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Public Bill Committee

HEALTHCARE (INTERNATIONAL ARRANGEMENTS) BILL

Second Sitting

Thursday 29 November 2018

(Morning)

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not later than

Monday 3 December 2018

The Committee consisted of the following Members:

Chairs: Mr Gary Streeter, † Graham Stringer

† Burghart, Alex *(Brentwood and Ongar)* (Con)
† Cadbury, Ruth *(Brentford and Isleworth)* (Lab)
† Cooper, Julie *(Burnley)* (Lab)
† Costa, Alberto *(South Leicestershire)* (Con)
† Day, Martyn *(Linlithgow and East Falkirk)* (SNP)
† Debbonaire, Thangam *(Bristol West)* (Lab)
† Hammond, Stephen *(Minister for Health)*
† Hughes, Eddie *(Walsall North)* (Con)
† Madders, Justin *(Ellesmere Port and Neston)* (Lab)
† Masterton, Paul *(East Renfrewshire)* (Con)
† Matheson, Christian *(City of Chester)* (Lab)
† Morton, Wendy *(Aldridge-Brownhills)* (Con)
† Norris, Alex *(Nottingham North)* (Lab/Co-op)
† Quince, Will *(Colchester)* (Con)
† Robinson, Mary *(Cheadle)* (Con)
† Throup, Maggie *(Erewash)* (Con)
† Western, Matt *(Warwick and Leamington)* (Lab)

Mike Everett, *Committee Clerk*

† attended the Committee

Public Bill Committee

Thursday 29 November 2018

(Morning)

[Graham Stringer *in the Chair*]

Healthcare (International Arrangements) Bill

11.30 am

The Chair: I remind the Committee that electronic devices should be turned to silent or turned off. Tea or coffee is not allowed in the Committee Room during sittings.

We now begin the line-by-line consideration of the Bill. The selection list for today is available in the room and on the Bill website. It shows how the selected amendments have been grouped together for debate. Amendments grouped together are generally on the same or similar issues.

A Member who has put their name to the leading amendment in a group is called first. Other Members are then free to catch my eye to speak on all or any of the amendments within the group, and a Member may speak more than once in a single debate. At the end of a debate on an amendment, I shall call the Member who moved the leading amendment again. Before they sit down, they will need to indicate if they wish to withdraw the amendment or seek a decision. I shall work on the assumption that the Minister wishes the Committee to reach a decision on all Government amendments if they are tabled.

Members should note that decisions on amendments do not take place in the order in which they are debated, but in the order in which they appear on the amendment paper. In other words, debate occurs according to the selection and grouping list, but decisions are taken when we come to the clause that the amendment affects. I shall use my discretion to decide whether to allow a separate stand part debate on individual clauses and schedules following the debates on the relevant amendments.

Clause 1

Power to make healthcare payments

Question proposed, That the clause stand part of the Bill.

The Minister for Health (Stephen Hammond): It is a pleasure to serve under your chairmanship, Mr Stringer. This is a short, sensible Bill to ensure that we are prepared, whatever the outcome of leaving the European Union. The Bill confers powers on the Secretary of State to make and to arrange for payments to be made in respect of the cost of healthcare provided outside the United Kingdom. It will allow for the funding of reciprocal healthcare arrangements for UK nationals living in the EU, the European Economic Area and Switzerland.

The Bill is part of the Government's preparation for EU exit and will allow us to take the necessary steps to broadly continue reciprocal healthcare arrangements or to otherwise support UK residents to obtain healthcare when they move to or visit the EU. It is an important and necessary piece of legislation, so that the British public can look forward to the future with the confidence that they will get the healthcare they need when they need it.

Clause 1 introduces a new power for the Secretary of State to make payments and to arrange for those payments to be made to fund healthcare abroad. I will start by setting out for the Committee why it is necessary for the Government to seek that power.

Currently, there are limited domestic powers in relation to the funding of healthcare abroad. The existing reciprocal healthcare arrangements with the EU are based on EU law. Reciprocal arrangements with other third countries at this time do not involve making payments, as they are based on waiver agreements. In line with the Public Accounts Committee concordat, the clause provides statutory authorisation for the expenditure in relation to future funding of healthcare abroad. It enables the funding of any reciprocal healthcare arrangements that the UK may enter into with EU member states, non-EU states and international organisations, such as the EU, as well as unilateral funding of treatment abroad if needed. It is a vital power to ensure a smooth transition post EU exit.

As a number of colleagues set out on Second Reading, including the Chair of the Select Committee on Health and Social Care, it is essential that the Government take appropriate measures to support a reciprocal healthcare arrangement and agreement with the EU. The Bill and the clause are crucial to that endeavour. Our arrangements with the EU are by their nature reciprocal and require a mutual understanding, and continuation of the arrangements are therefore a matter for negotiations between ourselves and the EU. It is incumbent upon any responsible Government to take forward responsible measures, and the Bill will ensure that we can broadly continue reciprocal healthcare arrangements, where agreed, with the EU. It is the Government's ambition to ensure that we have the powers and the legal basis to implement comprehensive reciprocal healthcare agreements with other countries around the world, where that would be cost-effective and support wider health and foreign policy objectives after the EU exit.

Clause 1 means that we are ready to respond to any scenario concerning future reciprocal healthcare arrangements with the EU on exit day. In a deal scenario, we would use the power to fund a future reciprocal healthcare arrangement with the EU following the implementation period. In the unlikely no deal scenario, our offer to all EU member states would be to maintain reciprocal healthcare arrangements on a bilateral basis for at least a transitional period. We would use the power to fund those arrangements.

On 2016-17 estimates, the United Kingdom spends about £630 million per year on the EU system of reciprocal healthcare. That is an accrued liability where payments are made to individual member states on a monthly basis in arrears. Once we leave the EU, the clause will allow the Government to continue to fund such a system of reciprocal healthcare, subject to any agreement with the EU and/or EU member states.

The payment system for funding reciprocal healthcare arrangements is set out in EU law. In the future, detailed provisions could be given effect domestically by the regulations under clause 2(1), which we will discuss later, and the payments could be made by exercising clause 1.

Of course, the spending of any public money is and should be closely monitored. The money spent under clause 1 would be no exception to that rule—the usual safeguards apply. As with all departmental expenditure, it would need to be authorised by the Treasury supply process and will be included in the Department's annual estimates, as well as being included in the annual resource accounts that are audited by the Comptroller and Auditor General. The exact arrangements will be provided for under the future reciprocal arrangements, which are obviously a matter for negotiation. It is envisaged that the current arrangements will be used as a basis for future arrangements with the EU.

It may be helpful to the Committee to look briefly at how the current process of payments works. At the moment, if a UK national were to injure themselves on a holiday in France, they would present their European health insurance card, commonly known as EHIC, at the hospital and receive the necessary treatment. The hospital would then raise an invoice for the treatment with its liaison body. In the case of the United Kingdom, that liaison body is the NHS Business Services Authority. The French liaison body would then submit a claim for the cost of the treatment to the NHS Business Services Authority based on receipt of the invoice from the hospital.

Once the NHS Business Services Authority is satisfied that the claim is accurate and valid, the UK would then release the payment to France, alongside any other claims received for that month. Our intention is to provide for those administrative and operational facets through the regulation-making powers in clause 2(1), which I referred to a moment ago and which we will discuss later. Clause 1 will provide for the payment element.

