



Select Committee on the European Union

Home Affairs Sub-Committee

Uncorrected oral evidence: Brexit: Reciprocal Healthcare

Wednesday 11 October 2017

10.30 am

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Members present: Lord Jay of Ewelme (The Chairman); Lord Condon; Lord Crisp; Lord Kirkhope of Harrogate; Lord O'Neill of Clackmannan; Baroness Pinnock; Lord Ribeiro; Lord Soley; Lord Watts.

Evidence Session No. 3

Heard in Public

Questions 17 - 25

Witnesses

I: Professor Jean McHale, Professor of Healthcare Law, Director of the Centre for Health Law Science and Policy, University of Birmingham; Professor Catherine Barnard, Professor of EU Law, University of Cambridge and Associate Fellow, UK in a Changing Europe.

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Examination of witnesses

Professor Jean McHale and Professor Catherine Barnard.

Q17 **The Chairman:** Welcome to you both, and thank you very much for coming and giving evidence to us. We have been looking forward to this—no pressure. This is a public session and it will be recorded. We will send you the transcript in the next day or so, to look at and let us have your comments. It would be helpful if you would introduce yourselves and your respective roles at the beginning, and then we can get going.

Professor Barnard: My name is Catherine Barnard. I am professor of EU law at the University of Cambridge and a member of the programme funded by the ESRC—the Economic and Social Research Council—called UK in a Changing Europe. We are required to be non-partisan when we speak, so not pushing a leave or remain type agenda, and to speak as objectively as we can.

Professor McHale: I am Jean McHale, and I am professor of healthcare law and director of the Centre for Health Law Science and Policy at the University of Birmingham. I am also funded under the ESRC's UK in a Changing Europe initiative, and all the caveats that Catherine has just set out also apply to me.

The Chairman: Thank you. There is a little background noise, so the more you speak up, the more those of us at this end will be able to hear every word you say.

Perhaps I could start by asking both of you to set out briefly for us what you believe to be the key reciprocal healthcare priorities for the Government during the Brexit negotiations. It would be helpful if you could distinguish between the priorities that will be covered by the withdrawal agreement and those that will pertain to the future. One of the things we will want to concentrate on in our report is the difference between what happens up until the time of withdrawal and what happens afterwards.

Professor McHale: Essentially, we are dealing here with the position of UK citizens abroad and their own rights to obtain medical treatment. This can be seen in relation to various categories, both in terms of emergency healthcare arrangements through the European health insurance card, and in relation to those groups of UK citizens who are resident in other member states for other purposes, whether because they are employees or students or because they have retired and were there at the time. The position in terms of UK citizens also has to be looked at with reference to the particular challenge for one of the devolved jurisdictions, namely the Northern Ireland/Republic of Ireland border question, and how that plays out in relation to reciprocal healthcare in the future. That land border raises some very different and distinct issues on a practical day-to-day basis. Those are some of the key issues initially.

How that translates out will depend, over time, on the terms of the initial agreement; the problem is that we do not know whether there will be an

agreement and, going forward, what the situation will be. There will be a need to address the firefighting type situation that will arise, if somebody is receiving treatment in another member state at the time, as to the position in relation to the funding of their healthcare and whether they will be liable to be charged once the reciprocal arrangements cease to apply to them. Those are the people who are literally in hospital on Brexit D-day.

In addition to that, there will be the category of people who have used EU law rights in other ways. In addition to the groups I have talked about, there is a third group of people who may be benefiting from EU reciprocal healthcare rights through the provisions of the patient rights directive, which allows individuals, in some situations, to seek care in another member state and have that reimbursed. There are also provisions under regulation 883/2004 concerning the situation where someone who is suffering undue delay and perhaps has been refused prioritisation of treatment has still gone abroad and whether that treatment can be reimbursed. You have citizens' rights situations where individuals are out in another EU member state and then come back. What actually happens then?

There is firefighting, people who are there long term, but also the situation of people we might not know are out there who might be seeking to assert their rights and claim reimbursement for treatment when they come back into the UK.

Professor Barnard: When we are thinking about the different groups of people who might be affected, a lot of attention is paid to people who have retired to the south of Spain to enjoy the sun. We also know about tourists who will be travelling on or around Brexit day. Actually, if we start to disaggregate the different groups who may be away from the UK and in need of treatment while they are there, we should think not just about the retired who are known in the jargon as PIMs—persons of independent means—but also people who are not retired or in receipt of a pension and may be living at least part time in another member state.

We also need to think about frontier workers. That is particularly acute in Northern Ireland, so frontier workers are those who live in the north and work in the south or vice versa. With the benefits of Ryanair and others, there are also people who work half their week in London and half their week in Madrid, so those are frontier workers. Then there is a category of posted workers. Again, that is a jargon term, but they are, for example, UK nationals who are posted temporarily abroad to France to work and then come back. All those categories need to be considered.

