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European Union Committee

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Brexit: reciprocal healthcare

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Evidence is published online at <http://www.parliament.uk/brexit-reciprocal-healthcare/> and available for inspection at the Parliamentary Archives (020 7219 3074).

Q in footnotes refers to a question in oral evidence.

SUMMARY

The United Kingdom's decision to leave the European Union could have a particularly significant impact on the UK's access to EU reciprocal healthcare arrangements, which support the free movement of persons by eliminating the financial or bureaucratic barriers that individuals would otherwise face in accessing treatment. Reciprocal healthcare oils the wheels of the day-to-day lives of millions of citizens, both UK nationals resident in the EU and those from the rest of the EU who are resident here.

By their very nature, the arrangements bring greatest benefit to some of the most vulnerable members of our society. Over the course of our inquiry, we heard convincing evidence about the vital role that reciprocal healthcare plays in improving the lives of people with disabilities, the elderly, and children. For people living with long-term health conditions (including those needing frequent dialysis, or who suffer from rare diseases), reciprocal arrangements mean that they can avoid the high insurance costs that would otherwise make travel prohibitively expensive. And, by providing treatment outside the country to UK citizens with complex needs, reciprocal healthcare has eased some of the burden that the NHS currently faces.

The Government's ambition post-Brexit is to continue the access to reciprocal healthcare provided by the current arrangements. December's 'Joint Report' by the UK and EU Brexit negotiators, recording progress made so far, went some way to guaranteeing reciprocal healthcare entitlements. In broad terms, those UK citizens accessing healthcare in the EU, and EU citizens doing the same in the UK at the time of Brexit, will have their rights protected to continued access to healthcare. This means that visitors to the UK or the EU receiving emergency treatment will be able to finish their treatment. On the other hand, those who are legally resident would have their access protected for life.

The Joint Report will find legal expression in a Withdrawal Agreement, to be given effect in domestic law by means of a Withdrawal Agreement and Implementation Bill later this year. While we look forward to the protection that the Withdrawal Agreement will give to existing rights, we note that until it is made legally binding, there will still be a question mark over access to reciprocal healthcare for the people covered by the agreement. We therefore support proposals to 'ring-fence' in law the agreement on citizens' rights embodied in the Joint Report, in order to provide clarity both to patients and to providers of reciprocal healthcare in the UK and EU.

The Joint Report contains two significant omissions, however. It does not cover the right of UK citizens resident in the EU at the time of Brexit to move between EU Member States. Nor does it cover the position of EU27 citizens resident in the UK on Exit Day who subsequently leave the UK and then return. We therefore call on the Government to seek to add to the Withdrawal Agreement provision for onward free movement rights, including the right to healthcare provision for UK citizens on the same terms as are enjoyed by EU citizens, and vice versa.

Nor does the Joint Report say anything about whether and how the reciprocal healthcare entitlements of those people who fall outside its scope will be protected post-Brexit. These people's rights are due to be discussed in the next phase of the Brexit talks, which will address the future EU-UK relationship.

But in the absence of an agreement on future relations, the rights to reciprocal healthcare currently enjoyed by 27 million UK citizens, thanks to the European Health Insurance Card, will cease after Brexit. Other rights, provided for by the S2 scheme and Patients' Rights Directive, which cover planned treatment in other EU Member States, will also come to an end.

We therefore remain unconvinced that reciprocal healthcare for people falling outside the scope of the Joint Report can continue in its current form. Without more detail from the Government about how exactly it intends to maintain reciprocal healthcare arrangements or provide a suitable replacement, this report argues that we should not take the future of UK-EU reciprocal healthcare for granted. Because reciprocal healthcare benefits derive from freedom of movement, we agree with our witnesses that it is difficult to square the Government's ambitions for reciprocal healthcare with its stated aim of ending freedom of movement of people from the EU.

We also heard from witnesses about the significant successes that cross-border collaboration in healthcare has brought to Northern Ireland and the Republic of Ireland. Ambulances are currently able to travel freely across the border, medical professionals from one country can work in the other, and patients can easily cross the border to access healthcare. In our view, a hard border on the island of Ireland would be highly detrimental to healthcare for patients on both sides of the border, including children and other vulnerable patients.

Lastly, we call on the Government to ensure the active participation of the devolved administrations in setting the UK's position on future arrangements for reciprocal healthcare, so that the implications of any potential changes fully reflect perspectives and powers across the United Kingdom. The importance of reciprocal healthcare in enabling citizens from across the UK to travel easily to the rest of Europe, and for European citizens to travel to all regions of the UK, demands a coherent approach.

Brexit: reciprocal healthcare

CHAPTER 1: INTRODUCTION

Overview: reciprocal healthcare and Brexit

1. The free movement of persons, one of the four freedoms of the EU internal market, provides for a right of movement and residence for workers, the right to enter and reside for family members, and the right to work in, and be treated on an equal footing with nationals of, other Member States.
2. One of the primary aims of the EU's reciprocal healthcare arrangements is to support free movement by eliminating the financial or bureaucratic barriers that individuals would otherwise face in accessing healthcare. In the words of the preamble to the Patients' Rights Directive of 2011, reciprocal healthcare arrangements seek "to improve the functioning of the internal market and the free movement of goods, persons and services".
3. The Government has repeatedly emphasised that one of the fundamental objectives of Brexit is to bring an end to free movement of persons: this is, indeed, a 'red line' in negotiations between the UK and EU. If this red line is adhered to in full, it follows that one of the fundamental rationales for reciprocal healthcare arrangements, as they have evolved during the UK's EU membership, will disappear upon Brexit. Yet much of the evidence heard in the course of this inquiry stressed the importance of continuing as far as possible with existing reciprocal healthcare arrangements post-Brexit, which, for the campaign group Brexpat in Spain, would be the "ideal outcome".¹ Raj Jethwa, Director of Policy at the British Medical Association (BMA), told us that that "the best situation is one in which you are able to replicate or mirror as closely as possible the current reciprocal arrangements".² Lord O'Shaughnessy, Parliamentary Under Secretary of State at the Department of Health and Social Care, said that the Government's ambition was to "continue the rights that the current arrangements provide".³
4. Underlying this apparent paradox is a distinction between, on the one hand, UK and EU citizens who have already exercised free movement rights (on the understanding that they will benefit from reciprocal healthcare arrangements), and, on the other, those who might wish, at some point after the date of Brexit, to travel or reside in each other's countries. In practical and human terms, the interests of these two groups coincide in many areas; but in terms of the negotiations on Brexit, they are entirely separate. The rights of citizens who have already exercised free movement rights have been treated as a 'phase 1' issue, which will be addressed in the Article 50 Withdrawal Agreement. The rights that UK and EU citizens may or may not enjoy post-Brexit are a 'phase 2' issue, which will only be discussed as part of the negotiations on the future relationship between the UK and EU—negotiations that cannot begin formally until the UK becomes a 'third country' on 29 March 2019 by officially leaving the EU.

1 Written evidence from Kidney Care UK ([BRH0016](#)), Royal College of Physicians of Edinburgh ([BRH0013](#)), British Medical Association ([BRH0012](#)) and Brexpat in Spain ([BRH0011](#))

2 [Q 59](#)

3 [Q 96](#)

5. The negotiations on the future relationship have yet to begin, but in December 2017 the UK and the EU reached the outlines of a phase 1 agreement. This is reflected in a ‘Joint Report’⁴, setting out the terms of what will ultimately become the final Article 50 Withdrawal Agreement. Most of our evidence, however, was taken before December 2017, and was heavily coloured by what was then the most pressing issue—namely, the protection of the rights of the over four million UK and EU citizens who currently live in each other’s countries. We have sought in this report to do justice to the deeply felt concerns expressed to us in late 2017—not least because those concerns, while they may have been allayed by the December agreement, will not be finally put to rest until they are ratified in the final Withdrawal Agreement.⁵
6. We sought further evidence after the Joint Report was agreed, including from key stakeholders and Lord O’Shaughnessy. This informed our analysis of the second issue: the extent to which the UK and EU could agree long-term reciprocal healthcare arrangements post-Brexit. That evidence remains, however, lacking in detail, reflecting the fact that the hugely complex negotiations on future relations have yet to begin, and that within those negotiations healthcare will be just one of many strands. We nevertheless make some recommendations about what the Government should be aiming for, and identify some of the issues affecting individuals and the NHS that may arise if no long-term agreement is reached on reciprocal healthcare. Lastly, we look at the possible future of reciprocal healthcare in Northern Ireland and the devolved administrations.
7. The report is part of a coordinated series of Brexit-themed inquiries launched by the European Union Committee and its six sub-committees following the referendum on 23 June 2016, which have sought to shed light on the main issues likely to arise in negotiations on the UK’s exit from, and future partnership with, the European Union. It draws on a series of evidence sessions that the Sub-Committee held between 13 September 2017, when the inquiry was launched, and 7 March 2018.
8. **We make this report to the House for debate.**

4 European Commission and HM Government, *Joint Report on progress during phase 1 of negotiations under Article 50 TEU on the UK’s orderly withdrawal from the EU*, (8 December 2017): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/665869/joint_report_on_progress_during_phase_1_of_negotiations_under_article_50_teu_on_the_united_kingdom_s_orderly_withdrawal_from_the_european_union.pdf [accessed 20 March 2018]

5 On 28 February 2018, the Commission published a draft Withdrawal Agreement that represents in legal form its interpretation of December’s Joint Report. European Commission, *Draft Withdrawal Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community*, (28 February 2018): https://ec.europa.eu/commission/sites/beta-political/files/draft_withdrawal_agreement.pdf. [accessed 20 March 2018]. This was transmitted to the United Kingdom on 15 March 2018. European Commission and HM Government, *Draft Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community* (15 March 2018): https://ec.europa.eu/commission/sites/beta-political/files/negotiation-agreements-atom-energy-15mar_en.pdf [accessed 20 March 2018]. An updated version of this agreement was published on 19 March 2018, with the agreed text colour-coded. European Commission and HM Government, *Draft Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community* (19 March 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/691366/20180319_DRAFT_WITHDRAWAL_AGREEMENT.pdf [accessed 20 March 2018]. The Government’s current proposal is to “enshrine” the Withdrawal Agreement in UK law through a ‘Withdrawal Agreement and Implementation Bill’. Department for Exiting the European Union, ‘New Bill to implement Withdrawal Agreement’, 13 November 2017: <https://www.gov.uk/government/news/new-bill-to-implement-withdrawal-agreement>. [accessed 20 March 2018]

CHAPTER 2: HOW RECIPROCAL HEALTHCARE WORKS

9. The EU's reciprocal healthcare framework has 32 participating countries. It seeks to provide a mechanism for the coordination of separate national health systems, not to align them—meaning that provision under the scheme can differ from country to country. The framework includes the 28 Member States of the EU, in tandem with the three European Economic Area (EEA) European Free Trade Area (EFTA) states (Norway, Iceland and Liechtenstein). There is also a bilateral arrangement with Switzerland, which participates in the same way as the 31 other states.⁶
10. There are currently four main 'routes' for EU and EEA citizens to access healthcare in Member States other than those in which they are ordinarily resident: the European Health Insurance Card (EHIC), the S1 system, the S2 system, and the Patients' Rights Directive. These four routes are described below.

The European Health Insurance Card (EHIC)

Box 1: The European Health Insurance Card (EHIC)

Provided for in Article 19(1) of Regulation 883/2004, the European Health Insurance Card entitles EU/EEA and Swiss citizens to "needs-arising" healthcare in another Member State, as if they were an insured resident of that country. The EHIC also covers treatment for long-term conditions, such as the costs associated with dialysis that EU/EEA and Swiss citizens with kidney conditions would otherwise incur when travelling.

The EHIC is not valid for private treatment and only entitles the holder to access state-provided healthcare during temporary stays in the EU/EEA and Switzerland. It does not cover costs such as repatriation; for this reason, the Government advises individuals to purchase travel insurance when visiting other EU/EEA Member States and Switzerland. In addition, the EHIC does not cover individuals who use the card to travel abroad specifically to have treatment—such costs are covered by the S2 scheme.

Source: Written evidence from Kidney Care UK (BRH0016) and Department of Health and Social Care (BRH0021)

11. The EHIC is designed to be used by short-term travellers, including tourists and business travellers, and the vast majority of UK-issued EHIC cards go to UK residents. Charlotte Swift told us that "EHIC cards are not appropriate to anyone other than holiday-makers",⁷ and Roger Boaden, of Expat Citizen Rights in EU, reported that fewer than 5% of UK-issued cards went to UK citizens living in the rest of the EU.⁸
12. For the Brexit Health Alliance (BHA), these arrangements "work well for the mutual benefit of UK and EU citizens and healthcare systems", giving "peace of mind to travellers who know that if they carry an EHIC they will be covered for urgent treatment, regardless of any pre-existing conditions". The system, they claimed, was also relatively simple for healthcare systems to administer.⁹ Similarly, the Royal College of Paediatrics and Child Health

6 [Q 36](#)

7 Written evidence from Caroline Swift ([BRH0005](#))

8 [Q 37](#)

9 Written evidence from Brexit Health Alliance ([BRH0018](#))

(RCPCH) noted that care received by UK citizens in other EEA nations was frequently cheaper than the equivalent provided by the NHS, meaning that the UK spent less on healthcare funded through existing reciprocal arrangements than it would if that care had to be provided domestically.¹⁰ Indeed, John Trevor Moss claimed that costs of provision in the EU were about 60% of those in the UK.¹¹ The RCPCH wrote that such discrepancies were partly a result of the use of co-payments in other healthcare systems.¹²

13. According to the BMA, there were approximately 27 million active UK EHIC cards in circulation in September 2017.¹³ Of the 53 million visits made to the EU from the UK each year, and the 25 million visits from the EU to the UK, only around one per cent result in an EHIC claim, suggested the BHA.¹⁴ Hugh Savill, Director of Regulation at the Association of British Insurers (ABI), told us that estimated medical costs associated with the treatment of UK citizens under the EHIC added up to £156 million per year.¹⁵ The BHA said that in return for these reimbursements, the UK recoups about £70 million from other EU/EEA countries.¹⁶
14. Under the present arrangements, according to Mr Savill, travel insurance “covers you for the cost of medical treatment that is not covered by the EHIC card”.¹⁷ It is therefore, as Professor Jean McHale of the University of Birmingham told us, “not an alternative to travel insurance”, but complementary to it.¹⁸ According to the Royal College of Physicians of Edinburgh, it also “almost certainly” keeps private insurance costs down.¹⁹

