British citizens and settled persons work cash in hand, avoiding tax and regulation.

We recall a very memorable speech of Mr Jeremy Corbyn MP in the course of the passage of the Bill that became the Immigration and Asylum Act 1999. The House of Commons fell quiet as it listened to it:

> *"Those of us who have the honour of representing one of the large number of inner-urban constituencies know many people who have been overstayers for many years. They lead a twilight existence. They live in perpetual fear of getting a parking ticket, of being stopped in the street, of witnessing a crime and being brought forward as a witness and of going to any authority because they know that they will be asked for their passport, their papers will be searched for, the Home Office will be contacted and their whole life will be torn apart.*
>
> *If overstayers have a settled relationship and children, that fear is transmitted to their children, who are afraid to come forward and get involved. That simply is not right. If overstayers are looking for work, they are often subject to the worst possible exploitation. They will be exploited in sweatshops, burger bars, kebab houses and other places where people can get a job for a short time with no 2 questions asked. They will be paid disgraceful wages, and if they are abused by the employer, they cannot do anything about that. They cannot go to the Health and Safety Executive to complain about safety, and they cannot complain about not receiving the minimum wage or about anything else.*
>
> *We have to recognise that we will damage the fabric of our society unless we try to make sure that everybody is legally entitled to work and able to lead a normal existence.*
>
> *Although I recognise that the Minister has moved in the direction requested by my hon. Friend the Member for Slough (Fiona Mactaggart), it is essential that overstayers have the fullest possible rights of appeal. Case law indicates that in applications that rely, ultimately, on compassionate grounds, those grounds often reflect family relationships and structures. That is fine for people who happen to be in a relationship and to have a family, but the procedure often militates against single people who cannot claim such a network of support.* HC Deb 15 June 1999 vol 333 cc267-86

That is the life people who come to the UK to work lead. They do not claim asylum.