



HOUSE OF LORDS

Select Committee on the European Union

Home Affairs Sub-Committee

Corrected oral evidence: Brexit: Reciprocal Healthcare

Wednesday 15 November 2017

10.30 am

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Members present: Lord Jay of Ewelme (The Chairman); Lord Condon; Lord Crisp; Baroness Janke; Lord Kirkhope; Baroness Massey of Darwen; Baroness Pinnock; Lord Watts.

Evidence Session No. 10

Heard in Public

Questions 77 - 84

Witness

I: Professor Martin McKee CBE MD DSc, Professor of European Public Health, London School of Hygiene and Tropical Medicine.

Examination of witness

Professor Martin McKee CBE MD DSc.

Q77 **The Chairman:** Good morning. Thank you very much for coming and giving evidence to us today in our inquiry on reciprocal healthcare. It is very good to have you. We have been looking forward to this session. It is a public session and a recorded session—you know the ropes—and we will send you a transcript when it is over to have a look at. Would you like, just very briefly, for the sake of members of the Committee and myself, to introduce yourself, and if you would like to say anything by way of introduction, that would be very welcome? Otherwise, we will go straight into the questions.

Professor McKee: Thank you very much indeed. My name is Martin McKee. I am Professor of European Public Health at the London School of Hygiene and Tropical Medicine. I am also Director of the European Observatory on Health Systems and Policies, which is a partnership that involves universities, Governments—including the Department of Health in England—the European Commission and the World Health Organization. I am trained in medicine. I am not a lawyer—I need to make that very clear at the beginning—but I have written extensively, including with Professor Hervey, on European law and health policy, but mainly providing the health policy elements. I should say, just by way of introduction, that the more I read into this, the more confused I get, so I hope I will illuminate your discussions rather than further complicate them.

Q78 **The Chairman:** You are not alone in feeling that, but we hope very much you will be able to clarify some of the issues that are quite complex, and also, given your background and your experience, put yourself from time to time in the position of some of those elsewhere in Europe, looking back at what all this is going to mean for them as well as what it means for us. That would be very helpful as well.

Perhaps I could ask the first question and just ask whether you could set out for us what you believe to be the key reciprocal healthcare priorities for both the EU and the UK during the Brexit negotiations, and whether you can distinguish between the priorities that will be covered by the withdrawal agreement and those that pertain to the future.

Professor McKee: I am sure other people have said the same thing, but one of the big issues will be British pensioners living abroad, in Spain and in many other parts of Europe. It is slightly complicated because many of them may be people who are entitled to pensions by virtue of having aggregated their service; they have worked all their life in the UK but they may not be UK nationals. For example, if we look at the Spanish population, which we have studied in some detail, first of all, they are complicated because there are different waves and they went at different stages. The original ones went to the Balearics and then to the mainland. Also, there is a group of people who came in adolescence and worked, for example, as Spanish waiters and spent their entire working life in the UK and then retired to Galicia, particularly, in the same way as many people

from Ireland spent their working life in the UK and went back. That adds to the complication in that they are not the stereotype that many people have of a British expat living in Malaga or something like that. Pensioners, then, are one obvious group.

In terms of cross-border workers, in Ireland, there are something like 102 million border crossings a year, and many people work across the border. There are particular agreements that are already there, and I am sure that you have already been told about them, such as Cooperation and Working Together. Many are funded by the European Union. Also, there is a large number of people—one meets them on Eurostar and elsewhere—who commute on a weekly basis between Paris or Brussels and London. Cross-border workers are now much more mobile, with budget airlines, Eurostar and so on.

Clearly—and I would maybe put it lower down the list, although there are particular issues—there are British people who are abroad, and vice versa, on holiday who become ill and who depend on the EHIC. One group that I hope has been mentioned but may not have been is a group of people who are unable to travel unless they have access to healthcare, and those are people on dialysis. I am sure that that has been picked up already.

The Chairman: We had a very interesting session with experts on dialysis and so on a couple of weeks ago. Can I just ask: are there any figures at all for the category you mentioned just now of EU citizens who have pensions from their work in the UK but who are now living back in their original country, like the people from Galicia?

