



HOUSE OF LORDS

Select Committee on the European Union

Home Affairs Sub-Committee

Corrected oral evidence

Brexit: Reciprocal Healthcare

Wednesday 25 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; Baroness Pinnock; Lord Ribeiro; Lord Soley.

Evidence Session No. 7

Heard in Public

Questions 51 - 59

Witnesses

I: Niall Dickson CBE, Chief Executive of NHS Confederation and Co-Chair of the Brexit Health Alliance; Raj Jethwa, Director of Policy, British Medical Association.

Examination of witnesses

Niall Dickson CBE and Raj Jethwa.

Q51 The Chairman: Welcome to both Mr Dickson and Mr Jethwa. You are very welcome and we are very grateful to you for coming to talk to us today. We have a slightly shrunken Committee this morning, I fear, from illness and one or two things. Anyway, we are glad to see you. The session will be recorded and at the end of it we will send you a draft transcript to look at and to send back to us. Perhaps I can start by asking you briefly to introduce yourselves and the organisations that you represent.

Niall Dickson: I am the Chief Executive of the NHS Confederation and the co-chair of the Brexit Health Alliance. The NHS Confederation is an organisation that represents the broad interests of the National Health Service, both commissioners and providers, including the independent sector providers and mental health providers within the health service. We have networked organisations within the Confederation. The Confederation has led two pieces of Brexit work, if I can put it that way. One is by the Cavendish Coalition, under one bit of the Confederation, NHS Employers, which convenes that organisation, with some social care input. The Cavendish Coalition is looking at the staffing implications of Brexit. The Brexit Health Alliance fills in everything other than the staffing implications for health. It brings together the research, science, medical and health elements within this country, including the Royal Colleges and the pharmaceutical and the medical devices industries. It is concerned with research, regulation, the future funding of healthcare services and the impact on the NHS. The Brexit Health Alliance is chaired by me and Hugh Taylor, the former Permanent Secretary at the Department of Health.

Raj Jethwa: My name is Raj Jethwa and I am director of policy at the British Medical Association. The BMA is an apolitical professional association and even a trade union. We represent doctors and medical students from across all branches of practice of medicine across the United Kingdom. We support and deliver the highest standards of patient care. We have a membership of around 160,000. I am grateful for the opportunity to give evidence to the Committee today. We will also submit written evidence to the inquiry.

Since the referendum, the BMA has been at the forefront of efforts at both an EU and a UK level to establish what Brexit could mean for medical professionals, patients and health services. We are exploring a range of issues, including the impact of Brexit on the NHS workforce, on Northern Ireland, on access to medicines and on Euratom. We had a symposium on patient care just a couple of weeks ago, which Tamara Hervey spoke at. Just last week, we published five new briefing papers on Brexit—

The Chairman: Could you speak a little more slowly, please? The acoustics are not brilliant in this room.

Raj Jethwa: I beg your pardon. Just last week we published five new briefing papers on Brexit, including one looking specifically at the importance of reciprocal healthcare arrangements. We believe that retaining or replacing existing reciprocal arrangements is highly important. Failure to do so could have a severe impact on patients and place the NHS and doctors under even greater pressure, so I am grateful for the opportunity to talk about that this morning.

Q52 **The Chairman:** Thank you. A number of the questions that you have both raised will come up in our discussions, but I am grateful to you for that. Could you both set the scene by telling us what you believe to be the key reciprocal healthcare priorities of the Brexit negotiations? Do you draw a distinction between priorities that will be covered by the withdrawal agreement and those that pertain to the future after we have left? Perhaps you could also add something on what would happen if we walked away without a deal.

Niall Dickson: First—I suspect that there may be quite a lot that we agree on—we want as far as possible to preserve current arrangements. That could sum up our evidence in many respects. We believe that that would be of greatest benefit not only to UK citizens but also to EU citizens. Secondly and allied to that, we want to remove uncertainty as quickly as possible. We can see the impact of uncertainty already affecting the way people are behaving and the way people are feeling. That is needed to give citizens and indeed healthcare systems time to plan. It could include ring-fencing any agreement reached on reciprocal rights as part of the withdrawal deal so that, whatever else happens, that bit would be protected.

