PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

HEALTHCARE (INTERNATIONAL ARRANGEMENTS) BILL

First Sitting

Tuesday 27 November 2018

CONTENTS

No proofs can be supplied. Corrections that Members suggest for the final version of the report should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor's Room, House of Commons,

not later than

Saturday 1 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

Witnesses

Mr Alastair Henderson, Chief Executive, Academy of Medical Royal Colleges

Raj Jethwa, Director of Policy, British Medical Association

Alisa Dolgova, Manager, Brexit, Association of British Insurers

Fiona Loud, Policy Director, Kidney Care UK

Public Bill Committee

Tuesday 27 November 2018

[Graham Stringer *in the Chair*]

Healthcare (International Arrangements) Bill

9.25 am

The Chair: Before we begin, I have a few housekeeping notes. I ask hon. Members to switch their phones and other electronic devices to silent mode, and remind them that tea and coffee are not allowed during sittings. Today, we will first consider the programme motion on the amendment paper, then a motion to allow the reporting of written evidence for publication, and then a motion to allow us to deliberate in private about our questions before the oral evidence sessions. In view of the time available, I hope that we can deal with those matters formally, without debate. The programme motion was discussed yesterday by the Programming Sub-Committee for the Bill.

Ordered,

That—

(1) the Committee shall (in addition to its first meeting at 9.25 am on Tuesday 27 November) meet—

(a) at 11.30 am and 2.00 pm on Thursday 29 November;

(b) at 9.25 am and 2.00 pm on Tuesday 4 December.

(2) the Committee shall hear oral evidence in accordance with the following Table:

Table

Date	Time	Witness
Tuesday 27 November	Until no later than 10.25am	Academy of Medical Royal Colleges; British Medical Association
Tuesday 27 November	Until no later than 10.55 am	Association of British Insurers
Tuesday 27 November	Until no later than 11.25 am	Kidney Care UK

(3) the proceedings shall (so far as not previously concluded) be brought to a conclusion at 5.00 pm on Tuesday 4 December.—*(Stephen Hammond.)*

The Chair: The deadline for amendments to be considered at the first line-by-line sitting of the Committee was Monday 26 November and therefore has passed. The deadline for amendments to be considered on the second day of line-by-line consideration of the Bill is the rise of the House on Thursday.

Resolved,

That, subject to the discretion of the Chair, any written evidence received by the Committee shall be reported to the House for publication.—*(Stephen Hammond.)*

The Chair: Copies of written evidence that the Committee receives will be made available in the Committee Room.

Resolved,

That, at this and any subsequent meeting at which oral evidence is to be heard, the Committee shall sit in private until the witnesses are admitted.—*(Stephen Hammond.)*

The Chair: We will now go into private session to discuss the lines of questioning.

9.27 am

The Committee deliberated in private.

Examination of Witnesses

Mr Alastair Henderson and Raj Jethwa gave evidence.

9.29 am

Q1 The Chair: We will now hear evidence from the Academy of Medical Royal Colleges and the British Medical Association.

I remind hon. Members that questions should be limited to matters within the scope of the Bill, and that we must stick to the timings in the programme motion that the Committee agreed for this session. We have until 10.25 am. I hope, because the Minister has to be on his feet on the Floor of the House immediately after this, to cut a couple of minutes off the session to enable him to carry out his duties.

Are there any relevant interests to declare? No. Will the witnesses introduce themselves?

Mr Henderson: Thank you. I am Alastair Henderson, the chief executive of the Academy of Medical Royal Colleges, which is the umbrella body for all the different medical royal colleges and faculties in the UK and Ireland. We represent the range of specialties, particularly on training, education and standards matters.

Raj Jethwa: I am Raj Jethwa, director of policy at the British Medical Association, which is the trade union and professional association for doctors in the UK.

Q2 The Minister for Health (Stephen Hammond): Good morning, gentlemen. Thank you for coming to give evidence to us this morning. Mr Henderson, in your evidence to the House of Lords European Union Committee, you noted that you want to see the current arrangements preserved. Could you just say how you think the current regulations for reciprocal healthcare work and why they are so satisfactory?

Mr Henderson: Yes, certainly. I think that the feeling of clinicians and health organisations, and also of patients, is that the current regulations work well because they are simple, well understood, easy to operate and pretty well universal in their coverage. We have a good system at the moment that is effective and easy to operate, and going forward we are looking for something that repeats or replicates that as closely as possible.