10 Written evidence from Royal College of Paediatrics and Child Health ([BRH0015](#))

11 Written evidence from John Trevor Moss ([BRH0010](#))

12 Written evidence from Royal College of Paediatrics and Child Health ([BRH0015](#))

13 Written evidence from British Medical Association ([BRH0012](#)) and [Q 94](#)

14 Written evidence from Brexit Health Alliance ([BRH0018](#)) and [Q 94](#)

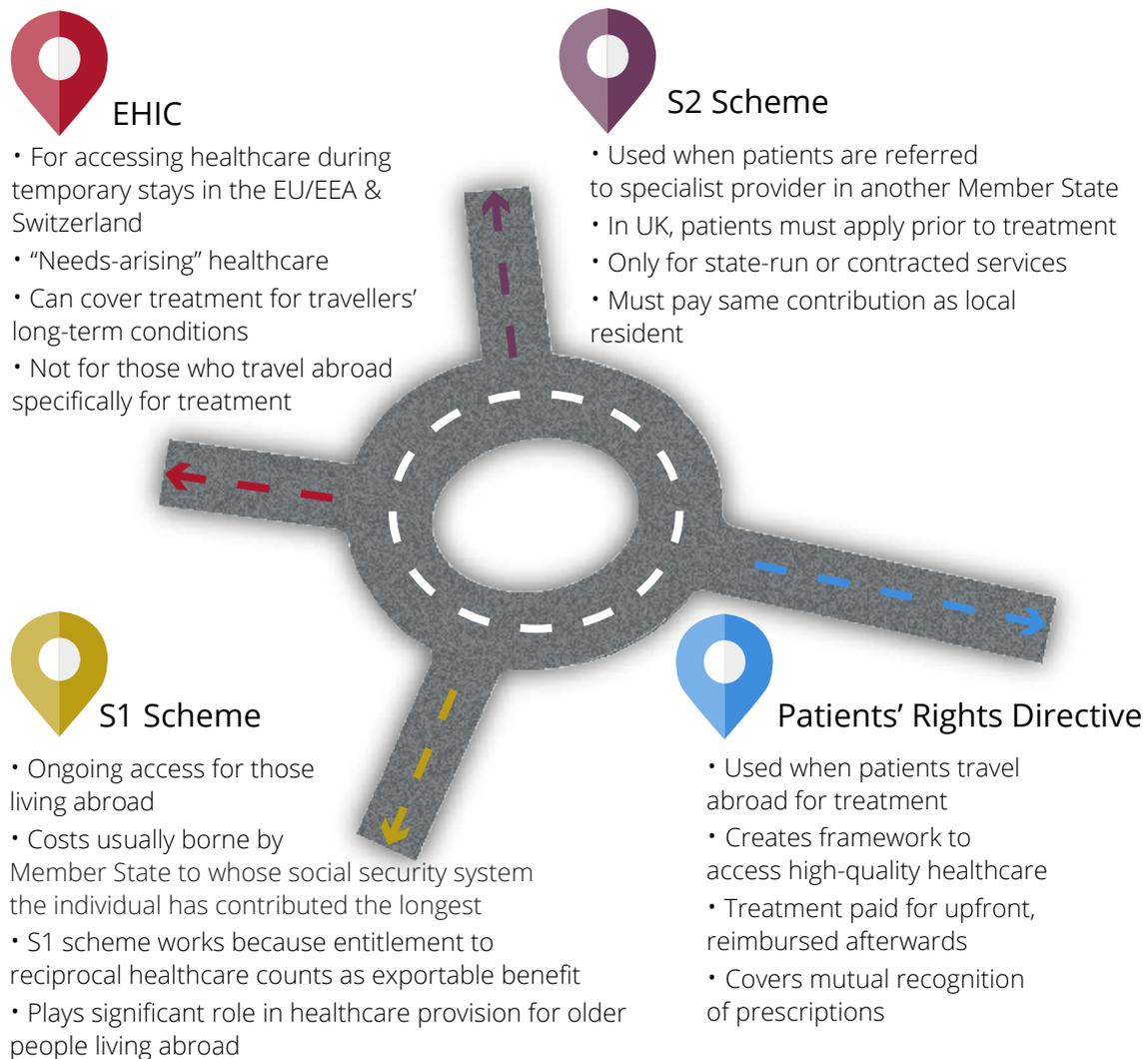
15 [Q 61](#)

16 Written evidence from Brexit Health Alliance ([BRH0018](#))

17 [Q 61](#)

18 [Q 18](#)

19 Written evidence from Royal College of Physicians of Edinburgh ([BRH0013](#))

Figure 1: The four routes to reciprocal healthcare

The S1 scheme

Box 2: S1 scheme

Under the S1 scheme individuals apply for coverage by completing an ‘S1 form’, which allows ongoing access to health and care services for people living abroad, with the cost met by the government of the ‘competent Member State’ (usually the Member State to whose social security system the individual has contributed for the longest time). Pensioners’ entitlement to reciprocal healthcare is an exportable benefit under EU Regulation 883/2004 on the coordination of social security systems. Other exportable benefits, such as employment support allowance, also carry healthcare entitlements, while workers posted to another EU Member State can use the S1 scheme to fund their care.

The S1 scheme plays a significant role in healthcare provision for older people. Approximately 190,000 UK state pensioners now live in other EU/EEA countries.

Source: Written evidence from Department of Health and Social Care ([BRH0021](#)), British Medical Association ([BRH0012](#)), [Q 2](#) (Paul Macnaught); Regulation (EC) No. 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems, [OJ L 166/1](#) (30 April 2004)

15. John Trevor Moss noted that S1 assisted a cohort of older people who “carry substantial health risks”.²⁰ Indeed, several witnesses spoke from personal experience in stressing the importance of S1 in providing their healthcare. One told us that it represented “a lifeline not only for those who have reached pension age, but also to those expats approaching it”.²¹ For the BMA, the S1 scheme was “particularly effective”, because allowing UK state pensioners living within the EU to access health and care services in their country of residence on an ongoing basis, with the cost met by the UK Government, ensured “simple access to care”.²² Roger Boaden of Expat Citizen Rights in EU outlined how some individuals relied on the S1 scheme while ‘topping up’ their coverage with private healthcare insurance.²³
16. A disproportionate number of UK citizens benefit from the S1 scheme. There are only around 1.2 million UK citizens living in other EU countries, compared with around three million EU citizens living in the UK.²⁴ But some 190,000 of those UK citizens are pensioners, who are more likely to benefit from the S1 scheme, compared to only 5,800 EU/EEA citizens who have registered for the S1 scheme in the UK.²⁵
17. On top of its EHIC expenditure, the UK spends approximately £500 million a year in reimbursements to Member States for healthcare provided to pensioners and others who have exported their accumulated benefits.²⁶ The Department of Health and Social Care accepted that the system was cost-effective for the UK, not least because the cost of treatment overseas was often cheaper than in the UK. For example, Spain’s latest pensioner average cost—despite a recent upward revision—is now €4,173 compared with £4,396 in the UK.

The S2 scheme

Box 3: S2 scheme

The S2 system under Regulation 883/2004 gives patients authorisation to receive healthcare or maternity care on the same terms as the local population, with the cost of that treatment met by their country of residence. Individuals need to apply for S2 funding ahead of their treatment, providing evidence that they meet the eligibility criteria and a clinician’s statement regarding their case. S2 only covers treatments that are provided by a state-run or contracted service. Patients must pay any contribution to the costs that a local citizen in the other state would normally pay. In some countries this can amount to up to 25% of costs.²⁷

Source: Written evidence from UK Coordinators of European Reference Networks (BRH0014), Department of Health and Social Care (BRH0021), British Medical Association (BRH0012) and Law Society of Scotland (BRH0019)

20 Written evidence from John Trevor Moss (BRH0010)

21 Written evidence from Alexander Wilson (BRH0007)

22 Written evidence from British Medical Association (BRH0012)

23 Q 37

24 Written evidence from Law Society of Scotland (BRH0019)

25 Written evidence from British Medical Association (BRH0012)

26 Written evidence from Brexit Health Alliance (BRH0018)

27 For a full list of co-payment systems in EU/EEA Member States and Switzerland, see supplementary written evidence from the Department for Health and Social Care (BRH0030).

18. The S2 system delivers cover that S1 might not provide. The BHA described the “not infrequent situations on the Continent where UK citizens and their dependents may live in one country, work in a second and receive medical treatment” under S2 arrangements in a third.²⁸ They also told us that the S2 scheme and Patients’ Rights Directive worked “very well” for UK or EU citizens who needed planned treatment in another EU country, and was especially valuable for patients with rare diseases or in border situations, where the nearest suitable facilities might be in a different country.²⁹
19. Lord O’Shaughnessy told us that in 2016 about 1,342 S2 portable documents were issued by the UK to its citizens, and about 1,100 were granted to EU, EEA and Swiss nationals for treatment in the UK.³⁰

Patients’ Rights Directive

Box 4: EU Directive on Patients’ Rights in Cross-border Healthcare

Patients can access healthcare in another EU Member State under the EU Directive on the Application of Patients’ Rights in Cross-border Healthcare (2011/24/EU). The Directive clarifies patients’ rights to purchase healthcare in another EU/EEA country and apply for the reimbursement of costs from the Member State in which they are resident. It creates a framework for people to access high-quality healthcare in other European countries, for instance to access specialised expertise. Unlike the S2 system, the treatments that patients receive must be ones that they are entitled to in the healthcare system of the Member State in which they are resident. This rules out some procedures, for example proton beam therapy, which is available in Europe for a wider range of conditions than in the UK. Reimbursement is capped at the amount that it would have cost had the treatment taken place in the patient’s Member State of residence. Switzerland is not party to the Directive.

In the UK, patients are only required to apply in advance for a limited number of treatments (those currently linked to NHS specialised services); otherwise patients are entitled to apply for reimbursement without any prior approval. They pay the healthcare provider directly and, in England, apply to NHS England for reimbursement (which then bills the relevant NHS commissioning body). If approved, reimbursement to the patient under the Directive is set at the costs that the NHS would have incurred if it had provided the treatment, or the actual treatment cost if lower. The Directive also covers mutual recognition of prescriptions, and the establishment of European Reference Networks (ERNs)—platforms for cross-border cooperation on complex or rare diseases.

Source: Written evidence from UK Coordinators of European Reference Networks (BRH0014), Department of Health and Social Care (BRH0021), Law Society of Scotland (BRH0019) and Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients’ rights in cross-border healthcare, OJ L 88/45 (4 April 2011)

20. In 2015 1,186 individuals from the UK were reimbursed for treatment in accordance with the Patients’ Right Directive. Poland, Latvia and France were among the most popular destinations for treatment.³¹ Around 40 NHS hospitals are involved in the European Reference Networks (ERNs) that were established under the Directive.

28 Written evidence from Brexit Health Alliance (BRH0018)

29 *Ibid.*

30 Q 94

31 Written evidence from Department of Health and Social Care (BRH0021)

Box 5: Reciprocal healthcare reimbursements

The Department of Health and Social Care funds and administers reciprocal healthcare on behalf of the UK as a whole, liaising where appropriate with the NHS in England, Scotland, Wales and Northern Ireland. There are two primary mechanisms in place for the reimbursement of healthcare costs between EU/EEA countries (and Switzerland):

- Actual costs—treatment within the temporary visitor category (carried out, for example, under the EHIC scheme) is billed on the basis of actual healthcare use.
- Average / fixed costs—costs per person, per month.

The majority of countries now bill only on the basis of actual healthcare costs. Only eight countries, including the UK, use average costs (although the UK uses actual costs for the temporary visitor category). However, the countries that the UK pays the most to—Spain and the Republic of Ireland—also use average costs.

In addition, the UK has several waiver agreements with individual EU/EEA countries, which involve the relinquishment of healthcare costs between Member States. Waiver agreements exist where they are considered mutually beneficial to ease the administrative burden. The UK's waiver agreements are with Denmark, Estonia, Norway, Finland, Hungary and Malta.

Source: Written evidence from Department of Health and Social Care ([BRH0021](#))

CHAPTER 3: RECIPROCAL HEALTHCARE AND CITIZENS' RIGHTS

UK citizens resident in the EU/EEA

21. It will be apparent from the preceding chapter that the most important route to reciprocal healthcare for UK citizens who are resident in the EU is the S1 scheme. There was general agreement among witnesses that this scheme was advantageous to both the UK and to its citizens. It benefits the former because it ensures that UK citizens living in the EU receive healthcare in their country of residence and means that the National Health Service can avoid paying the higher costs that it would incur should the treatment instead be provided in the UK. But, more fundamentally, the S1 scheme also benefits individuals, who can receive healthcare where and when they need it.³²
22. Stuart Scullion of the Association of Medical Insurers and Intermediaries (AMII) argued that the many UK nationals living in the EU27 and using the S1 scheme therefore stood to be “quite significantly” affected by the potential loss of reciprocal healthcare arrangements.³³ Mark Dayan of the Nuffield Trust noted that it was unclear how many individuals would be able to cover themselves with private insurance in lieu of an S1.³⁴ Other witnesses made similar points, with the BMA noting that UK state pensioners relying on the S1 scheme for their care would need to “take out personal health insurance, self-fund, or return to the UK for treatment”.³⁵
23. UK citizens living in other EU Member States were particularly concerned about the impact of changes to S1 arrangements on their insurance premiums.³⁶ Christopher Chantrey from British in Europe told us that the cost of obtaining private medical insurance for people over 70 with pre-existing conditions would be “prohibitive”, and that people would “either be faced with a huge premium from a private insurer or be refused”.³⁷ Brian Cave, a retired UK citizen living in France, wrote that while he also had French health insurance, he and his wife were financially “totally dependent” on the S1 reciprocal healthcare arrangements.³⁸ The BHA believed that finding alternative healthcare insurance cover post-Brexit could be “expensive and bureaucratic” for pensioners residing abroad who are benefiting from the current arrangements.³⁹

EU/EEA citizens in the UK

24. The BMA told us that maintaining access to healthcare for EU/EEA citizens in the UK was also “highly important, as doing so prevents disruption or insecurity in access to care for EU/EEA visitors and residents”.⁴⁰ Around three million EU citizens currently reside in the UK.⁴¹ As we have noted,

32 Written evidence from Department of Health and Social Care ([BHR0021](#))

33 [Q 64](#)

34 [Q 14](#)

35 Written evidence from British Medical Association ([BRH0012](#))

36 For example, written evidence from Beverly Townsend ([BRH0001](#)), Brian Cave ([BHR0003](#)), Charlotte Swift ([BRH0005](#)), Brexpats in Spain ([BRH0011](#)), John Trevor Moss ([BRH0010](#)), Dr Lawrence Renaudon Smith ([BRH0009](#)), Alexander Wilson ([BRH0007](#)), Beverly Townsend ([BRH0001](#)) and British Medical Association ([BRH0012](#)).