As far as the withdrawal agreement is concerned, the key priority will be to safeguard the rights of the 1.2 million UK citizens currently living in other EU countries and the 3 million EU citizens who are living in the UK. Obviously, we are pleased that both sides in the negotiations have agreed this in principle—we absolutely welcome that—but we are not under any illusions that that is a done deal. Therefore, we want to keep people's attention on that.

On future flows, the UK Government has helpfully set out its wish for all current and future UK state pensioners to keep the right to move to the UK and receive healthcare when they retire and for all current and future UK residents to keep the right to the EHIC card and to travel to the EU for planned treatments, as well as for these rights to be reciprocated for EU citizens. Again, we absolutely support that, but these rights may have to be in some future agreement between the UK and the EU. As you know, the EU is not willing to discuss citizens' rights pertaining to future movement until it has agreement on its three big things. Our hope is that they will secure an agreement both on the existing stock, as it were, and on the future. Our ideal position, frankly, is to retain the status quo.

The Chairman: You said towards the beginning of your remarks that uncertainty is already affecting people's behaviour. In what ways? How is that showing itself?

Niall Dickson: Certainly we hear in the confederation from our members about levels of anxiety among EU staff. It is quite a complex picture in terms of how people are behaving. There has been a massive drop-off in applications for nursing, but there are complicating factors within that. Clearly, the fall of the pound—we do not know whether it is temporary or permanent—makes it less attractive for people to work here. I am not saying that it is all directly due to Brexit, but some of it is Brexit-related. As employers, we are very concerned about the impact at this point on people's thoughts and behaviours. There is real concern within the research community about how future co-operation and co-ordination will go on. These are all wider Brexit things that are starting to affect people's behaviour. A lot of this could be relieved by the ending of uncertainty. I am aware that you cannot just snap your fingers and that happens, but uncertainty will affect people in all sorts of ways, in terms of not knowing what is going to happen over the next few years. That is very unsettling for organisations but also for patients.

Lord Soley: Are there things that would have happened if that uncertainty was not there? Can you think of examples of programmes or ideas that would have gone ahead were it not for the uncertainty?

Niall Dickson: No, I am not sure. I am wandering away from your principal question about reciprocal healthcare, but, in relation to the wider picture, within the research community people are already saying that staff are less keen to come to join them. I do not have any figures; this is all anecdotal. There is also real anxiety about staff who are here. From the Brexit Health Alliance's view, it is in the top-end research in some of our most prestigious institutions that we are already seeing this. I am not saying that it is not solvable or that it is the end of the world, but at the moment it is creating that worry in the minds of the people running those institutions and, perhaps more importantly, in the minds of some of the staff involved.

The Chairman: Thank you. Mr Jethwa, perhaps you would like to start on the first question. If you want to add anything about the uncertainty, that would also be good.

Raj Jethwa: I think so. There are probably three priorities for us. One of them is in the territory of uncertainty and is—as Niall has already alluded to—with regard to accessing care in the future. On uncertainty within the system and what our members are telling us, we carried out two surveys of international medical graduates in the last 12 months. Some 42% of doctors are telling us that they are uncertain about their future here working in the system. As you know, the NHS is heavily reliant on doctors who come from outside the United Kingdom. So there is a degree of uncertainty, and we have been starting to monitor that.

On our priorities in reciprocal healthcare, certainty is one of them. However, there are two others. One is the impact on demand for services; if there is not certainty or clarity, and arrangements come to a hard end, we have heard figures which say that maybe up to 190,000 pensioners in the European Union may feel that they have to call upon

services, and they are not factoring that in at the moment. Our third priority is ensuring that doctors are able to focus on providing care and not on cost recovery or administrative procedures. Those of the three areas we would probably prioritise in these discussions.

Niall Dickson: On the 190,000, that is a concern. I would not want to overstate it; it is unlikely that 190,000 people will suddenly turn up. However, again, there is probably real anxiety among many of those people at the moment about what they will have. Clearly, if a large number came back to this country, there are 10 million pensioners in the UK, but it would have a significant effect on a service that is already stretched; that is probably the point. Certainly, we would want the NHS to be compensated, because at the moment the UK Government pay something like £500 million to pay for those patients' healthcare in Europe. We would of course expect that, plus a considerable sum more to be able to deal with health and care in this country.