Q3 Stephen Hammond: In your evidence to the Lords Select Committee, you stated that pretty clearly as well. The Bill obviously aims to replicate and continue the current arrangements. I assume that, given your support for the regulatory system, you think that this is a sensible way for the Government to proceed.

Mr Henderson: Yes, I do; we are pleased to see that. I suppose our position is that, overall, the best and easiest thing would probably be for reciprocal healthcare agreements to be covered in an overall agreement. That seems to me to be the best thing. If we are not in the position of having an overall agreement, the Bill, which puts in these complementary arrangements, seems to be exactly the right thing. We are very supportive of it and are pleased to see that there.

Q4 Stephen Hammond: This is my final question to you, Mr Henderson. In your evidence to the Lords Select Committee, you also made the point about costs

and administrative burdens. As I understand it, if a new system were needed or if a no-deal scenario unfortunately arose—that is not the Government's intention—the costs or administrative burden would be a change in coding, rather than any other major administrative burden. Is that your understanding as well, in terms of cost recovery?

Mr Henderson: In terms of the overall cost, that may well be the position. It is not known what the arrangements for cost recovery would be. Both clinicians and health organisations are concerned that we could end up with a system that is both administration-intensive and time-intensive. If all people in this country from the European Union or European economic area have to be charged, what would be the implications for NHS organisations and clinicians?

It is important to say that doctors have had a consistent anxiety about becoming involved in being responsible for either immigration rules or charging rules, which would potentially have a quite adverse effect on the doctor-patient relationship. I think it is really important that whatever arrangements come in are as seamless and as simple as possible, so that they do not take people away from clinical duties or get in the way of delivering care.

Q5 Stephen Hammond: Thank you.

Mr Jethwa, good morning. I noticed in your written brief that the BMA stated that the Government should undertake every effort to retain the current model of reciprocal healthcare. My first question is the same as that to Mr Henderson: can you state why you think the current system works so well?

Raj Jethwa: For exactly the same reasons my colleague sets out: the arrangements are wide-ranging, secure and simple. They give security and clarity and are well established. Our view is that the best possible arrangement is for those arrangements to continue. If they cannot, the arrangements that come in their place should mirror them as far as possible.

Q6 Stephen Hammond: Given that, and given that that is the intention of the Bill, do you think that the Government are taking the right approach to ensuring that they put those arrangements in place and that the legislation has the flexibility to cover both what we hope for, which is an achievable deal, and a no-deal situation?

Raj Jethwa: We largely welcome the Bill for exactly the intention behind it, but because the detail in it is limited we have some concerns about exactly the clarity going forward that the Bill allows for. We support the broad intentions behind the Bill, but we would like to see more detail about exactly how the arrangements will operate in practice, particularly the scrutiny arrangements to ensure there is clarity and transparency in what the arrangements negotiated and facilitated through the Bill would look like.

Q7 Stephen Hammond: In terms of the security arrangements, do you mean security of data?

Raj Jethwa: No, I beg your pardon. We do have concerns about security, but I meant clarity, from the perspective of patients understanding and being secure in themselves about what the arrangements would mean.

Stephen Hammond: Thank you.

Q8 Justin Madders (Ellesmere Port and Neston) (Lab): Mr Henderson, you said you consider that the system works well at the moment. I think it is pretty universally accepted that the cost recovery element does not work so well. Do you feel that more ought to be done in respect of that, and if so what would you like to see done?

Mr Henderson: I do not pretend to be an expert on the cost recovery system. I think our members would be very clear that they believe the primary effectiveness of the current arrangements is about providing effective healthcare for citizens across the EU. As clinicians, that is their primary responsibility.

On the recovery of costs, not just in this area but for other areas where recoverable costs were brought in more recently, there are always questions about the amount of effort and return in the whole system. I am not at all opposed to the idea of recovery of costs, but I am not sure we have yet found a hugely simple and easy way of recovering any costs really. I would happily support that, but it seems to us that this works as a system on its most important requirement, which is providing quick, clear and safe healthcare for people.

Q9 Justin Madders: You say that you have basically the same system for 32 or 33 different countries. If we end up in a situation in which we have to make arrangements with each individual country—potentially significantly different arrangements depending on what is negotiated—what effect do you think that will have on your members, in terms of what they can deliver?

Mr Henderson: It is not a hugely attractive prospect, is it, 32 different settings, for those presumably trying to agree the arrangements? 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. What clinicians on the ground want is a clear and simple system—ideally a single system—that will cover all the people they are seeing.