Professor McKee: We did try to get that a few years ago. We have not tried recently, but when we were doing the research on British pensioners living in Spain, we approached the embassy in Madrid, who indicated that it was quite a large number but they could not give a precise figure, partly because of definitional issues, because of people getting married and all sorts of family relationships. The definitions are not hard and fast, and, of course, some of them may be people who were born in Spain but have taken British nationality. The definitional issues are quite challenging. When we tried to find out, however, the view was it is a non-trivial number. The precise numbers, at that stage, were too difficult to get out.

The Chairman: Even an order of magnitude? I am not sure what “non-trivial” means.

Professor McKee: It was in the order of 100,000 or something like that, but I would be hesitant to go too far. They talked about quite a lot of people but the precise numbers were not clear, and in other parts of Spain too, including some of the poorer parts inland. The focus for the embassy, however, was the people living in Galicia, which was a particularly poor part of Spain where a lot of people had come to the UK from.

The Chairman: In your work, have you drawn a distinction between things that would apply as part of the withdrawal agreement or later on and—

Professor McKee: Perhaps I could if I knew what the withdrawal agreement looked like. Sorry, I honestly have no idea. I like to think that I am somebody who tries to keep up to date with this but the negotiations are going on in the other place at the minute and, as we speak, the position is no doubt changing. Frankly, the difficulty is that one tries to make sense out of this. A lot of the statements that are made do not, frankly, make sense. I will be blunt.

This is particularly the case in one example I have been looking at recently in Ireland. I speak frequently to colleagues in Dublin, and they are saying, "We are close to some sort of an agreement. We will be able to do something", and so on, and then I spoke recently to a colleague who has detailed inside knowledge in the continent of Europe, who said, "That is all very well and good, but it just will not work with the treaties."

The point that has been made frequently is that whatever agreement is made has to be consistent with the treaties and with European law. This argument about negotiation is a bit misleading. It is about finding a solution compatible with the treaties. The danger is that a lot of things are being said that, if subject to rigorous scrutiny, as I am sure they are with you, are problematic. Often the problems arise when getting into the real detail of how this will work and how it will be compatible not only with the treaties but with the accumulated jurisprudence. The devil really is in the detail here.

Q79 **Lord Kirkhope of Harrogate:** Professor McKee, thank you very much for coming. I want to ask you a little bit about the machinery presently in place. When I say "machinery", I do not mean that literally. How many people, for instance, are employed in administering reciprocal healthcare? What sort of technology is currently being operated? Is that pan-European technology or is it, in each case, national technology? Can I just add one more thing to that? I am noticing your professorship in public health. Of course, there is a difference between the competences of the European Union over public health as opposed to the competences of the national Governments over their own health services. To what extent do you see an interesting mismatch here, or a residual problem in the areas in which the European Union has had full competence as opposed to the health services specifically?

Professor McKee: You have raised a very important question. First of all, again, this issue was raised with me only very recently and I was not able to find out the answer to your first question. I do not know how many people work in Newcastle in managing all this. We do know a little bit about how it has worked in the past. You need to ask the relevant Ministers for that information. I could have done it but, in terms of my experience of getting freedom of information requests back, the timescales are rather different.

I do know, however, that in the past, when we looked at it in detail in Spain, it was very much a paper exercise then, and one of the problems that we found was that often claims were not being made simply because it was bureaucratically too much. That is why, of course, we have waivers with a number of countries. Malta, Norway, Hungary, Estonia and Finland all have waivers because the view is that it is bureaucratically and administratively cheaper just to do a write-off either way.

The Chairman: Can you just explain what you mean by “waiver” in that sense?

Professor McKee: People from the UK are treated as they would be if they were a citizen of that country, and no money moves back and forward. The countries that have waivers are Denmark, Estonia, Finland, Hungary, Malta and Norway. Apart from some very small categories, for the vast majority of the categories no money moves across either way.

What we did find was that in Spain, for example, hospitals were not billing the UK. They had to do a lot of work in the hospital to send the paperwork to the Government in Madrid, and then the money came back to Madrid but did not go to the hospitals, so the hospitals took the view, “Why should we bother?” and they just treated people anyway. That is changing, and the European Union has just launched the European electronic social security system in July of this year, which is to be implemented over the following two years, which is meant to make all this work a great deal easier. The idea is that there will be an electronic system that will be in place to enable all of this.