37 [Q 41](#)

38 Written evidence from Brian Cave ([BRH0003](#))

39 Written evidence from Brexit Health Alliance ([BRH0018](#))

40 Written evidence from British Medical Association ([BRH0012](#))

41 Written evidence from Law Society of Scotland ([BRH0019](#))

their age profile means that EU citizens in the UK make less use of the S1 scheme than do UK citizens resident in the EU, and tend to access NHS services in the same way as any other resident taxpayer.

25. Nevertheless, the Government's June 2017 position paper set out proposals for safeguarding their position,⁴² suggesting that EU citizens living in the UK would be able to qualify for "settled status" once they had been continually resident in the UK for five years. It also aimed to protect access to UK pensions, economic and other rights.⁴³
26. For Anne-Laure Donskoy, Founding Co-Chair of the3million, a grassroots organisation representing the interests of EU27 citizens and their families in the UK, guaranteeing such access to UK healthcare was a "moral argument". She told us that "we have all been enjoying being able to come and live in other member states under [these] rules, and new rules should not be applied to us that will dramatically change our lives in a very unfair way." This was, she said, because she had migrated to the UK as an EU citizen in "good faith".⁴⁴
27. Anne-Laure Donskoy believed that there would be two outcomes should current healthcare arrangements end. Firstly, EU and EEA citizens might need to return to their countries of origin. She said that for many, returning home would mean "starting from scratch", which in some countries involved "qualifying periods" before a person would be eligible to access the healthcare system in the same way as other residents.⁴⁵ Secondly, they might be obliged to pay for their own care. She reported that members of her organisation, the3million, were concerned that "the Government would start to introduce charges ... or force them to take out private insurance, which quite a few [members] said they could not afford".⁴⁶
28. Ms Donskoy also reported that EU27 citizens had already faced "incidents of discrimination" in accessing healthcare. She related that identity checks of EU nationals seeking NHS treatment were already taking place, and in certain cases had gone beyond what the NHS could legally request. She told us that there had been "a number of reported incidents of discrimination against people with foreign names or accents".⁴⁷

Patients with diabetes

29. UK and EU citizens with long-term conditions such as diabetes are particularly dependent upon the S1 scheme. Robin Hewings, Head of Policy, Knowledge and Insight, Diabetes UK, estimated that around 4.5 million people live with diabetes in this country, of whom about 3.5 million have been diagnosed with the condition.⁴⁸ Though it was difficult to obtain data on the number of UK citizens living with diabetes in the EU27, he believed that the numbers were "significant, particularly if one thinks of people retiring to France or Spain, given that ... about a quarter of people in those

42 HM Government, *The United Kingdom's exit from the European Union: safeguarding the position of EU citizens living in the UK and UK nationals living in the EU*, Cm 9464, June 2017: <https://www.gov.uk/government/publications/safeguarding-the-position-of-eu-citizens-in-the-uk-and-uk-nationals-in-the-eu> [accessed 15 March 2018]

43 Written evidence from Law Society of Scotland (BRH0019)

44 [Q 46](#)

45 [Q 50](#)

46 [Q 47](#)

47 [Q 44](#)

48 [Q 68](#)

age groups have type 2 diabetes”. Nor are figures available for the number of people with diabetes from other EU countries resident in the UK.⁴⁹

30. Mr Hewings told us that it was likely that UK citizens with diabetes living in other EU Member States accessed healthcare through the S1 scheme, “because diabetes is a condition that is associated with being older”.⁵⁰ If, post-Brexit, these reciprocal healthcare entitlements were discontinued, he argued that it would become “harder for people to access basic primary care”. The risk for health systems in the UK and EU would be “that we store up serious complications for the future ... that goes for both UK citizens in EU countries and vice versa; it is really important that EU citizens living here are accessing basic primary care, and that they are being diagnosed earlier.”⁵¹

Dependents and children

31. The RCPCH wrote that the current reciprocal healthcare system appeared to “work effectively for children who require healthcare services in other EU countries and for children from other EU countries accessing services in the UK.”⁵²
32. However, they were concerned that if an agreement on children’s access to healthcare were not reached by Exit Day, children might be prohibited from using services abroad, “which could be extremely detrimental to the healthcare of children”. The BHA were concerned that “dependents (e.g. children and elderly parents) of UK citizens working in EU countries (and vice-versa)” would lose healthcare rights.⁵³ Samia Badani, Head of Campaigns, New Europeans, voiced a similar concern over family members who join EU citizens in the UK: “we cannot even conceive of families being split, or a member [of the New Europeans] being in a situation where they cannot reunite with their family because they cannot afford healthcare. We expect family members to be treated in the same way as EU nationals who are currently here.”⁵⁴
33. The RCPCH also warned that the children of EU/EEA citizens living in the UK could “face a significant change in their access to care ... becoming liable to pay the Immigration Health Surcharge (IHS)⁵⁵ or individual fees for their child’s care.” They therefore believed that it was “extremely important that children of EU/EEA citizens in the UK can continue to access healthcare services under the reciprocal agreement. If parents are required to pay for services, this could act as a deterrent to accessing services which could be detrimental to the health of children of EU/EEA citizens living in the UK.”⁵⁶

49 [Q 69](#)

50 [Q 72](#)

51 [Q 73](#)

52 Written evidence from the Royal College of Paediatrics and Child Health ([BRH0015](#))

53 Written evidence from Brexit Health Alliance ([BRH0018](#))

54 [Q 46](#)

55 The Immigration Health Surcharge is a fee levied on anyone who applies for permission to enter or remain in the UK. It is in addition to the visa application fee and is not optional, even if the applicant has purchased—or intends to purchase—private medical insurance. Home Office ‘Pay for UK healthcare as part of your immigration application’: <https://www.gov.uk/healthcare-immigration-application> [accessed 15 March 2018]

56 Written evidence from Royal College of Paediatrics and Child Health ([BRH0015](#))

Conclusions

34. **The S1 scheme has provided comprehensive healthcare coverage to many thousands of UK pensioners lawfully resident in other EU Member States, and has been especially useful for people living with diabetes and other long-term conditions. We welcome plans to include these people in the Withdrawal Agreement as the best means of securing clear legal entitlement to this scheme. We note that the legislation dealing with the implementation of this agreement in the UK will be presented to parliament in the coming months as part of the Withdrawal Agreement and Implementation Bill.**
35. **To allay any outstanding fears about the status of children and dependents, the Government should now provide details to EU27 citizens lawfully resident in the UK about its plans and timetable for legally protecting their rights, stressing in particular that they will continue to enjoy the same rights to access healthcare that they and their dependents currently enjoy under EU law.**
36. **We would be concerned if EU/EEA citizens were already being denied access to the treatment to which they are entitled, as witnesses suggested to us. We therefore underline the imperative of securing enforceability of rights in the Withdrawal Agreement. In addition, we call on the Government to restate as clearly as possible to the NHS and its staff the current healthcare entitlements of EU/EEA citizens, and to communicate the entitlements contained in any future UK-EU agreement on reciprocal healthcare as soon as it is possible to do so.**

CHAPTER 4: THE JOINT REPORT

37. In this chapter we consider how far the citizens' rights provisions of the Joint Report have answered our witnesses' concerns, and ask whether the Report has overlooked any existing aspects of reciprocal healthcare entitlements. We also consider the views of those witnesses who feared that their access to reciprocal healthcare would not be protected until the Joint Report was given a more secure legal status.

Box 6: Personal scope of the Joint Report

The personal scope of the Joint Report

In broad terms, the citizens' rights provisions contained in the Joint Report apply to people exercising their rights to healthcare on Exit Day, 29 March 2019.

The joint technical note that the European Commission and UK Government published alongside the Joint Report stated that people in a cross-border situation on Exit Day (whether resident or on a temporary stay) could continue to rely on their entitlements, "as long as that stay or residence position continues".

Moreover, the Joint Report stated that the rights of UK citizens who, on the date of the UK's withdrawal were lawfully resident and already exercising free movement rights in the EU27, would be protected, for life, from discrimination on grounds of their nationality, and must be treated equally with nationals of the host state with respect to "social security, social assistance, [and] health care".

The Joint Report also underscored that the rights of dependents would be maintained: "rights under the Withdrawal Agreement of EU/UK national family members are maintained irrespective of changes in status (e.g. an EU citizen-dependent child becoming a worker, student, self-sufficient person or self-employed person)."

The Joint Report and the four routes to reciprocal healthcare

The Joint Report guarantees in perpetuity the rights of citizens who have already exercised EU law rights to reside in another Member State, and who are using the S1 scheme, at the time of Brexit.

It also protects the rights of citizens who on the date of Brexit are visiting an EU/EEA country other than their country of residence, and who need to use their EHIC card to pay for emergency treatment. They will continue to be entitled to healthcare as long as that stay, residence or treatment continues.

Lastly, the Joint Report safeguards the rights of those already receiving pre-planned treatment on the date of Brexit under the S2 scheme and Patients' Rights Directive.

Source: European Commission and HM Government, Joint Report on progress during phase 1 of negotiations under Article 50 TEU on the UK's orderly withdrawal from the EU, (8 December 2017): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/665869/joint_report_on_progress_during_phase_1_of_negotiations_under_article_50_teu_on_the_united_kingdom_s_orderly_withdrawal_from_the_european_union.pdf and Home Office and Department for Exiting the European Union, Joint technical note on the comparison of EU-UK positions on citizens' rights (December 2017): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/665871/December_-_joint_technical_note_on_the_comparison_of_eu-uk_positions_on_citizens_rights.pdf [accessed 23 February 2018]

UK citizens in the EU27 post-Brexit

38. Witnesses such as the BHA, the Law Society of Scotland, and the Academy of Medical Royal Colleges welcomed the progress that had been made in the Brexit negotiations by the time that they submitted evidence⁵⁷, specifically the agreement to protect reciprocal healthcare provision for anyone living in an EU Member State on Exit Day.⁵⁸ The Academy of Medical Royal Colleges approved of the proposal that any planned medical treatment would be completed post-Brexit.⁵⁹ The burdens that might fall on the NHS as a result of citizens returning with complex health needs, or upon UK citizens resident in the EU27 in taking out costly private medical insurance, may also be allayed by the provision made in the Joint Report to safeguard the continuation of access to the S1 system.
39. The provisions of the Joint Report may be particularly welcome to UK citizens suffering from diabetes and other long-term conditions, who are likely to use the S1 system to access healthcare in other Member States. The Joint Report means that UK citizens in the EU27 who are receiving treatment for diabetes at the time of Brexit should be able to continue to do so for life. In addition, because the Joint Report guarantees that UK citizens resident in an EU27 state will continue to receive the same entitlements as the citizens of their host countries without discrimination, those individuals who are resident in the EU27 on Exit Day but develop diabetes or other long-term conditions later should be covered as well.⁶⁰
40. There is some ambiguity in the Joint Report about the extent to which patients who, at the time of Brexit, have begun a course of pre-planned treatment under the S2 scheme or Patients' Rights Directive, might be permitted to return to the EU after Brexit in order to receive further treatment. The text of the Joint Report states that healthcare should continue "as long as [the] treatment continues". Lord O'Shaughnessy clarified for us that this would include repeat visits to the EU for treatment if the course of treatment had begun before Brexit. He said that although such patients would "not have to be physically abroad on exit day" for their treatment to continue, the final Withdrawal Agreement would need to provide clearer definitions for such provisions.⁶¹
41. One issue, however, has not been resolved by the Joint Report. The Law Society of Scotland, for example, urged the continuation of what Lord O'Shaughnessy called "onward free movement rights"—the ability of UK citizens resident in one EU Member State to move to another EU Member State post-Brexit and enjoy access to reciprocal healthcare there.⁶² The Joint Report made no provision for the continuation of these rights. While the draft Withdrawal Agreement,⁶³ published on 19 March 2018, does not make provision for onward free movement either, a provision contained in

57 Written evidence from Law Society of Scotland ([BRH0019](#)) and Brexit Health Alliance ([BRH0018](#)).

58 Written evidence from the Academy of Medical Royal Colleges ([BRH0020](#))

59 *Ibid.*

60 [Q 73](#)

61 [Q 119](#)

62 [Q 96](#) and written evidence from Law Society of Scotland ([BRH0019](#))

63 European Commission and HM Government, *Draft Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community* (19 March 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/691366/20180319_DRAFT_WITHDRAWAL_AGREEMENT.pdf [accessed 20 March 2018]

earlier drafts, which would have precluded onward free movement, had been deleted. The significance of this change is unclear.

EU27 citizens in the UK post-Brexit

42. For EU citizens resident in the UK, the Joint Report guarantees that their rights be protected, for life, from discrimination on grounds of their nationality.⁶⁴ The fears that we heard about EU citizens being forced to move back to their home countries, or take out private medical insurance, may therefore be allayed by the Joint Report.⁶⁵
43. Since the rights of dependents of EU27 citizens lawfully resident in the UK and UK citizens lawfully resident in an EU27 country are provided for in the Joint Report, this should go some way to answering the concerns about continued healthcare for dependents that were outlined in the previous chapter.⁶⁶

The Joint Report in law

44. Until the citizens' rights provisions within the Joint Report find legal expression in a Withdrawal Agreement, and that Withdrawal Agreement is ratified, UK and EU citizens are likely to remain concerned about the continuation of their rights.⁶⁷ The Joint Report itself includes the caveat that “nothing is agreed until everything is agreed”,⁶⁸ and the Academy of Medical Royal Colleges argued that it would be essential for the UK and EU to reach a formal agreement, “or the repercussions for patients across the UK and

64 Home Office and Department for Exiting the European Union, *Joint technical note on the comparison of EU-UK positions on citizens' rights* (December 2017): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/665871/December_-_Joint_technical_note_on_the_comparison_of_EU-UK_positions_on_citizens_rights.pdf [accessed 23 February 2018]

65 However, see Articles 17k (ii) and (iii) of the draft Withdrawal Agreement, which make reference to comprehensive sickness cover. European Commission and HM Government, *Draft Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community* (19 March 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/691366/20180319_DRAFT_WITHDRAWAL_AGREEMENT.pdf [accessed 20 March 2018]

66 Home Office and Department for Exiting the European Union, *Joint technical note on the comparison of EU-UK positions on citizens' rights* (December 2017): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/665871/December_-_Joint_technical_note_on_the_comparison_of_EU-UK_positions_on_citizens_rights.pdf [accessed 23 February 2018]

67 On 28 February 2018, the Commission published a draft Withdrawal Agreement that represents in legal form its interpretation of December's Joint Report. European Commission, *Draft Withdrawal Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community*, (28 February 2018): https://ec.europa.eu/commission/sites/beta-political/files/draft_withdrawal_agreement.pdf. [accessed 20 March 2018]. This was transmitted to the United Kingdom on 15 March 2018. European Commission and HM Government, *Draft Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community* (15 March 2018): https://ec.europa.eu/commission/sites/beta-political/files/negotiation-agreements-atom-energy-15mar_en.pdf [accessed 20 March 2018]. An updated version of this agreement was published on 19 March 2018, with the agreed text colour-coded. European Commission and HM Government, *Draft Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community* (19 March 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/691366/20180319_DRAFT_WITHDRAWAL_AGREEMENT.pdf [accessed 20 March 2018].