Raj Jethwa: I do not want to get into a debate with Niall but I think we both agree on this. The capacity is just not there in the system to absorb any additional numbers. Even if it is less than 190,000 people, we have a system that is stretched at the moment. Some of the evidence suggests that paying that £500 million to other EU countries may be more cost-effective, because they are then paying under the arrangements in those countries, which may involve, for example, co-payments. It is a complicated issue. What we would both agree on is that the system is stretched at the moment, and without this certainty, we do not know exactly what increasing demand there will be in the future. We know that one of the greatest challenges facing the NHS is the demographic challenge: as people get older have greater demands with regard to the provision of healthcare. I think we would probably agree on that.

Q53 Lord Kirkhope of Harrogate: Good morning, gentlemen. I know that you stated a moment ago, Mr Dickson, that the status quo is the desirable situation. The Prime Minister in her open letter to EU citizens in this country indicated that we were "within touching distance" of an agreement. I am curious to see to what extent you have prepared different models and plans for the various outcomes which still appear to be on the table. To what extent have you planned for a failure, for instance, to reach an agreement in the so-called withdrawal agreement itself? I would also be quite interested in your assessment of how these negotiations are going and to what extent you are in any way involved other than in your own professional capacities.

Finally, on the question of resources, you mentioned anxiety a moment ago, Mr Dickson. Anxiety, apart from being a state of unknowing or concern, must have some medical outcomes as well. Does this anxiety go further in the sense of the resources that have to be deployed to deal with people who are perhaps suffering in some way, in a clinical way? Is this affecting the performance of staff? Is it in fact rather more serious as regards the use of resources than we anticipated? To what extent do the resources you are spending on being here today and on preparing for all these various outcomes take away from the use of your resources in

other ways? Is there anything there that you can enlighten us on?

Niall Dickson: I always go first, but you can do the next one. First, on your involvement question, to be absolutely clear, the Brexit Health Alliance and the Cavendish Coalition do not have a view on Brexit; we are not for or against. Our task is to mitigate the damage and, if there are any opportunities, to identify those, and to bring together those who are affected within the system to be able to do that. As a result of that, obviously we are not party to the negotiations, but we are attempting to influence both the UK Government through the Department of Health, NHS England and other bodies and through the permanent representative of the UK on the European side. Likewise, we have a European office, as do the BMA, so we have quite a lot of contacts within Europe, and we are members of the association of healthcare organisations in Europe. We are attempting in that sense to influence the EU side of the negotiations as well to try to reach the sorts of outcomes that we have described today.

That is our strategy: to identify where there are issues and concerns and to bring those to the attention of the negotiators. One of the problems that we all face in this area is that health is not an EU competence, so there is a danger that a whole lot of things can be pushed down the hierarchy of parity. One of our roles is therefore to try to maintain interest in that area and to draw attention to the implications, which are for UK plc as well as for individual patients going forward.

Lord Kirkhope of Harrogate: But public health is. The ordinary health services are not a matter for the EU, but of course wider public health issues are.

Niall Dickson: Yes, indeed. I am pointing out that there are lots of things that we are concerned about, which absolutely are affected by, for example, trade, but they will not necessarily bubble up in people talking in the generalities of trade or freedom of movement. However, they obviously have a significant impact.

You asked about the impact on individual staff, and again, Raj may be able to expand on this. Certainly, we have absolutely no evidence about the clinical impact of raised anxiety on this issue. I am sure that it varies from individual to individual. Some people will be troubled by it and will be concerned about it, and of course that could knock on to issues of demanding service. However, I would not put that as being at the top of our minds at the moment.

Raj Jethwa: I second that. Our answer is similar in that we are exploring all the potential scenarios to ensure that our members are aware of what may happen, and we are also taking soundings and insight from members which we are sharing with policymakers as to date. Our role is a similar one; we have a European office and we have been meeting with colleagues in Europe and other European medical associations to try to ensure—

The Chairman: I am sorry; can I ask you to speak a little more slowly.