Q10 Justin Madders: May I ask Mr Jethwa some questions? Have you looked at all at the situation as it might affect the island of Ireland?

Raj Jethwa: We have done some work on that.

Justin Madders: Would you like to say what you are doing?

Raj Jethwa: Our concern about the situation there is primarily based on the fact that there are some very effective cross-border agreements which have facilitated healthcare over the last two or three decades, particularly through co-operation and working together as a programme. That is only one aspect of it. Given the population demands on the whole island of Ireland, both in the Republic of Ireland and Northern Ireland, there have been some fantastic examples of where clinicians have either co-located services in a particular trust or facility where there is not the demand from the local population to warrant it, or travelled across the border to work on different sites. Those two facets together have meant that there have been some great examples of cross-border co-operation. One of our concerns is that those arrangements remain in place in the future.

Q11 Justin Madders: Do you have any idea what the contingency plans might be if an appropriate deal is not put in place?

Raj Jethwa: That is something that we can write to the Committee about afterwards. We have been talking to our members about this situation. Our anticipation—our hope—is that an arrangement will remain in place whereby that work can continue.

Q12 Justin Madders: Have you looked at what the possible impact might be of a no-deal scenario on increased demand on services if, for example, pensioners currently living abroad came back?

Raj Jethwa: We are familiar with the research that the Nuffield Trust has done on this, as most people are. Our members are very cognisant of this. I know the Committee will be familiar with the figure of approximately 190,000 UK pensioners who may require access to healthcare facilities in the future if the S1 arrangements do not remain in place. We have concerns about that. In particular, if the arrangements do not remain in place in the future, those people may need to access healthcare facilities back in the United Kingdom. That would be a concern in terms of doctor and clinician numbers and beds, and the tight financial resources that the NHS has to work under at the moment.

Q13 Julie Cooper (Burnley) (Lab): Good morning. Mr Henderson, you mentioned the protections around personal data in the Bill. Do you feel that the Bill gives enough protection? Are there enough controls in the Bill?

Mr Henderson: As Raj says, this is an enabling Bill, so it is slightly hard to say whether there is sufficient protection there or not. Clearly, it is a hugely important issue that needs to be fully addressed. Equally, we would say very strongly that, while individual patients' data must be protected, the free flow of data and exchange of information are absolutely crucial. We should never forget that side of the equation: properly and safely sharing anonymised data for research purposes, clinical trials and so on is crucial. While it is absolutely essential that we ensure that personal data is protected, I would put more emphasis on that other side, which is ensuring that we continue to share and benefit from the exchange of anonymised data for purposes that benefit the health service and research.

Q14 Julie Cooper: Thank you. Mr Jethwa, would you like to comment on the same issue?

Raj Jethwa: It is important that an agreement can allow a seamless operation, but there are some well-established ethical principles and safeguards in relation to this. First, it has to be relevant data and it 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.

Q15 Maggie Throup (Erewash) (Con): Mr Jethwa, when you look at the current regulations, do you think the powers in the proposed legislation are proportionate?

Raj Jethwa: We would like to see much more emphasis on scrutiny of all the discussions in the arrangements going forward. There are some negative procedures—I think that is the term. Given the weight of the issue and the number of people that could be affected by it—I have mentioned the 190,000 UK pensioners who live abroad at the moment, but there are close to 3 million people from the European Union who access healthcare in this country, and there are many more than that who travel across the European Union at the moment—there probably needs to be greater scrutiny of any arrangements going forward.

Q16 Matt Western (Warwick and Leamington) (Lab): Mr Henderson, I think you described the existing arrangements as pretty well universal. Could you explain a little more what the gaps are?

Mr Henderson: I am not actually sure I have all the detail. My understanding is that the European health insurance card and such arrangements work for all emergency situations, certainly, and most normal circumstances. I think, and Raj may know better than I, that there are some areas that are not covered particularly, but as I understand it, it is fairly universal. I am not an absolute expert in that, I am afraid.

Raj Jethwa: We can write to the Committee. My opinion is that it is pretty universal. There are probably niche areas that may not be covered. We can look into that and get back to the Committee if that would be helpful.

Q17 Justin Madders: I have one more question to both of you—I am not sure if either of you will know the answer. Some of the reciprocal arrangements we have at the moment are based on the actual cost expended and some are based on an average—Estonia, Denmark, Finland, Hungary, Malta and Norway. I am not clear why that is the case. Is there some sort of historical issue? If either of you can shed any light on that, that would be extremely helpful. One of you is shaking your head.