68 European Commission and HM Government, *Joint Report on progress during phase 1 of negotiations under Article 50 TEU on the UK's orderly withdrawal from the EU*, (8 December 2017): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/665869/Joint_report_on_progress_during_phase_1_of_negotiations_under_Article_50_TEU_on_the_United_Kingdom_s_orderly_withdrawal_from_the_European_Union.pdf [accessed 20 March 2018]

EU, as well as the health and social care system will be huge”.⁶⁹ Likewise, Professor Catherine Barnard of the University of Cambridge told us that “because the EU has been clear that nothing is agreed until everything is agreed ... it leaves British nationals abroad in a difficult position”.⁷⁰

45. One expatriate witness living in an EU27 country, John Trevor Moss, therefore called for a statutory “absolute guarantee of cover”.⁷¹ Witnesses from EU27 Member States resident in the UK were also exercised by the uncertain legal status of the UK Government’s desire to protect EU27 citizens’ rights. According to Samia Badani, without legal guarantees EU citizens could face a “loss of rights”.⁷²
46. As well as benefiting from a continuing right to long-term healthcare, EU citizens resident in the UK will need a practical means by which they can exercise this right. Dr Richard Lang told us that giving the Joint Report effect in domestic UK legislation would require a “strong link” between an EU migrant or family member’s “settled status”, and any entitlement that they had benefited from before Brexit.⁷³ But for Samia Badani, a focus on “settled status” was potentially problematic:
- “There are about 1 million EU nationals who will not have lived [in the UK] for more than five years by 2019 [the Government’s current proposal is for residents to attain ‘settled status’ after five years]. We are concerned about the type of immigration status that they would have and the restrictions placed on them about access to public funds and healthcare.”⁷⁴
47. She therefore proposed that in future, EU citizens’ access to healthcare might be protected by non-discrimination legislation.⁷⁵ The BHA called for any agreement on citizens’ rights to be ‘ring-fenced’, so that “both citizens and organisations such as healthcare commissioners and providers could have some certainty to plan for the future”.⁷⁶
48. On settled status, British in Europe and the 3million expressed concern about the Joint Report’s position on people temporarily absent from the country on Exit Day, stating that “clarity” was needed on “what test will apply to evaluate whether they will fall within the personal scope—will this be a test of habitual or normal residence or other such test to determine whether or not they should be deemed to be resident in the UK or EU27 country on the date of exit”.⁷⁷ In his evidence to us after the publication of the Joint Report, Lord O’Shaughnessy underlined that those EU citizens classed as “ordinarily resident” in the UK for the purposes of healthcare provision would have their entitlements protected; the rights of those without this status would be a matter for the negotiations over the future relationship between the UK and EU.⁷⁸

69 Written evidence from the Academy of Medical Royal Colleges ([BRH0020](#))

70 [Q 19](#)

71 Written evidence from John Trevor Moss ([BRH0010](#))

72 [Q 46](#)

73 Written evidence from Dr Richard Lang ([BRH0022](#))

74 [Q 47](#)

75 *Ibid.*

76 Written evidence from Brexit Health Alliance ([BRH0018](#)) and [Q 59](#)

77 British in Europe ‘Securing Citizens’ Right under Article 50: Reflections on Phase 1 & Considerations for Phase 2 of the negotiations’: https://docs.wixstatic.com/ugd/0d3854_3e2adeb0770a4e71b7d460957afbe926.pdf [accessed 19 March 2018]

78 [Q 114](#)

49. British in Europe and the 3 million also raised doubts about whether those who arrived in the UK or EU27 during the transition period would be covered by the personal scope of the Withdrawal Agreement.⁷⁹ Some of their concerns may have been met by the policy statement published by the Government on 28 February 2018, which stated that “EU citizens and their family members will be able to move to the UK during the implementation period on the same basis as they do today, which will be given effect through the Withdrawal Agreement.”⁸⁰

Conclusions

50. **The Joint Report agreed in December 2017 covers the entitlements of those within the personal scope of the Withdrawal Agreement benefiting from reciprocal healthcare arrangements at the time of Brexit. Though we acknowledge that its provisions are yet to be set down in law, and note that “nothing is agreed until everything is agreed”, we welcome the progress that the Joint Report has made in providing some reassurance to the millions of UK and EU citizens who currently reside in other Member States.**
51. **We would not wish to see this progress reversed in the future. This Committee has already called upon the Government to make a unilateral guarantee to protect the rights of the lawfully resident three million EU citizens who have, on the basis of EU free movement rights, made their lives in the UK.⁸¹ We therefore support proposals to ‘ring-fence’ in law the agreement on citizens’ rights embodied in the Joint Report, to provide clarity both to patients and to providers of reciprocal healthcare in the UK and EU.**
52. **We note that the Joint Report does not cover the right of UK citizens resident in the EU to move between EU Member States. Nor does it cover the position of EU27 citizens resident in the UK covered by the Withdrawal Agreement who subsequently leave the UK and then return. These are significant omissions, and we urge the Government to ensure that the final text of the Withdrawal Agreement includes provision for onward free movement rights, including the right to healthcare provision for UK citizens on the same terms as are enjoyed by EU citizens, and vice versa. If this proves impossible, we ask the Government, when replying to this report, to set out a detailed and clear position addressing this issue.**
53. **It is essential that, as well as having a continuing right to access long-term healthcare, EU citizens lawfully resident in the UK should be**

79 British in Europe ‘Securing Citizens’ Right under Article 50: Reflections on Phase 1 & Considerations for Phase 2 of the negotiations’: https://docs.wixstatic.com/ugd/0d3854_3e2adeb0770a4e71b7d460957afbe926.pdf. [accessed 19 March 2018] “Personal scope” refers to the individuals who are covered by the Withdrawal Agreement. See Box 6.

80 Department for Exiting the EU and Home Office ‘EU citizens arriving in the UK during the implementation period’ (28 February 2018): <https://www.gov.uk/government/publications/eu-citizens-arriving-in-the-uk-during-the-implementation-period/eu-citizens-arriving-in-the-uk-during-the-implementation-period> [accessed 19 March 2018]. This is reflected in part 2 of the draft Withdrawal Agreement published on 19 March 2018. European Commission and HM Government, *Draft Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community* (19 March 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/691366/20180319_DRAFT_WITHDRAWAL_AGREEMENT.pdf [accessed 20 March 2018]

81 European Union Committee, *Brexit: acquired rights* (10th Report, Session 2016–17, HL Paper 82)

provided with a practical means by which to exercise that right. We call on the Government to use domestic legislation to clarify the means by which all EU citizens lawfully resident in the UK at the time of Brexit will be able to continue to access essential healthcare. We note the suggestion that anti-discrimination legislation might assist in confirming the rights of EU citizens to continue to access healthcare post-Brexit, and look forward to further detail in the final text of the domestic legislation that implements this aspect of the Withdrawal Agreement.

CHAPTER 5: THE FUTURE RELATIONSHIP AND RECIPROCAL HEALTHCARE

54. The Joint Report goes a long way towards securing reciprocal healthcare arrangements for those UK and EU citizens who by the time of Brexit have exercised free movement rights and are residing in another EU country. But many other issues are not covered in the Joint Report, and can only be addressed by means of a separate agreement on future relations. Those negotiations have, at the time of writing, yet to start.
55. This chapter therefore outlines the issues that we believe future discussions on reciprocal healthcare will need to consider.

Affected groups

Short-term visitors

56. Short-term visitors usually access health services through the EHIC system. The Joint Report covers only those persons who are travelling at the point of Brexit: in other words, a UK citizen on holiday in the EU on 29 March 2019 (if that is Exit Day) would retain the right to access healthcare by means of the EHIC until his or her return to the UK. But it offers no protection to UK citizens travelling to the EU after 29 March 2019. Nor does it offer protection to EU citizens travelling to the UK after that date.
57. If the EHIC is not maintained in its current form, short-term visitors might instead, as the BMA told us, need to purchase individual travel insurance.⁸² This could in turn have implications for the price of travel insurance. Hugh Savill of the ABI said that the loss of the EHIC would require policies to “absorb the medical costs currently covered” by the card; indeed, “the highest cost of travel insurance is medical costs”.⁸³ Mark Dayan told us that without the EHIC the liability of travel insurance companies in the UK would increase, and “their prices to consumers would increase” in tandem.⁸⁴ Hugh Savill gave a “finger in the air” guess that there could be a hike of between 10% and 20% in the price of insurance premiums.⁸⁵ He felt that although the loss of the EHIC would affect everybody, certain groups—such as elderly travellers—were “likely to bear a higher proportion” of increases in costs, on the basis that they were more likely to claim.⁸⁶

82 Written evidence from British Medical Association ([BRH0012](#))

83 [Q 61](#)

84 [Q 16](#)

85 [Q 61](#)

86 [Q 65](#)

Box 7: Features of the travel insurance market

There are two types of travel insurance:

- single-trip; and
- multi-trip. Multi-trip policy (covers the traveller for a particular year).

In 2016:

- 13.2 million travel policies sold—2.7 million were single-trip policies; 10.4 million multi-trip policies.
- £369 million—total claims made; of which £199 million were for medical expenses.
- £156 million—estimated medical costs associated with the treatment of British citizens under the EHIC.

Source: Written evidence from the Association of British Insurers ([BRH0024](#))

58. The many people with long-term conditions, including kidney patients, and people with disabilities, will be particularly affected, given the prohibitive costs of travel insurance that they face.⁸⁷

Patients with long-term conditions

59. Treatment that might be necessary for patients suffering from long-term conditions while on a short visit to another Member State is reimbursed by the patient’s sponsoring state under the EHIC scheme. For the Academy of Medical Royal Colleges, this meant that patients with such conditions could travel across UK and EU borders “without the need for expensive travel and health insurance”.⁸⁸
60. 29,000 people in the UK currently receive kidney dialysis, typically three days a week. If the frequency of dialysis is reduced, even for a short period, the health of the patient deteriorates rapidly, in most cases requiring intensive and expensive specialist treatment.⁸⁹ The EHIC enables UK kidney patients to get the treatment that they need while travelling in the EU or EEA. According to Kidney Care UK, the “fundamental issue with dialysis is ... ease of access and we presently have a simple system to access care in other parts of Europe.”⁹⁰
61. Kidney Care UK stressed the importance of travel for the wellbeing of kidney patients and their families. They gave the example of one dialysis patient, Amanda, for whom the ability to take holidays “gives her the sense of freedom she so often feels is lost to her”.⁹¹
62. The organisation argued that people who needed dialysis would therefore be among those “most seriously affected” by any loss of reciprocal healthcare rights. Patients were anxious that their freedom to travel could be curtailed, because without access to treatment, travelling or working in the EU for longer periods of time would be “prohibitively expensive”. This was largely because existing travel insurance policies did not provide cover for such care.⁹²

87 Written evidence from British Medical Association ([BRH0012](#))

88 Written Evidence from the Academy of Medical Royal Colleges ([BRH0020](#))

89 Written evidence from Kidney Care UK ([BRH0016](#))

90 *Ibid.*

91 [Q 71](#)

92 Written evidence from Kidney Care UK ([BRH0016](#))

Box 8: Arranging dialysis abroad

Before they travel, people who use dialysis currently need to make arrangements with a clinic in the area that they are travelling to, in order to secure dialysis sessions. Such sessions are known as ‘Dialysis Away From Base’ (DAFB), and are funded through the UK’s reciprocal healthcare arrangements. EU dialysis units charge from €250 to €450 per session, with most costing towards the lower end of that range. Since dialysis is required three times per week, this gives weekly costs of between €750 and €1,350 that patients would need to fund themselves if no reciprocal healthcare arrangements were in place.

It is difficult to obtain data on how many EU/EEA citizens access dialysis treatment in the UK. This is because there are few opportunities for EU/EEA patients to obtain spaces for dialysis at UK NHS units.

Source: Written evidence from Kidney Care UK ([BRH0016](#))

Patients with rare diseases

63. Rare diseases are those that affect no more than five in 10,000 people. Taken together, between 6,000 and 8,000 rare diseases affect the daily lives of around 30 million people in the EU, many of them children. According to the UK Coordinators of European Reference Networks, such diseases can cause chronic health problems, many of them life-threatening.⁹³
64. When patients are referred by a doctor in their country of residence to a specialised provider in another EU Member State, the mechanism used is the S2 system. Alternatively, patients can use the route offered by the EU Directive on Patients’ Rights in Cross-border Healthcare.⁹⁴ For the UK Coordinators of European Reference Networks, stopping these reciprocal healthcare mechanisms would mean that UK patients would no longer be able to access elective care in the EU, unless they covered the cost themselves.⁹⁵

People with disabilities

65. The BMA told us that people with disabilities would potentially be among the most affected by any loss of reciprocal healthcare rights. Without the EHIC, for example, individuals with a disability might find that purchasing travel or health insurance could be “especially expensive and potentially difficult to arrange”. This could either reduce their ability to travel, or significantly increase the risk of their travelling without insurance.⁹⁶ Unlike the EHIC, which is available to all free of charge, we were told by the Law Society of Scotland that some 26% of disabled adults already felt that they were charged more for travel insurance, or simply denied it, because of their conditions.⁹⁷
66. For these reasons, the BMA suggested that the Government should make a full assessment of the potential impact of the loss of reciprocal healthcare arrangements on affected groups, including individuals with disabilities.⁹⁸

93 Written evidence from UK Coordinators of European Reference Networks ([BRH0014](#))

94 *Ibid.*

95 *Ibid.*

96 Written evidence from British Medical Association ([BRH0012](#)) and written evidence from Brexit Health Alliance ([BRH0018](#))

97 Written evidence from Law Society of Scotland ([BRH0019](#))

98 Written evidence from British Medical Association ([BRH0012](#))

67. Lord O’Shaughnessy provided us with the table below. The table summarises how the Joint Report covers the rights to reciprocal healthcare of certain groups of people, whereas other groups’ entitlements will be discussed as part of the negotiations on the future relationship.

