

Select Committee on the European Union

Home Affairs Sub-Committee

Corrected oral evidence: Brexit: Reciprocal Healthcare

Wednesday 13 September 2017

11.10 am

Watch the meeting

Members present: Lord Jay of Ewelme (The Chairman); Baroness Browning; Lord Crisp; Baroness Janke; Lord Kirkhope of Harrogate; Baroness Pinnock; Lord Soley; Lord Watts.

Evidence Session No. 2

Heard in Public

Questions 11 – 16

Witnesses

[I](#): Mark Dayan, Policy and Public Affairs Analyst, Nuffield Trust.

Examination of Witness

Mark Dayan.

- Q11 **The Chairman:** Welcome, Mr Dayan. Thank you for coming and talking to us. You have heard the first session that we had. As I mentioned at the beginning of that, these are the first two sessions, really, of our inquiry into reciprocal healthcare. We are very grateful to you for coming and talking to us.

This is a public hearing. I should say that again. It will be recorded but you will get a transcript shortly after the hearing, to give your comments on it. Can I just ask if you would like to make any kind of opening statement, which would be very welcome to us, or whether we go straight into the questions?

Mark Dayan: No. I am happy to answer as I am asked.

- Q12 **Lord Soley:** Can you tell us what incentive the United Kingdom has to gain from the existing reciprocal arrangement? As a reverse question, what gains do the EU have from the existing arrangements?

Mark Dayan: Taking the UK incentives first, there are basically two elements. There is first the fact that, under the S1 scheme, a significant number of pensioners who would be entitled to British healthcare are using healthcare systems in other European countries, at what appears to be a significantly lower cost than they would in the NHS. Another dimension to that is that, as I am sure many of you will be aware, the NHS is currently in something of a crisis of bed shortage, with resources very thinly stretched in terms of space. We appear to be getting quite a good deal, as it were, from the S1 scheme that allows us to effectively pay other European countries to look after pensioners with the right to reside in Britain.

The other side of the benefits to the UK, which is more diffuse and more a benefit to the public rather than the NHS or the Government, is the existence of the EHIC and what it does to smooth tourism and travel for British citizens in Europe.

Looking at the incentives on the European side, you have something very similar as regards EHIC. The majority of tourists to Britain are from the European Union. The EHIC greatly reduces costs and time and effort involved in getting travel insurance, and will smooth tourism and travel.

Another benefit to the other EU countries, particularly ones like Spain and France that have a high number of British retirees, is purely financial. As Paul said, there is a net financial flow of something like £450 million a year out of the UK to cover S1, and presumably there will be elements of health services out there that rely on that income to cover part of their cost base, as it were. It might not be easy or convenient if that were to suddenly disappear.

There are strong incentives on both sides to retain something like the current arrangements. Concerns are more about where that sits within the broader negotiations.

Lord Soley: On the pensioner one, for example, there will be far less EU pensioners in the UK generally.

Mark Dayan: Yes. I did not mention that as a benefit to the EU, and that is simply because, as you quite rightly say, the numbers are so much smaller. I believe some 4,000 EU pensioners live in Britain under S1, which is dwarfed by any of three or four European countries.

Lord Soley: What is the big gain to the European Union? What is the biggest gain of the system?

Mark Dayan: It is almost a philosophical question as to whether or not you think the benefits of EHIC to European citizens travelling to Britain, of which there are a lot, are greater or less than the benefits of £500 million to the governments and health services of those countries. They are both quite substantial and I would expect, particularly for the governments and health services in regions with a lot of British retirees, that it is a real concern for them.

Lord Soley: If it is not possible to keep the current system, what are the most important things to hold on to?

Mark Dayan: Retaining access to S1 for British pensioners already in the EU, at least from the point of view of a think-tank primarily concerned with the NHS, feels like the biggest concern. The NHS is not in a position to deal with a large, effectively unfunded liability of people who have a perfect right to use the NHS, and would probably need to if the scheme suddenly ended, but for whom space and resources have not been allocated so far.

Lord Soley: Have you done any work at all on the difficult cases, if you like, by which I mean people who need long-term care generally—particularly end-of-life care, perhaps—but also if someone goes from the UK to a European Union country because there are benefits for their health? It might be about climate or it might be treatment, or it might be someone coming here because a particular type of treatment is available that might not be available in their own country? Have you got any figures or information on that?