Raj Jethwa: I do not know that, but again we are happy to look into that and to come back to you if we find out that somebody back home does know the answer. I am not sure that I know.

Mr Henderson: It is probably lost in the mists of various previous agreements.

Q18 Stephen Hammond: Can I come back on the data point that you both commented on? Clause 4 deals directly with that and provides the usual protections in terms of data. I heard Mr Henderson's point, and it is important that there needs to be a flow of data, although that needs to be secure. Are you happy that the protections in the Bill at the moment are the normal and adequate protections?

Raj Jethwa: One of the concerns we have is the reference to the authorised person and who could fit into that category. Without seeing more detail about what the arrangements will look like in the future, we do have some concerns and we are seeking that level of understanding. Without seeing that and knowing exactly what process will be used to, for example, recoup the money or make payments, it is hard to know exactly what those arrangements would look like and on what

basis information would be shared. We do have concerns about the authorised person aspect of the Bill, and we need to ensure that we have greater understanding about exactly who would be an authorised person, beyond that list of specific bodies and individuals who are named in the Bill at the moment.

The Chair: Does the Committee have any more questions? No. I thank the witnesses for helping the Committee with its deliberations, and call the next witness.

Examination of Witness

Alisa Dolgova gave evidence.

9.49 am

Q19 The Chair: The next evidence is from the Association of British Insurers. Good morning. Would you please introduce yourself?

Alisa Dolgova: Hi. I am Alisa Dolgova. I am the manager looking after Brexit at the Association of British Insurers. We are a membership organisation representing more than 250 insurance and long-term savings firms in the UK, ranging across general, life and reinsurance companies.

Q20 Stephen Hammond: Good morning, and thank you for coming to give evidence this morning. Could you set out the advantages of the EHIC scheme as the ABI sees them?

Alisa Dolgova: I agree with those who gave evidence before me, in that the advantage of the EHIC is that it is a simple, easy-to-understand system. From an insurance perspective, the EHIC covers the medical treatment of UK nationals travelling through one of the covered countries, in the same way as local nationals would be covered in terms of state provision of healthcare. The insurance then covers anything that is not covered by EHIC, meaning things that are not covered by the state healthcare system—some countries have a greater tradition of state healthcare than others—but also things such as repatriation. The advantage of the current system continuing for customers is mainly that it is a system that is well understood, and there is a minimum that is covered for everybody, irrespective of whether they have travel insurance.

Q21 Stephen Hammond: Specifically on travel insurance, if reciprocal arrangements were not in place, what would be the implications in terms of cost, and are there any other potential implications that we should understand?

Alisa Dolgova: If EHIC were not in place, those costs would be covered by the person's travel insurance, if they have insurance in place. That means that costs that are currently covered by EHIC would be borne by the insurer. I think £156 million is currently covered by EHIC, so part of that would be covered by the insurer, and that would have an impact on the claims costs for insurance companies—costs that currently are not there. That might have an impact on the premiums that insurers charge their customers.

Q22 Stephen Hammond: Have you made any estimate of what the increase in premiums would be if reciprocal arrangements were not in place?

Alisa Dolgova: That is difficult. Insurers do not know what the impact is going to be, because currently they do not have the data on where the policyholders travel to. By far the most common type of travel policy that is bought in the market is a multi-year insurance policy, which covers an individual who can travel anywhere in the EU—or the rest of the world, for that matter. Currently, because part of that is covered by EHIC, insurers do not have the breakdown, and it is therefore difficult to give a number for what might happen.

Q23 Stephen Hammond: Do you have some indication of what the typical current premiums are for people with complex and acute conditions who travel to Europe, and what the premium increase would be if reciprocal arrangements were not in place?

Alisa Dolgova: Generally speaking, premiums will be higher for two reasons: first, if the chance of the person claiming is higher, and secondly, if the volume of payout is likely to be higher—so, if someone has a condition that is particularly expensive to treat. That is why health is one of the risk factors that may increase premiums. Again, it is quite difficult to say what the difference in the potential increase would be between those who have existing conditions and those who are in good health, because it basically depends on where that group of people is likely to travel to, in terms of how expensive healthcare is in that country. For example, if someone travels to the US, that is a lot more expensive than if they were to travel to some other destinations. I would just say that if you look at countries where you do not have EHIC or reciprocal arrangements, insurance policies are available but it may require a bit more effort to locate the right product for the right individual. We are working with the Financial Conduct Authority, Macmillan and other organisations on that.