Table 1: Overview of agreement in principle on reciprocal healthcare rights

Cohort (and examples)	Agreed in principle rights
S1 (Pensioners and other groups)	
<p>People resident in another EU Member State on the specified date [29 March 2019].</p> <ul style="list-style-type: none"> UK state pensioner aged 70 living in Spain and already covered for reciprocal healthcare. UK Early retiree aged 50 living in Spain and expecting to obtain reciprocal healthcare once they start drawing their state pension. 	<p>Ongoing right to reciprocal healthcare (once they reach state pension age).</p> <p>The right endures for as long as they remain permanently resident in the EU.</p> <p>Those who are UK state pensioners on the specified date can use a UK EHIC if they require needs-arising healthcare while on a temporary stay in another Member State (e.g. a resident of Spain on holiday in France with a UK EHIC).</p>
<p>People who have paid contributions in another Member State before the specified date.</p> <ul style="list-style-type: none"> UK national (of any age) who has at some point in the past worked in France and paid into their system. 	<p>Ongoing right to reciprocal healthcare, if they move to the EU, and once they reach state pension age.</p>
<p>UK citizens resident in the UK on the specified date who do not have a history of working in the EU.</p> <ul style="list-style-type: none"> UK state pensioner age 70 living in Liverpool (and has not worked in EU). Working-age UK citizen living in Liverpool (who has not worked in EU). 	<p>None—the Commission sees this as for the future relationship.</p>
<p>Anyone receiving relevant Department of Work and Pension (DWP) benefits and resident in the EU on the specified date.</p> <ul style="list-style-type: none"> 40-year-old exporting employment support allowance or disability benefits. 	<p>Ongoing right to reciprocal healthcare, for as long as they draw the DWP benefit and remain resident in the EU.</p>

Cohort (and examples)	Agreed in principle rights
Frontier workers	
Someone living in one Member State but working in another.	Agreement in principle that people who have begun frontier work before the specified date can receive reciprocal healthcare for the duration.
Posted workers	
Someone living full-time in another Member State because their employer in their home country has posted them there.	No agreement in principle—the Commission sees posted work as a matter for future talks.
Dependents	
Dependents of the groups above (who are in receipt of a state pension, DWP benefit, or who are a frontier or posted worker).	Agreement in principle that dependents can continue to receive healthcare.
European Health Insurance Card	
UK temporary visitors to the EU currently can use an EHIC to access needs-arising care. This includes tourists and students .	‘Pragmatic’ agreement in principle will ensure EHIC remains valid for the duration of any stay that crosses over specified date, e.g. <ul style="list-style-type: none"> • A holiday that started before the specified date; or • A course of study begun before the specified date.
Planned treatment (S2 route)	
UK residents who can currently travel to the EU to receive NHS authorised medical care, or to give birth in a home country.	‘Pragmatic’ agreement will allow people to finish courses of treatment/ maternity care that began before the specified date. There is no broader agreement with the Commission about ongoing S2 rights.

Source: Supplementary written evidence from the Department of Health and Social Care ([BRH0028](#))

The effects of loss of reciprocal healthcare arrangements

68. Many witnesses argued that changes to healthcare provision would discourage further migration to the UK by EU or EEA citizens. For some this may be a desirable outcome, and the Government itself has set an objective of reducing long-term net immigration. But the Academy of Royal Medical Colleges noted that such a reduction would have a particular impact on the health and social care workforce.⁹⁹ The Academy also believed that high insurance costs would be a disincentive to EU citizens, including tourists, considering short-term travel to the UK post-Brexit.¹⁰⁰

99 Written evidence from the Academy of Medical Royal Colleges ([BRH0020](#))

100 *Ibid.*

69. The Academy of Medical Royal Colleges were therefore clear that “the same rights should be extended to all citizens who move across the UK and EU borders in the future”¹⁰¹. And the BHA supported the idea of ensuring that, post-Brexit, rights of access to reciprocal healthcare should encompass future flows across borders, replicating current rights to healthcare provided by EU freedom of movement provisions.¹⁰²
70. Kidney Care UK also urged that the right of UK citizens to hold an EHIC be retained,¹⁰³ while the Royal College of Physicians of Edinburgh hoped that “in any negotiations or legislation regarding future reciprocal health arrangements with the remaining 27 EU countries ... affected groups will have the same rights and entitlements as everyone else.”¹⁰⁴ This would include the rights of people with rare diseases to continue accessing healthcare using the S2 or Patients’ Rights Directive.
71. There is some indication that the Government agrees with these ambitions. Paul Macnaught of the Department of Health and Social Care said that the Government was “seeking to clarify the position on EHIC ... to provide as much certainty to people ahead of exit day” as possible.¹⁰⁵ His Department wrote that it was “optimistic” that talks on a future relationship with the EU would secure the continuation of reciprocal healthcare rights.¹⁰⁶ Lord O’Shaughnessy told us that the while the Joint Report represented a “good outcome”, the Government had always wished to “go further” and “replicate” existing arrangements in order to “effectively maintain the system we have now”.¹⁰⁷ But because the EU’s negotiating mandate did not cover future relationship issues, they were unable to discuss these aims in phase 1.¹⁰⁸
72. On the other hand, Mark Dayan had already suggested to us that the Government’s ambition to maintain current arrangements might meet resistance from the EU negotiators:

“There are more general issues. Something that unfortunately is the case for reciprocal healthcare ... is that the issues will be settled in part not in their own right but by wider principles in the negotiations. A significant one for reciprocal healthcare, on which the EU27 so far seem fairly united, is a degree of resistance to the idea of the UK cherry-picking certain programmes to remain a part of while leaving the single market and no longer having free movement of people.”¹⁰⁹

Conclusions

73. **The Joint Report covers only the free movement healthcare rights of UK and EU citizens who are resident in another Member State before Brexit. It says nothing of whether and how the reciprocal healthcare entitlements of other UK and EU citizens will be protected post-Brexit. In the absence of an agreement on future relations that covers this topic, the rights currently enjoyed by 27 million UK citizens,**

101 *Ibid.*

102 Written evidence from the Brexit Health Alliance ([BRH0018](#))

103 Written evidence from Kidney Care UK ([BRH0016](#))

104 Written evidence from Royal College of Physicians of Edinburgh ([BRH0013](#))

105 [Q 7](#)

106 Written evidence from Department of Health and Social Care ([BHR0021](#))

107 [Q 117](#); [Q 120](#) and supplementary written evidence from Lord O’Shaughnessy ([BRH0028](#))

108 Supplementary written evidence from Lord O’Shaughnessy ([BRH0028](#))

109 [Q 13](#)

thanks to the EHIC, will cease after Brexit. Other rights, provided for by the S2 scheme and Patients' Rights Directive, will likewise come to an end.

74. **Our evidence suggests that it is not in the UK's interest for reciprocal healthcare arrangements to cease. Because of higher insurance costs—and in the case of dialysis patients, people living with rare diseases, and disabled people, the difficulty of obtaining travel insurance at all—without EHIC or an equivalent arrangement it will become much more expensive for UK citizens with chronic conditions to travel to the EU post-Brexit, for holidays, recuperation or treatment.**
75. **The Department of Health and Social Care wishes to continue to maintain reciprocal healthcare arrangements, including the EHIC, post-Brexit. We applaud the spirit underlying this ambition, but it is difficult to square it with the Government's stated aim of ending freedom of movement of people from the EU.**
76. **More generally, reciprocal healthcare arrangements will only be achieved by agreement between the UK and the EU. The Government has not yet set out its objectives for the future UK-EU relationship. We therefore urge the Government to confirm how it will seek to protect reciprocal rights to healthcare of all UK and EU citizens post-Brexit, as part of any agreement on future relations.**

CHAPTER 6: THE IMPLICATIONS OF BREXIT FOR THE NHS AND INSURERS

The NHS and healthcare providers

77. In the words of the Health Minister, Lord O’Shaughnessy, reciprocal healthcare is:
- “Quite a decent arrangement, because it means that the money stays locally in the economy but the public service bill, if you like, is picked up by another Government. If you think about it, it is like a little economic sector that we have exported into another country—which is perhaps not how pensioners would like to be thought of.”¹¹⁰
78. The Joint Report makes no provision for future pensioners retiring to countries such as Spain: to some extent, NHS and social care capacity planning relies on a number of UK pensioners being cared for in other countries, with the NHS meeting the costs. We have already noted that it is cheaper for the NHS to care for pensioners in this way.
79. The ending of reciprocal healthcare arrangements could therefore put a financial strain on the NHS—though it is difficult to quantify its severity. Partly this is because reciprocal healthcare arrangements form part of a wider package of citizens’ rights linked to membership of the single market and freedom of movement. While the BHA suggested that the financial implications for the NHS would be significant, they acknowledged that a full assessment was impossible “without knowing what the impact [of Brexit] on the UK economy as a whole is likely to be”.¹¹¹
80. These caveats aside, witnesses attempted to evaluate the impact that changes to the reciprocal healthcare regime might have on the NHS. The BHA believed that “if [the] arrangements were to be discontinued in the future, it is reasonable to assume that a proportion of [UK] pensioners, many of whom may have chronic conditions or more complex healthcare needs than younger citizens of working age, would return to the UK and that planning and funding provisions would have to be made for them in the UK’s NHS.”¹¹²
81. The concerns that we have just outlined relate primarily to UK citizens already exercising free movement rights, and may have been in large part allayed by the provisions in the Joint Report. But we also heard concerns about the future of reciprocal healthcare post-Brexit. Lord O’Shaughnessy acknowledged that if “a multilateral agreement with the entirety of the EU for continued reciprocal healthcare rights” were not possible, the UK might need to fall back on bilateral reciprocal healthcare agreements with individual EU Member States.¹¹³
82. Raj Jethwa of the BMA said that “while there may be other options” for reciprocal healthcare, “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”.¹¹⁴ And the BHA told us that should no EU-wide reciprocal agreement be achievable,

110 [Q 103](#)

111 Written evidence from Brexit Health Alliance ([BRH0018](#))

112 Written evidence from Brexit Health Alliance ([BRH0018](#)) and Nigel Tucker ([BRH0002](#))

113 [Q 114](#)

114 [Q 59](#)

the significant costs of establishing bilateral reciprocal arrangements with EU and EEA countries in the future would fall on the NHS:

“Managing access to health services by non-EU citizens is bureaucratically more burdensome than managing access for EU nationals currently ... in the event that the current reciprocal arrangements with the EU were to be discontinued, [it] could have considerable resource and administrative implications for hospitals in both the UK and the EU.”¹¹⁵

83. The RCPCH made a similar point:

“If UK health services are required to implement another system of recovering cost of care provided to EEA nationals, it could increase the pressure on medical and nursing staff to support the cost recovery process ... The primary duty of clinical staff is to treat patients, not to recover costs or decide who is eligible for treatment. Applying the existing non-EEA cost recovery measures, or new alternatives to EEA visitors and UK residents would also require significant resources and place a considerable additional burden on NHS providers.”¹¹⁶

84. Other witnesses criticised the UK’s lack of experience in successfully recouping healthcare costs from other countries. The Law Society of Scotland, for instance, suggested that “as the NHS has never been very effective in reclaiming the fees owed to it by overseas visitors to the UK, the UK may find itself substantially worse off financially when new arrangements for funding cross-national use of health services are put in place.”¹¹⁷ In his evidence to us, Lord O’Shaughnessy conceded that there was a “job to be done” by the NHS on cost recovery.¹¹⁸

Box 9: Cost recovery in the NHS

The UK has a residency-based healthcare system where eligibility is generally determined by patients being ‘ordinarily resident’ in the country and not by past or present payment of National Insurance Contributions or UK taxes. The Department of Health and Social Care explained that “ordinarily resident means, broadly speaking, living in the UK on a lawful basis and being properly settled for the time being”. Since 6 April 2015, non-EU/EEA nationals need to pay an Immigration Health Surcharge when applying for a visa to stay in the UK for over six months.

A Visitor and Migrant NHS Cost Recovery Programme has recently been established to support the NHS to better identify and recover costs from individuals not eligible for free NHS care. This includes the introduction of an EHC incentive scheme, where NHS trusts are paid an additional 25% of all EHC activity that they correctly record. The value of claims made by the UK to recoup the costs of NHS treatment for individuals insured by other EU/EEA countries and Switzerland has risen by £16 million (32%)—from £50 million in 2014/15 to £66 million in 2016/17.

Source: Written evidence from Department of Health and Social Care ([BRH0021](#))

115 Written evidence from Brexit Health Alliance ([BRH0018](#))

116 Written evidence from Royal College of Paediatrics and Child Health ([BRH0015](#)); cf. written evidence from British Medical Association ([BRH0012](#)).

117 Written evidence from Law Society of Scotland ([BRH0019](#))

118 [Q 122](#)

85. The Department of Health and Social Care told us that it had been planning for various outcomes of the negotiations:

“Our plans for the future of reciprocal healthcare arrangements have been designed to provide the flexibility to respond to a range of scenarios, including a negotiated agreement, as well as the unlikely eventuality of leaving without a deal ... Implementing the first stages of contingency plans in the coming months should not be interpreted as an expectation that talks with the EU should not be successful. [The Department] remains committed to our stated aims of continuing with current reciprocal healthcare arrangements for pensioners and those on a temporary stay in the EU.”¹¹⁹

Conclusions

86. **We received a large amount of evidence expressing concern both that the loss of existing reciprocal healthcare rights would impose significant additional future costs upon the NHS, and that the introduction of new reciprocal healthcare arrangements might impose a significant administrative burden.**
87. **We urge the Government, as part of its contingency planning, to clarify further whether it will seek UK participation in the EHIC, S1 and S2 schemes as a non-EU Member State; set up a separate scheme with the EU27; or explore the possibility of reaching bilateral arrangements with individual Member States.**
88. **Whichever is the case, we call on the Government to ensure that NHS procedures and practices are sufficiently robust to secure reimbursement for the healthcare of EU27 citizens provided by the NHS post-Brexit. Should the Government look to establish an independent scheme for reciprocal healthcare, we propose that it set out publicly its financial modelling of that scheme, including how the extra administrative costs will be met.**
89. **In the event that no future reciprocal healthcare agreements were agreed with EU countries, we would ask the Government to explain how NHS and social care capacity planning will secure sufficient capacity to care for future generations of retired people. In so doing, we suggest that the Government engage closely with the NHS and with those groups that will potentially be affected.**

119 Written evidence from Department of Health and Social Care ([BHR0021](#))

Insurers

Box 10: Features of the UK private medical insurance market

The estimated market value of the private medical insurance market is £4.83 billion.

There are around 4 million private medical insurance policies, affecting 6.89 million lives. This accounts for around 10.5% of the UK population.

About 3 million policies, covering about 5.5 million lives, come under companies' private medical insurance.

Just under 1 million policies (928,000) come under consumer private medical insurance. These cover around 1.47 million lives, representing about 2.2% of the UK population.

