

Health Committee

Oral evidence: Brexit and health and social care, HC 640

Tuesday 21 February 2017

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Members present: Dr Sarah Wollaston (Chair); Heidi Alexander; Luciana Berger; Mr Ben Bradshaw; Rosie Cooper; Dr James Davies; Andrea Jenkyns; Andrew Selous; Helen Whately; Dr Philippa Whitford.

Questions 130 - 258

Witnesses

[I](#): Professor Martin McKee CBE, Professor of European Public Health, London School of Hygiene and Tropical Medicine, Professor Jean V McHale, Professor of Health Care Law and Director of the Centre for Health Law, Science and Policy, University of Birmingham, Meirion Thomas, former Consultant and Lead Surgeon at Royal Marsden Hospital, and Christopher Chantrey OBE, British national resident in France.

[II](#): Professor David Lomas, Vice-Provost Health, UCL and spokesman for the Association of UK University Hospitals, Daniel Mortimer, Chief Executive, NHS Employers and Chair of the Cavendish Coalition, and Professor Martin Green, Chief Executive, Care England.

Written evidence from witnesses:

- [Professor Jean V McHale](#)
- [Meirion Thomas](#)
- [Meirion Thomas](#)
- [Daniel Mortimer](#)
- [Professor David Lomas](#)
- [Professor Martin Green](#)

Examination of witnesses

Witnesses: Professor McKee, Professor McHale, Meirion Thomas and Christopher Chantrey.

Q130 **Chair:** Thank you very much for coming this afternoon to our session on Brexit and health. Would you start by introducing yourselves and the capacity in which you are speaking to those following from outside the room?

Christopher Chantrey: This September I will have been living in France for 44 years. I am chairman of an organisation called the British Community Committee of France, which represents the British who live in France through the associations to which they belong and from which they benefit all over the country. I am working very closely with a dozen or so other relatively new organisations that represent Britons in other EU member states, particularly since last June. They have sprung up since the referendum. We have weekly conference calls and discuss what we are going to do to try to help solve the problems we are facing.

Q131 **Chair:** Before we move on, are there any groups in member states that are not represented at the moment?

Christopher Chantrey: There are. We are finding more groups all the time. We are managing to bring them together to our weekly conference calls, but those calls are now getting up to 20 participants and they are probably reaching a practical ceiling. We are trying to forge links with other organisations. Brits in Luxembourg—BRIL—has just joined us, and we are continuing to try to have contacts as widely as possible in other EU member states.

Q132 **Chair:** It would be very helpful if you could drop us a note saying exactly who you represent so that we have it for background.

Christopher Chantrey: I will send it to you tomorrow when I get back.

Professor McHale: I am Jean McHale, professor of health care law at the University of Birmingham and director of the Centre for Health Law, Science and Policy at that university. My interest in this area is related to my work as both a health lawyer concerned with EU health law and a UK health lawyer, looking at it from one side and the other.

Meirion Thomas: My name is Meirion Thomas. I was a consultant cancer surgeon at the Marsden for 30 years and professor of surgery at Imperial College for five years. I retired from the health service in March 2014. Since then I have been working part-time in private practice and have been campaigning on aspects of the health service that I am trying to improve and not allow to deteriorate.

Professor McKee: I am Martin McKee, professor of European public health at the London School of Hygiene and Tropical Medicine, where I



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manage a large research programme covering everything from epidemiology to health policy across Europe.

Chair: Welcome back to the Committee. Helen will start the questioning

Q133 **Helen Whately:** I will start with quite a big question, but I ask you not to give too long an answer because we have quite a long list of questions to get through. I am sure the detail will be picked up by other members of the panel. As a current EU member state we have reciprocal healthcare arrangements with other EU member states. What is the view of members of the panel on the extent to which those current reciprocal arrangements benefit the UK and UK citizens?

Christopher Chantrey: They benefit enormously UK citizens who are registered in and live in the UK and use the European health insurance card when they go away on short trips; they benefit posted workers—people sent on assignments to other EU member states for periods of up to two years; and they benefit British retirees who, after a lifetime contributing to the system in the UK, decide to go abroad and have their healthcare provided by the host country under the same conditions as nationals of the host country, but the cost is paid by the NHS because they have contributed over their long lives to the NHS before leaving. Is that an answer to your question?

Q134 **Helen Whately:** That is clear. Does any other panel member want to add to that, or perhaps disagree with it?

Meirion Thomas: I am concerned about the EHIC. I put in my evidence that the UK pays out five times as much to other European countries as it recovers from them. When I realised that, I felt it was terribly counterintuitive as we are a magnet for EU migration. I have explained in my evidence why I think that is happening. Everybody thinks, fancifully, that everybody in Europe has a native EHIC and that when they go to another country they produce it and get emergency care, and the money is paid, but that is not what happens. What people do not understand is that in mainland European countries unless you pay into the health system you are not entitled to a native EHIC, but the minute you migrate here you are immediately entitled to every bit of NHS care, because you are ordinarily resident—any migrant coming to this country. Quite frankly, I think the EHIC has to end with Brexit, because the pendulum is heavily weighted, in an imbalanced fashion, against the UK.

Professor McKee: As will not be a surprise, I take a contrary view. I think the EHIC has many benefits. It is inevitable that we will have an imbalance like that, and I know Meirion has written about it elsewhere. We have a very large number of pensioners living in other EU member states—Spain, Ireland and elsewhere—whom we pay for because they consume health services. It is true that we import a large number of migrants as well. They generally tend to be healthy young people who provide healthcare in this country, so the imbalance to some extent certainly reflects that.



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In terms of the benefit to UK citizens, the advantage of the EHIC is that it covers pre-existing conditions. If as a British tourist you want to travel to France you are covered, and vice versa. Therefore, our tourism industry will get a lot of people who come here. They will perhaps have pre-existing conditions, but they will not require healthcare. I put in a few comorbidities, like diabetes and a history of mild depression, to see how much I would pay for health insurance for a one-week stay in France. It came out at between £800 and £2,500. Those were the four cheapest estimates. Among the many other problems that would arise, it would have some impact on our tourism.

Q135 **Helen Whately:** That is interesting. You would not incur those costs if you went outside the EU to countries where we do not have reciprocal arrangements.

Professor McKee: Indeed; you would be paying that. I used France as an example. I put in a 70-year-old with a series of common conditions. Remember that with the rise in multimorbidity, most people over the age of 70 will have multiple conditions. Effectively, it means they will not be able to travel, or at least they can travel, but they will take a significant risk if something goes wrong.

Q136 **Helen Whately:** Say somebody like that currently travelled to the US.

Professor McKee: They would have to pay that. They would probably have to pay more. I did not put the US into it, and medical bills are higher there.

Christopher Chantrey: When you are talking about imbalances and flows in all directions, imagine a very large piece of paper that has 28 boxes down one side and 28 boxes on the other. How many potential flows are there? It is about 750. They will not all be equal; you will always have some sort of imbalance between what we put in and what we get out. The concept behind freedom of movement and the rights that derive from it, the ones we are talking about, is that you do not seek to get back exactly what you put in—not a penny more, not a penny less; you are doing it as part of a wider community. The imbalances could perhaps be addressed in a different way. If we had greater influence within the EU we would have done it already, but there will always be imbalances.

Professor McKee: One of the challenges is the complexity. Individual member states have separate bilateral relations with other countries. For example, Irish people returning to Ireland will have healthcare benefits if they have been working in a number of countries including, interestingly, Quebec in Canada, the United States, South Korea and so on, but not other countries in the world. If they are Danish, they will have their own different set of arrangements. Of course, we have a number of agreements that predate the European Union that we could fall back on, but each of those has different terms and conditions, different eligibilities, different limits and different numbers of people who can be covered. For



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example, we have an agreement with the dependent territories but, for many of them, it is only for people from them. The complexity of that and summarising it in anything less than a short textbook will be incredibly challenging, as opposed to the system we have at the minute.

Q137 Helen Whately: Looking at it the other way round, do any of you have a view on whether the European Commission and individual EU states are likely to seek to continue the current reciprocal arrangement after we leave the EU, or do you think the EU states will seek to change the arrangements themselves?

Christopher Chantrey: The EU member states do not want to have to invent a new system just for Britain; they have a system that works to their satisfaction among 28 member states. There will be 27 member states in the future. Those 27 do not want to have to change the system they have; they find it works perfectly all right. If you are French and have an EHIC and go to Italy, that works.

Professor McKee: There are two issues that need to be considered, and I think they will underpin all your considerations. Any arrangements that we have on Brexit day plus one will continue to evolve both because of primary European legislation and judgments in the European Court of Justice that set precedents. The question that has to be asked is: if the UK is to continue to buy into or have arrangements under that system, how will it work? It will change over time as the EU position changes. Will it be, as in the case of Norway, essentially government by fax, as it is called, where they simply accept all EU legislation, including court judgments, and it is incorporated?

The second issue is dispute resolution. Who will resolve disputes? The Prime Minister has said she does not want the European Court of Justice to do it. If that is not the case, I cannot think who else will do it. I think she has also ruled out the EFTA Court. Then you get into things like World Trade Organisation dispute settlement processes, which are between states. We do not have answers to those, so it is very difficult to see how you could continue to keep the EHIC system until you have resolved the issue of the evolution of European Union policy in the future and the dispute resolution process. As the two simplest ways of doing that have been ruled out by the Prime Minister, I do not see how you can do it.

Q138 Mr Bradshaw: Do you think it was wise to rule those out at this stage?

Professor McKee: I would not have done it, but I am not the Prime Minister.

Q139 Dr Davies: If the EHIC is to continue, is there any question that there can be individual negotiations with countries in the EU, or, as you understand it, will it all need to work through the European Commission?

Professor McKee: Health is a national responsibility. I would take advice from others. Bilateral agreements could be reached, but there are many



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elements of health policy that are European competences, so you get into the difficulty of jurisdiction. Some of it could be done, and you might revert to pre-existing agreements. It is not clear whether you could revert to the pre-existing agreements. Unlike much of this, it is not at all settled. Even in the discussions we have been having with people who might be expected to know, we do not know. It could be done, but it will be incredibly complicated.

Christopher Chantrey: I do not think they will want to do it. Although health is a national area, health co-ordination is a European domain. As I said a moment ago, they have a system that works for the other EU 27. Why should they change it? They would prefer to carry on with what they have. We have an interest. I think the UK's interest is to secure a Europe-wide agreement with the Commission on this subject.

Meirion Thomas: I know I am here because I have said that the EHIC should end. I am very interested in Martin's statement about how much health insurance would cost. Maybe you need a different broker, Martin. Quite frankly, anybody from the UK going outside the European Union has to have health insurance. What difference is it going to make if they have to get health insurance to stay inside the European Union? Many people buy it by the year anyway. Certainly, I buy my travel insurance by the year, and it is at very reasonable cost.

Professor McKee: I went to Moneysupermarket.com, and to one of the very highly respected experts who give financial advice. He said that it is often cheaper for people with pre-existing conditions to get single-trip insurance, because the annual ones are priced in such a way because of unpredictability. The four quotations I had were: £757, £1,698, £2,008 and £2,452. Those were the cheapest.

Q140 **Mr Bradshaw:** For a week.

Professor McKee: For one week.

Q141 **Mr Bradshaw:** For someone with multiple morbidities.

Professor McKee: Yes. They were meant to be not unrepresentative for older people.

Q142 **Dr Davies:** Is it not the case that the advice is that you should have travel insurance regardless of an EHIC card when travelling within the EU?

Professor McKee: Because if you fall on a ski slope it will not cover your evacuation. It will cover many things, but if you want to be repatriated, for example, the EHIC will not cover that, so there is an argument for it, but you pay an awful lot less in the EU. This is the current situation for people with an EHIC, so it is only for pre-existing conditions. They are already covered, so the bill post Brexit would be substantially greater. In retrospect, I should have done Switzerland as well. Switzerland would be covered too, but maybe I should have taken somewhere else that would



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be comparable. That is already with the EHIC, so it is significantly discounted from what it would be.

Q143 **Dr Davies:** We have discussed the EHIC card. We have not really touched so much on the S1 arrangements for those who are retired. Are any of you concerned that there could be arrangements reached post Brexit in relation, for instance, to EHIC, or something similar, but not in relation to SI?

Christopher Chantrey: It is absolutely essential for all UK pensioners who live in other EU member states and rely on the S1 to have an equivalent system in place. A lot of those people are on very low incomes. They are aged and therefore are likely to have health problems in the future. If the S1 system stops on Brexit day because there is no appropriate system in place for Brexit day plus one and beyond, those people will come back to the UK and be a further burden on housing resources and on the healthcare and social services resources of this country. I cannot see that the Government or anybody in Parliament would want that. We are talking possibly of between 100,000 and 300,000 people being forced to return in a state of poverty to this country.