Raj Jethwa: I beg your pardon. We are raising the profile of the issues and planning to make sure that policymakers are aware of the concerns our members have. "Anxiety" is a word you can use quite loosely, so I will be careful with my language. However, we have asked our members, and a number of them, through our surveys and by contacting us, have expressed concern about what the future may have in store. As I said before, when we have a health system and a profession which relies on a large number of people who come from outside the United Kingdom, it is very important to ensure that there is certainty about their ability to work in the future as well as certainty about what patients could access. We are therefore making sure that we take every opportunity to flag it up, as well as providing information to our members about what the future may have in store. But at this stage there is quite a degree of uncertainty.

Q54 **Lord Kirkhope of Harrogate:** We all know the stories about the pressures on general practice in particular. As I understand it, there are health issues within general practice. Much of that is a result of normal pressure that always happens. But I am still quite curious about this preparation issue. If you are saying that you have these scenarios which you have been looking at—I think Mr Dickson said that a moment ago—to what extent do you think there is currently sufficient preparedness for any of these scenarios, or is there something which is just kept on the back burner and which, in the case of the BMA, you are not alarming members too much with at the moment? Alternatively, on an NHS basis, are you just hoping that we will end up with the status quo?

Raj Jethwa: "Hope" is the wrong word. We are definitely making our case about wanting to see arrangements in the future which, as far as possible, mirror the current arrangements, because that is probably the best process we could use to ensure certainty in the future.

General practice has been under pressure for a number of years, so it is not as though we are hoping that something will get better. We are lobbying quite hard on behalf of our general practice members. The vacancy rates in general practice are at something like 12% at the moment, which is the highest it has ever been. In the year to date to last December, about a third of general practice surgeries reported having staffing difficulties. So general practice is stretched already, and we are doing everything that we can to make sure that policymakers understand those pressures.

Niall Dickson: There are two levels. There is what the Brexit Health Alliance is doing—and the briefing that we put out last week sets out clearly what the implications could be for individuals, and so forth. Then there is an issue for NHS planning; the planning round for 2020 will start next year. There is a need to raise awareness in the health service at local level about some of the implications of this. A lot of it is extremely unclear, because we are not sure what will turn out to be the case. From our point of view, reciprocal healthcare is important, but it goes alongside some of the other seismic issues around the future of research and regulation and the ability in terms of supply chains and how those chains may or may not be interrupted. At the moment, the concentration is on

the possible implications of that—and we will certainly look at that and talk to procurement colleagues about the implications of some of those things for the NHS.

As for coming up with a grand number at the end of it, and the implications of that, we are certainly not at that point. I would expect my colleagues at NHS England and within the statutory organisations at the Department of Health to be starting to look at that over the next period. Again, I am not saying that they can magic up an answer, because some of this stuff is so complicated at this juncture. Perhaps after the first phase is through we may have a clearer idea about what some of the options facing us will be.

Q55 Lord Ribeiro: Both of your presentations and briefings were very clear and gave good, clinical scenarios on either side of the problem. In particular, I was looking at BMA box 3, which seemed to imply that there has been a partial agreement, moving forward from August 2007, and one would be hopeful that what we are discussing today would not actually happen. But in the event that it should, what are the implications for your members if the reciprocal arrangements change or come to end?

Raj Jethwa: We are supportive of the fact that there has been a partial agreement so far. Our understanding is that this would mean that on 29 March 2019 those people living in or visiting the EU at the point when the UK officially leaves the European Union would continue to receive care under reciprocal schemes for the duration of that stay. That gives certainty to those in that situation. Primarily, I am talking about people who retire to live in Spain—there are tens of thousands there—under the S1 scheme. That would give clarity and certainty for those in that position at that time. What we are not clear about is what happens to those people who, after the point when we leave the European Union, find themselves in a similar situation either working or having chosen to retire to sunnier climes. There is a lack of clarity there, which we are concerned about, but we think that the partial agreement so far offers some basis on which to build.

Would you like me to talk about the question of cross-border arrangements now or later on?

Lord Ribeiro: Later on, because cross-border arrangements depend on the second stage of negotiations, rather than the primary stage.