As is clear to all Committee members, the UK Government's ambition is to have a reciprocal healthcare agreement with the EU, which should include reciprocal healthcare for state pensioners, UK participation in the EHIC scheme, and co-operation on planned treatment. We expect that that will continue to involve our making payments—for example, on the hundreds of thousands of British citizens who require treatment each year during their holidays in Europe. It also reflects current arrangements, whereby we receive money from EU member states when healthcare has been provided in the United Kingdom—for example, when a tourist to the United Kingdom has presented their EHIC.

It is, of course, our ambition to secure a future deal with the EU on the matter. Should that not be possible, we would seek to agree a broad continuation of the current system with EU member states on a bilateral basis for at least a transitional period. The Bill also provides flexibility to fund healthcare even where there is no bilateral agreement, which we might explore using in exceptional circumstances to secure healthcare for certain groups of people.

At the outset of the Committee's line-by-line scrutiny, I put on the record my thanks to all hon. Members who spoke on Second Reading and who were supportive of the Bill in principle, and I thank hon. Members for their attendance today. I am also grateful, as I am sure everybody is, to the witnesses who attended on Tuesday. I put on the record my thanks to them, not only for giving us their valuable insight but for supporting the Bill.

Hundreds of thousands of people rely on reciprocal arrangements to access healthcare every year. Ensuring that the Government have a clear legal basis on which to fund these arrangements in the future is an essential component of allowing us to meet our shared goals in this area. I therefore recommend that the clause stand part of the Bill.

Question put and agreed to.

Clause 1 accordingly ordered to stand part of the Bill.

Clause 2

Healthcare and healthcare agreements

Question proposed, That the clause stand part of the Bill.

Stephen Hammond: This clause goes to the heart of the purpose of the Bill. It will ensure that the Government have the discretionary powers they need to respond flexibly to all possible outcomes of EU exit; to make regulations in relation to making or arranging payments in respect of healthcare provided abroad; to make regulations to support the provision of healthcare outside the United Kingdom; and to make regulations to give effect to complex international healthcare agreements. The Government can use such regulations to confer or delegate functions. The clause also provides that the Government can issue directions to a person about exercising functions as circumstances require. The powers in the clause are needed to provide the Government with both the flexibility and capability to implement detailed and complex arrangements concerning healthcare abroad. These powers ensure that we are taking the appropriate measures to be able to respond to the multiple EU exit scenarios.

As I remarked earlier regarding the powers in clause 1, as a responsible Government we believe that it is important to take forward appropriate measures. The Bill, and the clause, will ensure that we can broadly continue reciprocal arrangements with the EU where agreed, or, if necessary, with individual EU states on a bilateral basis. The Bill will support the potential strengthening of existing reciprocal healthcare agreements with countries abroad and around the world, and will potentially add to their number as part of future health and trade policy. I am grateful to my hon. Friend the Member for East Renfrewshire, who supported this facet of the Bill on Second Reading.

Facilitating the provision of healthcare for UK nationals abroad can be incredibly complex, and the scope of these powers necessarily reflects that. For example, the EHIC system is a broad and generous scheme for all UK and EU nationals. It covers a variety of different types of care, including emergency care, ongoing routine maternity care or a trip to a GP while abroad for someone with a chronic condition.

As I mentioned, it is our intention to negotiate a future arrangement with the EU that provides broad continuation of the current reciprocal healthcare system,

[Stephen Hammond]

including our participation in the EHIC scheme. That is a complex arrangement to provide for, and requires suitable domestic implementation to ensure that it operates effectively. It is therefore necessary and appropriate for the Government to seek suitably flexible powers to make regulations and directions that will allow us to implement such a scheme. It is also appropriate that these powers should afford us the capacity to implement and make provision for similar arrangements with other countries all over the world where this would be cost-effective and would support wider health and foreign policy objectives. The powers in the clause ensure that we are taking the appropriate measures to be able to respond to multiple EU exit scenarios, including the making of regulations for, or in connection with, the funding of provision for healthcare abroad and for implementing healthcare agreements.

11.45 am

The regulations made under clause 2(1)(a) can be used to make provisions relating to the exercise of the payment power in clause 1. Such regulations will be by their very nature technical, operational and detailed, and so suited to secondary legislation. Regulations made under the clause may make provisions for bodies such as the NHS Business Services Authority to process and administer payments to other countries as appropriate and in accordance with any international reciprocal healthcare agreements, as it does now.

The regulations made under clause 2(1)(b) can be used to set out arrangements in connection with providing healthcare outside the UK, such as setting out administrative requirements for individuals who access healthcare services outside the United Kingdom. It may involve setting out what documents an individual might need to present, such as a valid UK driver's licence or passport, to enable access to healthcare services outside the United Kingdom. For example, under the current system individuals need to present the EHIC card when accessing healthcare in the EU. Such details would be better suited to secondary legislation, as they are likely to be technical and detailed. They may set out different requirements for different countries, to account for variations in different healthcare systems.

Clause 2(1)(c) provides the power to give effect to an international healthcare agreement. This power can be used to implement a future reciprocal healthcare agreement with the EU, or with individual member states. It may also be used to implement future reciprocal healthcare agreements with other countries around the world as part of any future health and trade policy.

The powers in clause 2(1)(a), (b) and (c) can be used on their own or in combination with each other. They will enable the Government to provide for multiple EU exit scenarios, different types of agreements that could be implemented and variations in healthcare systems. The subject matter to which regulation powers relate is focused. They can be used only to give effect to healthcare agreements or in connection with the provision of funding for healthcare abroad.

Clause 2(2) sets out examples of the types of provision that may be included in the regulations made under clause 2(1). This list is reflective of the kind of provision that is already included in our current more comprehensive reciprocal healthcare arrangements with the EU. It has been included to give Parliament clarity about how the Government may exercise the regulating powers. Clause 2(2) is illustrative, as the Government must retain the flexibility to implement international healthcare agreements through the regulations created in clause 2(1), where details of those agreements are subject to negotiation.

Clause 2(3) provides that the Secretary of State may give directions about the exercise of functions delegated or conferred in the regulations under clause 2(1). The Secretary of State can set out to relevant bodies how their functions should be carried out by using directions. They may use directions to ensure that any conferred or delegated functions are discharged effectively and in accordance with the relevant healthcare arrangements; they may also direct bodies that administer reciprocal healthcare agreements, such as the NHS Business Services Authority, which currently administers the EHIC arrangements. Once healthcare agreements and arrangements are negotiated, we will be in the best position to decide on the appropriate bodies to administer the arrangements, which may need to be directed as a result.

Clause 2(4) gives the Secretary of State the power to vary or revoke the directions given under clause 2(3). Clearly, over time, directions may need to be updated or replaced. This is the standard power that provides for that. The delegated powers enable the Secretary of State to legislate for whatever negotiated outcome is reached with the EU, including the possibility of maintaining full policy coverage of EC regulation 883/2004, and the associated rights concerning access to healthcare.

It is essential that the Government take appropriate measures to ensure that we can respond flexibly to facilitate healthcare for UK nationals abroad, and that is ultimately what the clause is about. In my closing remarks on the clause, I stress to members of the Committee exactly how vital it is for the Government to retain sufficient flexibility to facilitate the access to healthcare abroad across a range of potential EU exit outcomes. The powers in the clause will ensure that the Government can make regulations to provide for complex and varied schemes, such as EHIC, should they be part of future reciprocal arrangements. I recommend that the clause stand part of the bill.