Professor McKee: That is an important point. Many will come back in a state of poverty because they bought properties in Andalusia and other places. The massive glut in the market already will be exacerbated by all the British people leaving, so that property will be essentially worthless. They will be throwing themselves on the mercy of the state when they come back.

We should not forget another group of British pensioners living abroad. Those are people who came in their teens to work in the UK, paid national insurance contributions and taxes all their life and then returned, mainly to Ireland, Spain and Italy. They are not pensioners in their own country because they did not build up an entitlement. We have been discussing at length what coverage they will have in those circumstances, and we are unable to resolve it. Certain arrangements have been made in other countries like Ireland. We looked at what happened to Irish people who went to Canada or the US and came back. There are some bilateral arrangements, but they are complicated and they are with individual countries. There are a significant number. For example, if you look at British pensioners in Spain, the older generation who were born in the United Kingdom are living in Malaga and the Balearics, but there is another group in Galicia who tended to be Spanish waiters in the UK; they lived here most of their lives and then went back. We have no idea what will happen to them.

Meirion Thomas: Can I make the point that people with S1 visas are perfectly entitled to come back to the UK for treatment, and loads of them do? I can tell you from my clinical experience that lots of people come back for surgery and follow-up consultations. They are perfectly



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entitled to come back. Many of them prefer to come back to have their treatment in the UK. It is not very far.

Q144 **Chair:** When people return from outside the EU, even if they are British citizens they sometimes find they are not eligible for treatment because they are not ordinarily resident.

Meirion Thomas: I thought we were talking about the EU.

Q145 **Chair:** I am talking about the day we leave the European Union. Perhaps Professor McHale would like to come in on the legal position the day after we leave the European Union. If pensioners return but they are not ordinarily resident in the UK, could they find themselves ineligible for treatment?

Professor McHale: They could indeed find themselves in a very difficult situation if they are not ordinarily resident. They will not come under *Shah v. Barnet* and they will be in a very difficult position. In many ways, Brexit D-day is going to be absolutely critical. There is almost a danger of relying on the fact that we may have transitional arrangements, and that might lull us into a sense of false security as to what actually could happen. We almost need to plan for the cliff-edge scenario and perhaps work back to all the scenarios we have. That picks up some of the points we have already heard and is linked to them.

Essentially, we need certainty. The White Paper talks about the need for certainty. This is an area where we have the question of reciprocity. It will need to be sorted out in the great repeal Bill; otherwise, there will be practical problems, with patients stranded in other EU member states at midnight on Brexit. Who is going to pay? Will they be presented with a request for a MasterCard, Visa or American Express at that point? What will the arrangements be in terms of certainty around that, or will we be driven to a cliff edge at that point? Those questions will need to be resolved.

There is a separate matter that I think we have started to allude to. We have the European health card question; we have the question of free movement generally, and more regular planned treatment, but also prior authorisation treatment, or people generally exercising their rights under the patient rights directive. You then have the situation of retirees and the broader questions that have already been outlined. We have something else that no one has mentioned until now: the border with Northern Ireland and the special position of people from the Republic. That relates both to when they are treated in this country anyway and, more broadly, to the provision of cross-border services. In some ways, in terms of the negotiations there are those four categories. Different issues will then arise practically in relation to the four categories. There is an interesting question about how much the Government intend that health should be negotiated separately from other social rights, where this debate is situated in terms of Government policy, and how much one can/should do that, or whether things have to be packaged together.



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Chair: That is very helpful.

Q146 **Dr Davies:** It is worth considering that there is a small number of reciprocal health arrangements with non-EU countries, such as New Zealand. To what extent do you think that agreement could be used as a template to negotiate with our EU partners, should it be necessary?

Christopher Chantrey: I had a look at the New Zealand agreement recently. You have to prove that you are a national of the contracting state to get treatment in the other, but we know that healthcare is a residence-based service, so you would have to make that adjustment. There is an Australian agreement that takes account of residency rather than nationality, but something inspired by the Swiss agreement with the EU would give us pretty much what we have at the moment, so if you are looking for a model, look at the Swiss agreement.

Professor McKee: None of these is fully reciprocal, because they do not give the same entitlement. Australians in the United Kingdom have free access to general practitioners, but not vice versa. Again, you get into complexity. All these things are possible, but compared with the unified single system of the EHIC, they introduce a greater burden. We may come to it later, but there is already an enormous cost in collecting money from people coming from overseas. If you add to that the fact that you then have to look at the individual entitlement for each country, it will be significant.

Q147 **Dr Davies:** Is this an opportunity to look at reciprocal arrangements across the world, expand the list and try to bring about some conformity?

Professor McKee: Have you tried it with the United States?

Q148 **Dr Davies:** Not personally.

Professor McKee: I rest my case.

Q149 **Dr Davies:** Does Brexit give us an opportunity to redress the balance between the amount of money we recoup from other EU nations and the amount that goes in the other direction?

Professor McKee: How?

Meirion Thomas: The thing I know for sure is that one of the problems is that a mainland EHIC is not as generous as ours. Ours lasts for five years before you have to renew it. As I put in my evidence, in Poland, for example, you are offered either 40 days or 90 days. Very few people have anything like 90 days. The other thing that shocked me when I researched this is that, when mainland Europeans come here and they do not have a native EHIC, the first thing they do is obtain a UK EHIC. They can use that when they go back to their own country—we have proven that—and the bill is sent back to this country. I think that is an infringement.



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Christopher Chantrey: That is because they are working in the UK and they start to contribute to the UK system.

Meirion Thomas: Correct, but the minute they arrive, whether or not they are employed, all they need is an address and either an NI number or NHS number and they can get a five-year EHIC card.

Christopher Chantrey: If I moved to Germany tomorrow and started working for a German employer, I would have the right to healthcare in Germany and I would be able to have an EHIC card issued by the Germans, which I could use in any other member state.

Meirion Thomas: How long would it last?

Christopher Chantrey: I do not know. As you say, it is different. If I get an EHIC card from the French, I think it is valid for six months.

Professor McKee: The challenge is that at the minute the British Government can present a consolidated bill to another member state to get all the money back. The transactional costs of chasing up the insurers or individuals for 1,000 French people might be considerably greater than the money you might recover.

Christopher Chantrey: Member states, for their own nationals, can agree either to pay per act or make a per capita payment a year. Each member state chooses.

Professor McHale: I understand that the issue of recouping has been looked at by the Committee of Public Accounts very recently. The NHS (Charges to Overseas Visitors) Regulations place a duty on the NHS in relation to recouping those charges. Regulations have been in place for a long time. I know that 2015 guidance has been issued. I also understand that there are considerable practical problems. My understanding is that it does not apply to GPs in the same way, because GPs are subject to separate contractual arrangements. Although there is reference in the guidance to GPs, it is phrased in terms of hospitals. The charging regulations are phrased in terms of the NHS, so there is an interesting question of alignment.

You then hit the practical question of how you do it. I understand that there are various attempts to undertake this in different parts of the country. Pilot schemes have been undertaken. The guidance emphasises sensitivity and the need to ensure compliance with equality legislation, for instance, in the way it is undertaken.

Professor McKee: Following the earlier informal discussions with some of you, we did a study, which is under review at the minute, where we submitted freedom of information requests to every acute trust in England to ask them how much they spent collecting money from overseas patients and how much they recovered. Most of them were spending more money than they were recovering. They had a very low



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level of recovery, but as time went by they found they were often trying to recover from people who were entitled anyway. The complexity is enormous. We also made a freedom of information request to Peterborough hospital trust—it is often cited as an example—asking for the evaluation that had been reported. They told us that they had not done an evaluation.

Q150 Heidi Alexander: Mr Thomas, forgive me if this was in your written evidence. I do not have it in front of me at the moment. You said that, when EU nationals came to the UK, the first thing they did was get an EHIC. Could you give me some idea of the scale? For example, in the last year for which data are available how many EU nationals have secured EHICs?

Meirion Thomas: I have no idea of the extent of it.

Q151 Heidi Alexander: How do you know that it is the first thing they do when they arrive in the UK?

Meirion Thomas: I work with a group of people as a mild campaigner, if you see what I mean. They are overseas visitor officers who work in NHS hospitals and their job is to identify and charge people who are ineligible for free NHS care. Do you know what OVOs are?

Heidi Alexander: Sorry.

Meirion Thomas: They are overseas visitor officers. Every hospital—every trust—should have an OVO. Their job is to identify and charge people who are ineligible for free NHS care.

Q152 Heidi Alexander: The statement you made at the beginning was that the first thing people do when they come to the UK as an EU national is get a British EHIC issued in this country. You do not have available data on that.

Meirion Thomas: I do not have data available, but I know it is extremely common. My OVOs tell me. When they go to see these people when they come into hospital, they say, "Please can I see your EHIC?" and they produce the UK EHIC.

Q153 Heidi Alexander: That does not sound particularly extensive or quantitative data, but I was interested because I thought it was quite a sweeping statement, to be honest.

Meirion Thomas: It is, but I am a private individual and I do not have the ability to do that investigation. Just because there is no evidence, it does not mean it does not exist.

Q154 Mr Bradshaw: You claimed that 60% of EU nationals who are migrants to this country are unemployed, which is also not true.

Meirion Thomas: I think it is true. That was the figure they gave. I did not say they were unemployed; I said they had no job on arrival—they were unemployed on arrival.



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Q155 **Mr Bradshaw:** Would that include students whose treatment costs are reimbursed by their own countries and EU national pensioners living here?

Meirion Thomas: That is a statement I remember David Cameron making in some interview. That is where I got it.

Q156 **Dr Whitford:** We have already explored quite a lot about the S1 transfer, which is almost a greater issue than the EHIC because it affects people actually living there. If I could turn first to Christopher, do you think the concerns of British nationals who have retired, particularly those living in southern Europe, would be finance and having to come up with insurance cover or whatever, or are there bigger issues for them?

Christopher Chantrey: Healthcare is the principal concern of hundreds of thousands of UK pensioners living in other EU member states, whether they are in the north or south of Europe.

Q157 **Dr Whitford:** I said that because the south of France and Spain are where we tend to seek the sun.

Christopher Chantrey: They seek the sun because often the condition of their health means they are better off in a warm atmosphere, so why not go where you can live better? It is the main problem area. If you have a pre-existing health problem, how will you get private insurance if the UK no longer pays for the cover you contributed to all your working life in the UK? The host country will not do it, because you have not contributed to that system. That is why the Europe-wide system of co-ordination exists in the way it does. You cannot get anything from the host country. The home country, the UK, turns its back on you and says, "We're doing Brexit. Therefore, we are going to cut you off with nothing," the famous cliff edge my colleague referred to. The cliff edge has dramatically awful consequences. How can anybody say—I am afraid this was in the White Paper—that no deal would be better than a bad deal? It is the reverse. No deal would be far, far worse than a bad one; it is the worst possible deal. This will affect hundreds of thousands of UK citizens who have moved out there and are receiving their pensions and healthcare. They moved out in good faith on the implicit promise that these arrangements would continue. Suddenly, something happens that brings those arrangements to an end. It is absolutely terrible for many people.

My colleague John Shaw behind me has allowed me to say that he is a triple cancer sufferer. He went to France having been treated for his first bout of cancer in the UK. If he had gone out there and had to fund his basic health insurance through private sources, it would not have been possible. They would not have taken him on, or they would have taken him on at a hugely prohibitive rate. What is going to happen to all these people if there is a cliff-edge Brexit and they have no arrangements? They will have to come back in droves. What will happen when they come



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back? They will be poor because they cannot sell their properties, and they will be a huge drain on the NHS and the state in general.

Q158 **Dr Whitford:** Martin, you looked at the replacement for the EHIC for a week away for a 70-year-old.

Professor McKee: It was for travel insurance, but with the EHIC in place.

Q159 **Dr Whitford:** Did you look at someone who chooses to stay in the south of Spain, or wherever, and what the annual health insurance might be?

Professor McKee: No, I did not. The difficulty is that, because the EHIC is in place at the minute, nobody is offering a price. In a way, it is a hypothetical. Even if you get private health insurance in Spain, it is a bit like BUPA membership here. It will cover you for elective surgery and various other things, but you would need to go to a specialist broker to get advice and even then I suspect it would be speculative.

Q160 **Dr Whitford:** Even thinking of equivalent countries outside the EEA might give some kind of scale for that.