The other issue that has been neglected and poses a problem in terms of the negotiations is in respect of EEA nationals. By those, I mean the citizens of Norway, Liechtenstein and Iceland. Citizens' rights, including healthcare rights, are at the forefront of the agenda for the Article 50 negotiations, but by definition the Article 50 negotiations are about withdrawal from the EU, not withdrawal from the EEA—European Economic Area—agreement. This is where it gets more legally

complicated, because Article 127 of the EEA agreement requires a departing state to give one year's notice. There is a political debate being had about whether we need to notify under Article 127 in addition to the notification that we have given under Article 50, and I can explain more if the Committee would like to hear.

For your point of view, the practical question is that a lot of the issues being thrashed out at the moment about all these groups of people we have talked about, in respect of EU citizens, apply equally to EEA nationals. The problem about the process for leaving the EEA and whether we have to trigger Article 127 is that those countries also need to have time to work out what to do for their citizens in the UK, so Norwegians living and working in the UK, and British nationals living and working in Norway, who get sick.

The Chairman: Thank you. That has given us a lot to go on, and we will come back to some of those issues later on. Could I come back to one point, and that is Ireland, which you have both mentioned? On the main EU Committee, we have done a report on Ireland, and one thing that struck us there and when we visited Belfast and Dublin was the way in which a number of people are seen first of all in the north and are, for certain complaints, referred to a hospital in Dublin to get treated. Is that unique? My question is whether the relationship between the north and the south means that there is a separate Irish issue within this question of healthcare.

Professor McHale: Undoubtedly, there is a question. You have seen and will know already, from the previous report, how long cross-border healthcare partnerships have been working, since 1992, originally partly funded by the EU, and then onwards after that. There are practical challenges. Certain healthcare services are delivered on one side of the border that are not on the other. My understanding is that children's cardiac surgery finished at Belfast Royal Victoria Hospital in 2015, and children from Northern Ireland are treated in Dublin as a whole. If we are moving towards a hard border situation, that is a practical problem.

In addition, picking up the more practical cross-border questions that Catherine has raised, on an almost daily basis individuals are crossing the border, going for work or otherwise. It changes the dynamic on a practical, day-to-day basis and shows up some sharp problems. Indeed, there are Ryanair working arrangements, but there are also particularly sharp questions as to what their healthcare position is going to be. It is vital to ensure that the safeguards are in place through that part of the negotiations.

Q18 **Lord Soley:** You have given quite a detailed assessment, but, if you take an overview of the current arrangements for reciprocal healthcare, what is your assessment of how effective they are, and for what particular groups are they most effective?

Professor McHale: First of all, in terms of how effective they have been, they appear to be working smoothly, or we would have probably

heard if they had not been. That does not mean, of course, that everything about them is absolutely perfect, but, if you take the European health insurance card, that provides a degree of support to individuals seeking emergency medical care in another member state. It is not an alternative to travel insurance; it will only cover certain costs, and that has to be stressed as well. Moreover, precisely what is provided for in terms of reimbursement varies from state to state. The diversity should be recognised: in some situations, co-payment may be required; in other situations it will not. In some countries, it may vary according to which hospital you are taken to; if it is critical, you are taken to a public hospital.

None the less, overall it has been a success story. Moreover, the implications of that being withdrawn could be considerable in terms of individuals being able to get travel insurance. In my understanding—I have not spoken to the insurance companies themselves, so I am only going by media reports about what they have been indicating—there is some suggestion that the European health insurance card is taken into account in assessing travel insurance premiums. We are going to look at that in our research; we are not totally there yet.

Lord Soley: One of the reasons I am interested in this is because we were given an assessment a few weeks back that the European health insurance card is not claimed on very much. I cannot remember what it was at the moment, but it was a very small figure. You begin to ask: why are we doing this? Obviously there is the emergency one you are talking about, but is it used effectively? Is it used very much?

Professor McHale: That goes into the whole question of charging for NHS services and claiming reimbursement more broadly. There were some concerns that there had not been effective procedures put in place for reclaiming money that was available, both in this country and vice versa.

Lord Soley: Is your answer that it is not terribly effective or that it is effective?

Professor McHale: For UK citizens, we have been paying out reasonably large sums of money to other EU member states for quite a while. I understand that in your second session you will probably be able to get the precise figures on that. The evidence to the Public Accounts Committee illustrates that, from our perspective, people have been treated successfully in other jurisdictions. The fact that we at our end may not have been quite as effective in claiming it back goes down to the practicalities of administrative arrangements.

Lord Soley: Would you agree with that, Professor Barnard?

Professor Barnard: Yes. I would add that we think about 27 million people have an EHIC. Between 4 million and 6 million are issued a year, many of which might be duplicates or ones that have expired and been replaced. It is valuable to the individual. It is particularly valuable to the

older individual, because of course it is not subject to any exclusions for pre-existing conditions, so it means that older individuals can travel even if they cannot get affordable travel insurance because of their pre-existing conditions and they get some degree of comfort.

