OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 11 December 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 11 December 2018

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HEALTH AND SPORT COMMITTEE
32nd Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Keith Brown (Clackmannanshire and Dunblane) (SNP)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Ian Davidson (Scottish Government)
Paul Gray (NHS Scotland)
Shirley Rogers (Scottish Government)
Liz Sadler (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 11 December 2018

[The Convener opened the meeting at 10:02]

Healthcare (International Arrangements) Bill 2017-19

The Convener (Lewis Macdonald): Good morning, and welcome to the 32nd meeting of the Health and Sport Committee in 2018.

We have received apologies from Brian Whittle.

I ask everyone to ensure that their phones are off or on silent, and not to record or film proceedings. We have in place arrangements to do that ourselves.

The first item on our agenda is an evidence session on the Healthcare (International Arrangements) Bill 2017-19, which is United Kingdom Parliament legislation, in relation to which a legislative consent memorandum has been lodged and which we anticipate will be formally referred to the committee in short order.

The bill was introduced in the House of Commons on 26 October 2018. It is one of a series of bills that are intended to adjust UK legislation for Brexit, in addition to the European Union (Withdrawal) Act 2018. Specifically, it is intended to allow the UK to maintain reciprocal healthcare arrangements with the European Union and its member states after Brexit, whether or not a withdrawal arrangement is reached. However, the provisions of the bill are not limited to arrangements with the EU. The UK Government states that the bill will also allow the UK to strengthen existing reciprocal healthcare agreements with countries outside the EU or to arrange new ones.

To give evidence on the relevant issues, I welcome to the committee Paul Gray, the director general for health and social care and the chief executive of the national health service in Scotland. With him on the panel are four Scottish Government officials: Shirley Rogers is the director for health workforce, leadership and service transformation; Liz Sadler is the deputy director of the planning and quality division; Ian Davidson is the head of constitution and UK relations; and John Paterson is a divisional solicitor.

Paul Gray has let us know that he intends to step down from his role in the coming weeks. I record the committee's thanks to him for his leadership of the health service over the past five years. On my own behalf, I thank him for his leadership on health and care over an even longer period. On behalf of the committee, Paul, I wish you well in your future endeavours. It falls to this committee to interrogate you one last time, at least, and I invite you to make an opening statement.

Paul Gray (NHS Scotland): Thank you for your kind words, convener. I have certainly felt it to be a great privilege to hold the role and to appear before parliamentary committees, which I regard as an essential component of public service and being held to account.

I am pleased to be here today with colleagues to discuss the legislative consent memorandum for the United Kingdom Healthcare (International Arrangements) Bill, which was lodged in the Scottish Parliament and published on Thursday 6 December.

On leaving the European Union, the reciprocal healthcare arrangements that are in place might no longer apply in their current form, and UK legislation is required to provide for future arrangements. In broad terms, the bill would give powers to the Secretary of State for Health and Social Care to fund and arrange healthcare outside the UK and to put in place reciprocal healthcare arrangements between the UK and other countries or international organisations such as the EU.

The Scottish ministers and the UK Government agree that the bill impacts on the devolved function of health. As a result, it requires the consent of the Scottish Parliament. UK Government officials have indicated that the bill will be amended to recognise the responsibility of the devolved Administrations. The proposal is to introduce a requirement to consult the devolved Administrations and to agree a memorandum of understanding with them before regulations can be introduced that impact on devolved matters.

In the event of a deal being reached between the EU and the UK, the European Union (Withdrawal) Act 2018 would allow the current reciprocal health arrangements to continue during the implementation period. However, in the event of there being no deal, the Healthcare (International Arrangements) Bill would be needed to put new arrangements in place quickly.

The committee is, no doubt, aware that, in June, the UK Government passed the European Union (Withdrawal) Bill, despite the refusal of the Scottish Parliament to give its legislative consent to relevant provisions of that bill. UK Government ministers expressed the view that Brexit is "not

normal", so it falls within the exceptions that apply to the Sewel convention.