Justin Madders (Ellesmere Port and Neston) (Lab): It is a pleasure to serve under your chairmanship, Mr Stringer. First of all, I join the Minister in thanking those witnesses who came and gave evidence on Tuesday. There were certainly some helpful comments that we will no doubt return to in Committee.

As was made clear on Second Reading, this is a very important piece of legislation. More than 190,000 UK expats live in the EU and of course there are 50 million British visits within the EEA countries each year: all those people want clarity about what the arrangements are in the event that they will need healthcare. So we do not oppose the principle of the Bill. We absolutely agree that it is important that there are arrangements in place after 29 March 2019 and into the future. However, we are concerned about a number of issues, some of which I referred to on Second Reading and some of which we will discuss today.

It is fair to say that there are concerns about the breadth of powers that the Secretary of State is requesting in clause 2; I do not believe they would be countenanced

at all under normal circumstances. I appreciate that we are not in normal circumstances and I am grateful to the Minister for setting out how he envisages those powers will be used in practice. We are not here to judge things just on what the situation is at the moment, but on how the powers could be used at some point in the future. With regard to that, the Minister referred to this Bill being used possibly to further foreign policy and trade objectives. When he responds, I would be grateful if he expanded on what he has in mind.

To compound our issues about the scope of the regulations, we are also concerned about our lack of opportunity to scrutinise them; we will return to those concerns when I move amendment 2 to clause 5 later on. Of course, we are not alone in having concerns about the scope of this clause and the lack of clarity about how the powers might be used. In the evidence session, Raj Jethwa, Director of Policy at the British Medical Association, said:

"We would like to see much more emphasis on scrutiny of all the discussions in the arrangements going forward."—[*Official Report, Healthcare (International Arrangements) Public Bill Committee,* 27 November 2018; c. 6.]

We will certainly push for that today.

The Delegated Powers and Regulatory Reform Committee in the other place went further than that, describing the scope of clause 2 as "breath-taking". As that Committee correctly pointed out, there is no limit to the amount of any payments, to who can be funded or to the types of healthcare being funded. The regulations can confer or delegate functions to anyone, anywhere, and primary legislation can be amended for these purposes.

It is also worth noting that although this legislation has been presented as a Bill to enable us, as far as possible, to retain the arrangements that we already have—who would disagree with that?—the powers conferred by the clause, as I think has been conceded by the Minister, can go far beyond the current EU and EEA countries that we are primarily concerned about.

We consider the powers in the clause to be inappropriately wide, if they are not going to be subject to the correct levels of scrutiny. At this eleventh hour, we understand why a certain level of flexibility is being sought by the Government, but with that request comes a responsibility to ensure that proper parliamentary scrutiny is exercised.

Rather than oppose the clause in its entirety, we believe that the appropriate remedy would be to ensure that any regulations introduced under the Bill will be subject to the affirmative procedure. We will return to that point when we consider amendment 2 to clause 5.

Stephen Hammond: The hon. Gentleman is right to say that these powers are flexible. Part of the reason for that is that there may well be a need to anticipate the sort of bilateral arrangements that we put in place in the future—notwithstanding our hopes that we will secure a continuation of the current reciprocal healthcare arrangements, which is our ambition. When we come to debate not only the hon. Gentleman's amendment, but clause 5—when the discussion on scrutiny of these arrangements should take place—I will seek to reassure him that the procedures in place will allow for the usual and appropriate parliamentary scrutiny of the Bill.

The hon. Gentleman talked about the powers being too broad. The Bill has a very focused purpose: to ensure that the reciprocal healthcare arrangements, which benefit UK nationals abroad and also EU and non-EU nationals in the UK, are continued. He also challenged me on the issue of potential future trade or foreign policy objectives. As he will know, we already have arrangements with a number of countries outside the EU, and the Bill must have the flexibility for the continuation and updating of those arrangements. The matter will clearly be of operational importance—potentially, it will be a policy decision after exiting the EU. Were a UK holidaymaker going abroad to a non-EU country, they would clearly expect the Government to have in place—or to have the potential to put in place—the reciprocal healthcare arrangements that would allow them to be treated should that be necessary.

I hope those words will satisfy the hon. Gentleman that the clause needs to stand part of the Bill. We can have the appropriate discussion about scrutiny in somewhat more depth when we debate clause 5.

Question put and agreed to.

Clause 2 accordingly ordered to stand part of the Bill.

Clause 3

MEANING OF "HEALTHCARE" AND "HEALTHCARE AGREEMENT"

Question proposed, That the clause stand part of the Bill.

Stephen Hammond: Mr Speaker—sorry, Mr Stringer: although who knows what may happen later next year?

The Chair: A serious promotion!

Stephen Hammond: One that I am sure would be welcomed by Members on both sides of the Committee.

Clause 3 is very simple and sets out the definition of "healthcare" and "healthcare agreement" used within the Bill. The definition of healthcare is modelled on the definition provided in the Health and Social Care Act 2012, which we have adapted to include the additional element of ancillary care. That is to reflect where current arrangements provide for ancillary costs, such as travel, which do not fit strictly within the definition of healthcare. As in France, this is for use in circumstances where residents are reimbursed a contribution of their travel costs when attending healthcare appointments.

I would like to clarify that access to social care in England would not be provided for through any reciprocal healthcare agreement. It is up to each individual country to determine what is available through the public healthcare system, just as we do with the NHS. The clause would enable individuals to access healthcare on those terms.

A healthcare agreement could be made either bilaterally or multilaterally, or it could be an agreement between states, countries or multilateral organisations. Such agreements provide access to agreed forms of healthcare when individuals from one country seek healthcare in the other, and vice versa. They also provide for how the funding will be shared between parties. Funding could mean a direct payment, arrangements to waive or set off costs, or other arrangements to cover costs. Clause 3 is short but important.

Question put and agreed to.

Clause 3 accordingly ordered to stand part of the Bill.

Clause 4

DATA PROCESSING

12 noon

Julie Cooper (Burnley) (Lab): I beg to move amendment 1, in clause 4, page 3, line 17, leave out paragraph (d).

It is a pleasure to serve under your chairmanship, Mr Stringer, and I am pleased to have the opportunity to speak to clause 4. At this time of great uncertainty, when the nature of our future relationship with the European Union is still unknown, we welcome the intention outlined in the Bill to give some confidence to those who currently rely on the reciprocal health arrangements between the UK and the nations of the EU and EEA. We are only surprised that the Bill has taken so long to come before us.

The scope of the Bill is designed to cater for all possible outcomes of the UK and EU negotiations. The intention is that, deal or no deal, the Bill will empower the Secretary of State to negotiate future reciprocal healthcare arrangements between the nations of the UK and the EU, and any other such nation as is desired. Providing for pensioners, visitors, students and workers to live, work, study and travel in EU member states with complete peace of mind regarding the provision of healthcare is a priority for Labour. We therefore recognise the need for the Bill.