On the point about the disequilibrium in terms of what EU countries are charging to the UK for British nationals who are treated abroad, about £650 million has been reclaimed from the UK. We have only reclaimed about £50 million, so there are questions about whether we are effectively reclaiming, given the very large inflow of tourists to this country. I smiled when, preparing for this session, I noticed that there was a headline in the *Daily Express* saying, "Now the EU is taking away our EHIC card". Leaving aside the question of law on that point, it is notable that the *Daily Express* journalists at least, and presumably their readers, value the EHIC card. That is probably not the sort of evidence you are looking for, but it made me smile at the time.

- Q19 **Lord Soley:** They will probably take it with them when they go. Can I move on? There is much more I would like to know about that, but we have to leave it for some other questions. I would like to know what the default position on reciprocal healthcare rights will be if we leave without an agreement.

Professor Barnard: This is where the European Union (Withdrawal) Bill kicks in; that is what was previously known as the great repeal Bill. The European Union (Withdrawal) Bill is absolutely essential for providing some sort of safety net in the case of a chaotic Brexit where we leave without any deal at all. Indeed, one of its main aims is to provide a comfort blanket, to try to provide a degree of protection. The trouble is that it can only guarantee the rights in an asymmetrical way, because by definition it only applies to UK territory and it cannot in any way mandate what the French, the Spanish or the Germans do.

As to what it will do, Clause 3 in the Bill converts what is called direct EU legislation, which means things like regulations, including regulation 883/2004, the social security regulation, which has these provisions on healthcare. Its effect would be that a Polish national who falls sick in the UK in or around Brexit day, and is being treated at the time, will still get their EHIC rights protected, but it will not extend the other way round.

However, some states such as Spain have a system whereby you can contribute to a state scheme and you will get treatment. There are ad hoc arrangements but on a general level, if there is no deal in respect of the divorce, let alone transitional arrangements going forward, the steps that have been made in the negotiations so far towards protection of the rights under the EHIC card will fall away, because the EU has been clear that nothing is agreed until everything is agreed. Therefore, it leaves British nationals abroad in a difficult position.

Lord Soley: In fact, if there was no agreement, the citizens of any of these countries on that date would have to fall back on private insurance, or the state providing, as most states would do, emergency care. After

that, there might be bills involved. Is that right?

Professor Barnard: Yes.

Professor McHale: I understand the Secretary of State for Exiting the European Union has indicated that there will be a scheme in relation to some form of EHIC card for UK residents—there have been reports of that—so that there would be some scheme operating from the UK. As to practically how that would operate, I am very unclear. My understanding is that, first of all, you would have to establish an administrative system, to facilitate and ensure that individuals were able to reclaim the money. There will be a problem practically if, in another EU member state, you were asked for payment upfront, because you would have to have the money to pay it and then have it reclaimed afterwards.

For the system to work, there would have to be an office in London or elsewhere that somebody could ring up and say, "Sorry, I am stuck in this hospital in another EU member state. I need my treatment refunding. My card is number X. Can you pay the bill?" There would need to be that sort of administrative process in place. I have no idea, and I certainly have not seen any documents to indicate, how such a scheme could operate in practice.

Q20 **Lord Watts:** Can I clarify in my own mind what emergency treatment is? When someone has a heart attack in Spain and they are taken for immediate healthcare, where does emergency treatment stop and normal care or recovery care start?

Professor McHale: This will vary from hospital to hospital. I am afraid I do not have the Spanish position documents precisely to hand. There are differences from state to state in terms of what is reclaimable anyway. Usually you will be dealing with a condition that has developed when you are there, and the consequences upon that and the treatment in relation to it. You would not usually envisage something that would otherwise be ongoing care, or care for which you have gone to travel, in that situation.

Lord Watts: I am still not clear when you would be thrown out of the hospital after your heart attack.

Professor McHale: Yes, exactly. In terms of that, my understanding is that your ongoing care would be continued under the existing arrangements.

Professor Barnard: I think you are asking about how emergency "emergency" is, and that depends on each individual country.

Professor McHale: That will inevitably depend on each country, yes.

Lord O'Neill of Clackmannan: Do you think the decision will go down to local health authorities, or will it be an English health question? What about the devolved Administrations?

Professor McHale: That raises some other interesting issues, because the position is not the same in terms of the regulations that apply for overseas visitors in different parts of devolved jurisdictions. The regulations that apply in England are separate and distinct from those that apply in Wales, Scotland and Northern Ireland. The regulations that apply in Wales and in Scotland derive from the 1989 regulations, which originally also applied to England. There are also separate regulations that exist in Northern Ireland. Various aspects of those regulations, in terms of EU citizens in this country, are more generous, I should say.

Lord O'Neill of Clackmannan: By this country, do you mean in England?