Since the European Union (Withdrawal) Bill was passed, the Scottish Government has taken the view that it should not seek formal legislative consent from the Parliament for Brexit bills. The Scottish Government has, however, made it clear that it will co-operate in developing bills and supporting this Parliament's scrutiny of them. It has lodged LCMs on the Trade Bill, the Agriculture Bill, the Fisheries Bill and now the Healthcare (International Arrangements) Bill. The Scottish ministers have also said that formal legislative consent could be sought for Brexit legislation in exceptional circumstances.

The Scottish Government believes that there are exceptional circumstances for the Healthcare (International Arrangements) Bill, given the need to provide reassurance to Scots who access state healthcare in the European Economic Area under the existing reciprocal schemes. The Government will, therefore, lodge an LCM for the bill.

On reciprocal healthcare more generally, my letter of 4 December to the committee indicated that six NHS boards, including NHS Greater Glasgow and Clyde, were not participating in the UK Government's European health insurance card incentive scheme. We have since received further returns, and we now have the November statistics. I am pleased to report that NHS Greater Glasgow and Clyde has recorded EHIC activity and has recovered £120,000. I will meet the health board chief executives this evening, and I propose to ask the remaining five boards why they are not participating in the scheme.

We have anticipated the range of questions that the committee might ask in the officials whom we have brought to the meeting, but the subject is broad and could attract questions from members on many aspects. If there is any information that I do not have, I give the committee an undertaking to provide it at the earliest possible moment after the evidence session has concluded.

The Convener: Thank you, Paul. That is much appreciated.

You rightly say that this is a broad subject. The committee is keen to understand the scope of the current arrangements and how they operate. What currently happens if a visitor from outwith the European Economic Area wishes to register with a general practitioner?

Paul Gray: I ask Liz Sadler to answer that question. My understanding is that we encourage GPs to establish a person's country of origin but we do not wish to deprive people of primary healthcare services, so we have not so mandated.

Liz Sadler (Scottish Government): Recent general guidelines on GP registration included a section on overseas visitors, encouraging but not requiring GPs to establish a person's country of origin. As Paul Gray says, that is primarily to ensure that people can access primary healthcare if they require it. I am afraid that I do not have any more details on that subject, but we can write to you about it. The regulations make it clear that people from outwith the EEA are required to pay for healthcare, and we expect GPs to be able to establish people's country of origin.

The Convener: That is an interesting reply. Does Scotland differ from other parts of the United Kingdom in not requiring evidence either of residency or of nationality for registration with a GP?

Liz Sadler: I am afraid that I do not know the answer to that question.

The Convener: Given the nature of the bill that is before us and the implications that it might have for Scottish NHS finances, I think that it is important to understand the implications of what you have described. Correct me if I am wrong, but it seems that, if a person with no entitlement to free treatment is able to register with an NHS general practice without evidence of being entitled to free treatment, they could easily go through the entire healthcare system without being recognised as being ineligible for NHS treatment.

Liz Sadler: The legislation covers people from within the EEA who are entitled to free healthcare under the reciprocal healthcare arrangements. Non-EEA people are not eligible for free healthcare, so the bill would not have an impact on those individuals. Separate arrangements are set out in the regulations relating to payment for healthcare by people from non-EEA countries.

The Convener: I understand that point. However, I presume that the bill will apply to citizens of EEA countries the same rules that apply to non-EEA visitors in the event of the UK leaving the European Union without an agreed arrangement. Is that broadly the principle of the bill?

Liz Sadler: The Government's policy is that the existing reciprocal healthcare arrangements for EEA people should continue to be in force in the event of a Brexit agreement and would continue until the end of the implementation period. In the event of there being no deal, additional provisions would need to be put in place straight away to enable that to continue. That would apply only if there was no agreement to continue reciprocal healthcare.