Professor McKee: It is complicated because there are certain bilaterals like the Irish one, obviously because they have a diaspora and they have some relationship.

Q161 **Dr Whitford:** Does anyone on the panel have any idea how much money the NHS saves? My understanding is that we take a block price for the S1 form elsewhere in comparison with, say, 250,000 S1 forms if those people were being treated for their multimorbidities here. Have you looked at that?

Professor McKee: It is very difficult to calculate because people who move abroad tend to be healthier when they move. They also tend to be somewhat more affluent, because they buy somewhere abroad. The methodological challenges would be considerable. In its ongoing discussions, the Department of Health has looked at whether it can negotiate down the amount of money it pays to Ireland, for example, and it has come up against those challenges. That is the case with a lot of these things. There simply are not the data to allow you to come to any agreed figure, so the process of negotiations will be lengthy. This is true in a lot of these areas. The classic example that I am sure you are familiar with is the discussion on the WTO lamb and mutton quota. It seems perfectly straightforward until you get into the mathematical details of renegotiating it, which is why the European Union has not changed it since before 2004, or whenever the EU enlarged; it is so complicated.

Q162 **Dr Whitford:** Obviously, one of the reasons we are doing this as the first of our inquiries is that, if you are in hospital on Brexit day plus one, you need to know who is covering you. Martin, is there any evidence on unit costs for equivalent treatments in places like Spain and Portugal and how



that would compare?

Professor McKee: There are. I do not have it to hand, but there is a project called EU health BASKET led by colleagues at Berlin Technical University. They have looked at prices for diagnosis-related groups across Europe. I could provide you with some of the information on that. The challenges are that the costing mechanisms vary greatly. To take the Netherlands and Germany as an example, in Germany, many, but not all, of the hospitals are funded by the regional governments—the Länder—and that comes out of taxation, which is separate, and social insurance pays for care within them. In the Netherlands, which has a system that is in many ways very similar, partly because it was introduced by the Germans in 1942, the money for capital development of hospitals comes out of social insurance funds, so there is an immediate difference. The issue of comparability of costings across Europe is extremely complicated. There are differences between the National Institute for Health Research, which is part of the NHS here, and Health Education England, but not in other countries. That has to be apportioned. There is a lot of work, particularly by the OECD and in EU research projects, but it is not simple.

Christopher Chantrey: To answer your question, although it is anecdotal, we know that in certain member states unit costs are, if anything, lower than in other places. I suspect that, if you could isolate the long lists of different medical acts or procedures, you would probably find that the unit cost is lower in places like Spain, Portugal, Romania and Bulgaria than elsewhere. If it is a per act or per procedure reimbursement, if that is the way the relationship is with that country, it would only be the co-payment. In France, the basic reimbursement level is, let's say, 70% for a GP, so 30% is borne by the patient, and that is the co-payment. The 70% is all that the NHS would be charged.

A further point is that the capital costs of creating facilities—the resources used for medical procedures, hospitals and so on—are borne by the host country; for example, France, Spain and all the countries we have been talking about. It means that in those countries the NHS is paying for certain treatments for S1 and EHIC beneficiaries on a variable cost basis only. There is not a need for the NHS to put up capital funding to build more hospitals. Obviously, more hospitals will be needed for the residents of this country, but in respect of British people in other EU member states there is no need to provide capital funding. All the medical care is paid for on a variable cost basis.

Q163 **Dr Whitford:** What about the people who work in those countries, not the pensioners? You have talked about the short-term traveller and the pensioner, but what about someone who has been living in France for 20 years, working and paying? At the moment, because they pay into the system, they are just like any other citizen. Christopher, will that continue?



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Christopher Chantrey: Will that continue? I do not know whether I will have the right to reside after Brexit day. That is a right that derives from EU citizenship rights that this country is going to put an end to if there is no adequate replacement arrangement in place. I don't think they will throw me out, but I do not have that right after midnight on Brexit day. Up till then the situation you have just described is correct. I paid into the system all the time I was a salaried worker and a self-employed worker, and now I am a retired person. As long as I have the EU citizenship right to reside in that member state, I am okay.

Q164 **Dr Whitford:** My husband has been a GP here for 31 years, and it is access to healthcare that he is anxious about.

Christopher Chantrey: Of course. You mention spouses. There is a problem for mixed nationality marriages. We have people writing to us saying, "What do we do? My spouse is a non-EU national. What will happen to us?" I do not know how to answer that. These are families at risk of being broken up. There is a case involving divorce in Italy. I think the mother is in the throes of divorcing an Italian, and in order for her to have access to the children, who are Italian, she cannot go to the UK. Her marriage is at an end and she has no resources. If she came back to the UK she could throw herself on the mercy of the state, but she would never see her children.

Professor McKee: There is an important distinction between the right to reside and rights as an EU citizen. The right to reside is one part of that. Unfortunately, in a lot of the discourse we hear about the right to reside, which really does not address issues like the right to own property, the right to transfer pensions and the right to transfer capital. A whole series of issues will make it very difficult.

Q165 **Dr Whitford:** You can only take advantage of one if you are able to take the other rights with you.

Professor McKee: Exactly.

Q166 **Dr Whitford:** Mr Thomas, is the imbalance you talked about due to the fact that we tend to retire to the sun and not so many people want to retire to the rain? As a Scottish MP, I can vouch for that. The other thing, which was mentioned by Professor McHale, is that it is our end that is not collecting the data. That is not the fault of the EU or EU countries. We simply do not have a system where we can painlessly be aware that we should bill France because that person is French.

Meirion Thomas: We know there is a five to one difference in receipts and collection. Whether it is due to the S1 or the EHICs, I am not sure.

Q167 **Dr Whitford:** Do you recognise that part of the problem is at our end of the equation? The NHS is not set up to collect those data at the front door. Even after the PAC inquiry and the £500 million, how much will it cost us to collect all those data? How much change will we get? It is not Europe's fault that we cannot tell them how many people were treated in



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Guys and St Thomas.

Meirion Thomas: Not only do we not have the method to collect it; we do not even agree that people have to pay it.

Q168 **Dr Whitford:** It would not be the people who would pay it; it would be their Governments. That is how it is done at the moment, so the imbalance is not particularly Europe's fault; it is ours.

Christopher Chantrey: I think you are right. To me, it is extraordinary that a Bill is scheduled to be debated this year in Parliament to enable NHS hospitals to charge unentitled people for treatment received. You have to show you are entitled to it. Anywhere else in the world you have a card like this. This is the French one, but it could be anyone's. If I go into a French hospital I will be asked, "Do you have your Carte Vitale, please?" They take it and read it, and that is how they know who is going to pay. It will not be the UK, because my cover is all on the French side, but they know how to do it. The system works extremely well. It is a question of proving entitlement. I should not normally go to St Thomas' Hospital across the way and get treatment there. I sound like a Brit and I am a Brit, so they would say, "Give me an address and we won't ask you for any money," but they should ask me for money. I am not entitled to NHS treatment unless I produce an EHIC card. That is the way the system is supposed to work.

Dr Whitford: Before the session started, we were talking about the fact that we do not have ID cards. We keep rejecting them and then we come up with, "Bring a utility bill and a driver's licence."

Q169 **Chair:** Could I ask a technical point? If you are a UK citizen living in an EU country where the entitlements are not similar to NHS entitlements, does the NHS pay privately for top-ups to your treatment?

Professor McKee: No.

Q170 **Chair:** It is just entitlement within the EU.

Christopher Chantrey: It pays for the entitlements that the fellow inhabitants of your host country get; it is on the same basis.

Chair: Thank you for clarifying that.

Q171 **Andrew Selous:** Starting with Mr Thomas, is it your concern that EU nationals using the NHS are using it unlawfully, or that they are using it without charge? What is the basis of your concern?

Meirion Thomas: Are we going back to "ordinarily resident"?

Q172 **Andrew Selous:** We are talking about EU nationals using the NHS.

Meirion Thomas: As I understand it, the NHS (Charges to Overseas Visitors) Regulations 2015—they are available on the internet—tell you immediately that, if any EU national comes to this country and says, "For just this small part of my life I am ordinarily resident in this country and,



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by the way, I am also ordinarily resident in another country," that is fine. You are allowed to do that and immediately you are entitled to NHS care. I saw that happening many times when I was in practice. The commonest thing I saw was a European person who had been living in this country for some time. Then a relative—a sister, brother, cousin, aunt, or anybody—becomes ill and they bring them over. They say, "Look, I am the only one who can look after this person," so they have to have all their very expensive treatment here. There is absolutely nothing you can do about it. Absolutely nothing. They are ordinarily resident because they say, "For this period of my life I am living here."

Q173 **Andrew Selous:** It is extension to other family members.

Meirion Thomas: I gave you an example of extension to a family member, but anybody could do it. There are 500 million people living in Europe. If they only knew it, any one of them could come to the UK now, while we are in the EU, and claim to be ordinarily resident and they would all be entitled to any care they want to have. There is nothing to stop them.

Christopher Chantrey: I do not think it would work in another EU member state.

Meirion Thomas: It is one-way traffic—exactly one-way traffic.

Christopher Chantrey: But it is because of the slackness in the system; you are not asking people to prove entitlement. If you are running a health service, from day one in 1948, you should have sussed that one out. You have to ask people to prove they are entitled.

Meirion Thomas: I think it is about our definition of ordinarily resident. A moment ago you mentioned *Shah v. Barnet*, which was how it all arose, in 1983, I think. It was not an Act of Parliament; it was purely a judgment by Lord Scarman in the House of Lords to do with education. From that moment on, the concept of ordinarily resident sneaked into our lives. For example, we do not have to have it, because the Inland Revenue ditched it in April 2013. Since then, they have had a different legal requirement for paying tax. I think it is called habitual residency, which means that you have to be in this country for a period of time before the tax laws apply to you. I cannot understand why we did not get rid of ordinarily resident a long time ago, but it has lingered.

Christopher Chantrey: That is a matter for national legislation.

Meirion Thomas: It is not legislation.

Christopher Chantrey: It is the UK that can do something about it.

Q174 **Chair:** Can I ask Professor McHale to clarify that point?



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Professor McHale: Without going back through the regulations, I am not quite convinced that the interpretation would be as open as you suggested.

Meirion Thomas: I have it written down here.

Professor McHale: I mean the way ordinarily resident has been interpreted in terms of the guidance itself—without riffling through the pages.

Meirion Thomas: It is in the first few paragraphs of chapter 3 of the guidance.

Professor McKee: It is quite difficult to register with a GP without providing proof of address, passports and all sorts of other things. When I have talked to general practitioners, they go through quite a few checks to make sure people are entitled. The point is that any time you have case law that has been there for some period of time and has not been addressed, I would simply say, with all due respect to those Members of Parliament present, it is up to Parliament to settle it. That is how most of the EU legislation on patient mobility started. It started off from a series of cases in the European Court of Justice. That was felt to be unsatisfactory, so the European Union brought about primary legislation to address it.

Q175 **Andrew Selous:** I will come back to the issue of identifying charging for patients in a moment. Mr Thomas, based on your clinical experience over your career as a doctor, what evidence is there that providing care to EU nationals is causing detriment to the overall delivery of care by the NHS?

Meirion Thomas: I was working in an ivory tower hospital and we had plenty of facilities, but the whole point about the NHS at the moment is capacity. There just is not the capacity. I was having a cup of coffee and watching the news at 1 o'clock today. Apparently, we are going to shut more hospitals and reduce the number of specialist units. We are going to do all sorts of things today. The big problem is capacity. That is the answer.

The other thing about ordinarily resident is that it does not apply just to EU citizens; it applies to Brits living abroad. I saw a number of Brits walking back into the country and saying, "I'm ordinarily resident." The best example I have is someone who had been abroad for 46 years who walked back in and said, "I'm ordinarily resident; I have moved back now for this time in my life, and I want treatment." I know someone who did that; they had two bone marrow transplants and were in intensive care for three months. I have loads of examples in my personal experience of this happening.

Q176 **Andrew Selous:** We were talking about this matter just before the session started. As MPs, in some of our constituency casework all of us have examples of that working both ways. Some returning Brits have not



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been offered treatment, but I accept what you say.

I want to turn to the cost of setting up systems to identify and charge patients, which we have heard a bit about, particularly from GPs. To get some figures on the record, a parliamentary written question answered in February of last year showed that the UK paid £147 million to France, £215 million to Ireland and £223 million to Spain. I think we recovered just over £1.5 million from Poland and just under £500,000 from Romania. I picked out five to illustrate the issue. On the question of identifying and charging, is there an insurmountable hurdle? What are the practical difficulties involved? I note that France, Ireland and Spain seem to have set up systems to do it quite efficiently, so what is the issue here?