Professor McHale: Yes, in England, for these purposes.

Q21 **Lord Kirkhope of Harrogate:** Thank you very much for coming. While I recognise your opening statements on objectivity and so on, I have also read, as have colleagues, some of your published work in relation to these matters and your comments. I want to focus on two points, if I may. One is going back to this issue of citizens' rights, which of course is a very touchy area in the present discussions regarding reciprocal healthcare. You have mentioned certain issues here already. I wonder if you could elaborate slightly on the main sticking points in that particular field.

Secondly, though, I want to probe you a bit on the European Court of Justice. As you know, that is another one of those things that are simply focused on by newspapers and others, and indeed colleagues here in Westminster, as being a sort of red line area. Where there are disputes in the future, whether that be as a result of the withdrawal agreement, transitional arrangements or any future ongoing agreement for reciprocal healthcare, where does the ECJ fit in? Are there alternatives in your mind, or have you heard of alternatives, for resolving disputes or indeed arbitration issues on reciprocal healthcare? Those are the two points on which I would like your clarification.

Professor Barnard: Thank you for that. Obviously the questions you ask are far-reaching and complex.

Lord Kirkhope of Harrogate: That is one of the reasons they were asked.

Professor Barnard: Let us start on the citizens' rights issue. We have to distinguish between those who are already here and those who might come to the UK post what the UK Government have called a "specified date". However, that specified date is currently unspecified, so we are in a world of some uncertainty about what the unspecified specified date is. In essence, in respect of EU citizens who are currently here, the Government have proposed that, if they have been resident here for five years, they can apply for settled status. The settled status will require them to complete a form and go through criminal checks. They will be entitled to be here. It will be equivalent to permanent residence, which is

the EU terminology, but they have to apply for it; it will not be granted automatically.

In respect of those who have not done five years, they are on a track to try to obtain the five-year status, and then they can apply for settled status. However, they have to have been here before the unspecified specified date, and we do not know how those who arrive after the unspecified specified date will be treated. At the moment, they will be treated like non-EU nationals, but that may change in the course of the negotiations.

The sticking point, and the reason why what the Government proposed in the summer has been criticised, is that the Government said it would be a generous offer. In fact, when they published it, the language changed from "generous" to "fair". The reason why it is being criticised is because it does not replicate what EU citizens enjoy at the moment, particularly in respect of third country national family members. It also looks like we shall be taking a much tougher line on deportations in respect of criminal convictions, bringing the position of EU nationals more into line with the approach we take to non-EU nationals.

You asked specifically about the other vexed question, which is the Court of Justice. Here, if I may digress just for one moment, the Prime Minister says that our courts are some of the most respected in the world, and I think we would all agree with that. The British courts, post Brexit, will have to comply with UK law as it then stands. If we agree in the withdrawal agreement to give a comprehensive package of citizens' rights, as all sides seem to want, parliamentary sovereignty, as the EU understands it, means that, even if that is agreed on Brexit day, a month later there is nothing to stop Parliament from reversing that decision. That means that citizens are in a difficult situation. British courts will have to apply the later Act of Parliament, because that is the essence of parliamentary sovereignty. It is the judicial mandate to respect national law as it then stands.

What I see in the language of the Prime Minister, particularly in her Florence speech, is that she says, "I want to incorporate our agreement fully into UK law and make sure the UK courts can refer directly to it". That seems to be quite an important shift in language, and I may be reading too much into this, but it seems to be saying that the withdrawal agreement will be incorporated into UK law, either using powers in the withdrawal Bill or, more likely, through an Act of Parliament. That withdrawal agreement will have a special status, which the courts can refer to directly, so it will be a bit like having directly effective rights in respect of EU nationals who are already in the UK. She does not say that absolutely explicitly, but that may be the direction of travel. That is intended to help ensure that the rights of EU citizens currently in the UK are protected beyond Brexit day.

Lord Kirkhope of Harrogate: We have—whatever it is called—the great withdrawal Bill, and we take on the various regulations or laws from Europe on day one. What I am really interested in is this: the ECJ, in its

competence, and other European courts could change their arrangements on day two, day three or day four. We have suspended ourselves at a particular point in time in a legal situation. How do we deal with the changes that then take place relating to matters such as reciprocal healthcare in the European courts?

Professor Barnard: To your question about the continued role of the European Court of Justice, as you know, the EU has said that, in respect of citizens' rights, the European Court of Justice must continue to have jurisdiction for the lifetime of those citizens. That is controversial, in the sense that it could be for decades, because it would be the lifespan of the youngest EU national born in the UK. On the other hand, it may be that they negotiate some sort of alternative to the European Court of Justice in respect of protecting citizens' rights and protecting other issues that we have signed up to.