Mark Dayan: We have not. We do not have a breakdown of exactly who is in the S1 scheme in the EU countries. Our modelling has had to assume that they are a population basically equivalent to people over 65 living within the United Kingdom. There is another scheme, perhaps less discussed and less significant, called S2, which actually enables people, in England only if they are signed off by the NHS, to go abroad specifically for treatment they could not obtain in Britain. The amounts of money and the numbers of people involved in that are not huge, but that is again a benefit to the British patient of reciprocal healthcare as it currently works.

Lord Soley: Were you surprised to hear this figure of 1% of the money coming back to the UK from the use of the EHIC—i.e. the European Union charging us for healthcare?

Mark Dayan: No, I was not. There are 25 million people who have an EHIC in Britain. I do not know what proportion of those go abroad each year but it is certainly a minority. I have heard before the figure of 215,000 uses of the EHIC each year. When you put it like that you realise that actually, quite a substantial number of British citizens are availing themselves of that. Particularly when you consider that most of the travel covered under EHIC will be pretty short trips, there is a limited exposure to risk of health deterioration. Presumably people travelling abroad under EHIC, which is for temporary travel, would tend not to be people with serious, long-term conditions who are at high risk of hospital admission.

Lord Soley: You might not know the answer to this but I am interested in the way that in this country, and certainly in one or two other European countries, frankly, hospital staff do not ask questions about where you are from. They just treat.

Mark Dayan: That is absolutely right, and one of the things that the National Audit Office has picked out is that currently, when you look at how much Britain should potentially be getting from the EU for treating temporary visitors versus how much we actually get, we only get about a sixth as much as we probably should. That is the National Audit Office's figure. One of the other things that is actually a plus about the current system, in a way, is that it appears we could be doing an awful lot better out of it than we in fact do.

As you rightly say, that reflects the fact that the NHS is set up as a universal system. It is not an insurance-based system. In a country like France or America, everybody who comes into a hospital will have to be allocated to a particular way that they are going to pay for their treatment, usually through insurance. The NHS generally does not have that system, which means that many trusts will not have in place systems for identifying who needs to pay and following that up. The National Audit Office did find quite a stark and probably unjustified level of variation between different hospitals in how much money they were getting back, which suggests that some of them were pretty "on it" and others were not.

Lord Soley: Finally on that, some countries in Europe also do not charge. I took someone to a hospital in Italy where that happened; there was no charge and no questions or anything, and that was ongoing care for a while. I do not know about other countries but I am told it happens in other countries in Europe too. Is that your knowledge or not?

Mark Dayan: I do not have any particular figures. They may be available within the Italian or, say, Spanish systems. However, it is the case that some other countries in Europe also have a system that is not set up to identify how people have to pay, such as Spain and the Nordic countries. You might expect some places there to suffer similar challenges to the

NHS, in basically having to have a system of charging people that is only applied to a small minority of your patients, whereas others, like France and Germany, have an insurance-based system where it is second nature.

The Chairman: Can I just follow up? I have one small question on pensioners from other EU countries coming here. What nationality are those?

Mark Dayan: I do not know.

Lord Watts: People who like rain. Someone who does not like the heat, I think, Chair.

The Chairman: I had heard quite a lot were Irish.

Mark Dayan: I have heard the same thing but I do not have actual data on it.

The Chairman: Is data available, do you know?

Mark Dayan: The figure of 4,000 actually came from an FOI request submitted to the Department of Health by the BBC, so it is available to someone but I do not have it.

Q13 **Lord Watts:** The arguments over the divorce bill are concentrated on how much money you put in and how much money you get out. It is very good to concentrate minds on this issue, is it not, in the sense that people start becoming more in tune with how much it is costing them and making sure that bill systems work across Europe? Is there going to be a difference of view, do you think, within the member states on how we look at this issue? As we know, most of the liabilities are in Spain, Portugal and, to a lesser extent, Germany. Is there likely to be a difference of view, in your opinion, about how member states see this issue?