Niall Dickson: At risk of repetition, we take some comfort from the fact that some agreement around those who are currently benefiting appears within touching distance. The key point is whether we can secure that for the future; if we do not, there is the possibility of bilateral agreements—but the question is how quickly they could be set up. Again, we keep resorting to the fact that it is in everyone's interest to retain the current system. It is in the interests not just of the UK but of the EU to maintain the status quo. If we have to, we will set up bilateral arrangements, which again, if we were going down that route, we would seek to be as near as possible to retaining the existing system. Clearly, you cannot

have an EHIC card—you would have to reach an individual agreement with each country on healthcare.

Lord Ribeiro: To take a doomsday scenario where that does not happen and, come March 2019, there is a cliff-edge arrangement, what are the key implications for staffing in particular—and other implications, taking into account social care in the UK?

Niall Dickson: So you are talking beyond the healthcare thing and into the wider issue.

Lord Ribeiro: Yes, about the other implications.

Niall Dickson: There are huge implications, yes. We are clear that, if there were a cliff edge and no agreement was reached, there would be significant supply-chain issues in relation to access for medicines. We would have to work out in regulatory terms how far we were going to mimic what was happening in the European Medicines Agency. On staffing, again, we would have to set up an immigration policy. I would hope that whatever immigration policy we set up in relation to Europe would be as open as possible because, frankly, we need to encourage that. Again, even if you have a very open immigration policy, the danger is that you are seen as not being a welcome place for people to come. That is another factor.

On research, clearly, the Government would have to—and I think they have indicated that they would—compensate for the loss of EU funding for research. But it is much more than that. Again, a lot of this is soft cultural stuff. Will researchers want to come and work here under a system where we are outside the European framework? We are concerned about that. The Government would have to have a very clear strategy about how they would give their support and try as far as they could to make Britain an attractive place for researchers to come. A lot of research is terribly interdependent; it is not as it was before, with one person doing one little study somewhere else. It tends to involve cross-national studies. Of course, we have links with other countries as well—so you can doomsday this too far. We would obviously want to set up as far as we can close agreements with other leading research countries and, where we possibly could, try to retain whatever we can of co-operation in Europe.

So there is a whole range of issues, from how you get access to medicines and how the health service plans for the future to the possibility of elderly people returning to this country, as well as what is going to happen on research. You can run through it and then frighten yourself a lot. Most of our task has to be to make sure that that does not happen and to remind people what the implications are if we are not sensible in reaching agreements which are in the interests of both sides.

Raj Jethwa: On finance, capacity and staffing, it has been well documented that the NHS already struggles financially and has a very tight settlement. The projection is that, as a share of GDP, our spending

on the NHS will go down from 7.3% to 6.6% by 2021. That compares to our EU competitors, at around 10.5%—a substantial difference. So you already have a tight funding settlement for the NHS, before absorbing any new pressure that may come in as a result of uncertainty.

Funding can or cannot be turned on, but the reality is that extra staff, capacity and beds take time to bring to the fore. We have a much lower proportion of beds per 1,000 of population than we had 15 years ago. In England it is something like 2.4 beds per 1,000, whereas 15 years ago it was 3.8 beds. The common acceptance is that bed occupancy rate should be at around 85% in a trust, although even that is contested. But that is academic because, as of January this year, three-quarters of trusts in England had occupancy rates of 95%.

As for staffing and making this an attractive place to work, according to the survey almost 70% of junior doctors work on a rota with a permanent gap. So the staffing pressures are pretty clear. Recruitment to medical schools has gone down by 13% over the past five years. So there is a clear set of issues that could become much worse if we do not have clarity and certainty for the future. You can project forward what the pressure might be, and some of the scenarios that we have seen may not turn out to be as bad in future. But anything above what we are coping with at the moment will push the system, given that we are straining at the moment—doctors are struggling, other NHS staff are struggling and the system itself is struggling.

Lord Ribeiro: One final question, if I may. You said that your desire would be to ring-fence this arrangement, but I am slightly concerned, given that the Prime Minister has been very clear around the red lines and one of them being the role of the ECJ, that ring-fencing this will have implications for the jurisdiction and legal cover. How do you see that happening?