The ECJ, as you rightly say, has been a red line for the Government. It may be unsustainable as a red line for the Government during transition, if there is transition, because the EU has made it clear that the full regulatory and supervisory arrangements must apply during transition but, post transition, it may be that they can compromise. The compromise is not obvious. A logical compromise might be to say, "We will set up a new court, not the European Court of Justice, which has some judges from the ECJ and some judges from the Supreme Court. They will get together and they can sort out these issues". However, the Court of Justice might not accept that arrangement, because it was originally proposed for the EEA agreement, and the Court of Justice declared it incompatible with EU law.

Another suggestion that has been made is that we dock to the EFTA Court and have judges on the EFTA Court. That does not mean we join the EEA, but we dock; in other words, we use the services of the EFTA Court.

Lord Kirkhope of Harrogate: Am I wrong in this: that the EFTA Court is in fact almost entirely to do with commercial trade agreements, as opposed to things of this nature?

Professor Barnard: Yes and no. Very confusingly—and I accept that it is a barrier for comprehension, because there are so many jargon terms here—the EFTA Court is the court that adjudicates on the EEA agreement. It is called the EFTA Court because the original plan for an EEA court was struck down by the Court of Justice in Luxembourg. The EFTA Court rules on the EEA agreement. One of the limbs of the EEA agreement is on free movement of persons, so it rules on aspects of citizens' rights.

The EFTA Court is one possible solution. As you have indicated in your question, another possibility would be to have a more political system for adjudicating on difficult issues arising out of the withdrawal agreement and under the future deal. That is a sort of Swiss model, but the trouble is that the Swiss model is seen, at least by the EU, as deeply unsatisfactory. It has been trying to negotiate that the Swiss should be

able to use the Court of Justice, but those arrangements have got nowhere so far.

We are then in the realms of what else we should put in place. Should there be some sort of arbitration arrangement? This is all absolutely up in the air. The position paper that the Government published earlier in the summer offered these as a range of alternatives without in any way suggesting that they wanted one or the other.

Lord Watts: Can I just be clear? Under our parliamentary democracy, we have never been allowed to commit future Governments to legislation. You seem to be suggesting that the Government's proposal is that we will take action to make sure that a Parliament in the future cannot reverse the decision that a previous Parliament has made. This would seem to set a precedent that, as far as I know, has never been accepted in any other form. Is that what you are actually saying?

Professor Barnard: It has been accepted in other forms. The European Communities Act 1972 does just that, as we know from the decision in *Miller*, which was the case that went to the Supreme Court recently, challenging whether the Prime Minister had the power on her own to trigger Article 50 or whether it needed a parliamentary vote and Act of Parliament. In *Miller*, the Supreme Court said that the European Communities Act acted as a conduit pipe to bring that whole body of EU law into UK domestic law.

The way it works at the moment is that it gives effect to principles of direct effect, the enforceability of rights and supremacy of EU law, and that comes into the UK system. That has essentially bound future Parliaments, but always subject to the possibility of repealing the European Communities Act.

Lord Watts: That is the point.

Professor Barnard: That is exactly what we are going to be doing with the great repeal Bill or, as it is properly known, the European Union (Withdrawal) Bill. It may be that, if we want a future deal with the EU, they will insist that we respect citizens' rights, so it is essentially a sort of legacy issue from our EU membership days. The legacy is that there needs to be protection, essentially in the old way, of rights of EU citizens who are already here.

Lord Watts: Just to be clear, the proposal put forward by the Prime Minister would not commit a future Parliament to repeal that Bill, so it would not be able to fill the gap that we are trying to fill.

Professor Barnard: You are right, because the European Communities Act has been repealable throughout the existence of the European Communities Act, but we have signed up to a very complex system, which we give effect to through the mechanism of the European Communities Act. It may well be that, if we have a withdrawal agreement, an Article 50 divorce agreement, that will operate in a rather

similar way to the way that EU law operates at the moment, but only for a transitional period until we move on to our future arrangements. Legally, it is complicated; I absolutely accept that.

- Q22 **Lord Ribeiro:** I now move on to the impact on EU citizens in the UK. In the UK, healthcare is free at the point of need and it is on a residency basis, although of course in the UK we do not have an ID card, so we actually have no way of proving people are resident. How important is it to maintain reciprocal healthcare with the UK for EU and EEA citizens travelling and working in the UK, and also for EU and EEA countries? It seems to me that they get more out of this than we do.

Professor McHale: It depends on the point at which your rights are settled for these purposes, in terms of a citizen from another EU member state being based here. If you are talking about somebody here who has been ordinarily resident here and who has been settled here for a long time, the NHS protection will apply. The problem will arise in relation to the position of individuals who are here for shorter periods of time—they may be particularly vulnerable—or people who simply have not been in the country as long generally. It is important to clarify this, particularly bearing in mind that the Government have been tightening up the requirements in relation to reimbursement for overseas visitors as well. The rules vary; they vary based on which part of the UK you are in, as do the exceptions and provisions given under the regulations.