Q24 Stephen Hammond: I want to ask you broadly the same set of questions, but specifically with regard to health insurance and what the implications would be if reciprocal arrangements were not in place for UK citizens travelling to the EU.

Alisa Dolgova: Most private medical insurance policies in the UK are generally designed to cover treatment within the UK. It is relatively rare for the policies to also cover healthcare while you are travelling.

Q25 Stephen Hammond: If reciprocal arrangements were not in place, you would have to have extra healthcare insurance to cover eventualities abroad and in the EU.

Alisa Dolgova: Yes. It may vary depending on the type of policy, but generally speaking that is the most common situation.

Q26 Stephen Hammond: Have you given any thought as to what the cost implications would be if you had to put those arrangements in place?

Alisa Dolgova: For health insurance?

Stephen Hammond: Yes, for health specifically.

Alisa Dolgova: The implications for health insurance are a lot less than for travel insurance. Apart from that, health insurance would primarily be affected in the same way as any other insurance in terms of transferring

data across borders. I am not sure there is likely to be a significant impact on health insurance if the reciprocal healthcare arrangements are not in place.

Q27 Stephen Hammond: Given what we have just said and some of the implications for not having reciprocal arrangements in place, can I assume that in principle the ABI thinks that the Government are acting in the correct way to put in place reciprocal arrangements, or arrangements to make reciprocal arrangements?

Alisa Dolgova: We are supportive of the Bill and giving the Government the powers they need to implement reciprocal healthcare arrangements. From the insurers' perspective, the most important thing for us is to know as early as possible, whatever the outcome, so that insurers can plan for any changes and so that we can let our customers know what the impact is likely to be.

Stephen Hammond: So, the sooner the Bill gets Royal Assent, the happier you will be.

Q28 Justin Madders: On the cost point, I think some evidence was given to the House of Lords Committee that in a no deal you expected premiums to increase by between 5% and 10%. Does that sound like a familiar figure?

Alisa Dolgova: My colleague Hugh Savill gave evidence to the House of Lords, where he stated that there is likely to be an increase of between 10% and 20%. To be honest, we do not really know, because it very much depends on the particular insurer, who it insures and where that specific group of people travels to.

Q29 Justin Madders: In that context, what advice are you giving to people about insurance requirements post 29 March 2019?

Alisa Dolgova: The main message that insurers are giving to the customers is that it has always been important to have travel insurance because it covers things that EHIC does not, but it will be even more important to have it in case there is not a transitional period, because travellers would no longer have the benefit of EHIC. The message is that you need to have travel insurance in place, and that travel insurance will cover you, irrespective of whether you have EHIC.

Q30 Justin Madders: Has there been an increase in premiums because of that added uncertainty, do you know?

Alisa Dolgova: We have not currently seen an increase in premiums. Firms are currently pricing in the assumption that there will be a withdrawal agreement in place with a transitional period that will allow more time for the Government to enter into a reciprocal healthcare arrangement.

Q31 Justin Madders: In the event that there are not arrangements in place, have your members done any work on the number of people who might not be able to travel, because they effectively become uninsurable or the premiums are so high that they are prohibitive?

Alisa Dolgova: I have briefly alluded to the work that we have been doing with the Financial Conduct Authority. The FCA published a feedback statement in June this year, looking at travel for people with pre-existing conditions. The finding was that there are products available on the market but they may be difficult to locate at the moment, which is why we are doing additional work at the moment. So there are products available that will cover people.

Q32 Justin Madders: I appreciate that. There will almost always be a product; it is the size of the premium that can dictate whether that product is really available. Have you looked at the potential size of premiums in those situations? Are there particular pre-existing conditions that people might have that will have a negative impact on the size of the premium?

Alisa Dolgova: I do not have information with me about which types of conditions are more expensive than others, but it will be the types of conditions that are more likely to require treatment while you are travelling, and insurers do take factors into account such as, "What has been your recovery time?"

Q33 Justin Madders: My final question is about the overlap between EHIC costs and insurance costs. I had a recent example in my constituency of a constituent who came back from Spain with a medical bill for £15,000. It was not for repatriation costs; it was purely for medical treatment. Obviously, the question is, why is that not covered by the normal arrangements? How often does that situation arise, and can you give me some insight as to why that might be happening?