Niall Dickson: That is a matter for the Government. Our view is that this is absolutely worth preserving and that they should not throw it out. They will have to balance it with all other aspects of the negotiations, which, obviously, we cannot second-guess.

Q56 **Lord Soley:** If there were to be a transitional agreement on reciprocal healthcare, what would be the key priorities for your members?

Niall Dickson: I suppose they would be for the current arrangements to continue throughout the transitional period. The other priority would be to have, as far as possible, certainty in advance of Brexit day. The length of the transition period matters less than having the maximum amount of time beforehand for people to plan, to deliver services and to plan ahead for what will happen. It is about removing that uncertainty and trying to preserve the status quo for as long as possible.

Lord Soley: Would not some of your members say that research would be a key priority?

Niall Dickson: Absolutely. Within the Brexit Health Alliance, research is one of the areas where we have concern—industry is extremely concerned about the flow of goods and services around—and whether that might affect access for patients. Again, nobody is saying that none of these things can be solved at all, but there is a lot of uncertainty around both research and the future as regards access to medicines, and indeed the regulation of medicines in making us an attractive country where people will want to do things because our regulations are such that people will regard us as an attractive place to invest.

Lord Soley: What are the key priorities for your members, Mr Jethwa?

Raj Jethwa: In terms of reciprocal healthcare, I think that I have covered them. It is about certainty for the future, ensuring that there is no greater demand on services, and ensuring that doctors are able to focus on providing care and not being involved in recouping money or administrative processes, which get in the way of that relationship with the patient.

Lord Soley: For both of you, if I ask you how long this should last, it is easy to say, "As long as possible". But that is not likely to be. Do you have an idea of how you could manage change? Will this take five, two or 10 years?

Raj Jethwa: It depends on clarity about the destination. That is the problem at the moment. If we have certainty about what the future will look like, every part of the system—whether it is the doctors and members of staff who work in it or the employers and providers—can start to work together towards ensuring that we have the arrangements in place to provide the training, support, information and the guidance and make sure that people have the conversations that they need to. There will be—to use that word—anxiety out there; families will want to know what it means for their loved ones who live abroad. However, until we have certainty about the future, it is hard to know exactly how long you will need to get there. So we are not in the business of saying how long it takes. Certainly, however, this is one of the occasions where there should be less haste and we should think about this properly. The implications of getting it wrong are pretty severe for the system.

Lord Soley: Would the arrangements for staff be a key one for both of you to get right very quickly?

Raj Jethwa: Absolutely. Niall talked about immigration policy. There is already a concern that people are starting to feel that this is not a welcoming place for them. There was that effect straightaway. We worked with our members straightaway, covering this through our surveys and through support we gave them. We do anything we can to send out positive signals. One of the good things that the Cavendish Commission has done, which we are also part of, has been to try to make sure that there are positive messages out there for staff with regard to some of the concerns they may have. That is important, but, as Niall said, there is a workforce planning issue. We rely to a large extent, to

keep the NHS going, on staff who come from outside the United Kingdom. Therefore employers need to know what the arrangements will be in the future, but there are staff working at the moment who need to understand whether this is a destination they will stay in for the long term.

Lord Kirkhope of Harrogate: On a point of information from our witnesses, could we have the actual percentage of medical staff at different levels who are currently working in our system and come from non-UK, EU or EEA countries? I would be interested to have those statistics.

Raj Jethwa: I am sure we would be happy to provide them to the committee.

The Chairman: That would be helpful.

Niall Dickson: Briefly, on the staff, there is absolutely a role for employers, and they have been trying to reassure staff about the issue of being welcome. But you cannot overestimate the soft cultural aspect of what we are going through now and the need for us to try to provide that certainty.

Q57 **Lord Condon:** In the event of the status quo on reciprocal healthcare not prevailing and there being a small or great deterioration, do you have anxieties or can you tell us anything about particular affected groups which might be disproportionately affected. Intuitively, do you feel that it would be disabled people, people with long-term conditions, or other groups?

Niall Dickson: In the briefing we produced there are a whole series of examples, which I hope the committee will find useful. Just to highlight one, I have no idea what the numbers involved are, but if you are a kidney patient receiving dialysis, at the moment you can plan to have a holiday in Europe and you can go there and get free healthcare and support under the agreements. Obviously, that will no longer apply; those people would not be able to go abroad thereafter. That is a clear example.