Lord Ribeiro: In terms of how it will impact on the EU countries, is the loss of the reciprocal healthcare relationship we have at the moment likely to hurt them more in the long term? Is it likely to hurt EU countries more in the long term, having that reciprocal arrangement removed?

Professor McHale: In the long term, it is a separate issue. If you are talking about people coming to the UK from another EU member state, and they are regarded as a third country for these purposes, it depends on how we approach that healthcare in the future. Are they going to be charged, for example, an immigration health surcharge at the start? Will they therefore be expected to pay right from the outset, as individuals coming from other countries would at the present time be required to in that situation? Will the same situation also apply to students? In effect, would you be considering them in exactly the same way as people from other countries in that situation? There would be a degree of payment in that situation.

Professor Barnard: We need to be practical here. The fact is that a large number of British citizens go on holiday in Spain and France; they are the two biggest destinations. Sadly, they will continue to have car accidents and fall into swimming pools and break their legs. They will need treatment, and the question is who will pay for that. Do we have bilateral arrangements with each of these countries, which is possible and was the position prior to 1972, or do we have a more global scheme, rather similar to what we have at the moment? People will continue to travel.

Lord Ribeiro: There seems to be a real discrepancy between the money that we recover through the EHIC scheme and the money that we pay out. I well understand that part of the problem is that a large number of the Brits living overseas are pensioners, and therefore a huge contribution of that is the pension fund. The 2014 figures from the National Audit Office suggested that we received £50 million and paid out £675 million. That is a huge discrepancy, really. I wonder what incentive the EU has in maintaining the situation we have at the present time. I would have thought these figures rather speak for themselves.

Professor McHale: First of all, in terms of us being able to effectively reclaim things, that is an administrative question as to how effectively and efficiently we have done that. There are certain costs that we seemingly could have had reimbursement for, had the systems been in place. That has been picked up by the Public Accounts Committee and indeed by the Government.

The separate point—and I did not make this clear in terms of my original answer to you—is that, if somebody is receiving emergency care here anyway, we provide that, and that is to all individuals generally coming into the country. The broader question then applies outside that situation. We also provide a range of other healthcare in various situations without charge to individuals who are citizens of other countries. The extent to which that applies, again, varies between the jurisdictions within the UK. The rules are different.

Lord Ribeiro: Obviously, emergency care and general practice are currently excluded, although there is the surcharge for students and other short-term migrants coming in. Overall, can you comment on both the incentives concerning the EU 27 nationals who are in the UK at present and those concerning EU nationals in the future?

Professor McHale: More broadly, it will depend on which rules we decide to put in afterwards and the precise position, long term and ongoing, as to the incentives in relation to them in that situation.

Professor Barnard: Being a lawyer rather than an economist, I am not well placed to answer this question, but the fact is that, at the moment, we have more EU citizens living in this country than UK citizens living in other countries, although in terms of tourism, of course, which is where the EHIC kicks in, it may be the other way round. The EU's incentive is that it wants a streamlined process for getting its money back when British nationals turn up for emergency treatment. It may well be that, if you are young and you go on holiday, you do not necessarily get travel insurance because you think it is an unnecessary expense; you are young and you think you are invincible. Then the question is, when you end up in hospital, who will pay, and at the moment the EHIC system at least provides some sort of streamlined process for those hospitals to claim money back from the UK, to cover the cost of your treatment. It is a financial incentive for them, in that they want that to continue in some form.

Lord Ribeiro: It seems to me that it is an unequal situation, because currently we pay more to them. Therefore, their system for claiming seems to be a lot better than ours.

Professor McHale: There is a financial incentive, absolutely. It is thought that we significantly underclaim and there have certainly been press reports that we underclaim; it could be up to £1 billion, but the fact is that it is a significant sum of money.

Lord Ribeiro: When you say that we underclaim, do you mean that people going to Europe do not make use of the EHIC and rely on their insurance?

Professor Barnard: No. When a French visitor gets sick here, we are not very good at claiming back from the French system.

Lord Soley: Is that because we do not have ID cards; i.e. you cannot insist on identification?

Professor Barnard: We can ask for passports, and by definition they will have a passport or an ID card to have got into the country in the first place.

Lord Crisp: Can I ask a very quick supplementary on the point that Lord Ribeiro was picking up on? As you say, there are more EU citizens in the UK than UK citizens in the EU. Do we know anything about the age profile, which is of course significant in terms of health costs?

Professor Barnard: I know more or less the figures, for example, for British nationals in France and French nationals here. They are very stark. The majority of French nationals who are living here are in the 20 to 40 age bracket.

Lord Crisp: They do not use the health system very much.

Professor Barnard: If you think of a pyramid, the bulge is in the younger age range, whereas, if you look at the UK nationals in France, the bulge is much higher up: it is 50 to 70.

Lord Crisp: You would expect it to be much more expensive for precisely that reason.