Alisa Dolgova: Yes, sure. EHIC covers you for public healthcare in the same way as a person from that country would be covered, and healthcare provision differs a lot, depending on which EU country you are in. Some countries, such as Italy, have healthcare systems that are much closer to the NHS than others, and if you travel there, EHIC will give you greater coverage. Some countries, such as Spain, have a mixed public/private system and some countries, such as Germany, have a greater tradition of private healthcare. Actually, that means the degree you are covered by EHIC varies depending on where you travel and that is why you need insurance.

Q34 Justin Madders: Okay. I think my constituent's situation was an emergency and I do not think that any consideration was given to the type of hospital. I think that what you are saying is that reciprocal arrangements do not necessarily give you the same or equivalent coverage in other countries, because it depends on the system that operates there.

Alisa Dolgova: Yes. It will give you more coverage across all countries, but what that coverage is depends on what the situation is in that country.

Q35 Alberto Costa (South Leicestershire) (Con): You said that private insurance policies cover the areas above the benefits of the EHIC. But is it not the case that those of us who take out private travel insurance policies precisely for the healthcare benefits may not make use of EHIC? And is it the case that, because of that, the premium costs for private travel insurance are less, given that those of us who take out private insurance might not use EHIC and might rely on the private healthcare side instead?

Alisa Dolgova: It depends on the specific terms of the travel insurance policy that you have. For example, some policies have a specific provision that you need to

use EHIC first and then have resort to your insurance policy, and insurers may also provide incentives to use EHIC as well. For example, they might provide a waiver for access costs of EHIC; that has been used.

Q36 Alberto Costa: What I am trying to ask is whether it might be the case that, without this Bill and without reciprocal arrangements, the cost of travel health insurance is likely to go up? Those of us who take out these policies are not necessarily reliant on EHIC, because we would refer to the private claim, whereas others who perhaps do not have healthcare benefits under a travel insurance policy would be entirely reliant on EHIC. What I am trying to tease out is whether, without this Bill, the healthcare side of travel insurance—the premiums—would potentially go up?

Alisa Dolgova: The claims cost will definitely increase, which may lead to an increase in travel insurance costs as well.

Q37 Matt Western: Out of interest, can I ask you a really simple question? What happens currently, but also perhaps in future, when someone is abroad and has an injury, an accident or whatever for which some form of implant is required, and that implant subsequently fails when the person returns to the UK and it is not supported by the NHS? Where does the cost burden fall and how does that impact on insurance, and how may that work in future if we do not have regulatory alignment?

Alisa Dolgova: Sorry, your question is who would pick up the cost if treatment were provided overseas, but it fails?

Matt Western: Yes. If that implant failed, whatever it might be, and the cost to revise that implant were then borne by the NHS, who picks up the cost, and how does that work? How does it work currently, and how might it work in the future based on this?

Alisa Dolgova: I am not sure I have a detailed enough answer to give at the moment. I would be happy to come back to the Committee on that, but again, I think it would ultimately depend on exactly what travel insurance policy is in place. I would assume that the travel insurance policy is likely to cover a person for the treatment they receive overseas, and if they then need additional medical treatment back in the UK, they would be treated within the UK healthcare system in the same way as they are currently.

The Chair: Are there any more questions from members of the Committee? If not, I thank you very much for helping the Committee with its deliberations on this Bill, and I call the next witness.

Examination of Witness

Fiona Loud gave evidence.

10.8 am

Q38 The Chair: We will now hear oral evidence from Kidney Care UK. Could you introduce yourself, please?

Fiona Loud: My name is Fiona Loud, and I am the policy director for Kidney Care UK. We have been around for over 40 years and were formerly known as the British Kidney Patient Association. We are the national kidney patient support charity, so we give emotional, financial and practical help to patients and their families who are affected by kidney disease, but particularly kidney failure.

Q39 Stephen Hammond: Good morning and thank you for coming. I am particularly keen to hear evidence from you about how the current reciprocal arrangements work for patients with high needs and complex arrangements. It would be very helpful to hear how you think the current arrangements work.

Fiona Loud: At the moment, 29,000 people in the UK are dependent on dialysis. That is three times a week, about five hours at a time, and those people cannot miss a session, because those sessions maintain their life. If a person is on dialysis and wishes to travel—anywhere in the world, but let us talk about the EU here—whether to meet family, to have a holiday, or to work, they need to be able to pre-book a slot or slots at a dialysis unit that is convenient to the place they are travelling to. At the moment, the EHIC card either covers it completely or, in countries where there is a co-payment because local residents make a co-payment, it covers the bulk of your care. Many patients tend to go to places such as Spain and France, and some go to Italy, because they are holiday-type destinations. It works for them because they get the EHIC, are able to get their life-maintaining treatment and have the opportunity, for themselves and their families, for a much-needed break. That is an example of one of the main reasons people might use that.