While understanding that any future agreement must allow for the smooth transference of data for the achievement of the best possible outcomes for patients, we believe it is also crucial that the Bill provides robust powers to protect personal data. Health records contain both personal and sensitive data, and access to such information must be allowed sparingly and only for medical purposes. Access to personal data should be available to health professionals who are bound by a duty of confidentiality on the basis of need to know. The Data Protection Act 2018 outlines the key principles relating to the protection of data; compliance with the spirit of those principles is fundamental to good data protection practice, and embodies the spirit of lawful, fair and transparent use of data.

Currently, the General Data Protection Regulation places restrictions on the transfer of personal data to countries outside the EU and EEA. As the UK leaves the EU, we will not automatically enjoy existing protections; indeed, this Bill provides powers for negotiations to take place with nation states across the world, to reach agreement on a bilateral basis. That makes it imperative, in our view, that the Bill protects against potential misuse of personal data.

Clause 4 outlines the detail of how data will be processed for the purposes of the Bill. We have noted the wide-ranging powers to be given to authorised persons, who may

"process personal data held by the person in connection with any of the person's functions where that person considers it necessary for the purposes of implementing, operating or facilitating the doing of anything under or by virtue of this Act."

We are not satisfied that sufficient safeguards are in place when defining an authorised person for the purposes of the Bill. We have listened carefully to the concerns of the British Medical Association, and share that organisation's concerns about the lack of detail in the definition of "authorised person" in subsection (6). Mr Jethwa, representing the BMA, said in his evidence to this Committee that data

"has to be accessed on a need-to-know basis, and only when it is in line with patients' expectations. Data sharing has to be transparent. We would be absolutely concerned that any safeguards meet those criteria and principles. I do not think the details in the Bill make that clear at the moment. We would like to see more clarity and detail about that in future."—[*Official Report, Healthcare (International Arrangements) Public Bill Committee,* 27 November 2018; c. 5, Q14.]

Mr Henderson, from the Academy of Medical Royal Colleges, said that although he recognises that there must be a "free flow" of data,

"individual patients' data must be protected",

and that

"it is slightly hard to say whether there is sufficient protection there or not".—[*Official Report, Healthcare (International Arrangements) Public Bill Committee,* 27 November 2018; c. 5, Q13.]

He is correct: it is hard to see that there are sufficient protections in the Bill. This is a hugely important issue that needs to be fully addressed.

With that in mind, we are of the view that subsection (6)(d) should be deleted, principally because it gives the Secretary of State a power—to authorise private health companies to access patient data—that is far too wide ranging. We believe that removing that paragraph protects personal data and achieves a balance, giving more confidence to patients while allowing the smooth transfer of data to designated qualified personnel.

The right to privacy and access to healthcare are rights that we value, and the one should not be conditional on the other. We wish to ensure that the Bill gives UK patients, and patients from the EU, full confidence that their personal information will not be shared inappropriately. That remains the case whether healthcare is received in the UK or overseas as part of a reciprocal healthcare agreement. As we leave the European Union, citizens accessing medical care as part of a reciprocal health agreement need to be sure that their personal data will not be shared inappropriately. Without that assurance, citizens may be discouraged from seeking medical assistance.

Stephen Hammond: I thank the hon. Member for Burnley for moving this amendment, because it gives me the opportunity to set out clearly and in some depth why we have chosen to include clause 4(6)(d) in the Bill. I want to lay out the reasoning for our concerns about this amendment. I hope that I will be able to reassure her of the vital importance of paragraph (d), and that it is necessary and appropriate, because we will be unable to accept the amendment.

Reciprocal healthcare agreements are made possible by close, consensual co-operation of different parties and bodies, such as the Department of Health and Social Care, the Commissioners for Her Majesty's Revenue and Customs, Ministers of devolved Administrations, healthcare providers and all their opposite numbers in EU and EEA countries. Since the Bill is about the provision of healthcare, it would be remiss of Her Majesty's Government to exclude healthcare providers, either those in the United Kingdom or those in other countries, from the list with authority and sanction to process and share data. Given that it is the Government's position that in the agreement with the EU, future

arrangements for the provision of healthcare abroad will reflect existing ones, it is worth reflecting on the place of healthcare providers in these processes, to illustrate the role they play in the commission and delivery of healthcare abroad.

Under the S2 route, a UK resident may decide to seek planned treatment abroad. As part of the ordinary procedure, the UK resident must visit a healthcare provider in the UK. The clinician would then provide written evidence that the person has had a full clinical assessment, which must clearly state why the treatment is needed in their circumstances and what the clinician considers to be a medically justifiable time period within which they should be treated again, based on their circumstances. As is clear under existing arrangements, this function can only be served by a medically trained healthcare provider. This paperwork is then passed on to NHS England or the comparable authority in the devolved Administrations for further processing. Many of those organisations are provided for by subsection (6)(c). Members will, I hope, understand that the lack of qualification around the term "provider of healthcare" is appropriate and necessary at this stage, given that future arrangements are not yet clear.

If the Government are adequately to fulfil the purposes outlined in clause 1, they need to be able to facilitate and fund healthcare for UK persons, for whom they feel responsible, whether the provider is based in the UK or overseas. In that connection, I think it is worth pointing out that the current reciprocal healthcare arrangements allow UK persons to access treatment from providers of healthcare in another country that are not NHS bodies or comparable state providers in another country, as defined by UK healthcare legislation. That might include an optometrist or a dentist, many of whom fall outside the state healthcare system.

Subsection 6(d) proposes to ensure that other types of healthcare providers are authorised to process personal data under the Bill, but most importantly that NHS bodies are able, where necessary, to share personal data for the purposes of the Bill with healthcare providers based outside the UK. Simply, if such providers were not also considered authorised, it would be impossible for healthcare commissioned, implemented, facilitated or funded by the UK to be authorised to be rendered abroad.

The hon. Lady is concerned that the clause will allow private providers access to patient data and the powers to process it. She should be reassured that that is already legal and proper under existing arrangements governed by EU regulations. Under existing reciprocal healthcare arrangements, UK persons are able to receive treatment in another country on the same basis as a local resident of that country. That includes healthcare or other treatments given by healthcare providers other than those that fall within the scope of domestic UK healthcare legislation.

After the fact and on return to the UK, the person would be able to seek reimbursement, where appropriate, from the relevant UK authorities. It is worth noting that the person who sought treatment abroad would typically only be reimbursed up to the amount it would have cost under the NHS. It would be for the person, not the Department of Health and Social Care, to bear the financial risk of any additional cost.

Since our desire to continue existing arrangements is shared by those on both sides of the House, I do not feel that the clause has inappropriate powers. To further allay any other fears, I remind members of the Committee that the clause contains safeguards to guard against any misuse of data. The Bill gives powers to providers, either in state healthcare systems or private ones, to process solely where it is necessary for the limited purpose of funding or arranging healthcare abroad—nothing more.

All processing of the data by all parties must also comply with existing data protection legislation. That is a crucial safeguard under UK data legislation. Data concerning healthcare is personal or specific category data. That can only be processed where specific conditions are met, namely that processing is necessary for the purpose of healthcare and in the public interest. Members will recognise that clause 4(6)(d) does not represent a deviation or new departure from existing arrangements and simply allows for the Government to maintain or improve those arrangements in whatever circumstances we find ourselves in after exit.