Professor Barnard: Exactly.

Q23

Baroness Pinnock: Turning to transitional arrangements, the Prime Minister has indicated, hoped or prayed that there might be a transitional period of two years or whatever. If a person in the street in the UK, and ditto in an EU country, said to you, "What are the key priorities for reciprocal healthcare in this transitional period?", what would you list?

Professor Barnard: Dare I say it, the answer to this is reasonably straightforward, in that the EU will only accept transition basically on the same terms as we have at present. It would therefore require the continuation of the scheme as is, including with the EU's existing

regulatory, budgetary, supervisory and judicial enforcement mechanisms. For transition, if we leave on 29 March 2019, as the Prime Minister repeated yesterday, we have transition for two or so years after that, so between March 2019 and March 2021. In that two-year period, it would look rather like what we are in at the moment, so the healthcare arrangements will stay as they are at the moment.

Baroness Pinnock: Is that including the ECJ?

Professor Barnard: Indeed, the Prime Minister said yesterday or the day before that we would be subject to the jurisdiction of the ECJ. It remains a question, which has not been resolved, whether it means full access to the ECJ as we have at the moment. Is it more limited access but still subject to the rulings of the Court of Justice? It looks likely that it will be rather as is at the moment.

Baroness Pinnock: That is very clear and straightforward.

Professor Barnard: I speak with caution, because nothing in this is clear and straightforward.

Q24 **Lord Condon:** As the Committee deals with all this uncertainty and looks forward, through the negotiations, to possible outcomes, is there any point, is there any value, is it possible to identify particular groups that may be disproportionately affected or vulnerable through this process? Intuitively, we have thought about the disabled, people with long-term problems, but is there any point in that sort of analysis or is that just swept up in the generality of it all?

Professor McHale: I do not think it is swept up in all the generality. The question is what constitutes vulnerable for these purposes and how we view these particular different groups. In the position of returning retirees, for example, the NHS has indicated that retirees returning to the UK on a settled basis will be classed as ordinary residents and therefore would be eligible for healthcare. Of course, that does not deal with all the other challenges and problems of coming back to the UK, particularly under a cliff-edge agreement.

The NHS regulations exclude from payment groups that are in a "vulnerable category", and typically those would include refugees, asylum seekers, individuals who are receiving some support under the Immigration and Asylum Act, children looked after by a local authority, victims of slavery, and individuals who are receiving compulsory treatment under court order and detained at NHS hospitals, deprived of their liberty. Some of the Mental Capacity Act provisions apply there under the mental health provisions.

In terms of vulnerable groups generally and individuals in the country who may or should be exempt from charges, one thing that is not clear from my understanding of the regulations in any of the four jurisdictions is precisely the position in relation to adults lacking mental capacity. We know that, if individuals are detained under the DoLS—deprivation of liberty safeguards—or under the Mental Health Act, they are exempt from

charges, but the regulations appear to be silent on this group. I have not, I confess, gone through all the guidance associated with Wales, Scotland and Northern Ireland, but my understanding is that there, too, it is not included. This begs an interesting question in terms of temporary lack of capacity as compared with permanent lack of capacity, but nonetheless it is an interesting point, particularly bearing in mind an increasing older population, the onset of dementia, Alzheimer's and other questions around mental capacity.

In terms of vulnerable groups, we have indicated that students might come within that. Different provisions for students apply across the jurisdictions; they are slightly more generous in some of the devolved jurisdictions than in England. Those people are going to be affected. We have already seen the position of people with disabilities full stop, because they are the people, to pick up Catherine's point, who are more likely to have problems obtaining travel insurance et cetera. I know evidence was given to the Health Select Committee by Martin McKee on that point. That would come within this as well. Moreover, greater clarity about the position of family members of individuals would be extremely helpful.

Q25 Lord Watts: I have two questions. You have dealt with the first one on future arrangements, so I will just give you an opportunity to add to it. The first question is this: what could or should post-Brexit healthcare arrangements with the EU look like and what options are available to the Government for a future arrangement? You have dealt with that.

The second one is about the EU (Withdrawal) Bill. What provisions of the EU (Withdrawal) Bill should be amended, clarified or added to in order to secure appropriate arrangements for reciprocal healthcare on the day of Brexit, during a transitional arrangement and in the future? I do not know if you want to add anything.

Professor Barnard: Shall I answer the second one and let Professor McHale answer the first one, so we have a division of responsibilities? The withdrawal Bill is obviously targeted at doing the divorce and not either the transitional or the future agreement. There is a technical legal point: if there is going to be transition, what would be the legal basis for transition under EU law? Theresa May said in her Florence speech that it could be done under Article 50. That is important, because the withdrawal Bill is about what is agreed under Article 50, which would include transition. That means that the withdrawal Bill would cover not just the divorce but any transitional arrangements that act as the bridge to get you to a future deal.