So it works well at the moment. It is not completely perfect because sometimes units that were public become private and it may occasionally happen that someone has booked a holiday a long way in advance. But, in general terms, it means that people are able to go away with the confidence that they will be able to be supported and receive the treatment they need.

Q40 Stephen Hammond: You will have heard the evidence we have just taken from ABI. I was particularly keen to understand the variations in insurance and exclusions that might currently exist where there are high needs and complex conditions. Could you set out for the Committee the experience of Kidney Care UK?

Fiona Loud: For people with a pre-existing condition, such as kidney failure, we always advise that they take out insurance in addition to having a current EHIC card, because there will be situations in which they may need to cancel their travel at very short notice due to illness. What we regularly hear from patients—this is probably one of the most common questions asked on our closed social media forums, especially at holiday time—is, "Where do I book? Where do I get insurance from? Where do I get the best deal?" My understanding is that some people go to specialist insurers to get their cover—they will be those that we tend to recommend to people because they are much more likely to understand and to be able to support these complex conditions. Whether everyone gets insurance, I honestly do not know. Some people will say that it is so expensive that they cannot afford it, and that could put them off travelling. Other people will say that they have incredibly cheap deals, and I do wonder whether those would actually cover the situation of someone really needing care.

Let me give you a recent example of someone who booked a holiday a year in advance, not in the EU but further away. They took out specialist travel insurance

and during that time their transplant failed, which meant that they became dependent on dialysis, were particular ill and had to cancel the holiday for them and all their family. They were able to get all their money back because they had given a clear declaration and that had been accepted. That is how it should work, and it was some comfort to them in what was not a very good situation.

We have people who are taking the option to travel now because they have no idea what will happen after 29 March. For them, the ability to travel with confidence—I think there is something in the Bill about people being able to travel with confidence—is something they can do now, and they are not confident yet that they will be able to do that after 29 March.

Q41 Stephen Hammond: The intention of the Bill is to provide that confidence, so may I ask whether you support that intention in principle?

Fiona Loud: We understand the reason for it and we support its intentions. You may have seen some of our comments: we want more assurance, some more detail and some things about contingency as well but, yes, we have been hoping for some time that something could be put in place to set this process in motion.

Q42 Stephen Hammond: I know that you and my colleague, the noble Lord O'Shaughnessy, have had a discussion. Could you tell this Committee what the contingency issues you refer to are?

Fiona Loud: The contingency issues would be for people who have holidays already booked for after 29 March. There are people who have already done that and, because their EHIC card has a date of after 29 March—the cards will go on for many years afterwards, as we all know; they are issued for five or 10-year chunks—they imagine that they can go away and receive their dialysis. What happens in the case of no deal, where holidays are booked on that presumption? Will there be cover?

The second question will be about emergency cover. I have just given an example of somebody who was fine when they booked the holiday but who now may not be fine, because people's health state can change. Generally speaking, holidays are booked in advance. It is basically about looking at what the immediate arrangements would be and to make sure that no citizens are caught in the gap of assuming they have cover and somehow not realising that things have changed. There is an awful lot about Brexit at the moment and this is a very specific detail in a much noisier environment. Those are the people who might be caught out and whom we are concerned about.

Q43 Stephen Hammond: Finally, without putting reciprocal arrangements in place, as this Bill intends to give the Government the powers to do, presumably it would make it more or less impossible for your sufferers to travel.

Fiona Loud: Yes, it is our conclusion that it would be very hard. It is worth mentioning that at the moment it is generally easier to obtain dialysis at a unit away from your home in Europe than it is in the UK, because we have a heavily pressed NHS. Trying to get capacity in other units is possible with a lot of planning, but if you want to travel for a funeral or for something at short notice, it becomes very difficult to go away for more than one or two days in between dialysis sessions. NHS staff will help and do their very best, but it is easier to go away for two weeks in Europe and take a break in that way than it is to get two weeks in a UK unit, unfortunately.

Q44 Justin Madders: It is alarming to hear about some of your members seeing the expiry date on their EHIC card and assuming that carries—

Fiona Loud: I have heard it as a comment.