In closing, were the amendment agreed, it could risk patient outcomes by excluding providers of healthcare from the list of authorised persons. The hon. Lady expressed some concerns, and I hope that my response has allayed them. I offer to make my officials available to provide a briefing on this matter to her and any other member of the Committee who should so wish, so that they can be completely reassured that the normal data protection legislation will apply to the Bill. The exchange of data may happen only for a limited and focused purpose. The hon. Lady was right to express her concerns, and I hope she will be reassured by my words and that she will not feel the need to press her amendment to a Division.

Julie Cooper: I am grateful to the Minister for those explanations, and I welcome him saying it is a very limited and focused use of the data. I would be happy to take a briefing from his officials, but further to that, to give assurance to our side, I would be grateful if he will undertake to go further on Report and outline the scope of the subsection. If he will do that, we will not press the amendment to a Division.

Stephen Hammond: We will carefully consider what the hon. Lady has said and her request for further details on Report. I have listened and have offered that briefing, and I hope that is sufficient for her to decide not to press the amendment to a Division now.

Julie Cooper: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Question proposed, That the clause stand part of the Bill.

12.15 pm

Stephen Hammond: I will try to limit my comments, given that we have already had discussions on the amendment. I am sure that will be welcome on this cold November day in a rather warm room.

[Stephen Hammond]

Clause 4 provides a clear legal basis for processing personal data under the Bill for the purposes of UK data protection legislation. At present, the EU regulations provide a lawful basis for processing data for the purposes of reciprocal healthcare. Personal data is integral for providing healthcare abroad. It is vital that authorised persons in the UK can process data for that purpose. The clause ensures that, after exit day, there is a clear and transparent basis for processing personal data for the purposes of providing healthcare abroad, as required by UK data protection legislation. Clause 4 will ensure that safeguards are in place for that processing.

Subsection (1) limits processing to that which is necessary for the purposes of the Bill. Subsections (2) and (3) ensure that any such processing must remain in compliance with UK data protection legislation and the Investigatory Powers Act 2016, and any other relevant restrictions. Finally, the persons who can process data under the Bill are limited to those authorised in subsection (6), which we have just discussed.

The safeguards limit the scope of clause 4 to what is necessary and proportionate to provide healthcare abroad. For reciprocal healthcare, personal data is required to process reimbursements to and from other countries, and where reimbursement is made to a person as well. It is also sometimes necessary for healthcare providers to share medical information to facilitate treatment. The clause ensures that the Government can continue to process personal data as necessary, after exit day, in an effective and lawful way. Personal data transferred from outside the UK will remain subject to the need for safeguards to be put in place before it is transferred. Those safeguards will not be able to be contracted out as part of any healthcare agreement with the EU or member states or third countries.

As I said a moment ago, subsection (1) provides for an authorised person to process data related to the provision of healthcare abroad. Personal data is defined in the GDPR as data that relates to a living person who can be directly or indirectly identified from the data. Specific category data is personal data containing health and genetic data. At present, there are different routes for providing healthcare abroad, such as the S1, S2 or EHIC routes, and each route requires different forms of personal data.

Subsection (2) disapplies the duty of confidence and any restriction on the processing that would otherwise apply. The exemption ensures that data can be disclosed where it is necessary for the limited purposes of the Bill. The measure is necessary and appropriate. For example, authorised persons may need to share data if a person is unconscious and therefore not in a state to provide it themselves. Importantly, as expressed in subsection (3), data processing must continue to comply with the UK data protection legislation, which ensures there are further safeguards around data processing. The GDPR also governs data transfers between the UK and other countries. All EU and EEA countries are bound by the GDPR, which means the relevant national data protection safeguards in each country are adequate, allowing the free transfer of data between countries.

Subsection (3)(a) expressly requires that the processing of data does not contravene existing data protection legislation, and subsection (3)(b) requires that the processing of data must comply with parts 1 to 7 or chapter 1 of part 9 of the Investigatory Powers Act 2016. The only purposes for which investigatory powers may be required are to investigate and tackle suspected cases of fraud and error relating to healthcare abroad.

As set out in subsection (1), the processing of data under the Bill is limited to authorised persons who, as we have discussed, are defined in subsection (6). The list reflects those persons and bodies currently involved in processing data, including personal data under existing reciprocal healthcare arrangements.

I mentioned that, for clarity's sake, subsection (6)(a) lists

"the Secretary of State, the Treasury, the Commissioners for Her Majesty's Revenue and Customs, the Scottish Ministers, the Welsh Ministers and a Northern Ireland department".

Healthcare abroad is entirely managed and operated by the Department of Health and Social Care in co-operation with the Executives in the devolved Administrations and their local healthcare systems. Although the Bill is about the provision of healthcare abroad, it is vital that the Executives of the devolved Administrations are considered authorised persons, since healthcare abroad is often facilitated in co-operation with them. Under subsections (6)(b), (c) and (d), healthcare bodies and providers are considered authorised persons as they are directly involved in the provision of healthcare.

Finally, subsection (6)(e) gives the Secretary of State the power to add to the list of authorised persons, which will ensure that the Government can respond appropriately, whatever the outcome of EU exit. It is also deemed necessary to allow the Secretary of State to respond to the changing demands of systems and operations. In future, duties may change and adding to the list will be difficult, so it is necessary to have the power in place.

Clause 4 is an important component of the Bill. It provides the Government with the necessary power to process and share data that relates to healthcare provided abroad. Therefore, I recommend that the clause stand part of the Bill.

Question put and agreed to.

Clause 4 accordingly ordered to stand part of the Bill.

Clause 5

Regulations and directions

Justin Madders: I beg to move amendment 2, in clause 5, page 3, line 44, leave out subsection (5) and subsection (6) and insert—

"(5) Any statutory instrument which contains regulations issued under this Act may not be made unless a draft of the instrument has been laid before Parliament and approved by a resolution of each House."

This amendment would make all regulations issued under this Act subject to the affirmative procedure and require approval from Parliament before they become law.

This amendment is probably one of the most important items that we will discuss in Committee. As I made clear when we discussed clause 2, there are widely held concerns about the scope of the regulations, which are exacerbated by the fact that these extraordinarily wide powers, necessary as they may be in the circumstances, are subject only to the negative procedure.

As I referred to earlier, the Delegated Powers and Regulatory Reform Committee in the other place clearly set out the potential impact of my amendment not being accepted when it said:

"If, without such amendment, the Secretary of State wished to fund wholly or entirely the cost of all mental health provision in the state of Arizona, or the cost of all hip replacements in Australia, the regulations would only be subject to the negative procedure. Of course, these examples will not be priorities for any Secretary of State in this country."

I hope that is the case, but we are here to look at how the powers could be used over, possibly, the next 100 years, and not just how we would expect them to be used in the foreseeable future.

Nobody knows where this process will take us, and when examining legislation there is always merit in considering the unlikely as well as the stated intentions of the Government at the time. The Minister's comments about wider objectives reaffirms the importance of our scrutinising the regulations as much as possible. We find ourselves in an unprecedented situation in Parliament, and it is therefore important that we consider all eventualities.

If Committee members need further persuasion that the amendment should be carried, that Lords Committee set out a devastating list of reasons why the negative procedure is inappropriate. It said:

"There is no limit to the amount of the payments. There is no limit to who can be funded world-wide. There is no limit to the types of healthcare being funded. The regulations can confer functions…on anyone anywhere. The regulations can delegate functions to anyone anywhere."