As far as the transitional arrangements are concerned, that analysis may seem unnecessarily legalistic, but it is quite important, because the EU can only do what it is given the powers to do. At the moment, it can only negotiate the divorce under Article 50, and probably the transition under Article 50. There are, therefore, clauses in the withdrawal Bill that give the Government power in respect of not just the divorce but transition. I particularly have in mind Clause 9 of the Bill, which is a very general

clause called "Implementing the withdrawal agreement". This gives very broad powers to the Minister to "by regulations make such provision as the Minister considers appropriate for the purposes of implementing the withdrawal agreement", which presumably would also include transition, "if the Minister considers that such provision should be in force on or before exit day".

There are already provisions in the Bill, particularly Clause 9, but also Schedule 7, paragraph 13. Because of the way these powers are drafted, they are so general in scope, and one of the criticisms of them is that they give huge discretion to Ministers to give effect to whatever is necessary to deliver the divorce, the withdrawal and transition. Because the powers are so broad, it means that they can put in place whatever is necessary for healthcare provision, for example.

The Chairman: There is the question about the future, which is important.

Professor McHale: In many ways, of course, that is a political question as much as anything else, as to how one thinks in practical terms about what can be achieved. The ideal situation would be retaining the status quo as far as possible in terms of providing certainty in relation to reciprocity. There are various aspects that are unlikely to continue, and those are the specific provisions under the patient rights directive and regulation 883/2004. They will almost certainly go as a result of this.

In terms of other reciprocal healthcare arrangements, it would be desirable if we could maintain the status quo as far as possible and ensure that those provisions are negotiated and put in place, not least to ensure that we safeguard the position of individuals who are vulnerable in a general sense. Picking up the point from the previous question, individuals who are ill are vulnerable almost by definition.

The Chairman: If in five or six years' time, when we come to the end of the transitional arrangement and we are in some new sunny uplands, we want to travel to Poland, in your view, what would the arrangement be?

Professor McHale: Ideally in that situation, if we could have negotiated a reciprocal arrangement enabling emergency healthcare, for example, as covered at the present time, to be placed on the table and agreed, this would be in the interests of us and I would hope other EU member states.

The Chairman: That would be a reciprocal arrangement with the EU: a UK-EU arrangement.

Professor McHale: Yes, if that can be undertaken. Otherwise we are into the space of separate bilateral negotiations being undertaken after that, with all the problems Catherine mentioned.

Lord Soley: Basically, if you cannot do it with the EU, you can do reciprocal agreements with each country. It might be complex, but that is what you do. When we are talking about this, we are talking about international agreements. However you dress it up, it is an agreement

between two nation states, is it not?

Professor Barnard: That was our position pre-membership. Indeed, while here we are talking about healthcare, regulation 883/2004 does not just cover healthcare; it also covers the exportability of pensions. These issues are tied up for the several hundred thousand British nationals who are living in the south of Spain, because they are getting their British pension paid in Spain, which enables them to live there. If regulation 883/2004 is abrogated and is not continued in the context of the future arrangement, a lot of these people will have to come back if they cannot receive their pensions. That has issues for the NHS. It may well be that Spain has such an economic interest in having a bilateral arrangement that it will jump the gun and try to negotiate a bilateral arrangement with us because of the major issues that it has, given the number of British nationals living abroad. It is possible to have a bilateral arrangement, but I am also conscious of Civil Service capacity at the moment. If you have to negotiate bilateral arrangements with 27 or, including the EEA, 30 states, even if you do some sort of cut and paste arrangement, it is still an onerous obligation, in among everything else that is going to have to be renegotiated going forward.

Lord Soley: In fact, we cannot do it until after we have withdrawn, if the European Union sticks to its current position of saying no negotiation between individual states.

Lord Kirkhope of Harrogate: On that very point, trying to do bilateral agreement with 27 states, all of which are subject to European law and the European acts that relate to their relationship within Europe, is an extremely difficult thing to do, is it not, outside of there being a European structure, as opposed to an individual structure with an individual country that is a member of the European Union and remaining so?

Professor Barnard: It would not be possible for individual states to negotiate individual trade agreements in respect of goods but, in respect of persons, they would be able to enter into some sort of arrangement for healthcare and other issues.

Lord Kirkhope of Harrogate: Does that include all the Schengen members?

Professor Barnard: Then we are into issues about the competence of the EU. The EU has exclusive competence over arrangements for trade in goods. There is no exclusivity in respect of issues about persons.

The Chairman: Lithuania, Estonia or Spain would be able to negotiate bilaterally with us, on these issues, after we have left.

Professor Barnard: On these issues, they would.

The Chairman: Thank you very much indeed. That has been extremely helpful and we are grateful to you. Is there anything that you think we ought to have asked you, but we have not, which you want to say before you go?

Professor Barnard: Thank you very much indeed for your time.

The Chairman: Thank you.