Meirion Thomas: Christopher has just shown you his card. What is the card?

Christopher Chantrey: It is the Carte Vitale, which proves entitlement. If you go into a French doctor's surgery or hospital and show the card, you get the treatment.

Meirion Thomas: If I understand the system, you probably have a different card when you go to the hospital. When you go to the GP it is like an ATM. You put that card into the ATM and prove entitlement. There is no concept in this country of paying for any healthcare. We all assume that healthcare is completely free all the time. You mentioned general practice a moment ago. Of course, general practice is terribly important, but the big costs in running our health system are in hospitals. We need to identify people coming into hospitals. I know that general practice is costly, but the big costs are in hospitals.

Q177 **Andrew Selous:** In short, you would be reasonably optimistic that it is possible to set up systems that are not overly burdensome or costly.

Meirion Thomas: How will you do it if there is no system where you have any form of personal identification, and we do not have the card that Christopher has? We have absolutely nothing. How will you prove entitlement when you go to any hospital? Don't forget it might be happening very quickly—it might be an emergency. How do you ever prove entitlement? There has to be some system of identifying personal entitlement to free healthcare, and that is what I have been saying. I noted what Dr Whitford said a moment ago. It was my idea that we should produce for hospitals a passport and a utility bill. That was something I floated a long time ago. I see nothing wrong with that for hospitals. It is very difficult for any other system. For heaven's sake, what is wrong with doing that when you go for elective care in hospitals? I know it would not solve the whole problem, but at least it would start making inroads into it.

Q178 **Dr Whitford:** But you have to do something for all people who come. You cannot just say, "You look a bit French," or "You look a bit dark." It is not just for EU nationals; you have to do it for all people.



Meirion Thomas: Excuse me. I have made the point very clearly. It should be a screening test for everybody. I am surprised that people do not know exactly what overseas visitor officers do. If somebody was unable to provide a passport and a utility bill, the OVO would come down—every hospital has one—and, very compassionately, would ask, say, the elderly patient, “Why don’t you have a passport?” They say, “I do not have a passport.” “Why haven’t you got a utility bill?” They say, “Because it is all in my husband’s name.” “Okay, you’re on the—

Q179 **Andrew Selous:** I want to bring in Professor McHale.

Professor McHale: There are several things. There is almost a danger of our being deflected from the main focus of the Committee’s work on this, with respect. I absolutely take the point about establishing identity, but as has already been alluded to, the identity card issue has been a hot political topic in terms of general questions around civil liberties in this jurisdiction for a very long time. It might be optimistic. Given the tremendous amount of work that not just this Committee but your colleagues in Parliament have to do in the lead-up to Brexit, to try to resolve this now may be challenging, although I am not decrying your capacity to do it at all. That is the first question.

Q180 **Mr Bradshaw:** When your party converts to the benefits of having ID cards, get back to us, otherwise all this questioning is pointless.

Professor McHale: Or otherwise. As we have seen already, in the interim there are already practical problems—for example, the elderly patient who has never been abroad at all. What do you actually do?

Given that undoubtedly the NHS is in dire need of additional funding, any amount of money that could enhance that would be important. None the less, we do not know the precise amounts. In terms of priorities and the problems we have, perhaps there may be other questions for the Committee, if I dare say it.

Chair: Indeed. We are focusing on what happens after Brexit rather than the existing system continuing. Were there any other questions? I know Heidi has some follow-up questions.

Heidi Alexander: On the basis of what has just been said, pursuing some of the comments Mr Thomas made earlier is probably not the best use of the Committee’s time, so I will pass.

Q181 **Andrea Jenkyns:** Once Britain has left the EU, should the NHS seek payment from EU nationals for care provided?

Professor McKee: If they are not ordinarily resident in the United Kingdom and not entitled by virtue of that, of course it should. I am not sure how that would not be the case.

Q182 **Andrea Jenkyns:** Do you think it should be the case?



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Professor McKee: What I think should or should not be the case is neither here nor there; it is what has to happen, unless there is some mechanism by which you reclaim it from the insurers. Without going back over past questions, this will cost a lot of money. Hampshire NHS Foundation Trust invoiced in 2015 for £151,000 and got £50,000 back, but it paid £231,000 to collect that money, so it was losing money in the act of charging. In many parts of the country, there will be a very small number of patients who will have to pay. You will have to put in a system. It is not as if a hospital has one front door; it will be for every outpatient clinic and every ward. Remember that the NHS is cheap because we do not have linked systems. Most other health systems that spend a lot more do so, at least in part, because of the transaction charge costs.

Q183 **Andrea Jenkyns:** Mr Thomas?

Meirion Thomas: Can you ask the question again?

Q184 **Andrea Jenkyns:** Once Britain has left the EU, should the NHS seek payment from EU nationals?

Meirion Thomas: Are we just going to provide a Europe-wide free health service?

Andrea Jenkyns: No.

Meirion Thomas: No.

Q185 **Andrea Jenkyns:** We have established that. Do you think it is correct to assume that efforts to reduce access to the NHS for EU nationals would hinder efforts to negotiate a satisfactory reciprocal agreement for British nationals abroad?

Professor McKee: Almost inevitably. If we are saying that we do not want some mechanism like the EHIC system for people coming here, on the basis of reciprocity, they are likely to say that we do not get it going in the other direction.

Q186 **Andrea Jenkyns:** Is that everybody else's view?

Christopher Chantrey: It would have to have reciprocal effect. The whole point of the present system is that it is a level playing field. Some of the consequences are the imbalance in the flows of money. Everybody has agreed to live with that, as it were. It could be that a member state, in regard to some of these flows, feels that the imbalance is intolerable. That was what in substance the then Prime Minister tried to say to the European institutions in Brussels a year ago. I think he would have had a better chance of success if he had said, "There is a theoretical problem that could arise Europe-wide." Remember, there are 750 flows when you have a matrix of 28 by 28. There could be an imbalance. Therefore, you could seek in negotiation with the EU a level at which you have to have a cut-off. I don't think he said those things.



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Q187 **Andrea Jenkyns:** Do you think there is an imbalance with the current system?

Christopher Chantrey: It has been raised and discussed; those around the table have said that.

Q188 **Andrea Jenkyns:** Other than anecdotal evidence, is there any firm evidence that EU nationals have migrated to the UK to access NHS treatment?

Christopher Chantrey: No. They come to find work; they come because it is a free labour market. It is very easy if you are French or Spanish to find work in this country compared with back home.

Q189 **Andrea Jenkyns:** It is more to do with economic rather than health reasons.

Christopher Chantrey: It is just easier. You might be unemployed for months and months in France. If you come to Britain, you can find a job extremely easily.

Q190 **Andrea Jenkyns:** Professor McKee, what do you think?

Professor McKee: I do not think there is any significant evidence. If there is, I have yet to see empirical evidence as opposed to impressions.

Meirion Thomas: I am going to be told again that I cannot express a view because I do not have firm evidence, but I am told there are lots of people coming to this country.

Q191 **Chair:** Can I point out that you have not been told that? You have been challenged. It is a reasonable request.

Meirion Thomas: Okay. My information is that, for example, there are lots of eastern European women coming to East Anglia, getting NI numbers very quickly and having their babies. That is something they do. I am also being told—I have no evidence for this—that they get a Bounty pack. Are you familiar with the Bounty pack?

Q192 **Andrea Jenkyns:** Yes—at the moment of course.

Meirion Thomas: I am sorry; I could not quite see.

Q193 **Andrea Jenkyns:** There are two of us actually.

Meirion Thomas: You have the Bounty pack already for the first child. You will get a Bounty pack again. Bounty is a commercial organisation; it pays the NHS a lot of money. For example, last year Imperial College health trust got £71,000 from Bounty for those freebies—Sudocrem, nappies and that sort of stuff. In there is a child benefit application form. I am told that people fill in the child benefit application form, get child benefit and go back to eastern Europe, and that child benefit is paid for a long time.

Q194 **Andrea Jenkyns:** The general feeling among all of you is that it is not



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necessarily free healthcare that is driving people to come over. You mentioned an economic reason.

Meirion Thomas: There is an element.

Christopher Chantrey: If you are Spanish, you get free healthcare at the point of delivery in Spain. That is not a sufficient reason to move to England. You go to the UK because you are unemployed in Spain and have no hope of getting a job. You move to London and get a job.

Professor McKee: We have done a lot of research among British expatriates—retirees—in Spain. They love the Spanish system. It is more than that. Often, Spanish health centres have cafes and things. They go there to socialise as well. In the interviews we did with them, it was quite striking that the health centre was often the centre of the little British expatriate community. Of course, I am sure there are some who come for other reasons.

Q195 **Andrea Jenkyns:** Have you done any research on what happens in other European states?

Professor McKee: We have not, but what we do know about women who are having babies is that they tend to go back to their own countries because of family support. If you look at payments under the existing mobility systems for people here who are, say, French, German, or whoever, and are covered by the NHS, one of the key reasons for going back to their own country to give birth is that they have their extended family around them.

Q196 **Andrea Jenkyns:** Do you advocate changing the principles of access to the NHS to prevent patients claiming to be ordinarily resident to access it?

Meirion Thomas: I have said that we have to change ordinarily resident, so the answer has to be yes.

Professor McKee: I have no problem with clarifying entitlement; that is one issue. It has been made clear that there has been nothing to stop the United Kingdom doing that since 1948. It could easily have done so, but it has chosen not to do so. There are a number of reasons for that, but they have nothing to do with the European Union.

Christopher Chantrey: I agree. I have nothing further to add.

Professor McHale: I think the fundamental principles of the NHS are still as valid as they were.

Q197 **Heidi Alexander:** Mr Thomas, the point I was making was that it is all very well and good to make an assertion based on a small number of conversations with people, but to make a sweeping statement without backing it up with evidence is quite a dangerous thing to do. You have written extensively about health tourism. I read a number of articles on ConservativeHome before the Committee meeting today. I am interested



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in the extent to which you think health tourism is a problem generated by EEA nationals, as opposed to health tourism from other parts of the world.

Meirion Thomas: I suspect the worst thing is from outside the European Union, because anybody from inside the EU is ordinarily resident so they are not technically health tourists. They are entitled to come here by the rules on ordinarily resident. The biggest problem is from outside the EU. Possibly this is outside the remit of this discussion, but one of the main problems in London, for example, is maternity tourism. We have just seen it recently in a programme on BBC2.

Q198 **Heidi Alexander:** Can I challenge you on that? What evidence do you have that people come here specifically to have their babies, as opposed to, say, overstaying a visa, having no enforcement action taken against them, falling pregnant and needing to find somewhere to have their child? Would you accept that that is often what happens when people are accessing healthcare?

Chair: Perhaps you would be brief, because this is beyond the remit of what we are discussing today.

Meirion Thomas: Having a singleton baby does not matter; it is as cheap as chips. It will cost the NHS about £3,000 to deliver a mother of a singleton baby. The problem arises with multiple births. People specifically come to this country for multiple births. I can speak to you afterwards and provide you with evidence of that.

Chair: Perhaps you would do that.

Q199 **Heidi Alexander:** Mr Chantrey, on a totally different matter, how does the organisation you represent seek to make its views and concerns known to Government? What response have you had from Government, and which Departments?

Christopher Chantrey: I wrote to the Secretary of State for Exiting the EU about 10 days ago. I am waiting for a reply. We try to make contact with various organs of Parliament and Government. That is why I am here today talking to you. We are also increasingly trying to make contact with host country Governments. We do not want them to throw us out the day after Brexit, so we need a relationship with them as well. I and my colleague John Shaw behind me are making overtures to the French Minister who has responsibility for the French abroad, so he has responsibility for the 300,000-plus French citizens living in the UK. We are sure that he will be receptive to the talks we would like to have with him about UK citizens living in France and other EU member states.

Q200 **Mr Bradshaw:** To put a more general question to Mr Chantrey and Professor McKee, what is your assessment of the preparedness of UK Ministers to address and even be aware of some of the challenges and potential pitfalls that you have outlined in this evidence session?



Christopher Chantrey: I gave evidence a month ago to the Exiting the EU Select Committee. That was not Government of course; it was parliamentarians. Some of the questions came as a bit of a surprise, because I had made an incorrect estimate of the level of knowledge on some of these questions. I can only judge from what Ministers are doing and saying, and I think the level of knowledge is less than I had anticipated.