The Committee concluded:

"In our view, the powers in clause 2(1) are inappropriately wide and have not been adequately justified by the Department. It is particularly unsatisfactory that exceedingly wide powers should be subject only to the negative procedure."

The most significant reason why we do not object to the legislation is that the biggest risk at this stage is that arrangements are made that do not safeguard the ability of our constituents, when they travel abroad, or of UK citizens who currently live overseas to access healthcare, as they do now. However, because of the way the Bill is drafted, we will find that we are unable to debate whether those safeguards are in place as a matter of course. We have heard many references to the 190,000 UK expats living abroad and the 50 million or so nationals who travel to EEA countries every year. These are huge numbers of people, and the impact of the legislation on them is potentially huge. We owe it to all those people to ensure that any future arrangements are properly scrutinised.

We also need to consider the impact of any new arrangements on the NHS. As Alastair Henderson, chief executive of the Academy of Medical Royal Colleges, set out in evidence on Tuesday:

"Both clinicians and health organisations are concerned that we could end up with a system that is both administration-intensive and time-intensive."—[*Official Report, Healthcare (International Arrangements) Public Bill Committee,* 27 November 2018; c. 3, Q4.]

He went on:

"In practical terms, the idea that if you are a GP or a hospital doctor trying to work out whether there are different arrangements for 32 different lots of patients sounds pretty much like a nightmare set-up."—[*Official Report, Healthcare (International Arrangements) Public Bill Committee,* 27 November 2018; c. 4, Q9.]

If we do not agree to the amendment, Parliament could end up in that scenario without any voice.

While there is scope for the affirmative procedure to be used in cases where Henry VIII powers are invoked to amend primary legislation, I think it is pretty clear that potentially the most significant changes to reciprocal agreements that could be enacted under the legislation are those that are subject only to the negative procedure. As we know, the negative procedure means that an instrument is laid in draft and cannot be made if that draft is disapproved within 40 days, normally via a prayer against, which is usually by way of an early-day motion. If that does not happen, the legislation is then passed. That is a 40-day process in the best-case scenario.

If I am correct, and if we leave without a deal, the Secretary of State will have to reach agreement with each of the 30-plus countries no later than Friday 15 February, assuming that Parliament does not sit on the following Sunday. At this stage, who knows where we might end up, but we will assume for now that the sitting days are as set out, so Friday 15 February will be the last day that an instrument can be laid that will pass before 29 March, assuming that it is not prayed against. Hopefully the Minister will be able to advise whether my understanding of the timetable is correct.

Will the Minister concede that, on a practical level, it would be better for regulations moved under the Bill to be moved using the affirmative procedure? We could then get them through scrutiny in both Houses much quicker than the 40-day procedure currently allows.

Stephen Hammond: The hon. Gentleman raises some important issues, including the issue at the heart of the clause—the appropriate, necessary and correct scrutiny arrangements for Parliament. Let me be clear at the start: the Government absolutely recognise the importance of appropriate levels of scrutiny of the Bill and its subsequent secondary legislation. It is clearly the hallmark of any effective parliamentary system that there are processes in place by which we draft, consider and test legislation. After all, that is what we are doing today.

The appropriate parliamentary procedure for the scrutiny of regulations made under the Bill that do not amend, repeal or revoke primary legislation is the negative procedure. If I am not able to reassure the hon. Member for Ellesmere Port and Neston and he chooses to press the amendment to a Division, I am afraid the Government will resist it.

12.30 pm

The powers in the Bill give the Government the flexibility and capacity to implement deeper, detailed and complex arrangements concerning healthcare abroad. It is also clear that the regulating powers enable the Secretary of State to make provision to fund that healthcare, or to provide funding in connection with the provision of that healthcare, but that the subject matter to which the regulations relate is narrow. The remit of our regulating powers is tightly focused. They can be used only to give effect to healthcare agreements, or to arrange, provide for or fund healthcare abroad. Therefore, the subject matter is focused and provides the necessary reciprocal arrangements for UK citizens.

Where the UK negotiates an international healthcare agreement in the future, the most important elements setting out the terms of the agreement will be included in the agreement itself, as I am sure hon. Members

would expect. Those agreements are likely to contain all the detail that Parliament should consider, such as who is covered by their terms. In contrast, the regulations implementing the agreement would not include anything fundamentally new. They would contain procedural, administrative and technical details, such as the types of document or forms to be used. Therefore, it is right that those regulations issued under the Bill are subject to the negative procedure. I think most colleagues would consider that to be the right use of parliamentary time.

I hope I can persuade the hon. Gentleman and reassure the Committee further that when we strike a comprehensive healthcare agreement with the EU or individual states, it will be subject to parliamentary scrutiny. Such agreements would come under the ratification procedure in the Constitutional Reform and Governance Act 2010, which would provide an opportunity for parliamentary scrutiny of the substance of healthcare agreements that are given effect by regulations made under the Bill.

I remind Committee members of the Government's intention. I am sure all Committee members welcome reciprocal healthcare arrangements. We heard from the witnesses who presented evidence to us that the administration of the current arrangements works well and is, on the whole, extremely popular. Regulations made under the Bill will simply provide for the effective and efficient administration of those arrangements.

As I set out at the outset of my remarks, we will ensure that the affirmative procedure is in place for anything that amends, repeals or revokes primary legislation. For technical regulations, it is appropriate that the negative procedure is used. Given my remarks about the Constitutional Reform and Governance Act and my reassurances about how we intend to deal with the negative and affirmative procedures, I hope that the hon. Gentleman is reassured and does not feel the need to press the amendment to a Division.

Justin Madders: I am afraid the Minister has not managed to reassure me, despite his best efforts. When a Bill would confer power on the Executive, we have to be very careful about giving that power away. It cannot be done without good reason, even in these extraordinary times. I have not heard any justification for giving such sweeping powers to the Secretary of State without adequate scrutiny. No matter how well-intentioned the Minister is in his responses—I acknowledge his sincerity—we do not know who will be doing what in 12 months' time. As we said earlier, we could be handing a future Secretary of State the ability to enter into arrangements for hip replacements in Australia or such like.

As the Minister said, the regulations will enable the Government to enter into detailed and complex arrangements on future healthcare. That is precisely why we need them to be subject to the affirmative procedure. I appreciate the point about the treaties possibly containing more detail, but this is about how Parliament will be able to scrutinise and challenge those arrangements.

Stephen Hammond: The hon. Gentleman will have heard that the treaty arrangements will be subject to parliamentary scrutiny in the normal way. We are discussing the regulations as to how we enact those treaties. I was hoping that he might be reassured by that.

Justin Madders: I am afraid that I am not reassured.

The Minister has not really addressed the practical issue about the 40-day waiting time for the negative procedure. If we enter a no-deal scenario after 29 March, as I said earlier, all the instruments under the Bill would have to be laid no later than 15 February. I am imagining the Secretary of State whisking around the 30-plus countries that we would need to enter into bilateral arrangements with throughout the whole of January, and having to get that all signed up and put on the Order Paper by 15 February. I am actually trying to help the Minister here by suggesting that if we do it by affirmative procedure, we can get these things through Parliament more quickly and with the appropriate level of scrutiny that these arrangements deserve. Therefore, I will push the amendment to a vote.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 9.