There are other groups who at the moment cannot access one particular form of healthcare and go abroad to get it; they would not be able to do so. There is probably a whole series of people who currently manage to go to Europe on holiday because they can get insurance—and it is not so much the cost of insurance as whether you get it or not. They are told that “You are too old” or too something or other to go to the States, and so they are not allowed to go. They may be perfectly fit and healthy—I know of examples—but they cannot get that insurance, and so they would no longer be able to do it. So quite a lot of people—some cases are more obvious than others—will be affected if this thing goes down.

Then there is, obviously, the big thing, and the anxiety, around people who live in other countries at the moment who are benefiting from a system whereby their pension is paid by their host country. In effect,

their host country pays for their healthcare, but it is arranged and everything else at local level. Obviously, if that affects them it could mean that some of them would decide to go home because they would not want to, or could not afford to, pay for the healthcare themselves.

Raj Jethwa: I agree with much of that. The greatest claim will be from UK pensioners living in the EU or in EEA countries, individuals with disabilities and long-term conditions, students studying abroad and posted workers. You mentioned the situation potentially facing pensioners, but people with either a long-term condition or disability look at the prospect of purchasing either expensive travel or health insurance or being denied that. At the moment students are in a different category and can travel through Europe using the EHIC, so if that is not there in the future, that will limit their mobility.

As I mentioned at the outset in my rather hasty remarks, we had a symposium among patient groups at the BMA a few weeks ago at which about 100 people participated. Tamara Hervey was one of our guest speakers, which we were grateful for. We are exploring these issues, but concerns are rife among different groups about what this may mean. Up till now, people have operated on the basis of an assumption that they can travel. Only now, issues are starting to arise which they have never had to consider before.

Q58 **Lord Crisp:** You have made it clear that your future arrangements you want are the same as they currently are, whether achieved with the EU or bilaterally. So there is a clear stance coming from the British organisations. Are you in touch with your colleagues in Europe, and are they saying the same things? Are they making exactly the same points in the Spanish leader's ears, and so on?

Raj Jethwa: Yes, we are in touch with our colleagues. There are European umbrella organisations which the BMA is part of. We also have direct relations with national medical associations in each of those countries. We have regular dialogue with them. Many colleagues of mine, some of whom are behind me, go over to Brussels or have conversations regularly to try to ensure that we are sharing information about the position taken by each Government. I would say that our position is very similar. There is certainly no difference.

Most of our partner organisations are very sorry about the prospect of what this might mean and are keen to ensure that it does not impact either on healthcare for patients but also on some of the issues that Niall has alluded to. Research was mentioned a few times—there is the ability of clinicians or medics to participate in networks across Europe. Countries by themselves do not have the population size to allow proper research or to look at particular issues. Then there is provision of care; it may be so specialist that again, you do not get enough cases of that particular type in one country alone, so having those networks where clinicians work together is important.

Lord Crisp: Just purely on the reciprocal healthcare arrangements, do

they see it in the same way as you do, that it would be a bad thing for their country if the reciprocal arrangements fall, or do they see opportunities, perhaps?

Raj Jethwa: I am not aware that they see opportunities. I am more than happy to double-check these things and get back to the committee in writing about this. My instinct is that we are all pretty much of the same view about this and that this is something concerning which we have to make sure that we get right.

Lord Crisp: But you do not have a European-wide Brexit alliance, as it were, that is making these arguments about reciprocal arrangements?

Raj Jethwa: We are part of federal organisations which operate across Europe, of standing committees of different groups of doctors which we are part of. I believe that our position mirrors theirs, but I will have to check and get back to you. I am happy to do that if the committee would like that.

Niall Dickson: I mentioned that we have a European office—the NHS European office, which the Confederation runs. It has considerable contacts on the European side of things, both within the Commission and the European Parliament but also, perhaps more importantly, with the wider sector. Certainly, a lot of what we get is probably less about reciprocal healthcare and more about how the systems are working, but there is a general view within Europe that they absolutely want to try to preserve as much of the status quo as possible. That is certainly true of the pharma industry, which has come together to issue a statement which crosses both the British and the European industry. Certainly, the work we are doing with HOPE, which is the European Hospital and Healthcare Federation, indicates that it is supportive, and we have been with it in supporting its contacts with the European Commission to try to put that view across as well. So we are trying to do what you are suggesting.