Paul Gray: If I have correctly understood your question, your point is that, because we do not oblige general practitioners to determine

absolutely the country of origin of someone seeking treatment from them, it is possible that someone from a country that is not within the EEA could get treatment from a general practitioner without so declaring. I think that we should quickly write to the committee on that point, making the distinction that you have made and making clear whether we are doing something about that distinction. Furthermore, we must be clear about whether that system is different from the systems that exist elsewhere in the UK.

The Convener: That would be helpful. The legislative consent memorandum appears to say that the bill is intended to go beyond the EEA and to allow for reciprocal healthcare arrangements with other countries. We already have such arrangements with Australia and New Zealand, for example, so it is pertinent to understand the scope of the current arrangements. In addition to the points that you have outlined, there is also the question of whether, if there is no check on origin and nationality at the point of registration with primary care, checks will have to be made by hospitals when a GP refers a patient. Or are there, in essence, no checks?

10:15

Paul Gray: Checks are performed if acute services are required. Again, it would be good for us to be completely clear with the committee about that stream and for us to put that information on the record.

The Convener: Excellent. Thank you very much.

Emma Harper (South Scotland) (SNP): Good morning, panel. I am interested in any consultation that has taken place between the Scottish Government and the UK Government on the development of the scheme. Was the Scottish Government consulted as part of the introduction of the scheme?

Paul Gray: Do you mean in relation to the bill or the EHIC?

Emma Harper: I mean in relation to the EHIC in general.

Liz Sadler: The current arrangements have been in place for some time. In the summer, in anticipation of Brexit, we had discussions with the UK Government at a very high level about what the future might look like. Since then, there has been very little interaction, despite regular prompting from us for further information from the UK Government.

On Friday 19 October, we were informed at official level that there would be a bill, and we were given a copy of it, but it was not until Monday 22 October that we were informed that its introduction was imminent. The Cabinet Secretary for Health and Sport had a conversation with the Parliamentary Under Secretary of State for Health on Wednesday 24 October, when he confirmed that the bill would be published and that there was a requirement to consult the Scottish Parliament. Since then, we have had some limited conversations with officials in the Department of Health and Social Care about strengthening the bill to recognise the devolved implications, particularly around consultation and, ideally, seeking the Scottish Parliament's consent to amendments to any legislation that has been passed by the Scottish Parliament.

Emma Harper: So, there has not really been much contact with the Cabinet Secretary for Health and Sport in developing the scheme, but there is now a commitment to engage with the Scottish Government.

Liz Sadler: Yes. The current arrangements have operated effectively for a number of years, and there has been a lot of consultation and engagement with colleagues on them. Although we have not been involved to any great extent in the development of the bill, we expect to be very closely involved in the implementation of the new reciprocal arrangements, because those arrangements will impact on the NHS in Scotland.

The Convener: Will you briefly describe the reciprocal arrangements that currently exist with the UK Government?

Liz Sadler: The reciprocal arrangements are provided for at the EU member state level. The UK Government administers the arrangements on behalf of the UK, and there are three main schemes. S1 relates to the provision of healthcare for UK pensioners who have chosen to live in another EEA country or Switzerland. It covers the cost of their healthcare, and a lump sum of €4,000 a year is paid by the UK Government for that provision.

S2 relates to the provision of planned treatments. Through their health board, an individual can request to go elsewhere in the EEA to receive the same procedure as is provided at home. We understand from the EU returns that go to the Department for Work and Pensions that around 10 people a year from Scotland use that scheme.

The EHIC is the part of the agreement that most people know about. It enables individuals who become ill or have an accident in an EEA country to receive medical treatment in the equivalent of the state healthcare system in that country. Some EEA countries do not have as comprehensive a healthcare system as the UK's. In those circumstances, people may have to pay something towards the cost of their treatment, which they can

claim back from the DWP when they come home. The EHIC should not be seen as a substitute for healthcare insurance, however, because it covers only the cost of the treatment; it does not cover any additional costs such as the cost of repatriating somebody back home, the cost to the family of being with the person and the cost of rehabilitation.