Division No. 1]

AYES

Cadbury, Ruth	Madders, Justin
Cooper, Julie	Matheson, Christian
Day, Martyn	Norris, Alex
Debbonaire, Thangam	Western, Matt

NOES

Burghart, Alex	Morton, Wendy
Costa, Alberto	Quince, Will
Hammond, Stephen	Robinson, Mary
Hughes, Eddie	Throup, Maggie
Masterton, Paul	

Question accordingly negatived.

Question proposed, That the clause stand part of the Bill.

Stephen Hammond: Having failed to reassure the hon. Member for Ellesmere Port and Neston, I will have another attempt in this stand part debate. Clause 5 supplements the substantive regulation-making powers in clause 2. It provides detail on the parliamentary procedure, as we have already discussed, that will apply to regulations made under the Bill. Subsections (1) and (2) introduce standard provisions, and are consistent with regulation and direction-making powers in many other Acts of Parliament, such as the Health and Social Care Act 2012 and the National Health Service Act 2006.

The clause is required to ensure that regulations and directions made under the Bill will be fit for purpose. As I have said, the powers in the Bill provide the Government with the flexibility and capability to ensure and implement detailed and complex arrangements concerning healthcare abroad. For example, the Government may use regulations to confer different functions on different bodies, in order that they may implement and operate effectively what may be provided for in an agreed reciprocal healthcare agreement. We do that now in relation to the EHIC scheme, which, as I said earlier, the NHS Business Services Authority administers on behalf of the Department. That administration includes the registering and issuing of EHICs and the processing of EHIC claims.

Future administrative arrangements to implement reciprocal healthcare agreements may reflect the current situation, or may involve conferring different functions

on other bodies, as appropriate. Once the arrangements are negotiated, we will be in the best position to decide what the appropriate bodies to administer those arrangements are. We will be able to provide for the practical processes and implementation arrangements through the regulations. Clause 5 provides the Government with the flexibility to ensure that any healthcare arrangements can be implemented effectively and efficiently.

Subsection (3) provides that regulations made under clause 2

"may amend, repeal or revoke primary legislation…for the purpose of conferring functions",

or

"to give effect to a healthcare agreement."

I want to try again to reassure the Committee about that. The Government are conscious that Parliament rightly takes an interest in this area and, of course, we share the view about the importance of scrutiny.

This is a consequential power to make amendments to primary legislation, which is limited to three restricted uses: for the purpose of conferring functions, to give effect to a healthcare agreement and to make modifications to retained EU law. It is not a free-standing power; it is a focused power to ensure that we can implement healthcare arrangements effectively. That may involve conferring functions on healthcare bodies, which could involve amending primary legislation.

Subsection (4) provides that:

"Regulations under this Act may amend, repeal or revoke retained EU law",

which is the body of existing EU law that the European Union (Withdrawal) Act 2018 will convert into domestic law, together with the laws we have already made in the UK to implement our EU obligations. It is vital that the regulation-making powers extend to amending, repealing and revoking retained EU law, because the bulk of the existing provisions that relate to current reciprocal healthcare arrangements with the EU will be EU retained law.

Subsection (4) will ensure that domestic legislation in that area is clear and accessible. It will allow us to amend EU retained law, where appropriate, to give effect to new reciprocal healthcare arrangements. It would be an oversight if the Bill did not provide for such amendment, given that current reciprocal healthcare arrangements with the EU are entirely bound up in EU law.

I stress again that, of course, Parliament will be given the opportunity for the appropriate scrutiny of regulations made under the Bill that amend, repeal or revoke primary legislation. As such, subsection (6) makes it clear that regulations that contain provisions that make modifications to primary legislation will be subject to the affirmative resolution procedure and, therefore, Parliament will have the opportunity to debate them. That is the parliamentary scrutiny procedure befitting Henry VIII powers, and one that allows for proper scrutiny.

Regulations made under the Bill that do not contain provisions that amend, repeal or revoke primary legislation will be subject to the negative resolution procedure. It is our job—and I think it is only right—to ensure that legislation is afforded the appropriate level of scrutiny. Therefore, regulations that are made under the Bill that do not amend, repeal or revoke primary legislation should be subject to the negative procedure, as is normal.

The remit of our regulating powers is focused. They can be used only to give effect to healthcare agreements or to arrange, provide for or fund healthcare abroad, as is clear in the enabling powers found in clause 2(1). Where the UK negotiates a comprehensive international healthcare agreement, whether multilaterally with the EU or bilaterally with EU members, the most important element that sets out the terms of that agreement would be included in the agreement itself, as hon. Members would expect. Regulations that give effect to such an agreement would likely focus on procedural, administrative and technical details, such as the types of documents or forms that could be used to administer those reciprocal healthcare arrangements, which is a point I made earlier.

In a scenario where a comprehensive healthcare agreement is being implemented through regulations made under clause 2(1)(c), that agreement would be subject to parliamentary scrutiny under the ratification procedure contained in section 20 of the Constitutional Reform and Governance Act 2010. That ratification procedure provides an opportunity for parliamentary scrutiny of the substance of the healthcare agreements being given effect to in the regulations made under the Bill. It is for those reasons that I rejected amendment 2, which the hon. Member for Ellesmere Port and Neston moved a moment ago.

The final provision of the clause, subsection (7), sets out the definition of "primary legislation". To reassure the hon. Gentleman, and the Committee, the Government absolutely understand and appreciate the necessity for appropriate parliamentary scrutiny. The level of scrutiny must reflect the substance of the piece of legislation. That is what I believe the clause does, and I therefore recommend that it stand part of the Bill.

Justin Madders: The Minister and I will not agree on that, unfortunately. I will not repeat the arguments that we have already gone through, but I will remind hon. Members that the Lords Delegated Powers and Regulatory Reform Committee described the powers and regulation as "breath-taking", and said that

"There is no limit to the amount of the payments. There is no limit to who can be funded world-wide. There is no limit to the types of healthcare being funded. The regulations can confer functions…on anyone anywhere."

The scope of the clause is breath-taking. Although the Minister is trying to reassure us, as parliamentarians, we need the security of the affirmative procedure.

Christian Matheson (City of Chester) (Lab): I am grateful to my hon. Friend and constituency neighbour for giving way. Would he have been a little more reassured by the Minister's attempts at reassurance if this was not part of a process and of a pattern of behaviour by the Government? There have been power grabs and the use of Henry VIII clauses throughout the Brexit process.

Justin Madders: I thank my hon. Friend and neighbour for his intervention. He is absolutely right. One of the things that was stated during the referendum campaign was that Parliament should take back control, and that is what I believe should be happening following the result. Parliament needs to make sure that, as much as possible, the legislation that will be necessary in the coming months is subject to full parliamentary scrutiny.

[Justin Madders]

That is why the affirmative procedure should be included in the clause, which we cannot support as it currently stands.

Question put, That the clause stand part of the Bill.

The Committee divided: Ayes 9, Noes 8.

Division No. 2]

AYES

Burghart, Alex	Morton, Wendy
Costa, Alberto	Quince, Will
Hammond, Stephen	Robinson, Mary
Hughes, Eddie	Throup, Maggie
Masterton, Paul	

NOES

Cadbury, Ruth	Madders, Justin
Cooper, Julie	Matheson, Christian
Day, Martyn	Norris, Alex
Debbonaire, Thangam	Western, Matt

Question accordingly agreed to.

Clause 5 accordingly ordered to stand part of the Bill.