There will, however, be many challenges in linking up the healthcare providers in each member state to that, because our own experience in the UK, for example—and I am sure you have looked at it and other people have talked about it—is that the challenges of recovering fees and charges from people who are not entitled to NHS care are considerable. In fact, some work that we did showed that, apart from in London, the vast majority of hospitals spent more money collecting it than what they got back.

The system does not work ideally. It works better where there is a social insurance scheme where there is a tradition of billing and there is an electronic system in place, but particularly in countries that have systems that resemble the NHS that are tax-funded, like Spain, Portugal, Italy and the Scandinavian countries; maybe not the Scandinavian countries because they have great information systems. To summarise, there is work to be done.

Lord Kirkhope of Harrogate: On my supplementary point, can I ask you about this interesting point on public health?

Professor McKee: This is one of the problems in terms of the discussion about what would happen subsequently. Healthcare within the European Union is very much a derived issue from the need to enable freedom of movement of labour and freedom of movement of people. I am sure you

know all of this but it started off with cross-border workers in coal and steel, and then expanded progressively. Therefore, it is not there out of altruism to ensure that holidaymakers who fall ill abroad are looked after; it is there primarily to ensure that there is a single market and free movement of labour. It has been covered under the social security provisions rather than health, and there has been a great tension between DG SANTE and social security in the European Union for many years, but these provisions are social security, so they get wrapped up in pensions, sickness benefit and all sorts of other things.

That means that, in terms of the external relations, there has been a debate, which I am sure you are familiar with, about the extent to which there could be some sort of concerted European Union approach to negotiations with third countries, but that has been extremely difficult to get agreement on. That is going to be a real challenge for the UK because there are a lot of other priorities to sort out almost before that, so it is going to be difficult to find an interlocutor at the European Union level to negotiate on the EHIC system.

I would defer to others who have looked at this in more detail but, given the challenges that they have had with the Mediterranean countries, with Israel and others, where they have said, "We want to do this because there are a lot of people who work between Algeria and France and so on, with mainly pensions, so how do you accumulate years of service?" They have not been able to do that. There is an Ibero-American agreement. I may be getting off the topic, but the key issue is that the European Union, as you have said, has relatively little input into health, except in the exchange of information and convening, so it can support learning from good practice. It does that very effectively. It does have more competence in public health. Sorry, I may not have fully answered your question.

The Chairman: No, that is very helpful, thank you.

Q80 Baroness Massey of Darwen: Good morning and welcome. It is very nice to see you. Could I ask a question about reciprocal healthcare with non-EU countries? Let me focus on that a bit more precisely for you, which might or might not be helpful. Which non-EU countries does the EU have reciprocal healthcare arrangements with, what are the international agreements based on and what do they cover? I hope that is helpful.

Professor McKee: We currently have agreements with Anguilla, Australia, Bosnia and Herzegovina, the British Virgin Islands, the Falkland Islands, Gibraltar, the Isle of Man, Jersey, the Former Yugoslav Republic of Macedonia, Montenegro, Montserrat, New Zealand, St Helena, Serbia and the Turks and Caicos Islands—so, essentially, British dependent territories—Australia and New Zealand—and some countries of the former Yugoslavia. I maybe should qualify that because, up until 2016, we also had agreements with the countries that emerged from the Soviet Union. My suspicion is that, given the difficulties that the European Union has had in trying to negotiate an agreement with Kosovo—and others can advise better, and perhaps Lord Jay may know, as a former diplomat—

the problem seems to have been to find anybody to negotiate with to terminate the agreements. That is my suspicion, though, rather than based on any concrete evidence that I have. I know Bosnia reasonably well, having been there before, during and after the war, and finding someone to negotiate to unravel the treaty may be quite challenging.

Baroness Massey of Darwen: Who would that person be? Who did you find in Bosnia?

Professor McKee: I have worked with bits of the Bosnian Government over the time. I was not involved in looking at this particular issue but I suspect—and this is purely a supposition—that this may well have been put in the “too difficult” tray. They terminated the agreements in 2016 with the former Soviet countries, but I may be wrong. There may be some strategic reason why we wish to maintain a reciprocal agreement with Montenegro but not with Algeria, for example, but I doubt it somehow.