Mark Dayan: Certainly there is the potential for that. When you look at the financial side, obviously you are absolutely right that certain states gain far more from the current system and therefore might have more of an incentive to keep it, but there are more general issues. Something that unfortunately is the case for reciprocal healthcare and in fact many aspects of Brexit as it affects the NHS is that the issues will be settled in part not in their own right but by wider principles in the negotiations. A significant one for reciprocal healthcare, on which the EU 27 so far seem fairly united, is a degree of resistance to the idea of the UK cherry-picking certain programmes to remain a part of while leaving the single market and no longer having free movement of people. Yes, on the financial side and on the raw consideration of interests, it certainly applies more to particular EU states than others; but at the higher-level principles, perhaps not so.

Lord Kirkhope of Harrogate: Can I just follow on from that question? I am quite concerned about this. You referred to getting one-sixth of the

amount of money that we could or should have retrieved. Bearing in mind that a lot of the attitude regarding the European discussions is to do with how much money it costs us, one way or the other, we presumably have failed to collect a considerable sum of money from Europe, which we could have collected legitimately.

I will press you on this. You do all the research. I know you said it is because there is a different payment basis in this country from other European countries, being free at the point of use; but even so, can you clarify why you think that is, and why it is not clearer and more transparent that that is the case? How much money are we talking about?

Mark Dayan: To answer the last bit first, in 2012-13 the NAO obtained from the Department of Health the figure that we could have recovered £300 million from European countries and in fact only recovered £50 million. It is a fairly large sum, although in the scale of the NHS budget not colossal. In terms of why it happens, there are probably two factors. One is a cultural factor: the NHS is not used to the idea of being a service that demands ID and proof of residence, and in fact that applies not just to people working in the NHS but to British patients as well. People are not used to thinking that you have to prove your ID if you go to the NHS.

The other factor is simply the practical effort of setting up a system to do that. There will be hospitals for which it genuinely does not make financial sense to employ an extra two people to log temporary visitors in and out of the system, relative to the amount of money you would be able to recoup. There will be other trusts for which that is quite a significant number of patients, and it certainly is worth it.

Q14 **Lord Crisp:** Let me pursue the issue of costs a bit more. Have you personally, or the Nuffield Trust, got an estimate of the worst-case scenario if this all goes wrong, both in terms of money but also staffing and resources and so on, which is a problem that will fall on the NHS?

Mark Dayan: If you take a worst-case scenario of 190,000 people who are currently treated within EU health systems suddenly becoming dependent on the NHS, modelling that as an age group of over-65s and looking at the pattern of financial and bed use you would expect from that age group, you are looking at potentially £1 billion in costs to the NHS, some of which would be made up for by no longer having to send money to the EU states under S1.

Much more worryingly, as you alluded to, you would also expect that number of people in that age group to need about 1,000 additional hospital beds, which is two or three more hospitals, and potentially around 3,000 nurses. This is at a time when nurse staffing and beds in the NHS are both overstretched to nearly dangerous levels, so it is quite concerning. Even though that is a worst-case scenario, it is quite justified for that sense of unknown level of liability to be of real concern to people in the NHS.

Lord Crisp: Have you at Nuffield got a paper on the different scenarios you have gone through that you could let us have?

Mark Dayan: I have only looked at the worst-case scenario. You could easily extrapolate from that; if half of them came back, you would expect roughly half that amount. At the moment, with the limited data available, we have limited justifiable grounds on which to calculate different scenarios, really. Obviously, one of the questions that we have no way of answering is how many people currently in the EU under S1 would be able to cover themselves with private insurance and how many might actually be eligible simply to become residents of that country and access its healthcare as a resident would. That, of course, in turn depends on the terms of the exit deal. It is a pretty inexact science but the orders of magnitude you are talking about are of concern.

Lord Crisp: Somewhere between nought and a billion, depending on what the deal is. Let me come back to an answer you gave earlier, which intrigued me. You said the UK benefits from the scheme because it is getting people treated at a lower cost abroad.

Mark Dayan: That appears to be the case.

Lord Crisp: I always hear the story that the UK health system is actually cheaper than other health systems. Can you unpack that a bit for us and explain to us why being a pensioner in Spain is cheaper than being a pensioner in Blackpool?

Mark Dayan: The latest figures suggest that UK spending is about the EU average. However, countries like, in particular, Spain and Italy are among the lower-spending and probably lower-cost countries in Europe.