Professor McKee: You had the Secretary of State for Health in front of you a few weeks ago. I watched the evidence session. I thought it was quite revealing in exactly the same way. I speak frequently to colleagues in other member state Governments who are, to put it mildly, alarmed by the level of understanding of many of these issues, particularly given that some of the key individuals in the Department of Health who understood the issues have recently been made redundant.

Q201 **Mr Bradshaw:** I cannot remember who referred to a potentially serious problem that could arise in Ireland. It may have been you, Professor McHale. Could you give us a few more details?

Professor McHale: The cross-border question is an interesting one academically, and a perplexing one for patients. In terms of the common travel area agreements and arrangements with Northern Ireland, the White Paper clearly indicates that it wants them to continue. The problem at the moment is that everything is short on specifics as to how this is going to play out. One of the characteristics of the relationship between the Republic of Ireland and Northern Ireland has been the joint working on healthcare provision over the last few years. Some of that has also been funded by the EU to support it. As a result, there could be a range of potential impacts in terms of practical patient mobility if a hard border was imposed.

There are questions about Irish patients having a special position when they come to this country, and about what happens to the way in which delivery of services has been undertaken. For example, I understand that, to avoid considerable waits for ENT treatment, children have moved from the Republic of Ireland to Northern Ireland for treatment. It is also my understanding—there is evidence in Northern Ireland Assembly briefing papers—that children's cardiac surgery is pretty well centralised in Ireland itself, in Our Lady's Children's Hospital in Dublin, as a result of which there is a natural synergy in service provision.

In many ways it is a holistic approach, even though there are two parts to it, which can work in an EU context. When you go outside that, what will happen in practice in terms of emergency treatment when the patient is immediately taken in for care? It is your European health insurance card problem writ really large on a day-to-day basis. Somebody is just visiting a friend across the border. That is a very different question from just hopping on easyJet or going on Eurostar or whatever. There is a hugely different dynamic. More broadly, there is a service provision question. Martin can speak to the medical aspects far better than I can.



Professor McKee: There is a complex network across the border. Interestingly, the Co-operation and Working Together programme—CAWT—is funded out of the peace and reconciliation budget of the European Union, not the health budget. It was created as a means of getting people from different communities to talk to one another. That has meant that a whole set of networks, like cancer from Donegal being treated in Belfast and sexually transmitted disease clinics in Sligo being run from Belfast and vice versa, has built up over quite a few years, and has many tangible benefits, including joint planning, emergency planning and all sorts of things. It is very similar to many of the arrangements that exist at the land borders within Europe, like obstetric care between Dinant and Namur across the Pyrenees. There are lots of schemes like that. All those are based on EU law and the membership of both countries. The argument has been made that there were already arrangements before both countries were members of the European Union. Unfortunately, that does not hold, because at that time it was not possible to enter the Republic of Ireland from, say, Bulgaria without all sorts of restrictions.

An interesting test of the Irish situation is that, first, there are only about five different options, ranging from Lord Lawson's proposal that the Irish Government might realise their 100-year mistake and rejoin the United Kingdom to the UK staying in the EU. Because there is only a finite number of possibilities we can test each of them, which we have done. We have found that each is impossible for some reason or other.

A useful test in those circumstances is to look at the arguments made in relation to not having a border between the Irish Republic and Northern Ireland, even though the Irish Republic will remain in the customs union and the single market, and then just swap the word "Ireland" for "Scotland" and look at the same arguments. Each time the entirely contradictory arguments are made for each of the two situations, you cannot intellectually maintain the contrary positions on both.

Chair: We have time for one more quick question and then we must move on to our second panel.

Q202 **Dr Whitford:** This is for Martin and Christopher. Obviously, a lot of our questions have focused very much on the EHIC card and the pensioners, and what has been called health tourism. I still come back to your position, Christopher, and the position of people like my husband, who have worked one year in Germany, they paid to train him and he has spent his entire career working in our system here. How do we get those people more on the agenda, because I do not feel that they are being recognised in the same way? They will still require that their right be allowed to continue.

Professor McKee: I do not think it helps if we refer to them as bargaining chips. My colleagues in the university who are from other member states, some of whom have attempted to get permanent residency and have given up because of the complexity, feel extremely



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vulnerable and nervous. In fact, I worry about the health of some of them, because the degree of distress they are experiencing at the minute, having committed their lives to this country, is incredibly worrying.

Q203 Dr Whitford: I have started to advise constituents not to do that because people who have been long-term resident here but not reached the earning limits that are required have been turned down. You then get a “please prepare to leave” letter, even though you are an EU national. That is terrible.

Professor McKee: The problem my colleagues have is that our pay cheques are now on the intranet, so we download them, but because they are printed off a computer they are not the original forms. Now, five years of those have to be notarised individually, in co-operation with our human resources department, which clearly is an enormous workload for them. As you know, I travel abroad very frequently, maybe not every week but most weeks, and that is true of many of my colleagues. To provide details of every time they came in and out of the country over five years is, frankly, impossible.

Q204 Dr Whitford: Also, the application form, at 85 pages, is longer than the White Paper. That will simply rule out a lot of people.

Professor McKee: It has almost as many pages as the Bill has words.

Christopher Chantrey: The equivalent form for the residence permit in France is two sides of a sheet of a paper and you prove every period of six months over five years; so, you have 10 pieces of paper, maximum. You just send in electricity bills and three photographs. It is a simple form—just one sheet of paper. That is the equivalent, in France, of the 85-page monstrosity that the Home Office uses.

Q205 Dr Whitford: It is just that our second panel—

Christopher Chantrey: It is a UK decision to have the 85-page form and to demand all those pieces of paper. It is not determined by the EU. The EU says that each member state deals with the detail of how to issue a residence permit. To answer your question, for pensioners in Europe—in France, in Spain and all over the EU member states where they live—there is a high level of anguish about what is going to happen to them and great fear that they will have to leave.

Q206 Dr Whitford: What about the state of workers like yourself?

Christopher Chantrey: Not workers, no. We are not affected. We are much less at risk. I can persuade the French not to throw us out on the day after Brexit day.

Q207 Dr Whitford: In the debate that we had here on 6 July last year, the comment made by the Minister at the time, before the change of Government, was that people who have been here longer than five or 10 years could stay, but what rights they have to access benefits or public



services will be up for debate. That just sent a shiver throughout—

Christopher Chantrey: Yes, it would, but, of course, there is no legal basis yet for the statement “those people who have been here for more than” a certain length of time. You have to identify them. There has been no Act of Parliament reinstating the right that they will lose on Brexit day. That is what we need and we need it soon. It has to be the first item on the agenda. This is a people question—a citizen’s question. We are talking about people’s lives and livelihoods, and that is why, from my point of view, it has to be discussed and cleared up before all the stuff about trade and regulations.

Q208 **Chair:** On that point, Mr Chantrey, the Government have stated that they also see this as a priority after triggering article 50, but the Prime Minister has also said that she does not want to clarify the position of EU citizens here until she can link that to clarifying the position of British citizens abroad. Do those that you represent welcome that position, or would they rather see a unilateral offer made by the UK Government?

Christopher Chantrey: If the Prime Minister made a unilateral offer to assure the EU citizens living in the UK that they would not lose any of their right, that would put her on the moral high ground. I cannot see that the EU or any of the member states could veto that.

Q209 **Chair:** That is very interesting, because it is often used as the justification to say that it would disadvantage British citizens abroad.

Christopher Chantrey: I do not see that happening.

Q210 **Chair:** You do not see that happening. Thank you for clarifying that.

Christopher Chantrey: When you are negotiating, you have to know how the other side thinks and works.

Q211 **Chair:** Is that a view widely expressed by those on whose behalf you are speaking today?

Christopher Chantrey: Yes, it is.

Chair: Thank you for clarifying that. It is a very helpful point at which to finish today’s proceedings. Thank you very much, to all of you, for coming.

Examination of witnesses

Witnesses: Professor David Lomas, Daniel Mortimer and Professor Martin Green.

Q212 **Chair:** Thank you to our second panel for your patience. Welcome to this session, mostly focusing on workforce issues. Could we start by you introducing yourselves to those following from outside the room, starting with you, Professor Lomas?

Professor Lomas: I am David Lomas. I am vice-provost health at UCL, head of the School of Life and Medical Sciences and head of the Medical



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School, and academic director of the UCLPartners Academic Health Science Centre. From 1 January, I am now the deputy chief executive of the MRC.

Professor Green: I am Martin Green. I am the chief executive of Care England. We are a representative body for care providers and have about 7,900 care services. We cover services for older people, people with learning disabilities, people with mental health issues and some disabled and support services for people with brain injuries.

Daniel Mortimer: Good afternoon. Thank you for having me. My name is Danny Mortimer. I am the chief executive of NHS Employers. We are an organisation that represents every statutory employer within the English NHS—that is trusts, foundation trusts and CCGs. I also chair the Cavendish Coalition, which is a group of 33 health and social care organisations that are working together to consider the workforce implications of Brexit. Our members include Care England and the Association of UK University Hospitals as well.

Chair: We are grateful to you all for coming this afternoon. We are expecting a Division at some point this afternoon, so apologies for that in advance. Luciana is going to open the questioning today.

Q213 **Luciana Berger:** Can I ask you all about the impact and specifically what has happened in the wake of the referendum? I am particularly keen to know how it has affected the recruitment and retention of both NHS and social care professionals; whether you have any view on what the impact has been on the nature of public discourse and the morale of people working in your sectors, and, specifically, whether you believe that people are leaving the NHS in the wake of the EU referendum; and whether you have seen a decrease in applications. There are lots of different factors, but I will come back if you do not cover them all.

Daniel Mortimer: There are a few things there. First, in terms of retention within the NHS specifically, we have put a huge amount of effort into seeking to reassure our EU colleagues and to stress the value that we place on the contribution that they are making. Their biggest concern is the lack of certainty, which you touched on at the end of your last session. Also, some report some changed behaviour and some unwelcome behaviour from the public in their interactions with the public sometimes.

We are seeing a decrease in recruitment. There are lots of factors going on there. Some of it is because employers have not been out to recruit because of the lack of certainty. They would like more certainty before they go back out to recruit in southern Europe, in particular. Some of it is because we are not seeing the volume of applications that we have previously seen; some of it is because perhaps colleagues in those countries are making some slightly different choices.



Some hospitals in the NHS have done a lot of work with their EU nationals. Cambridge, for example, has done quite an extensive survey and had a series of conversations with its staff. A number report that the need for certainty and the lack of certainty at the moment is making them question whether they stay in the longer term. They have stayed in this period since the referendum result, but slightly more of them are worrying about whether they should leave in the longer term. Some of that is related to the experience that Dr Whitford touched on in that some EU national colleagues have made the decision to apply for citizenship or leave to remain, and that process itself has been counterproductive in terms of their experience. Again, that was rehearsed very well at the end of the last session.

Q214 Luciana Berger: Have you seen an impact, as a result of the immediate indicators that you have referred to, on vacancy rates, or is that data not yet available?

Daniel Mortimer: It is too early to say in terms of that data being available. We have seen, and the NMC has reported, a lower rate of EU nationals joining the nursing register, for example, so that reinforces some of the reports we are starting to get. We obviously recruit extensively outside the EU as well, particularly in nursing at the moment. There was a sense in which we were having to start to look more actively outside the EU to find nurses because of the demand we have for those posts.

Professor Green: We are seeing a similar issue in social care. In fact, in social care there is the issue of the specialist services—for example, nursing, which suffers the same issues that the NHS suffers. What has not been really well documented is that, as the pound slides and it gets more into parity with the euro, this is a less advantageous place for people to work because they can get on a train, get to Germany in two hours and get pretty much the same. It is anecdotal—and I appreciate there is not the data behind this—but, for example, one of my members had some nurse recruitment activity going on just after Brexit and half of the candidates withdrew because they felt there was a period of uncertainty. So, we are seeing both ends—the specialist and technical support staff—being affected, but the care staff are being affected and people are deciding not to come to the UK. Indeed, other people are making decisions about whether or not they stay in the UK.

Professor Lomas: I represent the Association of UK University Hospitals. We have a tripartite mission of clinical care, research and teaching. We are the specialist, hard-core research and development that drives innovation within the NHS. Therefore, we are after the very highest quality people from around the world that we need to attract to drive our research and development. I am a niche market but, I think, a very important market for the NHS. We have seen concerns among our staff and in our medical staff. For example, at UCLH in central London, 17% of



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our medical staff come from the EU, so there are enormous concerns across the hospital.