Q59 **Baroness Pinnock:** On the withdrawal Bill, at the minute, the proposal is that it transfers EU law into UK law, but with an ability to modify, if necessary, where things are “deficient”—I think that is the word. We have heard a lot about Regulation 883 over the last few sessions. The administrative systems that sit behind that, which regulate reciprocal healthcare, could be viewed as an area of deficiency. Would you agree with that, and if so, what should we try to do about it? The second question is, taking the withdrawal Bill as a whole package, what provisions within there as regards reciprocal healthcare should be amended, clarified, adjusted, added to or changed, in your view?

Niall Dickson: Yes, it would be deficient, because you cannot write an agreement which says that you agree with somebody if they have not agreed with you. The whole point is that you can write into UK law something which says, “We have a reciprocal agreement”, but the key thing is the word “reciprocal”. You need somebody else to do it on the

other side, and if they are not doing it, it is a pretty meaningless set of words.

As for what you could do within the Bill, one idea we have looked at is that it might be possible within the Bill to unilaterally ring-fence the rights of EU citizens in the UK, which could put pressure on the EU to reciprocate on that. That is one practical suggestion.

Raj Jethwa: On the question of the withdrawal Bill and “deficiency”, when we leave the European Union, we will no longer have access to the administrative structures that underpin the EHIC and SIS II, for example. That includes the Administrative Commission for the Coordination of Social Security Systems. So that is important not just for administrative questions but for data processing for healthcare. It is therefore not clear, and may not be for quite a while, which UK agencies or agencies will take on those roles. In that case, you may well have in effect gaps in the withdrawal Bill with regard to legislation, because you do not know what will replace that particular body.

The Chairman: Both of you have stressed the importance, if possible, of maintaining things more or less as they are now. The trouble is that things will not be the same as they are now; they will be different, because the way in which the EU operates means that if we are outside the single market and so on, we will have a different relationship with it. Have you thought at all about, if your ideal scenario of things continuing more or less as they are now does not work, what would be the best way of proceeding to protect the interests of British citizens in the EU and EU citizens here?

Raj Jethwa: We have looked at other models and at a range of other agreements with other countries in other parts of the world. The reality is that, while there may be other options, such as modelling the reciprocal arrangements we have with, say, New Zealand or Australia, they are far less effective in actual terms than what we have at the moment with the European Union. So our best efforts are marshalled on how we can help to think through how you replicate the practical effect of the reciprocal arrangements we currently have. Without that, you are taking a step back in healthcare coverage for both a large number of people in the UK and UK citizens who operate or live or have retired in the European Union. We are trying to point out the problems we will have if we do not have reciprocal arrangements. We have looked at other options, but none of them come close to the current arrangements we have. Our efforts have been focused on trying to make sure that we have made these arguments quite clear. The best situation is one in which you are able to replicate or mirror as closely as possible the current reciprocal arrangements.

Niall Dickson: Yes, certainly with reciprocal arrangements, it should be as close as possible. There are probably slightly different responses to the question depending on the sector, and you have been concentrating today on reciprocal arrangements. There are issues around research. Again, for example, if we were outside some of the current European

networks, are there deals we could do with them either on an informal or other basis? We would not be getting the funding—we would be providing our own funding—but we would be getting the co-ordination and co-operation.

On regulation, we have to look at whether we mimic what the EMA does. Is there anything additional we could do which would make us more attractive as a place for developing research? Each sector will require a slightly different approach. However, with regard to reciprocal healthcare, and maybe across the board, being as close to where we are now clearly has to be our objective—while accepting your point that it will not be exactly as it is now in every area; it cannot possibly be. But we might get close to it in some areas, if we are sensible on both sides.

The Chairman: Thank you very much. We are extremely grateful to you for sparing your time this morning. It has been very helpful for our inquiry. We are very grateful to you and, as I say, we will send you a copy of the transcript shortly. Thank you very much indeed.