This is speculation on my part but, potentially, just as we have trouble billing the EU for all the money that we could get under these schemes, it is possible that Spain and Italy do not really bill for the full cost of those people either. For example, in some instances you will effectively be billing for the marginal cost of a patient, discounting some of the fixed costs that are in physical buildings and fixed staff within, say, France or Spain; and in other cases they simply may not, as we do not, identify everybody who could have their costs recouped under S1.

Lord Crisp: In a number of other countries in Europe, there are co-payments by the patient. That money is therefore not included, presumably.

Mark Dayan: No. That is right.

Lord Crisp: So actually you are just paying the bit that the state pays and the patient is still bearing that cost.

Mark Dayan: That is right.

Q15 **Baroness Browning:** Just to put this into context, do you have any figures or did the NAO take a look at what the situation is for all of the

non-EU people who use the UK health service? I just wonder what the differential is between the two groups.

Mark Dayan: It did. I do not have the figures to hand. There is a complicating factor, which is that the Department of Health has brought in a system of simply charging people from outside the EU £200 up front when they come here, to put that money towards the NHS, which is a bit of a blunt instrument for recouping costs but has greatly increased the figure.

The Chairman: When they come to Britain or when they come to hospital?

Mark Dayan: When they come to Britain. For example, for students and some categories of temporary residents, you can only enter the country if you pay up front £200 as a health surcharge.

The Chairman: Does that go to the health service, or does it go to the Treasury and the Treasury sends it on to the health service?

Mark Dayan: Effectively, I believe it does go to the health service, yes. I could give you figures from the 2012-13 report, but I suspect the Department of Health could quite accurately say they are changing quite quickly.

Baroness Browning: It would be useful to see the difference between these two groups of people.

The Chairman: I agree.

Mark Dayan: I do not have those figures here but I can certainly send them.

The Chairman: It would help the Committee hugely if you could let us have whatever you can find.

Baroness Browning: Is there an NAO report that we should be referenced to?

Mark Dayan: Yes, there is. I believe it came out last year. It is quite a thorough look at the high-level figures in terms of charging EU and non-EU temporary residents. It also gets into some of the specifics of what different trusts are doing and what the differences between them are in how successful they have been recouping costs.

The Chairman: That is a very helpful reference and we will look at that.

Lord Watts: Can I just ask you about people who are entitled to healthcare in the countries they are resident in because they have worked in the past? Is that up for grabs? Would it dramatically change the numbers and the cost if those people could no longer access the healthcare in that area because the Government changed the rules?

Mark Dayan: That is not an issue of reciprocal healthcare but actually of the reciprocal immigration system that exists under freedom of movement. You are absolutely right that if some of the 1.2 million British citizens overall who live and work and retire in the EU were for some reason forced to return either generally or, because they could not cover costs, for healthcare, the implications of that for the NHS would be quite sobering. Most of those people are not covered by a reciprocal healthcare scheme but they simply enjoy rights as people who are ordinarily resident within that country.

Q16 Lord Kirkhope of Harrogate: We are talking about all the challenges here. What about opportunities? What about new ways of paying for healthcare? UK healthcare providers in this country are always anxious to look at new opportunities. Looking ahead, post-Brexit, do you see new funding arrangements coming into play? There may be new commercial proposals or healthcare providers taking opportunities. Are there any opportunities here, do you think?

Mark Dayan: I think insurance companies would see an element of opportunity, under S1, to offer people essentially private health insurance to cover their healthcare needs. People who currently use EHIC are obviously an opportunity for the travel insurance industry. You would not say that that is really an opportunity for Britain as a whole. It basically creates new marketing opportunities, perhaps, for insurance companies but it comes out of the pocket of the British consumer. There will potentially be a shift from reliance on these reciprocal healthcare schemes to reliance on the private insurance market.

Lord Kirkhope of Harrogate: A lot of people, of course, do both. They have their card but they also take out travel insurance before they go anywhere. That is a private benefit, obviously, to the companies. Is that something you see developing even more?

Mark Dayan: The price of travel insurance would go up without the EHIC. At the moment travel insurance for EU countries effectively fills in the gaps around what EHIC will cover within that country. If you had to pay so that essentially, the full liability of all the healthcare costs you might incur fell on your private insurance, you would have to pay a lot more. Consequently, the liability of travel insurance companies in Britain would increase and their prices to consumers would increase.