Source: [Q 61](#) (Hugh Savill and Stuart Scullion)

Issues facing insurers

90. Private insurance could in principle fill any gaps in healthcare provision occasioned by a disruption to reciprocal healthcare provisions, but we heard that travel insurance companies were already concerned about the implications of possible changes for their planning cycles. Hugh Savill of the ABI reported that, because most policies sold were multi-year, insurance companies needed to “start thinking about how [to] take into account these extra costs and set up these facilities from March 2018 ... By April, we will be selling policies that will still be in force after [the UK has] left the European Union.”¹²⁰
91. Stuart Scullion of the AMII told us that private medical insurers needed “a steer from government”.¹²¹ Both the ABI and AMII expressed concern about the insurance industry’s ability to plan for any future changes to the S1 regime for those people wishing to move to the EU after Brexit. Hugh Savill noted that “until we know what the Government have negotiated to replace S1 ... it is quite difficult to know what the role of the private sector” would be.¹²²
92. For the travel insurance industry, the future of the EHIC system is more important than the S1. Mr Savill noted that:

“The basis of contingency planning is quite simple. It is EHIC or no EHIC. We are not modelling different relations with the European Union; we are just looking at those two basic scenarios ... We are looking at how we will underwrite these additional costs and how we will set up claims assistance facilities or expand them in these countries to cope with the increased number of claims.”¹²³
93. To help with their planning, the insurers underlined the desirability of a transition or implementation phase following the UK’s departure from the EU. Hugh Savill saw a transition period as “extremely important”, and urged that it be “based on the current single market arrangements”.¹²⁴ Mr Savill

120 [Q 63](#)

121 [Q 64](#)

122 *Ibid.*

123 *Ibid.*

124 [Q 66](#)

called for future arrangements to include “access to the European Market”, and for European insurers to be able to continue to trade in the UK.¹²⁵ Stuart Scullion sought clarity about the new arrangements “as soon as possible”.¹²⁶

Opportunities for the insurance industry

94. Alongside the insurers’ concerns, Mark Dayan suggested that there might be “an element of opportunity” for the industry to offer private health insurance to those currently covered by the S1 scheme.¹²⁷ Professor Martin McKee of the London School of Hygiene and Tropical Medicine had “no doubt” that changes to reciprocal healthcare leading to increased premiums represented a “wonderful opportunity” for the insurance industry.¹²⁸ Furthermore, Stuart Scullion thought that if the UK were no longer part of the EHIC scheme, this “could be considered to be an opportunity”, if it led to more people buying private medical insurance. Some policies could add new benefits to “compensate for the loss and lack of an EHIC”.¹²⁹
95. Hugh Savill, on the other hand, felt that the opportunities were not altogether clear.¹³⁰ The ABI had started to look into the “possibility of increased markets overseas by stand-alone UK free trade agreements”, but Mr Savill called this “a very long-term strategy”.¹³¹ Stuart Scullion noted that the industry had been “quite vibrant” in responding to market changes, but underlined that it might take time to identify new products: “the insurance market is now more conservative with a small ‘c’ in its product development”.¹³²
96. Mark Dayan stressed that while changes to healthcare provision could present opportunities for the travel and private medical insurance markets, altered reciprocal arrangements should not be considered “an opportunity for Britain as whole”.¹³³ As we have already seen in our discussion of people living with long-term conditions, many patients will suffer significant disadvantages from moving to a system with greater reliance on private health insurance. Such a system would involve greater individual responsibility in paying close attention to what an insurance policy covered, and would potentially raise the need for greater legislative or regulatory oversight. Lord O’Shaughnessy related how his Department had been:

“talking to [insurers] about what they would do in contingency situations. We think that they would respond with additional products or maybe even higher premiums as a result. We are also aware that that could have differential impact on different social groups or more vulnerable people, so this is one of the things that we have to take into account in our planning for various scenarios. EHIC provides equally for everybody. It is not obviously the case that another scenario would do that, so it would need to be adjusted accordingly.”¹³⁴

125 [Q 66](#)

126 *Ibid.*

127 [Q 16](#)

128 [Q 84](#)

129 [Q 64](#)

130 [Q 66](#)

131 [Q 67](#)

132 *Ibid.*

133 [Q 16](#)

134 [Q 123](#)

Conclusions

97. **Time is now short for the Government to provide much-needed clarity to the insurance industry to help with planning, particularly for multi-trip travel insurance policies that will include the period beyond March 2019. The European Commission has proposed a transition period that will expire on 31 December 2020, during which existing reciprocal healthcare arrangements will be maintained. This period will be essential for the insurance industry as it plans for the future arrangements that the UK agrees with the EU.**
98. **There will be consequences not just for the insurance industry, but for tourism and individual travellers. While the industry might derive some benefit should it be required to play an expanded role in providing cover, we recommend that any move to greater reliance on private medical insurance by UK citizens travelling within the EU post-Brexit be subjected to careful scrutiny, particularly in terms of the further regulatory oversight that might be needed to ensure that patients and consumers are protected fairly.**

CHAPTER 7: RECIPROCAL HEALTHCARE PROVISION IN NORTHERN IRELAND AND THE REPUBLIC OF IRELAND

Cross-border healthcare on the island of Ireland

99. Reciprocal healthcare arrangements on the island of Ireland date back to agreements reached before the Republic of Ireland and the UK joined the EU. Because these arrangements function on either side of the UK's only land border with another EU Member State, Brexit will pose specific problems to healthcare provision that deserve to be analysed separately from the other concerns that our witnesses raised.
100. Professor Martin McKee noted that “many of the [reciprocal healthcare arrangements between the UK and the Republic of Ireland] take place on a purely bilateral basis, although they are underpinned, ultimately, by European Union law.”¹³⁵ Such arrangements include bilateral cooperation under the Common Travel Agreement (CTA), and Strand Two of the 1998 Belfast/Good Friday Agreement. For Damien McCallion, Director-General at Co-operation and Working Together (CAWT), a partnership between the Northern Irish health services and the border counties of the Republic of Ireland,¹³⁶ there were probably “as many people availing themselves of directly agreed services [i.e. bilateral arrangements]” as used EU reciprocal healthcare schemes such as EHIC, S1, S2 and the Patients’ Rights Directive.¹³⁷
101. Mr McCallion explained that healthcare cooperation on the island of Ireland covered a wide range of services, including emergency care, travelling from one jurisdiction to another to access health services, the provision of direct services, and cooperation on new initiatives.¹³⁸
102. Various bilateral healthcare schemes and initiatives are run by CAWT, whose board is comprised of Chief Executives of Health and Social Care on both sides of the border.¹³⁹ It receives funding not just from the UK and Ireland but also from the EU, primarily via the EU regional development INTERREG programme.¹⁴⁰ Damien McCallion described EU funding as “invaluable” in stimulating and encouraging cooperation.¹⁴¹ European funding had supported cooperation in a range of areas, including “acute, mental health, disability, older people, primary care and emergency services”.¹⁴²
103. The border area has a dispersed population of around 2 million, and CAWT’s work focuses on “very rural” and disadvantaged areas.¹⁴³ Bernie McCrory, Chief Officer at CAWT, underlined that “from a staffing point of view ... quite often, you would not be able to attract a consultant in a particular speciality if you did not have the population. The combined population allows us to provide services that we would not ordinarily have if we were doing it on a back-to-back basis.”¹⁴⁴ The Royal College of Physicians of Edinburgh also noted that cross-border health programmes on the island of Ireland “serve

135 [Q 82](#)

136 [Q 85](#)

137 [Q 87](#)

138 [Q 86](#)

139 [Q 85](#)

140 [Q 86](#)

141 [Q 90](#)

142 [Q 86](#)

143 [Q 85](#)

144 [Q 87](#)

communities on both sides of the Irish border, thereby reaching sufficient patients to secure the economies of scale necessary to justify provision.”¹⁴⁵ Joint services include oral and maxillofacial services; a radiotherapy centre opened in November 2016 in the Western Trust at Altnagelvin Hospital was “co-funded and co-planned by both jurisdictions”.¹⁴⁶

104. Ms McCrory told us how cooperation in ear, nose and throat (ENT) services had led to improved access to healthcare to people living in the border areas:

“Children were waiting for maybe four years for their first appointment if they had hearing difficulties, with all of the problems that that would have thrown up education-wise and so on. There was a very robust ENT service in the Southern Trust in Northern Ireland where we had four ENT surgeons working on a rota. The EU money allowed us to employ two more ENT surgeons. The surgeons rotated into the south of Ireland, into Monaghan, where they did out-patient and day-case work. Then the patients travelled to Northern Ireland, to Craigavon and Daisy Hill Hospitals in the Southern Trust, to receive more complex surgeries that were not possible in a small rural hospital ... [In 2016] 155 patients travelled from the south of Ireland to Northern Ireland for complex surgery, but the consultants who travelled down to the Republic saw over 2,000 patients in both out-patient and day-case procedures.”¹⁴⁷

105. Damien McCallion explained how patients also travelled across the border, north or south, to access emergency health services. Although the numbers taking advantage of this arrangement were small, the need was critical.¹⁴⁸ Dr Anthony Soares, from the Centre for Cross Border Studies, stressed that “one of the crucial issues” arising from Brexit was the risk of “exacerbating the overall peripherality of the border regions”.¹⁴⁹

Practical effects of losing access to cross-border healthcare

106. Witnesses described a range of real-life consequences for cross-border healthcare in the event of changes to existing reciprocal arrangements. Professor Martin McKee highlighted the many cross-border workers who would potentially be affected (there are around 102 million border crossings per year).¹⁵⁰ Professor McHale expressed concern about potential impediments to cross-border movements, which would present a “practical problem”, because “certain healthcare services are delivered on one side of the border that are not [available] on the other”.¹⁵¹
107. The Royal College of Physicians of Edinburgh warned that, because cross-border collaboration in health was an integral part of the peace process, Northern Ireland could “experience substantial disruption in service delivery” due to Brexit.¹⁵² Professor McKee noted that “when you get into the detail ... 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 are all

145 Written evidence from the Royal College of Physicians of Edinburgh ([BRH0013](#))

146 [Q 86](#)

147 *Ibid.*

148 *Ibid.*

149 [Q 90](#)

150 [Q 78](#)

151 [Q 17](#)

152 Written evidence from the Royal College of Physicians of Edinburgh ([BRH0013](#))

sorts of issues that relate to free movement of services and people that could be complicated.”¹⁵³

108. Ms McCrory highlighted “many examples” where “patients’ lives had been saved because of free and open access” of emergency services across the border. She contrasted this situation with a time when “ambulances would drive up from one side of the border, [while an] ambulance on the other side of the border would meet them, and the patient would transfer” into the other ambulance.¹⁵⁴

Structures supporting cross-border healthcare

Belfast/Good Friday Agreement

Box 11: Belfast/Good Friday Agreement and cross-border healthcare

Strand Two of the Belfast/Good Friday Agreement established the North/South Ministerial Council. The North/South Ministerial Council has a joint secretariat staffed by the civil service of the two jurisdictions.

The Council brings together those with executive responsibilities in Northern Ireland and the Irish Government, to develop consultation, cooperation and action within the island of Ireland—including through implementation on an all-island and cross-border basis—on matters of mutual interest within the competence of the Administrations, North and South.

Northern Ireland is represented by the First Minister, Deputy First Minister and any relevant Ministers, and the Irish Government by the Taoiseach and relevant Ministers.

Source: *The Belfast Agreement, Agreement reached in the multi-party negotiations (10 April 1998)*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136652/agreement.pdf [accessed 19 March 2018]

109. Dr Soares described cross-border healthcare as “one of the success stories” of the Belfast/Good Friday Agreement. It was not a question of whether to continue cooperation, but “how we undertake cooperation in future”.¹⁵⁵ He gave compelling evidence on the critical need not to let Brexit undermine the Agreement:

“The UK Government, the Commission and the various institutions in Europe stress repeatedly that the withdrawal agreement cannot undermine the 1998 Agreement in any of its parts ... ‘any of its parts’ means all three strands. It means the totality of relationships, the commerce and human flows that occur on a north-south and east-west basis within and between these islands. That is what must be safeguarded.”¹⁵⁶

110. This bears out the conclusion in our December 2016 report on *Brexit: UK-Irish Relations*, where we stated that cross-border healthcare on the island of Ireland was a “demonstrable success story”, and that it was “vital that these and future projects are not placed in jeopardy by Brexit”.¹⁵⁷

153 [Q 82](#)

154 *Ibid.*

155 [Q 86](#) and [Q 93](#)

156 [Q92](#)

157 European Union Committee, *Brexit: UK-Irish Relations* (6th Report, Session 2016–17, HL Paper 76)

111. Dr Soares warned that maintaining healthcare arrangements would mean resolving “a wide range of issues”, including, but not limited to, “the timely movement across the border of ambulances, patients and healthcare professionals, and, perhaps most important, the avoidance of divergence in terms of relevant policies, regulations and standards.” He also highlighted the significance of “continued reciprocal recognition of professional qualifications”. He expressed particular concern about the Government’s desire to leave both the single market and the customs union, which would make it “rather more difficult” to maintain the current ease of cooperation that takes place in the border area.¹⁵⁸
112. The importance of ensuring continued reciprocal healthcare arrangements was put in stark terms by Bernie McCrory of CAWT, who warned us that:
- “The patients, the citizens themselves, will not be very happy if there is no agreement. It is fine if you have never had those services, but if a service that you have become used to is removed, I do not think the citizens would be happy about that. It is very natural for them to cross the border and receive services and I do not think they would accept anything less.”¹⁵⁹

Common Travel Area

113. Like the EU’s freedom of movement provisions, the Common Travel Area (CTA) also underpins reciprocal healthcare agreements between Northern Ireland and the Republic of Ireland. The CTA pre-dates EU membership but is acknowledged in the EU treaties. It is an agreement permitting freedom of movement between the UK, the Republic of Ireland, the Crown Dependencies of Jersey and Guernsey, and the Isle of Man. The Department of Health and Social Care wrote that under the CTA arrangements, Irish citizens resident in the CTA enjoyed “access to UK health services”, including “emergency, routine and planned access to health services”.¹⁶⁰
114. Dr Soares stressed the difficulty of maintaining the CTA post-Brexit on the basis that “Ireland will continue to be an EU member state”, meaning that the “degree to which it can reciprocate some arrangements might be constrained”.¹⁶¹

The Joint Report and Northern Ireland

115. Both the CTA and the 1998 Belfast/Good Friday Agreement will remain in place after the UK leaves the EU. The Joint Report recognised “that the UK and Ireland may continue to make arrangements between themselves relating to the movement of persons between their territories (Common Travel Area), while fully respecting the rights of natural persons conferred by Union Law.”¹⁶² With regard to the Belfast/Good Friday Agreement, the

158 [Q 90](#)

159 [Q 93](#)

160 Written evidence from the Department of Health and Social Care ([BRH0021](#))

161 [Q 92](#)