Q45 Justin Madders: It is perfectly understandable: why would they not assume that? Are you aware of any publicly available guidance to warn people that that date may not be absolutely set in stone?

Fiona Loud: I have not come across any publicly available guidance on that at all. We have given advice and organisations that we work with give advice, but it is informal advice. It is not formal, because it comes from us as a charity, not from any public health or other such body.

Q46 Justin Madders: Obviously, we hope that we do not need to get into that situation. Do your members plan things quite far in advance because of the need to get the right treatment?

Fiona Loud: That is what many people would do, for the very reasons we have given. We have people who are sometimes thinking about two years in advance. If you have kidney failure, it may well be that your income is quite limited. If you are spending three days a week in hospital and you are not particularly well, you would be likely to plan a long way in advance, because it is so important. As a charity, we give grants to kidney patients to be able to go away and have that break, so we hear quite a lot about it from various patients. Some can be up to two years in advance; others will be at shorter notice.

Q47 Julie Cooper: Good morning and thank you for coming along to help us. I want to ask about a couple of things. The aim of the Bill is to provide the confidence that we have talked about, to mirror as far as possible the reciprocal arrangements that we already enjoy. However, it does give the Secretary of State the authority to enter into any number of differential agreements with individual EU states. Do you have concerns about that? If we were in this situation—I hope we are not—the Bill empowers the Secretary of State to do that. What would be your view be on the arrangement with Spain being one thing and that with Italy another, and so on?

Fiona Loud: Although we completely understand the need to be able to have the latitude to make bilateral arrangements for everyone's benefit, from a patient point of view we would like to see a simple arrangement that is the same across all countries. People will not be sitting in these Committees or reading these Bills in great detail. They simply want to be able to go away. They know how a system works at the moment: they will perhaps turn to somebody in their own NHS unit, or they will turn to us or to other specialists, and ask, "How do I go ahead and book my holiday?" and they will assume that, because they have that card, that is how it will be. That would be our wish and our preference, but we understand that that is not always possible.

If I may make a separate comment about Northern Ireland, there are potential issues there that are nothing to do with holiday but are simply about residents who are used to going across the border day to day for their care and treatments. There are pre-existing arrangements and protocols there. For example, somebody might be on dialysis in Northern Ireland but, because the rest of their family live in Ireland—it is only 10 or 15 miles away—they might be planning to retire there in a year or two and assume that they can just carry on having their dialysis there.

The provision exists for people who live in Northern Ireland to be listed on the Irish organ donor register—you can only be on one—and vice versa. They will need to look at where they are registered. Does that change immediately? There are also other arrangements for organ sharing. If an organ is donated in one of those two jurisdictions and the weather is too bad to take it to the mainland, it can be taken across by road. That is not used very often, but those are just a couple of examples of some of the detail that might affect people. That is to do with healthcare but it is also separate. There may, therefore, need to be some other bilateral arrangement for Northern Ireland, which is separate from the more general one that we have just discussed.

Q48 Julie Cooper: Thank you, that is very helpful. Could I just ask you one more question about costs? You rightly made the point that, if somebody is attending for dialysis three days a week, they are likely to have lower income than average. If it is not possible to continue something similar to the EHIC card, are you concerned that transferring extra costs to insurance premiums is going to make travel virtually impossible?

Fiona Loud: We are. A dialysis session in the EU would cost between €250 and €350, so that is about €1,000 a week. We have had correspondence with Sabine Weyand, who is the deputy chief negotiator for exiting the EU. She confirmed to us that British nationals would be treated as third-country nationals, in the case of no negotiation being in place. Therefore, our conclusion is that for third-country nationals, those costs that I have just referred to would be applied. Therefore, only people who were able to afford that, alongside a higher insurance policy—which would not cover the dialysis, though it would cover other things—would be able to travel, effectively making it out of reach for most patients, unfortunately.

The Chair: Are there any more questions from the Committee? If not, I thank you very much for helping us with our deliberations today. That concludes our oral evidence-gathering for the Bill. The Committee will meet again on Thursday 29 November at 11.30 am in Room 12, when we will commence line-by-line consideration of the Bill.

Ordered, That further consideration be now adjourned. *—(Wendy Morton.)*

10.23 am

Adjourned till Thursday 29 November at half-past Eleven o'clock.

Written evidence reported to the House

HIAB01 Jill Brian

HIAB02 Expat Citizen Rights in EU (ECREU)