We have not seen people leaving. We have worked extraordinarily hard to reassure them, and we believe that you will give them the right to remain. That is the message that we are giving. Our message is, "It will be okay. Trust us. We think it will be fine." That is the message we are giving out to medical staff. Remember, we also deal with medical students and university applicants, and we are giving exactly the same message out to them as well.

We have had people going through the application process; it is exactly as described. It is truly awful, and we are saying, "Don't. Just hang on and keep your fingers crossed, and it should all be fine."

Are we losing staff? I surveyed a whole variety of different hospitals before coming to give evidence here. Moorfields was the only one that came back with numbers. Moorfields specialist eye hospital is seeing an increase in numbers of medical staff, although very small. So, we are not seeing people leave. Many of the medical schools across the region and the university hospitals, Glasgow and Leeds being two in particular, have reported people pulling out having been offered jobs, so we have lost stellar people who would have come otherwise. The big issue for most of the university hospital academics is applying for grant applications. We have seen people bumped off grant applications to the EU.

Q215 **Luciana Berger:** Can you explain that? Bumped off by whom, sorry?

Professor Lomas: We raise money by applying for European funding. We do terrifically well. We get more back in the country than we put into the European Union and we are very successful in research and development. Previously, having a British member and British expertise would help you with your grant application and getting funding, because we bring real hard-core science. Now, you are less of an asset. We have had academics being removed from grant applications to the EU. I will come back to grant applications later on, I suspect, but I will stop there.

Q216 **Luciana Berger:** Thank you very much. Can we perhaps try to reflect on the data just a little bit? We have had lots of different evidence from lots of different organisations and bodies, and, as you know, we have taken evidence from the Secretary of State about the exact numbers of people in the EU who are working across health and social care. I was keen to know—anyone can contribute should you so wish—your view on whether we have the data collected to formally track those trends in the recruitment and retention of EU staff. I have different numbers in front of me and it is quite difficult to drill down what those numbers are. I would be really keen to know your view of what proportion of staff in the NHS and social care come from the EU.

Professor Lomas: Shall we see if we have the same numbers?



Daniel Mortimer: There are two things there. First, one reason why we came together as a coalition was to address exactly that issue and to make sure that across health and social care, in its broadest sense, across the four countries, we had as much accurate data as possible. We are still in the foothills of that collection exercise. Also, we are trying to collect that data consistently from social care, the NHS and non-NHS providers of healthcare—dentistry, pharmacy, optometry and so on. We have just had a first cycle of that and we have some more work to do.

The data sources that we have are probably the same as the ones that you have, which is the second piece. We are all putting a lot more effort into trying to improve that data. In social care, they are perhaps a little bit further ahead in terms of their confidence around the data than we are in healthcare in its broadest sense. We have to use proxies sometimes, so the NMC, for example, is a proxy for EU nurses. Broadly, we believe between us that 6% to 7% of the health and social care workforce across the UK are EU nationals.

Professor Green: Part of the problem is that we are in a bit of a data desert with some of this. There is a lot to talk about integration, and we need to remind ourselves that it is not only about the end point of the service but we should be thinking about having some integration around the stats and the training packages and how we deliver a workforce that is fit for purpose when citizens move across the system. We need to be able to have staff who move across the system. As we see greater pressure on staffing, we will require people to be much more flexible and able to work across health and social care.

Professor Lomas: In the Association of UK University Hospitals numbers that I was given before coming here—we will see if they dovetail with what you have—about 10% of NHS doctors and about 5% of nurses are EU nationals. In my own hospital at UCLH, the number of EU nationals has risen from 10% to 15%, as total staff, over the past five years, and 17% of our medical and dental workforce at UCLH are EU nationals.

Q217 **Luciana Berger:** I am particularly keen to know your views on the regional breakdown as well. The Royal College of Nursing has told us that 32% of all new nurses in the last year have come from the EU. Of course, that is a very significant number in terms of what might happen to the nursing workforce going forward. I do not know whether your considerations include those regional breakdowns as well, where in some parts of the country, obviously, the figures are a lot more elevated.

Daniel Mortimer: They are. Particularly in London and the south-east, for both healthcare and social care there is a much higher concentration of EU nationals in our workforce across all the organisations that we represent, from the very specialist organisations to the much less specialist. We see that much greater concentration there. What our RCN colleagues were referring to was that there is a greater component of registrations with the NMC in the last three years that are from outside the UK, particularly from within the EU but also increasingly from outside



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the EU as well, as we have sought to fill the vacant posts we have, particularly in nursing.

Professor Green: There is another issue as well though—that there are some areas where it is very difficult to recruit, certainly in social care. Often, people have come from the EU into those areas where it has been nearly impossible to attract candidates. For example, in some rural areas it is very difficult to attract people into social care, so EU nationals have gone into those services.

Professor Lomas: For me, I am after a slightly different group. As well as the nurses and the professions allied to medicine—the radiographers, the physiotherapists and the OTs, who are really important—we are after the really high-quality people that we want to recruit from around the world. We recruit from the EU but also further afield as well, so that we have the very best scientists to drive innovation for the NHS.

Q218 **Dr Whitford:** Daniel, you were talking about the fact that there has been a drop in registrations. It is quite dramatic; it is a 90% drop from 1,300 a month to 101 in December, but that was already a halving from about 3,500 a month; so it is really huge. While we have had a lot of discussion about protection for EU nationals here, is the turnover not about 25%, which means that gradually we could get into a position where more people are going home? We need a supply; it is not just the people who are already here now.

Daniel Mortimer: We do, and I know you are meeting regulator colleagues in future weeks as well. The system for gaining entry is harder now than it was previously. There is language testing in particular, and there is some controversy around that. Absolutely, we do need that kind of supply. We do see turnover for EU nationals; people come for a period of time and return home to their own country. They come to a particular area, it does not suit them, and they move then within the UK sometimes to work or return to their own country. So, yes, we do. For some employers, there has been some reluctance to commit to large-scale recruitment within the EU, given the uncertainty that we have been talking about this afternoon.

Chair: My apologies. Luciana had not finished her questioning.

Q219 **Luciana Berger:** When we had the Secretary of State here, he talked about the programme to train additional doctors. He said that he believed the NHS would be able to become self-sufficient by way of the programme that introduced those 1,500 doctors. I ask because, Daniel, it was the evidence from the Cavendish Coalition that talked about the value of doctors coming from outside our country, not just in terms of numbers. I do not know whether you want to reflect on that and tell us the expertise and the different cultural contribution that they make. Also, the evidence from the King's Fund said that, despite the Government's best ambitions, this programme is not going to address the current shortage of doctors. I wondered what, collectively, your position was on



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that.

Professor Lomas: We welcome the increased numbers of medical student places. Remember, this is a regulated profession, so we have to hit a certain number of training places every week. If we go one over for my medical school, we will not get paid to train that doctor; so we have to hit a Government figure every year in order to get people into medicine, but we welcome the expansion. At UCL, it will take six years to turn out a high- quality doctor, two years of foundation training, and then another 10 years of specialist training to turn out someone as a consultant and three years as a general practitioner. That is a long pipeline, and that is to turn out someone who will be, hopefully, a consultant skilled in a whole range of specialist areas to provide care.

Also, we need to feed a pipeline of research and development, and we need experts in order to drive the very best things that we do. We are world leaders in cancer immunotherapy, cell and gene therapy, and regenerative medicine. We need to feed that pipeline, and not all of them come from the UK.

Professor Green: We certainly have a problem, in social care anyway, in getting access to primary care. In residential care, it is extremely difficult in some areas to get GP access for people living in care services, so anything that reduces the numbers of available doctors is going to be very difficult. We should remind ourselves that people, particularly in residential social care services, whether they are people with learning disabilities or older people, have very great numbers of comorbidities. These are people who have very complex needs, so anything that reduces the amount of primary care support is going to have a big impact on our service users.

Daniel Mortimer: I have nothing to add.

Q220 **Heidi Alexander:** Mr Mortimer, can I just ask you about recent trends in doctors and nurses coming into the NHS from countries other than the UK? Is it not the case that in the last seven to eight years, both for doctors and nurses, the majority come from within the European Union, as opposed to other countries?

Daniel Mortimer: Yes. That has been a change for nurses, in particular, where it has been easier to recruit nurses from within the EU. There is mutual recognition of qualifications; registration is much more straightforward. As the UK has needed to recruit and the English NHS, in particular, has needed to recruit more nurses, it has looked more naturally towards the EU. In the last two years we have seen that employers were starting to find that there was not the same availability or quantity of nurses to recruit from within the EU as the economy has picked up and because our recruitment had hitherto been so successful. We have switched back slightly to recruitment outside the EU, as well as within the EU, and that is one of the reasons why we campaigned so hard



for nurses to be added to the shortage occupation list, so that it would be much easier to recruit nurses from outside the EU.

Q221 Heidi Alexander: How would you characterise the speed of bringing in nurses from within the EU, compared with via the shortage occupation list from outside the EU?

Daniel Mortimer: It is still much quicker.

Q222 Heidi Alexander: Within the EU.

Daniel Mortimer: Within the EU, yes. It is still much quicker to recruit a colleague from within the EU. There is an added language-testing requirement now that is obviously in place, but it is still much quicker to bring somebody in from within the EU. There are a series of clinical examinations—OSCEs—that nurses from many countries outside the EU would need to complete before they could enter into the English register. There are also some financial payments that need to be made now as well, which are an added barrier.

Q223 Heidi Alexander: Just talking about nurses for the time being, if we were to extend the current arrangements for tier 2 visas, I think it is, is it not?

Daniel Mortimer: It is, yes.

Heidi Alexander: If you were to apply that to nursing staff coming from within the EU, after Brexit, what impact do you think that would have?

Daniel Mortimer: For NHS Employers, we are very clear that any post-Brexit migration system that just simply replicates the current non-EU system would be dysfunctional; it would not work well. The present non-EU migration system—the tier 2 system—does not work well, for a whole number of reasons.

There are two things to emphasise in particular. The first is that the present non-EU system equates earnings with skill and worth. Public sector employers, or at least public sector funded employers, cannot compete with colleagues along the river in the City in their access to tier 2 work permits. We want a system that takes much better account of skills and the needs of our country in terms of the skills, and we would obviously argue, all of us, that caring for our population is a particularly important test.

The second thing—we have touched on it already this afternoon—is that there is a risk that the current system itself and the whole administration of it is designed to disincentivise people coming to the country; the paperwork is long and complicated and there are numerous hurdles to jump through. We all share an interest in wanting skilled, talented people to come in and contribute to research or teaching, or front-line care. We want to make it as easy as possible for those people to come in, where we need them to provide those vital functions for our country. We need a



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new system, and, to think about it positively, there is an opportunity to set a new system.

Q224 **Heidi Alexander:** You would want a different system from the existing tier 2 arrangements for non-EEA nationals.

Daniel Mortimer: We would—very much so.

Q225 **Heidi Alexander:** Professor Lomas, could I just ask you about the recruitment of senior clinicians from within the EU and, if you are less able to recruit those senior clinicians from the EU, what the impact would be on the quality of patient care in hospitals?

Professor Lomas: Having a big pool within which to fish gives us more opportunity to get the very best people in for the UK, and there is no doubt about that. My sense, and as you have seen from the numbers, is that it is relatively straightforward for us to employ medical staff from the EU in the UK, and that is why the numbers have grown over time. It is almost impossible for us to employ medical staff from the US, Australia, New Zealand, India, China, Japan or wherever, who may also have the expertise that we need.

Can I also mention that, as well as medical staff, we are also interested in non-clinical staff because the non-clinical staff often drive that research and innovation that we need? Again, we need to fish around the world and get the very best people in. The current system works well in the EU, but it is almost impossible to get people from outside the EU into the country.

Q226 **Heidi Alexander:** In terms of the impact upon research and innovation, how would you characterise the impact of Brexit on that?

Professor Lomas: There are huge threats for us going forward and huge uncertainty. The biggest risk is the uncertainty. When that is resolved, things hopefully will settle down. If we do not get the very best people, we do not drive our research and innovation, where we punch above our weight. For the amount of money put into medical research the outputs are far greater, so we are very strong and we have an international reputation for that. If we cannot attract the very best, then we cannot lead in the innovations that will lead to patient benefit, because ultimately this is all about patients. This is about patients having the first access to novel therapies, devices, small molecules and biologics that they can't get elsewhere.

Q227 **Heidi Alexander:** You mentioned EU grant applications and things earlier. Would you like to say a bit more about that? Do you have any reflections on what the Secretary of State told us when he gave evidence about the fact that it is very likely that the European Medicines Agency would not be based in London following Brexit?