Baroness Massey of Darwen: You said that some international agreements will be very difficult because there is nobody to negotiate with.

Professor McKee: Yes. The thing is that there are probably not that many people who take advantage of these agreements. It is difficult to find out if they do. You simply need to demonstrate that you are in the other country legally, so I am just not sure that this has been raised high enough on the agenda for anybody to sort it out, I suspect.

Baroness Massey of Darwen: What would you think these agreements ought to cover?

Professor McKee: Most of them relate to social security when you look back at them. I have been trying to get them out of the National Archives. It is quite difficult to find some of them. There are a number of sources that I have looked at: the ILO register of treaties, the FCO register online and the National Archives. Often, these go back well into the dim and distant past. There may be PDFs. For example, I got the Finnish 1959 one. Most of the time, there is an exchange of notes between Ministers that clarifies an earlier document that I have not been able to obtain access to. In general, they just say, “If you are in another country, you can get treatment in the health facilities of that country”. Most of the content, however, appears to be about pensions and about sickness benefits and maternity benefits. For example, if someone from the UK is living in the other country legally and they are not entitled to maternity benefits in the UK, they would be entitled to them there, it would appear.

The Chairman: Could I just broaden this out? We are talking not just about the UK and non-EU countries, but what reciprocal agreements the EU itself has.

Professor McKee: The EU, as far as I am aware, has no agreements. There is the EU-EFTA treaty for Liechtenstein, Iceland and Norway. It has the EU-Switzerland treaty, which is complicated and there is very little appetite in the European Union to replicate that. There are a wealth of other treaties about which I could supply you with details, but you may already have them. They tend to be, for example, with countries that are former colonies: Belgium and the Congo, for example; France and its former colonies in Africa, such as Algeria and so on.

Others include Austria and Japan, and Germany and India, where there was pressure from large corporations to put in place some mechanism because it was becoming a problem in terms of the globalisation of industry. There is a very large mix, some of which does include health but a lot of which does not. For example, just looking at Austria, there are agreements, just taking it almost at random, with the USA for pensions and old-age insurance; Uruguay covers pensions but not sickness; Tunisia, Turkey and South Korea—none of these include sickness.

The Chairman: There is no common approach or template for these agreements.

Professor McKee: There has been a template that has been proposed in a study from about 2010, which did look at this, and I would defer to others who would know. As far as I can tell, however, it never really got very much further than producing a template, and it was a very generic template that looked at a lot of issues to be addressed, like who is covered. I am sure you have been apprised of the Gottardo case previously, which deals with the situation of a citizen of an EU member state, resident in another member state, getting their entitlement by virtue of their then going to a third country. There are complex agreements there in terms of whether or not that is included and whether it includes only people who are insured or whether it includes civil servants. Diplomats are often excluded, for example.

There is a proposal for a very generic common template but, as far as I am aware, that has never been used, and it would be at a very generic level. The challenges then arise following that in the implementation because, to make it meaningful or in any way comparable, you would have to have provisions on data protection, cross-border liability and a whole raft of other things—and, crucially, a dispute-settlement process, which, if it is not going to be the European Court of Justice, it is not clear what it would be.

Q81 **Lord Crisp:** My question has slightly disappeared with the discussion that you were just having. If I understand it, what you are saying is that the EU does not have reciprocal healthcare agreements with non-EU countries as the EU.

Professor McKee: No, because it is the responsibility of the individual member states. There has been a lot of argument as to why it should have one. The first would be economy of scale—for a small country, it is

difficult to do all of this; secondly, because of the exchange of information. For example, should the legislation in a country with which you have a reciprocal agreement change, as it did in India a few years ago, what mechanism is there for the country that first discovers that to let everybody else know. There is not one at the minute, and that may have a material impact on some of these agreements. The arguments have been made very clearly that you should have but it has not proven possible.

I do stress that the more I get into this, the more challenging I find it to be, so it is possible that I am wrong on something or not completely up to date, but the main discussions have been around the north African countries and an attempt to get something happening there. I am not exactly sure where those discussions have got to but, as far as I am aware, nothing has been concluded. That is in particular focusing on pensions more than anything else.