162 Home Office and Department for Exiting the European Union, *Joint technical note on the comparison of EU-UK positions on citizens’ rights* (December 2017), para 54: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/665871/December_-_Joint_technical_note_on_the_comparison_of_EU-UK_positions_on_citizens_rights.pdf [accessed 20 March 2018]

Joint Report noted that both parties agreed that it “must be protected in all its parts”.¹⁶³

116. The Joint Report also reaffirmed commitments to INTERREG and other funding programmes for the current EU multi-annual financial framework.¹⁶⁴ One of the four objectives of the INTERREG funding is cross-border health and social care (the programme covers the west of Scotland and the north of the island of Ireland).
117. Speaking prior to the publication of the Joint Report, Dr Soares was cautious about the ongoing negotiations, noting that progress had yet to be made in areas such as “the ability of health authorities to procure services and goods on a cross-border basis”.¹⁶⁵ Damien McCallion saw some room for optimism: he was “positive” that solutions could be found, and noted the commitment from both Governments to the Belfast/Good Friday Agreement. He flagged four areas that would need to be considered in order to find a solution to potential future reciprocal healthcare problems: workforce; cross-border services; procurement and regulation on medicines, drugs and medical devices; and EU funding.¹⁶⁶
118. After the Joint Report was published, Cooperation and Working Together was concerned that it did not “provide any detail on how a ‘soft’/open border will be achieved”, and that, while the Report covered some aspects of reciprocal healthcare, “there were many other aspects of healthcare that remain unclear as to future status and operation”. They wrote that “it would be important that patients, staff and ambulances can continue to cross the border unhindered”.¹⁶⁷
119. Dr Soares’s organisation, the Centre for Cross Border Studies, pointed out that the Joint Report could lead to a “differentiated set of EU entitlements within Northern Ireland”, since residents of Northern Ireland with Irish citizenship would, unless there were a future agreement, be entitled to healthcare in the Republic of Ireland whereas those with British citizenship would not. Lord O’Shaughnessy disputed this point, however, suggesting that rights to access healthcare would be protected by the Joint Report’s aim to safeguard rights afforded by the Common Travel Area.¹⁶⁸ Lord O’Shaughnessy also told us that the Government was “absolutely engaged” in working with counterparts in the Republic of Ireland on the matter of reciprocal healthcare, underlining that “we are very clear about wanting to respect the continuity of the common travel area”.¹⁶⁹
120. Despite the Minister’s optimism, the Joint Report provided little detail about how the EU and UK would manage the land border on the island of Ireland. Its various commitments will need to be turned into workable, practical solutions, and enshrined in legal text. The Joint Report states that

163 European Commission and HM Government, *Joint Report on progress during phase 1 of negotiations under Article 50 TEU on the UK’s orderly withdrawal from the EU*, (8 December 2017): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/665869/Joint_report_on_progress_during_phase_1_of_negotiations_under_Article_50_TEU_on_the_United_Kingdom_s_orderly_withdrawal_from_the_European_Union.pdf [accessed 20 March 2018]

164 *Ibid.*

165 [Q 91](#)

166 [Q 90](#)

167 Supplementary written evidence from CAWT ([BRH0026](#))

168 Supplementary written evidence from the Centre for Cross Border Studies ([BRH0027](#))

169 [Q 100](#)

the first aim is to protect north-south cooperation through “the overall EU-UK relationship”; failing this, the UK will propose “specific solutions” to address the situation in the island of Ireland. If that approach fails, there is a UK commitment to “full alignment” with those rules of the internal market and the customs union that support north-south cooperation, the all-island economy and the 1998 Agreement. The Government has yet to explain in detail what any of these options might mean in practice, but to meet our witnesses’ concerns, it is clear that the Government will need to secure the full range of reciprocal healthcare arrangements that we have described.¹⁷⁰

Conclusions

121. **We note the success of cross-border collaboration on healthcare between Northern Ireland and the Republic of Ireland, particularly in radiotherapy and Ear, Nose and Throat services. We also note that ambulances are currently able to travel freely across the border, that medical professionals from one country can work in the other, and that patients can easily cross the border to access healthcare.**
122. **We welcome the assurances contained in the Joint Report about the importance of maintaining freedom of movement under the Common Travel Area and cooperation under the 1998 Belfast/Good Friday Agreement. Regardless of the other arguments against a hard border, any such barrier would be highly detrimental to healthcare for patients on both sides of the border, including children and other vulnerable patients.**
123. **We urge the Government to avoid such a hard border for patients and the health professionals who treat them, and to secure continued access under the Common Travel Area to emergency, routine and planned treatment.**
124. **Given the key role that bilateral and EU-level cooperation has played in improving access to healthcare in the border areas, we call on both sides of the negotiations to treat healthcare as a priority in the final settlement of issues relating to the island of Ireland.**

170 The draft Withdrawal Agreement includes a Protocol on Ireland/Northern Ireland that forms the Commission’s interpretation of the undertaking in paragraph 40 of December’s Joint Report. This paragraph stated that in the absence of agreed solutions, “the United Kingdom will maintain full alignment with those rules of the Internal Market and the Customs Union which, now or in the future, support North-South cooperation, the all island economy and the protection of the 1998 Agreement.” European Commission and HM Government, *Joint Report on progress during phase 1 of negotiations under Article 50 TEU on the UK’s orderly withdrawal from the EU*, (8 December 2017): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/665869/joint_report_on_progress_during_phase_1_of_negotiations_under_article_50_teu_on_the_united_kingdom_s_orderly_withdrawal_from_the_european_union.pdf [accessed 20 March 2018]. European Commission and HM Government, *Draft Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community* (19 March 2018): https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/691366/20180319_DRAFT_WITHDRAWAL_AGREEMENT.pdf [accessed 20 March 2018]

CHAPTER 8: RECIPROCAL HEALTHCARE PROVISION AND DEVOLUTION

Devolved administrations

125. Healthcare is a devolved matter in Scotland, Wales and Northern Ireland, and the recovery of costs from non-EEA nationals is also devolved. But, as discussed earlier in the report, the Department of Health and Social Care is responsible for overseeing reciprocal healthcare arrangements with the EU, liaising with devolved administrations and NHS England “where appropriate”.¹⁷¹
126. Lord O’Shaughnessy told us that the Department was “engaging with the devolved administrations” on Brexit, and that “they support the continuation of reciprocal healthcare”. He said that the existing centralised system for managing reciprocal healthcare in the UK “works well”, and that the Government was “moving ahead” on the basis of retaining the current operating structure, which remained “appropriate for the future”.¹⁷² In further written evidence, the Minister gave little indication of the extent to which the Department of Health and Social Care had engaged with the devolved administrations following the publication of the Joint Report, noting only that Department officials were having “regular engagement” with the administrations.¹⁷³
127. Fiona Loud told us that Kidney Care UK had written to each of the devolved administrations, but had received a reply only from the Scottish Government, and was not aware that any of the devolved jurisdictions was looking to do “something separately” on reciprocal healthcare.¹⁷⁴ The RCPCH saw a need to put in place a process for all devolved administrations to play a role in agreeing future reciprocal healthcare arrangements with the EU.¹⁷⁵
128. Professor McHale also highlighted the degree of divergence across the devolved jurisdictions. In Scotland, unlike in England, certain categories of resident non-EU overseas patients are exempted from healthcare charges, including the self-employed, volunteers, and students. In Wales and Northern Ireland regulations provide similar exemptions, and in Northern Ireland they clarify that entitlements are applicable to both primary and secondary care.
129. Professor McHale therefore concluded that, post-Brexit,
- “if there are no reciprocal agreements on healthcare made with other EU member states and treatment is sought other than in an emergency situation, then certain EU citizens could be exempt from NHS charges for secondary care ... if they are living in Scotland, Wales and Northern Ireland, whereas this would not be the case in relation to those resident in England.”¹⁷⁶

171 Written evidence from the Department of Health and Social Care ([BRH0021](#))

172 [Q 100](#)

173 Supplementary written evidence from Lord O’Shaughnessy ([BRH0028](#))

174 [Q 76](#)

175 Written evidence from the Royal College of Paediatrics and Child Health ([BRH0015](#))

176 Supplementary written evidence from Professor Jean McHale ([BRH0029](#))

Conclusion

130. **We call on the Government to ensure the active participation of the devolved administrations in setting the UK's position on future arrangements for reciprocal healthcare, so that the implications of any potential changes fully reflect perspectives and powers across the United Kingdom.**

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Reciprocal healthcare and citizens' rights

1. The S1 scheme has provided comprehensive healthcare coverage to many thousands of UK pensioners lawfully resident in other EU Member States, and has been especially useful for people living with diabetes and other long-term conditions. We welcome plans to include these people in the Withdrawal Agreement as the best means of securing clear legal entitlement to this scheme. We note that the legislation dealing with the implementation of this agreement in the UK will be presented to parliament in the coming months as part of the Withdrawal Agreement and Implementation Bill. (Paragraph 34)
2. To allay any outstanding fears about the status of children and dependents, the Government should now provide details to EU27 citizens lawfully resident in the UK about its plans and timetable for legally protecting their rights, stressing in particular that they will continue to enjoy the same rights to access healthcare that they and their dependents currently enjoy under EU law. (Paragraph 35)
3. We would be concerned if EU/EEA citizens were already being denied access to the treatment to which they are entitled, as witnesses suggested to us. We therefore underline the imperative of securing enforceability of rights in the Withdrawal Agreement. In addition, we call on the Government to restate as clearly as possible to the NHS and its staff the current healthcare entitlements of EU/EEA citizens, and to communicate the entitlements contained in any future UK-EU agreement on reciprocal healthcare as soon as it is possible to do so. (Paragraph 36)

The Joint Report

4. The Joint Report agreed in December 2017 covers the entitlements of those within the personal scope of the Withdrawal Agreement benefiting from reciprocal healthcare arrangements at the time of Brexit. Though we acknowledge that its provisions are yet to be set down in law, and note that “nothing is agreed until everything is agreed”, we welcome the progress that the Joint Report has made in providing some reassurance to the millions of UK and EU citizens who currently reside in other Member States. (Paragraph 50)
5. We would not wish to see this progress reversed in the future. This Committee has already called upon the Government to make a unilateral guarantee to protect the rights of the lawfully resident three million EU citizens who have, on the basis of EU free movement rights, made their lives in the UK. We therefore support proposals to ‘ring-fence’ in law the agreement on citizens’ rights embodied in the Joint Report, to provide clarity both to patients and to providers of reciprocal healthcare in the UK and EU. (Paragraph 51)
6. We note that the Joint Report does not cover the right of UK citizens resident in the EU to move between EU Member States. Nor does it cover the position of EU27 citizens resident in the UK covered by the Withdrawal Agreement who subsequently leave the UK and then return. These are significant omissions, and we urge the Government to ensure that the final text of the Withdrawal Agreement includes provision for onward free movement rights, including the right to healthcare provision for UK citizens on the same terms

as are enjoyed by EU citizens, and vice versa. If this proves impossible, we ask the Government, when replying to this report, to set out a detailed and clear position addressing this issue. (Paragraph 52)

7. It is essential that, as well as having a continuing right to access long-term healthcare, EU citizens lawfully resident in the UK should be provided with a practical means by which to exercise that right. We call on the Government to use domestic legislation to clarify the means by which all EU citizens lawfully resident in the UK at the time of Brexit will be able to continue to access essential healthcare. We note the suggestion that anti-discrimination legislation might assist in confirming the rights of EU citizens to continue to access healthcare post-Brexit, and look forward to further detail in the final text of the domestic legislation that implements this aspect of the Withdrawal Agreement. (Paragraph 53)

The future relationship and reciprocal healthcare

8. The Joint Report covers only the free movement healthcare rights of UK and EU citizens who are resident in another Member State before Brexit. It says nothing of whether and how the reciprocal healthcare entitlements of other UK and EU citizens will be protected post-Brexit. In the absence of an agreement on future relations that covers this topic, the rights currently enjoyed by 27 million UK citizens, thanks to the EHIC, will cease after Brexit. Other rights, provided for by the S2 scheme and Patients' Rights Directive, will likewise come to an end. (Paragraph 73)
9. Our evidence suggests that it is not in the UK's interest for reciprocal healthcare arrangements to cease. Because of higher insurance costs—and in the case of dialysis patients, people living with rare diseases, and disabled people, the difficulty of obtaining travel insurance at all—without EHIC or an equivalent arrangement it will become much more expensive for UK citizens with chronic conditions to travel to the EU post-Brexit, for holidays, recuperation or treatment. (Paragraph 74)
10. The Department of Health and Social Care wishes to continue to maintain reciprocal healthcare arrangements, including the EHIC, post-Brexit. We applaud the spirit underlying this ambition, but it is difficult to square it with the Government's stated aim of ending freedom of movement of people from the EU. (Paragraph 75)
11. More generally, reciprocal healthcare arrangements will only be achieved by agreement between the UK and the EU. The Government has not yet set out its objectives for the future UK-EU relationship. We therefore urge the Government to confirm how it will seek to protect reciprocal rights to healthcare of all UK and EU citizens post-Brexit, as part of any agreement on future relations. (Paragraph 76)

The implications of Brexit for the NHS and insurers

12. We received a large amount of evidence expressing concern both that the loss of existing reciprocal healthcare rights would impose significant additional future costs upon the NHS, and that the introduction of new reciprocal healthcare arrangements might impose a significant administrative burden. (Paragraph 86)
13. We urge the Government, as part of its contingency planning, to clarify further whether it will seek UK participation in the EHIC, S1 and S2 schemes

as a non-EU Member State; set up a separate scheme with the EU27; or explore the possibility of reaching bilateral arrangements with individual Member States. (Paragraph 87)

14. Whichever is the case, we call on the Government to ensure that NHS procedures and practices are sufficiently robust to secure reimbursement for the healthcare of EU27 citizens provided by the NHS post-Brexit. Should the Government look to establish an independent scheme for reciprocal healthcare, we propose that it set out publicly its financial modelling of that scheme, including how the extra administrative costs will be met. (Paragraph 88)
15. In the event that no future reciprocal healthcare agreements were agreed with EU countries, we would ask the Government to explain how NHS and social care capacity planning will secure sufficient capacity to care for future generations of retired people. In so doing, we suggest that the Government engage closely with the NHS and with those groups that will potentially be affected. (Paragraph 89)
16. Time is now short for the Government to provide much-needed clarity to the insurance industry to help with planning, particularly for multi-trip travel insurance policies that will include the period beyond March 2019. The European Commission has proposed a transition period that will expire on 31 December 2020, during which existing reciprocal healthcare arrangements will be maintained. This period will be essential for the insurance industry as it plans for the future arrangements that the UK agrees with the EU. (Paragraph 97)
17. There will be consequences not just for the insurance industry, but for tourism and individual travellers. While the industry might derive some benefit should it be required to play an expanded role in providing cover, we recommend that any move to greater reliance on private medical insurance by UK citizens travelling within the EU post Brexit be subjected to careful scrutiny, particularly in terms of the further regulatory oversight that might be needed to ensure that patients and consumers are protected fairly. (Paragraph 98)