Professor Lomas: The EMA will almost certainly move and that will be disappointing. You heard from Alasdair Breckenbridge as well, a few



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weeks ago, about the fact that there may be delays in pharmaceutical companies launching in the UK because we are a relatively small market compared with an EU, US or Japanese market; so, we may be slower in terms of getting the benefits through to patients.

As I said earlier on, we punch above our weight, and the figure I have is that we raised €760 million of funding between 2007 and 2013 from the European Research Council. My own university at UCL and Cambridge are neck and neck in bringing in the most money of any university in the whole of the EU. UCL has the highest amount of Horizon 2020 money in the EU, and that is an £80 billion fund that drives innovation from the bench through to the bedside.

What would we like? We would like access to the European Research Council funding, the Innovative Medicines Initiative, the Horizon 2020 funding and to ERC fellowships. We realise that post leaving the EU, post Brexit, we are not going to be given the same access, but we would argue for a pay-as-you-go scheme. There may be a system whereby we can pay in and have associate membership that will allow us to have some access to those funds.

Q228 Heidi Alexander: Have you had any discussions with the Department of Health about these issues, and what have they said?

Professor Lomas: Most of this is fed through the Office for Life Sciences, from my world, so it is through the research councils or the Office for Life Sciences. That is the way that we are trying to push that.

Q229 Heidi Alexander: What response are you getting?

Professor Lomas: It is interesting. I read the report this morning from the Science and Technology Committee, which has said, I am pleased to say, exactly the thing that I have just said. The Government response, which I also read, was, "No commitment, but it is something that we will consider—that we will look at."

Q230 Rosie Cooper: The Secretary of State has said that he wants to maintain the rights of EU workers in the UK, including low paid social care staff. That might mean having a migration policy or almost an arrangement that maintains the rights of workers pre Brexit that would be different post Brexit. How would you view that?

Professor Green: My view is that we have to find some mechanism both to maintain the staff that we have but also to recruit more staff, because the problem is that we have an increasingly greater number of people who need care and support. One of our challenges is that all the processes to get people who are non-EU people into the country, or indeed post Brexit it might be the same for EU staff, are very complicated and difficult, and often linked to salaries. Of course, care workers do an incredibly good job but they are very lowly paid. So, we have to understand the needs of the sector and work through an approach that will enable the staff from the EU to come back into our services because



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we desperately need them, as it is very difficult to recruit the numbers that we need from the UK population alone.

Daniel Mortimer: Martin has put it very well indeed, and, clearly, one of the practical things that needs to be resolved is what cut-off date would be used for EU citizens to have a right to remain. Our view, across health and social care, is that we would like that date to be as late as possible because we still have this pressing need to recruit colleagues to come and work within our system.

Q231 **Rosie Cooper:** What advice is currently being given to staff in the NHS and staff in social care on maintaining residency and employment rights? Do you have any knowledge or evidence of the experience of staff applying for permanent residency in the UK?

Daniel Mortimer: We have touched on the experience in applying for permanent residence this afternoon. It has not been a happy or straightforward one, and a large number of EU nationals have experienced that. Our advice to them is not to go through that process but to await the outcome of the Government's position once article 50 has been triggered.

Secondly, we and employers within the NHS have shared as much information as we can, but in particular we stress the points that David has stressed. We cannot believe that the NHS can do without our EU national colleagues. The Secretary of State has been very clear about this, from immediately after the referendum through to his appearance in front of you. We provide people with information, and those employers where there is a particularly high proportion of EU nationals in their own workforce have done a huge amount of work to understand what people's concerns are and to arrange meetings with Members of Parliament or Members of the European Parliament to give them information. There are a number of organisations that have set up networks for EU staff so that they can provide that kind of peer support to each other. We all look forward to the question being settled very quickly after article 50 is triggered.

Q232 **Rosie Cooper:** Anybody looking at it quite sensibly would believe that the Government must take some action, but I am sure, if you were the EU worker delivering a service that we much need and feeling that kind of pressure, you would be pretty angry about it. Could you say what the implications for adult social care would be if existing tier 2 arrangements were not altered to accommodate lower paid social workers? I think we can see that, but you have also mentioned the campaign whereby workers in social care can be added to the shortage occupation list. Have you had any success or encouragement?

Professor Green: Part of the problem with all this is that we are not clear, from the Government, what they are going to do. All this lack of clarity and uncertainty has an impact on the staff themselves. In the previous session to this, there was a lot of debate about whether people



could access healthcare, for example. If I was a care worker and I was thinking whether I should come to the UK or go to another EU country where it is very clear what my rights and entitlements are, I might make a different decision in the post-Brexit world than I made in the pre-Brexit world.

Q233 Rosie Cooper: If Brexit EU migrants are not able to work in adult social care, do you think that the workforce model would have to change to a high-wage, high-skills model? How would we manage that one?

Professor Green: The answer to that is yes, but I want that model to proliferate anyway and I want us to be in a high-paid model because we are in a high-skills model now. If you see the skills of care workers when they go to deal with very complex issues and they support people in a very personalised way, they are doing a very skilled job. What we have is a system that does not acknowledge that and refuses to pay for it, so we have endless discussions with politicians about how we improve the status of the workforce but no follow-through with the money that would help them do that.

Q234 Heidi Alexander: I just wondered about current labour shortages in the social care workforce and the extent to which you believe that EU nationals currently fill the gap, if you see what I am saying. I would just be interested in your reflections upon the pressures that the sector currently experiences in that regard.

Professor Green: They are filling a gap, but they are not filling the gap. We have seen, and there has been very good evidence from organisations such as Independent Age and Age UK, that, increasingly, people are getting to the point of crisis before they get a service. So, we are seeing that there are more people in need than we have the capacity to support. At the same time that we have that as the reality, we have the noises off of politicians telling us that it is all about prevention and integration. In fact, Dr Whitford and I were at an event this morning about STPs, and they talked about this in relation to how it was going to transform the system and how it was going to deliver much better outcomes for citizens. Yet, it was not really clear how the circle was going to be squared, which was about less money and better outcomes.

Q235 Heidi Alexander: I have seen some research that links the level of delayed discharges in an area to low levels of unemployment, simply because care providers cannot access domiciliary staff or residential care home staff. Is that something that you believe to be the case as well?

Professor Green: Yes, that is the case, but there is also another dynamic in this, which is that, even when you can get the staff, if you have the low levels of funding and if you have a system that is in a silo—for example, you could solve the delayed discharge issue by utilising your residential care beds, where you have them in those localities—what happens then is there is a battle over whether or not it is going to be paid



for by the NHS or by the local authority. There are vastly disproportionate budgets.

Q236 **Chair:** These are all issues that are hugely important to this Committee, but I am just conscious of the time.

Professor Green: To come back to your original point, the issue is that in every situation where there is not enough resource it is difficult to recruit, and that is why we had to go both to the EU workforce but also, for specialist roles, to those outside the EU. If that is destabilised, the system will go into even greater crisis.

Q237 **Mr Bradshaw:** I shared a platform, during the referendum campaign, with a well-known publican, who was a leading advocacy of leave, who said that far from wanting less immigration he wanted more immigration, but from non-EU countries. I wonder whether any of you thought that that would be the solution to your problems, given the practical obstacles that you have just outlined.

Daniel Mortimer: Again, it will come back to the system that we have for managing migration. The current system we have for managing migration from outside the EU does not do our sector any favours, and that has been our recent experience.

Q238 **Mr Bradshaw:** What are the main countries, Mr Green, outside the EU that you recruit from?

Professor Green: We have, for example, nurses that come in from places like the Philippines, but often what happens is they come in and the difficulty of getting their qualifications agreed means that they go into caring rather than nursing roles. Sometimes, because of the structure and the system, you get people who have higher level skills and we are not using those skills effectively.

Q239 **Mr Bradshaw:** So it is the Philippines. Are there any other countries?

Professor Green: India, for example, and the Philippines. Those are probably two of the major ones from outside the EU.

Q240 **Mr Bradshaw:** There is a lot of talk, is there not, of linking these wonderful new trade deals that we are going to strike with some of these countries with taking more migrants from those countries, but, whatever happens, if we have fewer people coming from the rest of the EU to fill the gaps, they will have to come from somewhere? So, the likelihood is that they will have to come from non-EU countries such as India, the Philippines and elsewhere.

Daniel Mortimer: Part of the difficulty we face is that other parts of the world are also competing for those staff, particularly in the Philippines. The United States is a big competitor for nurses. We have seen a big growth in demand for trained registered nurses in the middle east and massive investment in their healthcare system, so there is a huge amount of competition. The WHO published a report, just towards the



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end of last year, which identified that kind of imbalance between the developed countries and their demand for nursing staff.

- Q241 **Dr Whitford:** We are talking about social care workers who fall way below the income level, but it is proposed that there would be an income level of £35,000, which would be above what the majority of our nursing workforce would earn. The majority maybe get to the top of band 5, bottom of band 6 at best, and they would be well below that. It is more a general thing, but in the devolved countries, certainly in the rural parts of Scotland, nobody earns £35,000. You can run a distillery and you are not earning that. Have you put the case to the Government that, if we end up in that situation, the earning levels will need to recognise the kinds of people whom we want to attract in?

Professor Green: We put evidence to the Migration Advisory Committee on those issues because we have this skill shortage, but it does not equate to the levels of salary they require to get people into the country. There needs to be a review of whether salary is a good proxy in terms of skill. If that is going to be used as the proxy, then the Government need to think carefully about how they resource the system, to enable people to get to that level, or how they run the system without the requisite number of staff.

- Q242 **Chair:** You have set out so far things such as mutual recognition and skills, paperwork, language testing and extra financial costs. All those things need to be resolved in the future system that is used. Have you come to a settled view as to how this should look in the future?

Daniel Mortimer: Part of the work that we have done between our organisations picks up the points that Martin has just made, and we did reflect that in our evidence to the Migration Advisory Committee, particularly around the case for nurses being placed on the shortage occupation list. They themselves have looked at whether there should be a weighting for public service and public benefit in how they assess applications for tier 2 visas. Whatever system we have, we believe that, if there needs to be a focus on salary, there needs to be some appropriate weighting for the kind of public service that our organisations provide. That is the first thing.

The second thing is that we are very mindful of the approach our regulators are developing in how they are looking to license or test healthcare professionals from across the world. The GMC is consulting on a common approach. Other regulators may also, we believe, be developing the same kind of approach in how they assess whether they register healthcare professionals.

For some of the other issues, we want to make sure that the system is as easy to use as possible. We have had conversations with the CBI, the CIPD and others, and what we see across the economy is that most major employers see an opportunity for a new migration system that is much easier to use for employers but also for people who are coming to



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this country to seek work. Again, there is a developing evidence base that we are drawing together across the economy, across the major employers, which is setting that out. I can share some of that thinking with the Committee.

Q243 Chair: That would be helpful if you are coming to a settled view. Certainly, I have heard from individuals who, as you pointed out, are not able to work as highly skilled nurses in this country because of the recognition of their qualifications. So, it would be interesting to hear your thoughts about how we could simplify that.

Professor Lomas: Can I give a different perspective, which is very different from the one you have heard from Danny, which is that the UK is highly attractive for people to come and undertake medical research and science? We need to facilitate that as best we can. The NHS is a fabulous organisation. Despite all the stresses, strains and difficulties, it is a fabulous, joined-up organisation that is a £130 billion engine that you can use for research and development. The Government have put in biomedical research centres, via the National Institute for Health Research, which are superb at ways of trying to translate basic science through to patient care. What I am getting at is that I would like to give us access to the whole world, so that we can bring in the very best people to facilitate our research and development engine, to improve patient care and to generate wealth for the country. I realise it is a completely different end of the spectrum, but it gives you the full range.

Chair: It is very useful to have your thoughts as to how that should be simplified. Philippa wanted to come in and then Heidi.

Q244 Dr Whitford: Almost the elephant in the room in that we have not mentioned it is that part of the reason we got the vote we did in June last year was this, "We need to stop immigration." We have talked about how we might reorganise it or whatever to make it easy, but has the profession had the opportunity to take this to the Department for Exiting the EU, because otherwise, if we do not change the narrative, this talk about getting down to tens of thousands and so on is not going to be a matter of the system—it is going to be a matter of the principle?