Lord Crisp: Just as another point of clarification, on something you said earlier, the EHIC arrangements are part of the social security system as opposed to the health system.

Professor McKee: Yes.

Lord Crisp: They are therefore tied into everything else that is part of that.

Professor McKee: Yes, although, of course, there are a lot of issues around other aspects of that, which relate to other directorate-generals as well, but primarily yes.

Q82 **Baroness Pinnock:** My question is the other way round, in a sense. Starting from the point of the UK not being in the single market and not having freedom of movement of people, what are the prospects for the UK making reciprocal healthcare arrangements with the EU? I think you have already answered that in a way, but this is putting it the other way round. What about prospects for bilateral arrangements—UK and an EU member state?

Professor McKee: We already do have other agreements, and there are agreements that sit outside the EU in particular, with varying degrees of formality and varying degrees of linkage. For example, in terms of the cross-border arrangements in Ireland, many of them take place on a purely bilateral basis, although they are underpinned, ultimately, by European Union law. It would require a detailed case study to see what the consequence of that will be. There would be consequences but a lot of these things almost require little vignettes, where you look at a particular case and, as you trace them through, find out what the legal basis is for everything that happens. When you get into the detail, as we have done previously, all sorts of things come up, like ambulances going across borders carrying morphine to treat somebody with a heart attack. That, for example, would be illegal, potentially, outside the European Union. There is the conformity of the sirens and ambulances and things like that.

There are all sorts of issues that relate to free movement of services and people that could be complicated.

There is the Malta agreement, which you have talked about before. I have a copy of the Malta agreement. I speak frequently to my colleagues in Malta—Chris Fearne, who is the Minister for Health and Deputy Prime Minister, and other colleagues—who are extremely concerned, and you might find it useful to talk to them at some stage. They have put a tremendous amount of work into that, because their medical training is linked to the UK through the deaneries. Their postgraduate programmes are linked and they have visiting consultants from the UK going there. They have a particular arrangement, which we evaluated some years ago, for children going to Great Ormond Street, long established, where the families are cared for by a religious order in London that looks after them. It preceded the EU, so it works very well. It covers 150 people a year and, with Malta, there is a knock-for-knock; they do not charge.

You could do something like that but Malta is a small country and the numbers are not big, so what you can do there may not be possible. I would be delighted to know if somebody else has proposed a mechanism to agree an arrangement with the European Union as such, as opposed to 27 bilateral agreements, but I frankly do not know what it is at present or who you would talk to. The EU-Switzerland treaty, which people sometimes talk about, has a number of limitations. Essentially, the Swiss Government have adopted the relevant regulations and directives as they are, but there is no dispute resolution process. First of all, the European Union sees the Swiss situation as anomalous and not one to be replicated or even encouraged—they are trying to roll back the relations with Switzerland and make them much more like EFTA—so it would be a big jump to replicate that in the UK.

The other problem with Switzerland, if I may be blunt, is that there is a high level of trust between the European Union and the Swiss Government and the Swiss authorities that the Home Office in the UK has somewhat undermined by some of its policies and, in particular, some of the letters it has sent out and the way it has behaved. That level of trust has meant that many people in the European Union and particularly in the European Parliament—Guy Verhofstadt particularly, but many others—take the view that there will have to be a very clear government-to-government dispute resolution process but also a mechanism by which individuals can assert their rights. If it is not the European Court of Justice, I do not know what it is.

Baroness Pinnock: If I can pick out the headlines of what you have said, it is going to be extremely difficult and challenging, with no precedents for it, for a non-EU country, which could be the UK, to make a reciprocal healthcare agreement with the whole of the EU. Equally, from what you have said, it is just as challenging to do bilateral arrangements.

Professor McKee: Nothing is impossible.

Baroness Pinnock: Challenging, not impossible.

Professor McKee: I do not know how they would do it.

Baroness Pinnock: That sounds like nearly impossible.