Keith Brown (Clackmannanshire and Dunblane) (SNP): To add to what the convener said, I offer my congratulations to Paul Gray on his imminent retirement. Having worked with Paul for a number of years in the Scottish Government, it is clear to me that he has regularly contributed to all sorts of areas of Government policy and he has often been the person ministers go to, especially during Scottish Government resilience room—SGoRR—crises, and other crises, to get something fixed.

You have a great deal to be proud of, Mr Gray, in your contribution to public service in Scotland. Just to help you out, as a pre-retirement gift, my question will go to Mr Davidson.

A lot of people say that Brexit has not really impacted so far and yet we look at the range of senior highly paid officials here today and see the work that you have had to do in preparation and the fact that, as Emma Harper highlighted, we are doing things at breakneck speed. Proper consultation is not being carried out and we are having to agree things without seeing them first. It is obvious that Brexit is having an impact, mainly because of the possibility of a no-deal scenario.

Would all the work that is going on in your directorate have changed if the amendment that was to have been discussed today at Westminster, which ruled out no deal, had gone ahead? Were you aware of that amendment and would that parliamentary guarantee that a no-deal scenario was not going to happen have stopped this work, or would you have had to continue doing the work as a contingency in any event?

Ian Davidson (Scottish Government): That is a very difficult question to answer. My particular expertise in relation to these matters is about the relationships between Governments on legislative co-operation and, together with Shirley Rogers and many others across the Scottish Government, I have had some involvement in the wider preparations.

The Government has, at all the stages, taken the steps that it has believed to be appropriate to prepare for all circumstances before us. I do not think that anything has changed in that regard. However, as uncertainty grows and we get closer to 29 March, those preparations need to be stepped up. I do not think that I am precisely answering your question, but I am not sure that it is really possible to do so other than to give that general indication that we are doing all the work that we need to do, proportionately, at different stages.

Keith Brown: Who knows what is happening in the complete shambles around Brexit? However, I would hope that if there is a prospect that something is going to rule out the need for this work, the Scottish Government—in doing the horizon planning that it should be doing—would take that into account and desist from work that would be unnecessary.

I have a more specific question, which may be for somebody else on the panel. I could be getting this wrong, but I think that it is the case that the Secretary of State for Health and Social Care will have the power to increase the fees. What if, three years hence, we want to increase the charges that are made to other EU countries to keep these reciprocal arrangements? I assume that just now, while we are within the EU, other EU countries would get quite annoyed about increased charges and could take action against that—I do not know. However, that limiting factor would no longer apply in this circumstance. Would it be possible for a future UK secretary of state to increase the charges that are made, because of budget pressures or whatever else? That is my concern. If that could happen, what possible detrimental impact might it have on the Scottish NHS?

Paul Gray: Thank you for your kind remarks.

As I said in my opening statement, UK Government officials have indicated that the bill will be amended to recognise the responsibility of the devolved Administrations. The particular point to which I would draw the committee's attention is the requirement to consult devolved Administrations and agree a memorandum of understanding before regulations can be introduced that impact on devolved matters.

The distance that I can go, based on what we have—and bearing in mind that these are proposals—is to say that the current proposal is that there is a requirement to consult the devolved Administrations before regulations can be introduced. To that extent, therefore, we would have influence over the decisions that were made.

Of course, reciprocal arrangements work both ways, and if we were to increase substantially the charges that are levied on other Administrations, within or beyond the EU, that would work in the opposite direction, too. We benefit quite substantially from the current arrangements. For example, around 15,000 state pensioners from Scotland benefit from the S1 scheme that Liz Sadler mentioned, at a cost of £48 million per annum. If something were to happen to increase those costs, that would not be a positive step.

Keith Brown: I note the list of non-EU countries with which the UK has a bilateral agreement. It might just be a sample, but it seems to be quite idiosyncratic. We can perhaps understand why there are agreements with Australia, the Falkland Islands and New Zealand, but are there particular reasons why we have bilateral agreements with Kosovo and Serbia?