Reciprocal healthcare provision in Northern Ireland and Ireland

18. We note the success of cross-border collaboration on healthcare between Northern Ireland and the Republic of Ireland, particularly in radiotherapy and Ear, Nose and Throat services. We also note that ambulances are currently able to travel freely across the border, that medical professionals from one country can work in the other, and that patients can easily cross the border to access healthcare. (Paragraph 121)
19. We welcome the assurances contained in the Joint Report about the importance of maintaining freedom of movement under the Common Travel Area and cooperation under the 1998 Belfast/Good Friday Agreement. Regardless of the other arguments against a hard border, any such barrier would be highly detrimental to healthcare for patients on both sides of the border, including children and other vulnerable patients. (Paragraph 122)
20. We urge the Government to avoid such a hard border for patients and the health professionals who treat them, and to secure continued access under

the Common Travel Area to emergency, routine and planned treatment. (Paragraph 123)

21. Given the key role that bilateral and EU-level cooperation has played in improving access to healthcare in the border areas, we call on both sides of the negotiations to treat healthcare as a priority in the final settlement of issues relating to the island of Ireland. (Paragraph 124)

Reciprocal healthcare provision and devolution

22. We call on the Government to ensure the active participation of the devolved administrations in setting the UK's position on future arrangements for reciprocal healthcare, so that the implications of any potential changes fully reflect perspectives and powers across the United Kingdom. (Paragraph 130)

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

Baroness Browning
 Lord Condon (June 2015–December 2017)
 Lord Crisp
 Baroness Janke
 Lord Jay of Ewelme (Chairman)
 Lord Kirkhope of Harrogate
 Baroness Massey of Darwen
 Lord O’Neill of Clackmannan
 Baroness Pinnock
 Lord Ribeiro
 Lord Ricketts (from December 2017)
 Lord Soley
 Lord Watts

Declarations of interest

Baroness Browning
No relevant interests declared

Lord Condon
No relevant interests declared

Baroness Janke
No relevant interests declared

Lord Jay of Ewelme
Member, Advisory Council, European Policy Forum
Member, Senior European Experts Group
Trustee (non-executive director), Thomson Reuters Foundation Share Company
Trustee, Magdalen College, Oxford Development Trust

Lord Kirkhope of Harrogate
Member of European Parliament (1999–2016) (Conservative Spokesman on Justice and Home Affairs (2009–2016))

Baroness Massey of Darwen
No relevant interests declared

Lord O’Neill of Clackmannan
No relevant interests declared

Baroness Pinnock
No relevant interests declared

Lord Ribeiro
No relevant interests declared

Lord Soley
No relevant interests declared

Lord Watts
No relevant interests declared

The Specialist Adviser for the inquiry declared the following interests:

Professor Tamara Hervey
Jean Monnet Professor of EU Law
Member of the Advisory Board of ‘Healthier In’

The following members of the European Union Select Committee attended the meeting at which the report was approved:

Lord Boswell of Aynho
Baroness Browning
Baroness Brown of Cambridge
Lord Cromwell
Lord Jay of Ewelme
The Earl of Kinnoull
Lord Liddle
Baroness Neville-Rolfe
Lord Selkirk of Douglas
Lord Woolmer of Leeds
Baroness Wilcox

During consideration of the report the following Members declared an interest:

Lord Selkirk of Douglas
*Diversified investment portfolio in McInroy and Wood Income Fund,
managed by third party*
*Director, Douglas-Hamilton Investments Ltd (company no SC343289: no
financial benefit)*

A full list of Members' interests can be found in the Register of Lords' Interests:

[http://www.parliament.uk/mps-lords-and-offices/standards-and-interests/
register-of-lords-interests/](http://www.parliament.uk/mps-lords-and-offices/standards-and-interests/register-of-lords-interests/)

APPENDIX 2: LIST OF WITNESSES

Evidence is published online at <http://www.parliament.uk/brexit-reciprocal-healthcare/> and available for inspection at the Parliamentary Archives (020 7219 3074).

Evidence received by the Committee is listed below in chronological order of oral evidence session and alphabetical order. Those witnesses marked with ** gave both oral and written evidence. Those marked with * gave oral evidence and did not submit written evidence. All other witnesses submitted written evidence only

Oral evidence in chronological order

**	Paul MacNaught, Director, EU, International and Public Health System, Department of Health	QQ 1–10
*	Mark Dayan, Policy and Public Affairs Analyst, Nuffield Trust	QQ 11–16
*	Professor Jean McHale, Professor of Healthcare Law, Director of the Centre for Health and Science Policy, University of Birmingham	QQ 17–25
*	Professor Catherine Barnard, Professor of EU Law, University of Cambridge and Associate Fellow, UK in a Changing Europe	
*	Laura Brackwell, Director, National Audit Office	QQ 26–35
*	David Raraty, Audit Manager, National Audit Office	
*	Bob Alexander, Deputy Chief Executive, NHS Improvement	
*	Roger Boaden MBE, Member, Expat Citizen Rights in EU	QQ 36–43
*	Christopher Chantrey OBE, Member of the Steering Committee, British in Europe	
*	Samia Badani, Head of Campaigns, New Europeans	QQ 44–50
*	Anne-Laure Donskoy, Founding Co-Chair, the3million	
**	Niall Dickson CBE, Chief Executive of NHS Confederation and Co-Chair of the Brexit Health Alliance	QQ 51–59
**	Raj Jethwa, Director of Policy, British Medical Association	
**	Hugh Savill, Director of Regulation, Association of British Insurers	QQ 60–67
*	Stuart Scullion, Executive Chairman, Association of Medical Insurers and Intermediaries	
**	Fiona Loud, Director, Kidney Care UK	QQ 68–76
*	Robin Hewings, Head of Policy, Knowledge and Insight, Diabetes UK	

- * Professor Martin McKee CBE MD DSc, Professor of European Public Health, London School of Hygiene and Tropical Medicine [QQ 77–84](#)
- ** Damien McCallion, Director-General, Co-operation and Working Together [QQ 85–93](#)
- ** Bernie McCrory, Chief Officer, Cross-Border Health and Social Care, Co-operation and Working Together
- ** Dr Anthony Soares, Deputy Director, Centre for Cross Border Studies
- ** Lord James O’Shaughnessy, Parliamentary Under Secretary of State for Health, Department of Health and Social Care [QQ 94–110](#)
[QQ 111–123](#)

Alphabetical list of all witnesses

- ** Association of British Insurers ([QQ 60–67](#)) [BRH0024](#)
- ** Stuart Scullion, Executive Chairman, Association of Medical Insurers and Intermediaries ([QQ 60–67](#))
- * Professor Catherine Barnard, Professor of EU Law, University of Cambridge and Associate Fellow, UK in a Changing Europe ([QQ 17–25](#))
- ** Brexit Health Alliance ([QQ 51–59](#)) [BRH0018](#)
- Brexpats in Spain [BRH0011](#)
- * Christopher Chantrey OBE, Member of the Steering Committee, British in Europe ([QQ 36–43](#))
- ** British Medical Association ([QQ 51–59](#)) [BRH0012](#)
- Brian Cave [BRH0003](#)
- ** Centre for Cross Border Studies ([QQ 85–93](#)) [BRH0027](#)
- ** Co-operation and Working Together ([QQ 85–93](#)) [BRH0026](#)
- ** Department of Health and Social Care ([QQ 1–10](#))
([QQ 94–110](#)) ([QQ 111–123](#)) [BRH0021](#)
[BRH0028](#)
[BRH0030](#)
- * Robin Hewings, Head of Policy, Knowledge and Insight, Diabetes UK ([QQ 68–76](#))
- David Dibbens [BRH0004](#)
- * Roger Boaden MBE, Member, Expat Citizen Rights in EU ([QQ 36–43](#))
- Paul Hearn [BRH0006](#)
- Kidney Care UK [BRH0016](#)
- Dr Richard Lang [BRH0022](#)
- Law Society of Scotland [BRH0019](#)

- * Professor Martin McKee CBE MD DSc, Professor of European Public Health, London School of Hygiene and Tropical Medicine ([QQ 77-84](#))
- ** Professor Jean McHale, Professor of Healthcare Law, Director of the Centre for Health and Science Policy, University of Birmingham ([QQ 17-25](#)) [BRH0029](#)
- John Trevor Moss [BRH0010](#)
- * Mark Dayan, Policy and Public Affairs Analyst, Nuffield Trust ([QQ 11-16](#))
- * Laura Brackwell, Director, National Audit Office ([QQ 26-35](#))
- * David Raraty, Audit Manager, National Audit Office ([QQ 26-35](#))
- * Samia Badani, Head of Campaigns, New Europeans ([QQ 44-50](#))
- * Niall Dickson CBE, Chief Executive of NHS Confederation and Co-Chair of the Brexit Health Alliance ([QQ 51-59](#))
- * Bob Alexander, Deputy Chief Executive, NHS Improvement ([QQ 26-35](#))
- Office for National Statistics [BRH0023](#)
- Royal College of Paediatrics and Child Health [BRH0015](#)
- Royal College of Physicians [BRH0025](#)
- Royal College of Physicians of Edinburgh [BRH0013](#)
- Dr Lawrence Renaudon Smith [BRH0009](#)
- Charlotte Swift [BRH0005](#)
- * Anne-Laure Donskoy, Founding Co-Chair, the3million ([QQ 44-50](#))
- The Academy of Medical Royal Colleges [BRH0020](#)
- Beverly Townsend [BRH0001](#)
- Nigel Tucker [BRH0002](#)
- UK Coordinators of European Reference Networks [BRH0014](#)
- Alexander Wilson [BRH0007](#)

APPENDIX 3: CALL FOR EVIDENCE

The House of Lords EU Home Affairs Sub-Committee, chaired by Lord Jay of Ewelme, has launched an inquiry into Brexit and reciprocal healthcare. The inquiry will focus on the healthcare implications of Brexit for UK citizens travelling, living and/or working in the rest of the EU, and for EU citizens travelling, living and/or working in the UK, in both the short and medium term.

This is a public call for written evidence to be submitted to the Committee. The deadline is Friday 24 November. The Committee values diversity and seeks to ensure this wherever possible. How to submit evidence is set out later in this document, but if you have any questions or require adjustments to enable you to respond, please contact the staff of the Committee. We look forward to hearing from a range of interested individuals and organisations.

Inquiry focus

Healthcare entitlements under EU law are tied to social security benefits. The EU's rules-based social security coordination system is part of EU law on the free movement of persons. Its aims are to ensure portability of benefits across the EU, and equality of treatment with nationals within the host social security system. Benefits, including access to healthcare, are reciprocal and apply to UK citizens in the EU/EEA, and vice versa.

EU citizens are entitled to hold a European Health Insurance Card (EHIC) that evidences entitlement to access state-provided healthcare during a temporary stay in another EU/EEA country on the same basis as nationals of that country. Loss of reciprocal healthcare rights would therefore affect UK citizens travelling to the EU and vice versa.

Loss of reciprocal healthcare rights could make travelling or working in the EU for longer periods of time prohibitively expensive due to higher insurance costs. This would apply to UK citizens travelling, living or working in the EU as well as EU citizens travelling, living or working in the UK. Certain groups, such as people with disabilities, people with pre-existing health conditions, children and others, could be particularly severely affected. UK pensioners and other UK citizens living and working in the EU might also be affected.

Reciprocal healthcare featured prominently in the Government's position paper on Safeguarding the Position of EU Citizens Living in the UK and UK Nationals Living in the EU. The Government notes that it "will seek to protect the healthcare arrangements currently set out in EU Regulations" for those who already benefit from these arrangements and "will seek to protect the right of UK nationals and EU citizens to obtain and benefit from the European Health Insurance Card scheme."

The Committee is seeking evidence on the following questions in particular:

Current regulatory regime

- What is your assessment of the current arrangements for reciprocal healthcare? To what extent is it effective and for whom?
- Assuming that the UK will be treated as a 'third country' once the UK is no longer a member of the EU, what will be the default position as a matter of law for healthcare coverage for UK citizens in the EU, and vice versa, if no agreement is in place on day one of Brexit?

Government's proposals for UK citizens already living and working in the EU

- What is your assessment of the Government's current proposals to the EU regarding reciprocal healthcare arrangements post-Brexit? What changes, if any, would you recommend?

Affected groups

- Which groups (e.g. people with disabilities, long-term conditions, children, etc.) and/or categories (e.g. residents, students, non-residents, etc.) will be most affected by any changes to existing reciprocal healthcare arrangements?
- What should be the priorities for these groups in terms of the negotiations and future UK law?

Implications for the UK health and social care sectors

- What impact would ending reciprocal healthcare arrangements with the EU have on the UK health and social care sector?
- What would be the financial, staffing, and other implications for the UK health sector if reciprocal healthcare arrangements were to end?

Impact on EU citizens in the UK

- How important is maintaining reciprocal healthcare with the UK for EU/EEA citizens travelling, living or working the UK, and for EU/EEA countries?
- What incentive does the EU have to seek to maintain existing reciprocal healthcare arrangements with the UK?

Judicial oversight

- What is your assessment of the implications of the Government's 'red-line' on the European Court of Justice for negotiating a withdrawal agreement, transitional agreement, and future EU-UK agreement covering reciprocal healthcare?
- What alternatives exist for resolving disputes or arbitrating on matters related to reciprocal healthcare? How do these compare to current arrangements?
- What is your assessment of what a "bespoke" dispute resolution arrangement might look like in this area?

Transitional arrangements

- What would be the key priorities for a transitional arrangement?
- In practical terms, how and when could a transitional arrangement be agreed and put in place? How long would the transitional period need to last?

Options for future arrangements

- What should post-Brexit healthcare arrangements with the EU look like? What guiding principles should shape the UK's approach to negotiating future reciprocal healthcare arrangements?
- What options are available to the Government for a future arrangement?

What opportunities does Brexit present for the UK to change healthcare coverage for its citizens travelling, working and living in the EU/EEA and vice versa? Could there be opportunities to change arrangements for those from non-EU/EEA countries at the same time?

The EU Withdrawal Bill

- What provisions of the EU Withdrawal Bill should be amended, clarified, or added, in order to secure appropriate arrangements for reciprocal healthcare on Brexit Day, during a transitional arrangement, and in the future
- What should the role of the devolved nations/regions be in future provision of reciprocal healthcare?

Submissions need not address all questions.