Professor McKee: I am not ruling out the possibility, with the right will, but I would temper that by saying that with good will all sorts of things are possible. I really do worry, however, that a lot of the good will has been squandered, because of the way in which messages are sent out. I would put this very clearly in the UK's court: messages are given one day and they are reversed the next day. The Home Office sends out letters and then they are taken back. That has poisoned the atmosphere and has said to the rest of Europe, "Frankly, gentlemen's agreements are not good enough". That is effectively what there is in the EU-Swiss agreement: there is no very clear dispute resolution process. As far as I am aware—again, somebody else might know—there is no ultimate arbiter of that agreement.

Lord Kirkhope of Harrogate: Can I just add to this question just for a moment? It is fair to say, however, that there is no block, as such, on bilaterals through the treaties, for instance, because of the competences remaining with national states. I was recently in the European Parliament, which would have competence—and Europe would have competence—over matters of campaigns for public health, whether smoking or drinking or all those sorts of things, and people's general lifestyles. In terms of the things we are talking about now, however, I am pretty sure there is nothing that would stop states negotiating individually with us post Brexit.

Professor McKee: No, there is not, but you would need to negotiate with each of them individually. We already have that with the Irish Republic, with Cooperation and Working and Together, and with Malta. All of those are possible. The one thing that I would say, as I have just qualified with public health, is that it is only relevant to cross-border issues. Tobacco advertising on billboards is not a European Union competence, because they do not move across borders, whereas, on television or in magazines, it is.

In terms of the issue of dealing with the national Governments, the agreement would also have to comply with European law. That has been established in the *Gottardo* case because European law has primacy in the member states. Therefore, there is a very clear statement that anything that any individual member state signs with a third country has to be compliant with European law. Ultimately, that would be arbitrated by the European Court of Justice, which is a complication. I am sorry if I seem to be confusing matters further. I have done my best to try to understand all of this.

The Chairman: It is not a straightforward position we are in.

Q83 **Lord Watts:** Professor, we are going around in circles in some respects. You have made comprehensive answers that cover most of the questions that we were going to ask. You are saying you do not believe there is a

possibility to do an EU-wide reciprocal agreement, so you would end up having to do individual ones, which could take some time and could be difficult. Without putting words in your mouth, is that really where we have got to?

Professor McKee: Essentially, because, for the European Union to have an agreement with a third country, it would require, first, all 27 EU member states to agree among themselves. They will do that with varying degrees of priority and good will. That would be the first hurdle: there would need to be a mechanism at a European Union level, as I understand it. In terms of my reading of the attempts to get such an agreement with the Mediterranean countries and so on, there is nothing to stop groups of countries, such as Spain and Portugal in the Ibero-American one. Most of this is in pensions and things like that. Health does not feature much in these, because health is so complicated. We saw that in the negotiation process on the directive on cross-border care. It took years to negotiate. I certainly was one of the observers of that process and was involved in many of the discussions, and it is often just put to one side because pensions are relatively straightforward.

The other issue is that you need to have all the infrastructure that goes with it: the information points, the recognition of qualifications and liability. Data protection is a key issue here because you have to have a mechanism to ensure that fraud is not taking place, for example.

Lord Watts: In earlier hearings, we have been told that the systems that are presently in place often do not work, and that the system for billing back to countries and back to us is not as straightforward as perhaps it should be. If we had reciprocal agreements with all the different member states, would we not have to have a very sophisticated system, if they were different in the content? A hospital would have to fill a different form in for one country than it would do for a second country.

Professor McKee: This is what the European Union has been doing with the new EESSI scheme—the electronic system for the exchange of information—because it realises that it is not working. That, however, has only been initiated in July of this year and will only be implemented fully over the next two years. We presumably will not be part of that, and the view has been expressed that we could not be part of that because of constraints on data protection, primarily, without the oversight of the European Court of Justice. My understanding from those who have looked at this is that we would have to be excluded from that.

The question is whether or not you could get agreement with all the member states to agree to a common template. That is not impossible but I do not think it would be easy. Many of them will say, “We have particular interests”, because clearly the relationship in terms of patient flows between, say, the United Kingdom and Latvia is very different from our pensioners in Spain or very different from Ireland, Malta or France. I am sure it could be done but maybe not in my lifetime.

The Chairman: Can I just ask a follow-up question on the EESSI? You

said you thought we would not be able to part of it.