Lord Kirkhope of Harrogate: I take it that these UK healthcare providers—the companies, for instance—are not necessarily UK companies anyway. A lot of them are European companies, are they not?

Mark Dayan: Britain does have a pretty extensive insurance industry, but I would come back, really, to the point that although it does create an additional market, seen from the point of view of the national interest of Britain it would simply act to take money from one group, the consumer and the traveller, and to give it to the insurance companies. It is not, perhaps, an opportunity for the country as a whole.

Another opportunity potentially is that we could look at new replacement reciprocal health agreements, with some or all EU countries, but I think experience suggests that would be difficult to arrive at. Countries like Australia, for example, try to set up their own arrangements with as many different countries as they can, and they find that negotiations take quite a long time. So far they have not managed to sort them out with that many countries.

Lord Kirkhope of Harrogate: Can I ask you something on the back of that? Obviously, it is a completely sacred situation: the National Health Service must always be free at point of delivery, and there must be no contributory element at the point of delivery of those services, which most European countries do have, so their overall health spending in many cases is higher than ours in percentage terms. You do a lot of research on these issues. There is this sacred cow: this view of British politicians that we cannot touch this ever, or we will all be thrown out of office or whatever—something even worse, Clive, I would think. Is research going on that suggests that if we moved to a different model, our health service would be much better funded and it would actually be, if you like, able to deal with some of its current problems?

Mark Dayan: There certainly are people in the Nuffield Trust who think about issues like that. Without wanting to veer too far from reciprocal healthcare, there are two separate issues there: how much you fund the health service, and where that money comes from. There is no intrinsic relationship between those two, so you could have a system with greater private contributions that actually spends as much or less than the NHS. Italy would be an example of that. Conversely, you could have a fully tax-funded system that spends more than the NHS per person, as they have, for example, in Norway, more or less. There is the question of how you pay for it and then the question of how much you pay. They should both be issues to be considered but there is not necessarily that link between them.

Lord Crisp: We have this particular reciprocal system in the EU. Looking around the world as a whole, are there any comparable arrangements or systems, say, with NAFTA in North America? Is there anything else comparable?

Mark Dayan: Yes. As Paul said, we do have some. We have reciprocal health agreements with Australia and New Zealand that are outside, obviously, the whole European Union, EHIC, S1 system, and they are actually much simpler. They basically say that if you are a British person travelling in Australia or an Australian person travelling in Britain, you can simply access their healthcare and there is no element of reimbursement that stands behind that. However, what you have to reflect on is that we have only been able to arrange that with, I believe, four countries in the world. That suggests to me that the EU's system of reimbursing countries in return for reciprocal healthcare rights has made it easier for us to do that deal than perhaps it would have been to arrange that piecemeal and in a more waiver-based way.

Baroness Janke: I just wondered whether you could give your opinion on how long a transition period would need to last, if there were to be such a thing.

Mark Dayan: Looking at the range of periods that is often quoted, which is something like two to three years, that really should be long enough to set up the logistics of a new system. Things would be more difficult if some sort of negotiation continued during that transitional period, so that you potentially did not have that whole period to prepare. The real concern with reciprocal healthcare is where we end up. The logistics of getting there should not be insurmountably complex. It is whether or not we can keep these schemes.

The Chairman: That was a point that your predecessor, Mr Macnaught, commented on. Is there anything else in his evidence that you heard that you would like to comment on or add to in any way? There were one or two things that he was understandably unable to go beyond a certain point on. You are perhaps less inhibited.

Mark Dayan: On dispute resolution, for example, Paul is obviously not able to say this, but reciprocal healthcare is among many examples of how a system in which disputes are resolved on a state-to-state basis would not really work, because a state is not going to take up as a diplomatic cause the case of an individual patient who might want to bring some sort of legal action relating to reciprocal healthcare. For a system that would do that—and the EU's negotiating mandate suggests it thinks the same—you need something that shares with the current system of the Court of Justice of the European Union the capacity that individuals have to bring cases before it.

The Chairman: Thank you very much indeed; we are extremely grateful to you. We have had a very interesting start to our inquiry. I hope you will forgive us if we come back to you from time to time with other questions that we may have. There were one or two pieces of work that you have very kindly agreed to let us have, which I think would help us a lot. Thank you very much indeed.