Paul Gray: I cannot comment on why the UK Government has particular relations in particular places. I would not go further than that.

The Convener: Who pays for the treatment of Scots in the countries with which we have reciprocal arrangements? How is that done?

Liz Sadler: Where there are reciprocal arrangements, the UK Government pays.

The Convener: And it does not recover the costs from the NHS in Scotland.

Liz Sadler: No. It does not recover the costs from the Scottish Government.

The Convener: It is helpful to understand that.

Alex Cole-Hamilton (Edinburgh Western) (LD): I echo my colleagues' comments about Paul Gray's service. Paul has always been very generous with his time—and his patience, particularly with lowly back-bench Opposition members of the Scottish Parliament such as me. I wish you good luck with whatever comes next, Paul.

I have a couple of questions about the recovery mechanisms for EHIC moneys. How was money recovered prior to 2014-15?

Liz Sadler: Prior to 2014, the Department for Work and Pensions simply expected that health boards—and trusts, in England—would inform it when people received treatment under the EHIC scheme. The DWP then claimed the money back from the person's country of origin. There was very poor take-up across the whole of the UK, because healthcare providers regarded the process as bureaucratic and of no benefit to them, given that they did not get any of the money back.

Therefore, in 2014, a scheme was introduced in an attempt to encourage providers to report that they had treated people under EHIC, which involved returning 25 per cent of the money to the provider. The UK Government thought that 25 per cent was a sufficiently large proportion to encourage providers to report. Since then, the number of reports has increased significantly, although, as Paul Gray said, five NHS boards in Scotland still do not report EHIC activity.

Alex Cole-Hamilton: You have, in part, answered my next question, which was about the 25 per cent from the DWP. Was that a cash incentive to encourage health boards to record their EHIC activity?

Liz Sadler: Yes.

Alex Cole-Hamilton: Things are still not perfect, if five boards do not report activity and some regularly delay doing so. In the future, under the new arrangements, could technology make life easier in that regard? The process feels a bit clunky and unnecessarily bureaucratic.

Liz Sadler: My understanding is that it is a relatively straightforward system to use; there is a secure portal, into which boards input the information. However, improving the technology would undoubtedly help.

We do not know why boards are not reporting. Some are smaller and might not have much EHIC business; they might think that the system is too bureaucratic and, even with 25 per cent cost recovery, reporting will cost them more than they get back.

As Paul Gray said, he will meet the chief executives this evening and will speak to the chief executives of the five relevant boards.

Alex Cole-Hamilton: Can you give us an idea of who those five are?

Liz Sadler: Yes.

10:30

Alex Cole-Hamilton: I am sorry to put you on the spot in that way.

Liz Sadler: I am looking for that information.

Paul Gray: I think that it is in the letter.

Alex Cole-Hamilton: Do not worry—it is not hugely important. I have a final question. How much is this about the culture on the ground with people not readily asking where the patients who present before them are from, or not making the connection and saying, "We need to recoup money here"?

Liz Sadler: First, the five boards are NHS Dumfries and Galloway, NHS Fife, NHS Forth Valley, NHS Lanarkshire and NHS Western Isles.

In acute care, there is a requirement for people to establish where non-UK residents have come from. I do not know whether, for those five boards, it is a cultural or administrative matter.

Paul Gray: To answer Mr Cole-Hamilton's question in a slightly different way, the culture of the NHS in Scotland is to provide care to people who need it and to ask questions later. I am not ashamed of that. We should recover money when we legitimately can and we should observe the regulations and provisions that are in place. This evening, I plan to ensure that we are doing all that

we can, because the NHS in Scotland should not do without money that it legitimately has access to. Our best foot forward is to treat the person who presents with a need, and to seek the recovery afterwards.