Professor McKee: My reading of what people have written about it is that we would not be able to, because of the various other requirements around signing up to the single market and data protection and things like that.

The Chairman: Are we part of it, now that it has started?

Professor McKee: We have been part of it. We are still a member of the European Union so we are, but quite what we are doing to implement it, I frankly have no idea.

Q84 **Lord Condon:** Professor McKee, we have, quite properly, focused on the problems and challenges that Brexit is going to create but, for the sake of completeness, is there any upside for reciprocal healthcare post Brexit? We have taken evidence from insurance companies, so that we can see that maybe there are new products, income streams and policies for the private sector but, for the UK and individual EU countries, is there any opportunity to recalibrate some of this for citizens?

Professor McKee: I read the evidence that the insurance industry gave to you and, in fact, we have done some work speculating as to what the impact on premiums would be, by looking at people with different medical conditions at different ages going to an EU member state and then going to other non-EU member states. We chose Israel and Canada as examples, Israel being a common tourist destination that is not too far away but outside the EU. Certainly, the one thing that it is clear is that it is a wonderful opportunity for the insurance industry—I have no doubt about that—because, if you take, say, an 80 year-old with angina who has had successful treatment for it, who goes to France for a week, they would pay £96 for a five-star premium; going to Israel, however, it would be £229 and, to Canada, £469. If they had a mental illness, it goes up about three times.

In terms of opportunities, in the interest of consistency, I will say what I always say: no.

The Chairman: Thank you very much. Can I ask if there are any further questions people would like to ask, or anything that you would like to say that you felt we ought to have asked you but have not?

Professor McKee: We have covered everything very well, and I hope I was able to shed some light on what was going on. I really do not claim to have all the answers. Even finding some of these agreements, which I tried to do in preparation for the Committee, has proven extremely difficult without going physically to the National Archives to trawl through them. I did print out—and maybe I could give to Professor Hervey or some of you—copies of the 1959 Finnish-UK agreement, for example, and the exchange of notes on the Swedish and Finnish ones, and even a draft but never-agreed agreement between the United Kingdom and Chile. There is material out there but, unfortunately, in terms of trying to work out how one would implement many of these things in practice, so much

of it is not simply a matter of movement of people and health, it is overlaid by all of the issues around liability and data protection and others. The crucial issue for me is dispute resolution: what is the mechanism to resolve a dispute, both state-to-state and individual-to-individual? That is the real problem that I find no solution to.

The Chairman: If you were an EU citizen in Britain, or a British citizen in the EU, would you be worried?

Prof McKee: I speak to my colleagues every day, and they are extremely upset. We are now finding it very difficult to recruit. I spoke to one of my colleagues; admittedly, her partner works for the European Medicines Agency and they are now preparing to leave. A lot of our best-qualified people are now looking at leaving, for a number of reasons: the uncertainty, or the portability of pensions, for example. The United Kingdom has not agreed any new reciprocal agreements in the past 30 years, and any that it has are on the basis that pensions will not be uprated with inflation. It may well change that but it has not in the past 30 years, and it is difficult to see why it would, particularly given the rhetoric around portability of benefits and the view in the discussions before the referendum about whether or not child benefit should be payable, for example, if a Polish citizen were in the UK and the children were in Poland—whether that would be indexed to the cost of living and inflation in Poland or not. My sense is that the Treasury may be unwilling to look at that. Where people come here for work and there is aggregation of periods of work—as in the Gottardo case—what happens? Can you make sure that the time that you spend in the United Kingdom counts towards your pension in the country in which you were born and to which you might want to return in older age?

My discussions with my colleagues tell me that they are extremely worried. You will be aware of the DREAM Act in the United States. There was a paper in *The Lancet* that we wrote a commentary on, looking at the President's talk about revoking that. These are people who are children who were born of illegal migrants, who are allowed to stay. In a very sophisticated analysis, they showed that those children who were in this category had a significant improvement in their mental health whenever it was introduced—measurable and large—and I worry that, if we were to do the same study here, we would find that our EU colleagues feel the same, because certainly that is what they report to me.

The Chairman: Thank you very much indeed for the evidence you have given us. It has been extremely helpful.