Daniel Mortimer: Speaking for the NHS, there is more that we can do domestically to make our careers as attractive as possible and make sure that we are recruiting from all parts of our communities. Part of that is because work itself is a health benefit and it is in our interests to do that. There is work within the NHS in terms of more employment opportunities for people with learning disabilities. We are doing some work at the moment to try to develop recruitment and employment of people from the forces, and there will be other things that we need to do where, frankly, we have not done enough. Because we are such large employers, we have not done as much as we should do in competing for local labour. So, we do accept the challenge, as it were, that the referendum result gives us in terms of upping our game. Clearly, there has also been a lot of investment in some new career and education structures within the



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NHS in England, which is designed to help that kind of domestic recruitment effort and make it easier for people to develop their careers outside the university setting, degree entry. There are things that we are doing but there is much more that we need to do in that regard.

Compared with some sectors within the economy, we are a relatively small employer of non-UK nationals; 12% to 13% of our workforce are non-UK nationals. That compares quite favourably with other sectors that will be giving evidence to other Committees elsewhere in the House. We see global recruitment as a complement to what we do, but we also see it, as David has touched on, particularly in the research-intensive work that we do, as a way of attracting the very best people in the world to come and work with us because that is in our interests, in the same way that we want our very best people also to gain international experience that they will bring back to our teaching, research and service provision.

Q245 Heidi Alexander: I just had a couple of follow-up questions for Mr Mortimer. You said earlier that the current immigration system for staff coming in from outside the EU does not do your sector “any favours,” which is, I think, the phrase that you used. I put it to you that it is worse than that—that it does cause real problems. Is that not the case?

Daniel Mortimer: What problems were you thinking of?

Q246 Heidi Alexander: In terms of the length of time and the bureaucracy in getting staff into the country. You talked about the fact that your preference is very much for EU staff in the speed and simplicity. Given the lack of staff and the vacancies that we have in the NHS at the moment, and the immigration system, when I speak to NHS chief executives, they have told me of real problems in getting the staff that they need from outside the EU. I just wanted to challenge you a bit. It is a slight understatement to say it does not do the NHS any favours. It is probably worse than that.

Daniel Mortimer: We can have semantics in terms of the language we use. The thing that we welcomed was the placing of nurses on the shortage occupation list. That made a material difference to health and social care in the last couple of years. That has been a really helpful step because it has avoided the kind of salary thresholds that Dr Whitford talked about. It has simplified the process in terms of tier 2 so we have seen some support, but, absolutely, my members do describe real frustrations with the system. Our biggest frustration is the one that Martin’s members and my members share, which is that the use of salary as a proxy for worth and for skills does not make sense for us.

Q247 Heidi Alexander: Can I ask you about the system that you would like to see in place as a new system and whether you have reflected at all on the whole issue of the time limits that are attached to visas for staff that come in? I certainly speak to non-EEA staff who are routinely having to reapply after a relatively short period of time, often paying £1,000 to reapply. They see it as a cash cow, to be honest, and I wonder what



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advice you would be giving to Government on that whole question of time limits around visas for NHS staff.

Daniel Mortimer: Again, for us, that speaks to having a system that is designed to support what our sector needs. If there are occasions—we are in this situation right now—where we need to supplement the domestic NHS workforce, social care workforce or research workforce with colleagues from elsewhere in the world, we should make it as straightforward as possible for us as a sector and for them as individuals to contribute.

Q248 **Heidi Alexander:** Would you prefer to see a situation where, if people are coming in, they are given indefinite leave to remain?

Daniel Mortimer: If they are from outside the EU, it would depend on the circumstances we are in. At the moment, the settlement we have for nurses with the shortage occupation list simplifies things for us for a considerable period of time. This is true for all the sectors here. As to how we move forward, clearly there is a political debate to be had about how the migration system is managed and what the spectrum would be from indefinite leave to remain to time limits. Whatever system we have, it needs to be as simple and as straightforward to use as possible. Our present system is not simple and straightforward to use, for either employers or employees.

Q249 **Heidi Alexander:** If, for whatever reason, we cannot recruit or train the additional new staff that we need here in the UK, one of the other options is that existing staff may be asked to work longer beyond pensionable age. What consideration has NHS Employers given to this and what work have you done in that whole area, if any?

Daniel Mortimer: Following the settlement of the public sector pension reforms by the coalition Government, we did work with our trade unions that looked in particular at the extended age of our workforce. It is a programme of work called the working longer review, and I can share some of the outputs of that with the Committee. As to working beyond retirement age, no, we have not looked at that in any detail. Of course, we have extended the pension age due to the public sector pension reform. We did a fair bit of work there and, as I said, I can share our thinking there that we developed with our trade unions.

Q250 **Heidi Alexander:** I suspect you do not detect much enthusiasm among your workforce for working longer, or do you?

Daniel Mortimer: The reality is that we have extended the retirement age anyway in the public sector, and in the NHS in particular. I do not doubt there are varying degrees of enthusiasm. There are also varying degrees of factors that affect the decision that people make. For some of the colleagues who would be working with David, some of the tax arrangements around pensions incentivised them probably to retire earlier than they might want to, so there are a number of factors at play here. As I say, I can share some of our work with you.



- Q251 **Andrew Selous:** I just wanted to ask Professor Lomas a question. We have had briefing that there are just over 30,000 EU doctors in the UK, about 3,500 arriving every year. In respect of that, I wonder what Professor Lomas feels about the fact that every year we turn down bright British children who have good enough grades to get into medical school and yet we are taking EU doctors. What is your view on that?

Professor Lomas: That is interesting. Let me just explain very briefly how medical admissions work. As I explained before, every medical school has a number that they have to hit, and if I exceed my number by one then we will not get paid to train that doctor. I am capped at 7.5% international students, so I cannot take any more than 7.5% into my medical school.

- Q252 **Andrew Selous:** But do you have to take 7.5%, or could you take more British children who have the grades and dearly have longed to be doctors all their lives, perhaps?

Professor Lomas: We take 7.5% because the international students pay more, so it helps to subsidise. Remember, in a research-intensive university such as UCL, we bring an awful lot of money in for research. Research does not cover its costs, and the way that the university model works is education and the income from education balances the research costs, so that we have a connected curriculum between research and education. That is how the university model works in the country. Universities have to bring in overseas students to contribute to the running of the organisations. That is the 7.5%.

Could we take in more? I have 18 applicants for every place at medical school at UCL; many of them will have suitable grades. We put ever more barriers in the way to people coming into medical school. They are fair and transparent. We put people through a BMAT assessment. They take the BMAT; we then rank everyone, draw a line, and only people from widening participation do we move above that line. That is so that we are fair, transparent, open and our actions are defensible. We could train many more doctors if we wanted to, but it would cost more money to do so and it would take longer to generate the workforce that we need.

The other thing that I would add, if I may, is that I qualified 35 years ago and have had a few weeks off sick in my life, but otherwise have worked for the NHS and the university sector continuously. My graduates from UCL would work for a couple of years and then often have a break. That is not just UCL—that is the current grade of junior doctors. Many will have a break after FY2, after two years of training, and then travel, go abroad and come back. It is not the same workforce; it is not the same grouping; the ethos is not the same as the one that I had when I went through medical school.

- Q253 **Chair:** On a similar point about newly qualified doctors and those in further training, if British medical training ceases to be bound by the European working time directive and regulations, do you see that there



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are opportunities to improve training, and, if so, how?

Professor Lomas: This is where my training 35 years ago plays to my prejudices, and I need to declare that.

Chair: I think there are a few of us in the room who—

Professor Lomas: What I want to talk about is the joy of working in a firm structure, with an organised team, where you had a consultant that you understood, and you worked for a period of time, typically three months, with a senior registrar or a registrar. You had a team, and when you made a mistake it was corrected by the next person up; and you have a love and affection for those people that lasts forever. That firm structure is what most of my generation would talk about in terms of the ideal way of training doctors.

The European working time directive has some real assets. It does not allow the three-day weekends that I did as a junior doctor any more; it does not allow starting at nine o'clock on a Friday morning and leaving at five or six o'clock on a Monday evening, as I did, and my predecessors did even worse than that for many years, but it has very much damaged the firm structure because people will clock on and clock off. Rotas are generated so that we do not breach the European working time directive and there are penalties for hospitals that do.

From my preamble, you can guess that the answer is, yes, we could be far more creative. My generation would argue about the joy of going back to firms. Educationalists will tell me that is the wrong model to use, but I still stick with that and say that is the best training I have ever had and seen, but it may be a generational factor. That is lots of prejudice, I am afraid.

Chair: I kind of share that.

Daniel Mortimer: However, our junior doctors who are in training felt so strongly about the benefits of the European working time directive that they asked for it to be placed on the face of the contract that has been introduced in the NHS. Whether or not the European working time directive stands in English law after 2019, its requirements are incorporated into the new junior doctors' contract in England. It does not matter what happens to the working time directive; it is there now within the contract.

Q254 **Chair:** Will there be any flexibility, though, around timing of breaks and any flexibility, because I know it is something that has been raised?

Daniel Mortimer: Not unless it has been agreed as part of the contract.

Q255 **Chair:** As it stands now is how it is set in the junior doctors' contract.

Daniel Mortimer: Yes, because the junior doctors asked for it to be in the contract. While generations have different views about the training,



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this generation wanted it incorporated into their contract and made that request before the referendum result was known.

Professor Lomas: I would agree with Danny and I would argue that my view is generational, so I fully accept that. However, if you work on the wards with the junior doctors, they are not happy. They are not happy because they went through a very damaging strike, which was really unhelpful, but they are not happy because, when I teach them as medical students, they graduate as doctors and they say, "It is not like you told me it was going to be; it is not the experience." So, working as a junior doctor does not give the same job satisfaction that it has done in years gone by. There is something wrong. I am not arguing that I know the answer, but I do not think we have got it right for the cohorts that we are training at present.

Daniel Mortimer: There is a risk, though, that we blame the European working time directive for a complex set of—

Professor Lomas: I think that is right. Remember, of course, what I would also like to do is to get these junior doctors not only just trained but into academic medicine as well. I want them to be fully qualified doctors, but I also want them to have a parallel career, take time off, do a PhD and do the very best they can for the profession, because that is what will drive us forward.

Q256 **Dr Whitford:** Is part of the responsibility for that not a little bit with our generation? I have been qualified for exactly the same length of time, and as a surgeon I used to do Thursday morning until Monday night, by which time I did not know my own name. In actual fact, in my hospital we kept the firm structure until very late on. There was the change from 56 to 48, but it was the breaks that seemed to be the problem. It struck me that it was then our generation who went, "Do you know what? That is just too hard; let us just do shifts." I would totally agree that at the end of two years of foundation, as simple task doers, our junior doctors say, "I worked hard at school; I worked hard at uni; this is not it." But I still think that there are ways of using the European working time directive. We are talking 48 hours. If we cannot train a clever person in 48 hours a week, there is something wrong with us. Meeting breaks and things is all a percentage of time; it is not 100%. Instead of looking at how we make sure you get something to eat and enough to drink, we just threw our arms up. I know that it might make an easy way, but the danger is that the easy way is, "Great; we don't need to bother," and it will drive more of them out.

Professor Lomas: We need to do something different. I do not even know what the answer is, but we need to do something different in the training of junior doctors at the moment.

Daniel Mortimer: My trade union colleagues would point out in relation to the European working time directive that when it came in, in the early 2000s, it guaranteed a set of rights for people within health and social



care that were not just about the hours they worked and the breaks they took, but also the annual leave they got. It felt to them like a move that improved safety and set some very sensible basic standards about how we employ people. We have become slightly fixated in the NHS about the European working time directive, and surgeons in particular. I am very respectful of the surgical colleagues in the room, but the conversation is slightly different in other branches of medicine than it is in surgery in particular. That loss of the firm is being felt hardest in surgical specialties, but in other parts of our workforce the EWTG was seen as a very progressive step. Annual leave entitlement, in particular for bank workers, was seen as a massive step forward because it extended annual leave entitlement to people who hitherto had never enjoyed it.

Q257 **Chair:** How concerned are you, Mr Mortimer, that one of the disadvantages of the European working time directive is that you get gaming of the way shifts are recorded, so that junior doctors are working far longer but their hours are just not correctly recorded?

Daniel Mortimer: That clearly is an area of concern. One of the reasons the new contract includes a different way of capturing concerns from doctors—it introduces a system of exception reporting as opposed to diary carding—is to get past some of that.

Q258 **Chair:** Has that been successful so far in where it has started to be—

Daniel Mortimer: There are not enough junior doctors on the contract, as yet. The surgeons move across in April, and that is the first big, large number of doctors that will move on to the contract. There are doctors on it already, but the big, significant change will be in April. By the end of this year, we will have a much better sense of how the exception reporting process is working in practice.

Chair: Thank you very much for clarifying that. Are there any other questions on this issue of Brexit and health? Are there any points that you feel you would like to make that you have not been asked, before you leave? No. Thank you very much.