Alex Cole-Hamilton: I fully endorse that. It is a culture that we should be proud of. My desire to get on the record the names of the five boards that are not collecting the money is to bottom out whether there is a corollary between that and their propensity to treat non-UK citizens, for example, to see whether they are particularly remote and not on the beaten path of the tourist trail. I do not really get that from the list of boards, so it strikes me as odd.

The Convener: Why and when was the decision taken for it to be the responsibility of boards to deal directly with the DWP and for it not to be provided for by NHS Scotland in order to have a standard approach around Scotland?

Paul Gray: That was because it is a UK Government rather than a Scottish Government scheme. Nevertheless, the committee's questions highlight an anomaly that I intend to pursue.

The Convener: In which direction do you intend to pursue it?

Paul Gray: I intend to pursue it in the direction of consistency. It is clear that there is money to which health boards could be entitled, so it would be sensible for them to have it. If any health board advances a case to say that, for example, it treats only two such patients a year and the bureaucratic cost of recovery would be higher than the amount recovered, I will listen to it. However, I would want to be assured that that was the case, rather than that a source of funds was being overlooked.

The Convener: You are thinking of it in terms of consistency of application by boards, rather than a structural change in the way that the matters are managed, and presumably in terms of a consistent approach to the registration or treatment of patients from outwith the UK and EU.

Paul Gray: That is correct.

Sandra White (Glasgow Kelvin) (SNP): Good morning, panel. I wish you well in the future, Paul. I reiterate what everyone else has said: you have always had an open door to people who have wanted to ask questions, and you are always diplomatic.

At the beginning, there were six health boards that did not join the scheme: NHS Dumfries and Galloway, NHS Forth Valley, NHS Greater Glasgow and Clyde—as you mentioned, it has just joined the scheme—NHS Fife, NHS Lanarkshire and NHS Western Isles. As NHS Greater Glasgow and Clyde is one of the biggest boards, there was concern that it had not joined, but you said that it has got back £125,000 since joining.

The health boards said in written evidence that the reason for not participating was that there was too much bureaucracy and it cost them more money to get staff to look into it. The fact that the cost outweighed the income is concerning. I understand what Paul Gray said about various health boards in that respect.

You mentioned that the EHIC incentive scheme has been running for a number of years—from the end of 2014, I think. Has any analysis been done of the costs and benefits of belonging or not belonging to the scheme?

Paul Gray: That is one of the things that I intend to pursue with the chief executives today. I intend in a simple way to ask those who recover money to tell their colleagues why they do it and why it is worth while. NHS Greater Glasgow and Clyde has recovered £125,000 for one quarter; that is the equivalent of £0.5 million a year, which is not a trivial sum. The sums may be smaller for the other boards, but it is important that we establish a consistent baseline of activity.

In my judgment, the best way to do that will be to get the health boards that are recovering money to explain to their colleagues why it is worth doing. By the end of the financial year, I want to have a consistent pattern across all health boards. If there are to be any exceptions, I want to understand them in a way that can be properly described.

Sandra White: Is it reasonable to expect that the five health boards that say that it would cost too much to assign the necessary staff would not join the scheme? Why did NHS Greater Glasgow and Clyde decide all of a sudden that it would join the scheme? Did it see the benefits?

Paul Gray: Yes. NHS Greater Glasgow and Clyde sees the benefits and recognises that there is an advantage in being in the scheme. It is not so long ago that NHS Greater Glasgow and Clyde got a new chair and a new chief executive. They have been looking at governance arrangements and seeking to refresh and strengthen them. All that will have contributed to the board's decision to take up the offer. To be frank, being asked by the committee why boards were not doing so will have prompted some boards to think about it.

Sandra White: Obviously, £125,000 is not a drop in the ocean. Given the size of NHS Greater Glasgow and Clyde, the total over the year could be £0.5 million. Our committee papers mention back money. Is the £125,000 back money? How far back can health boards claim?

Paul Gray: As far as I know, the boards have to claim as cases arise. Ms Sadler may be able to say more

Liz Sadler: The scheme is administered by the UK Government. We will investigate further and write to the committee.