Clause 6

EXTENT, COMMENCEMENT AND SHORT TITLE

Question proposed, That the clause stand part of the Bill.

Stephen Hammond: I wish to introduce this short clause, which I suspect will be somewhat less contentious than the previous one. Subsection (1) provides that the Bill extends to England and Wales, Scotland and Northern Ireland. Subsection (2) provides that the Bill will come into force on Royal Assent, which reflects the need to respond to the range of possible EU exit scenarios in a timely manner. Subsection (3) establishes that the short title of the Act will be Healthcare (International Arrangements) Act 2018. With that short explanation, I recommend that the clause stand part of the Bill.

Clause 6 accordingly ordered to stand part of the Bill.

New Clause 1

ANNUAL REPORT ON THE COST OF HEALTHCARE ARRANGEMENTS

'(1) The Secretary of State must lay before Parliament an annual report setting out all expenditure and income arising from each healthcare arrangement made under this Act.

(2) The annual report laid under subsection 1 must include, but is not limited to—

(a) all payments made by the government of the United Kingdom in respect of healthcare arrangements for healthcare provided outside the United Kingdom to British citizens;

(b) all payments received by the government of the United Kingdom in reimbursement of healthcare provided by the United Kingdom to all non-British citizens;

(c) the number of British citizens treated under healthcare arrangements outside the United Kingdom;

(d) the number of non-British citizens treated under healthcare arrangements within the United Kingdom;

(e) any and all outstanding payments owed to or by the government of the United Kingdom in respect of healthcare arrangements made before this Act receives Royal Assent; and

(f) any and all administrative costs faced by NHS Trusts in respect of healthcare arrangements.

(3) The information required under section 2(a) and 2(b) above must be listed by individual country in every annual report.'—*(Julie Cooper.)*

Brought up, and read the First time.

Julie Cooper: I beg to move, That the clause be read a Second time.

I should stress that we support the intention of the Bill. Providing that UK citizens can live, work, study and travel in EU member states with complete peace of mind with regard to the provision of healthcare is a priority for us. We are aware that, under existing arrangements, the healthcare of 190,000 UK state pensioners living abroad, principally in Ireland, Spain, France and Cyprus, and of their dependent relatives, is protected.

In addition, we seek to ensure that the health benefits currently enjoyed by UK residents who visit the EU on holiday or to study continue, so that they may use the European health insurance card to access healthcare and emergency treatment for healthcare needs that arise during their stay. We also seek to continue the arrangement under which EU nationals receive reciprocal provision when they visit the UK post Brexit.

We note, however, that the Bill is intended to provide for all reciprocal healthcare arrangements in the future, even though we still do not know—even at this late stage, two and a half years after the referendum—whether a satisfactory Brexit deal will be approved by the UK Parliament. Given the possibility of a no deal scenario, where the UK crashes out of the EU and potentially enters a period of unprecedented uncertainty, we are extremely concerned.

We understand and support the Government's preferred policy position with regard to future reciprocal healthcare agreements, where the intention is to seek a wider agreement with the EU that covers state pensioners retiring to the EU or UK and allows for continued participation in the European health insurance card scheme, together with planned medical treatment. We want to ensure, however, that appropriate safeguards are in place with regard to costs, not least because the Bill provides the authority for the Secretary of State not only to facilitate a continuation of existing arrangements, but to enter into any number of bilateral agreements with individual member states, with no provision for parliamentary scrutiny.

We also note that the Bill provides the authority to strengthen existing reciprocal healthcare agreements with countries outside the EU, or to implement new ones with countries across the globe, in line with the Government's aspiration to develop trading arrangements with countries beyond the EU. There is, therefore, the potential for the establishment of multiple complex agreements.

As it is not possible to know the detail of those agreements in advance, we cannot assess their likely cost implications. We therefore believe that the Government's impact assessment is woefully inadequate in that regard.

The assessment suggests that the cost of establishing a future reciprocal healthcare arrangement would be £630 million per year, which is the same as the current agreement and takes no account of inflation or future medical developments. The impact assessment's suggestion that costs might actually be less than those we already incur is not credible.

We will be in uncharted waters, facing the prospect of the necessity to negotiate multiple agreements, some of which may be complex. As the former Secretary of State said,

"It is perfectly possible to agree the continuation of reciprocal healthcare rights as they currently exist, but it is not possible to predict the outcome of the negotiations."

We agree that it is impossible to provide reliable estimations of likely costs in advance. We are therefore not prepared to give the Government carte blanche.

New clause 1 would provide a sensible requirement for the Government to report back to Parliament on an annual basis. Subsection 2(a) would require the Government to provide details of all payments made by the UK Government for healthcare provided outside the UK to British citizens. Subsection 2(b) would stipulate a requirement to provide details of all payments received by the UK Government in reimbursement of healthcare provided by the UK to all non-British citizens. Subsections (c) and (d) are straightforward and would require details of the numbers of citizens treated under reciprocal arrangements. Subsection 2(e) would write into law a requirement to report on all outstanding payments owed to or by the UK Government.

The Bill provides an opportunity to monitor efficiency in this area and may provide an incentive to address the concerns raised by the Public Accounts Committee in its 2017 report, "NHS treatment for overseas patients". It stated,

"the NHS has been recovering much less than it should",

and,

"The systems for cost recovery appear chaotic."

That is not good enough and we would not want to see that poor level of performance replicated as a result of any new reciprocal agreements.

Currently, the Public Accounts Committee reports that there is no evidence that EU reciprocal health arrangements are being abused. However, there is an increased risk of poor performance on collection targets if there are multiple future arrangements with differential terms. Subsection 2(e) will enable ongoing parliamentary scrutiny of performance levels. While respecting that urgent medical care is provided to any patient who needs it, the NHS and the Department of Health and Social Care must always ensure that money due to the NHS is recovered. We need a system that is fair to taxpayers and to patients who are entitled to free care either by virtue of being a British citizen or under a reciprocal agreement.

It is clear that, even under current arrangements, the collection of moneys owed for healthcare provided to foreign nationals, together with the administration of existing reciprocal healthcare agreements, is an onerous task for hospital trusts. As we leave the EU, it might be necessary for the UK to enter into multiple complex arrangements on a bilateral basis. Indeed, the Bill gives powers to the Secretary of State to enter into any number of agreements, which would introduce additional considerable financial burdens on hospital trusts whose duty it will be to administer the collection of charges for NHS services provided to foreign nationals who retire to the UK or who visit the UK under future reciprocal arrangements. It is likely to be a more onerous process as a series of differential arrangements might be required. The BMA and the Royal College of Paediatrics both agree that, should it be necessary to establish bilateral reciprocal arrangements with EU nations, significant additional costs would fall on the NHS.

Subsection 2(f) would introduce a requirement for the Government to report the detail of all costs incurred by hospital trusts in the pursuance of that duty. Cuts to real-terms NHS funding since 2010, together with increased demand, have pushed many NHS hospital trusts into deficit positions. The NHS is underfunded and understaffed, and hospitals face all-year-round crises. It is therefore imperative that hospital trusts are not required to shoulder additional financial burdens because of the costs of administering the collection of charges. It is absolutely essential that all agreements reached within the remit of the Bill do not direct funds for the treatment of patients to administration.

Ordered, That the debate be now adjourned.—*(Wendy Morton.)*

12.59 pm

Adjourned till this day at Two o'clock.