Sandra White: One of our papers says:

"It appears therefore that the claims can be backdated and that NHS GGC have been collecting data on EHIC holders since 2014-15".

Would the entitlement go back to when the scheme came in?

Liz Sadler: Yes. It will go back only to when the scheme started. There was no mechanism to reclaim money before that.

Sandra White: We can expect to get information from you on that.

My final question is on treatment for EEA non-residents. Do the health boards still collect data on those cases?

Liz Sadler: Is this about non-EEA residents?

Sandra White: Yes.

The Convener: I think that the question is about EEA non-residents.

Sandra White: I am sorry; it is all the acronyms.

The Convener: It is about people who, if they were resident here, would be entitled to treatment in the ordinary way. Is data collected about those from EEA countries who are not resident?

Liz Sadler: My understanding is yes.

The Convener: Could we deduce from the fact that NHS Greater Glasgow and Clyde has been collecting the data for several years but not making a claim to the DWP to recover costs that the other health boards may well be doing the same? Do we have any idea what has been done with the data since 2014-15 if it has not been used as a basis for recovering funds?

Paul Gray: That is what I want to find out from health boards, because we have all agreed that they should collect that data. I want to know what they are doing with it.

The Convener: Further to Sandra White's question, can we be confident that the boards know when they are treating people who are not UK citizens or who are not ordinarily resident in the UK—whether they are EEA citizens or otherwise?

Paul Gray: We touched on that issue in relation to general practitioners and primary care in your initial questions, and I would like to write to the committee about it. It would not be helpful to the committee for me to give any guarantee that I can be absolutely certain about every single one of the millions of people who are treated every year. Rather than speculate, I want to get the information that we have and give it to the committee in short order.

Miles Briggs (Lothian) (Con): Just to add to your blushes, Paul, particularly as I am an Opposition politician, I put on record my thanks for the work that you have often assisted me with behind the scenes. Politicians from across the Parliament have valued your assistance when we have been trying to support individual constituents.

I want to pursue issues about British-born nationals who are resident in other countries and who return home to the UK for treatment. Do you collect data on those people?

Paul Gray: I am scanning my paperwork for that information. Under the S2 scheme, we know that fewer than 10 patients a year from Scotland choose to travel to the EEA for treatment—in other words, fewer than 10 patients a year choose to go out of Scotland for their treatment. We probably do not collect data on those who come back for treatment, because such people will be Scottish citizens and be coming back from spending six months of the year in another country, for example. It is very unlikely that we would collect that data.

Miles Briggs: We do not know the picture around that. That leads me to my next question. Do we have any data on the number of Scottish pensioners who live in the EEA and other countries? Do we also know how many EU or EEA pensioners live in Scotland?

Paul Gray: I know that 15,000 state pensioners from Scotland are benefiting from the scheme—we have that fact. Do we have data for the number of pensioners from other European Economic Area countries?

Liz Sadler: No. The figure of 15,000 Scottish pensioners is extrapolated from the figure for how many UK pensioners live in the EEA, for each of whom the Department of Health and Social Care pays €4,000 per year for their health care. I am afraid that I do not have to hand the figure for how much that costs in total. The number of UK pensioners who live in Spain, Ireland, France and Cyprus is significantly higher than the number of EEA pensioners who come to live in the UK. Therefore, the UK pays out significantly more than it gets back in payment from other countries for their pensioners who live in the UK.

Miles Briggs: Further to Alex Cole-Hamilton's line of questioning, is there any mechanism for getting data on people who are resident in other countries under the S2 scheme, which has been mentioned, when they return to the UK? We might not necessarily be sure about where they are resident in the EU or about the numbers who receive treatment.

Paul Gray: If someone who would ordinarily be treated in Scotland comes back to Scotland, we simply cannot tell where they are resident. I think that Mr Briggs is asking whether we would know if someone who would ordinarily be resident in Spain—a Spanish citizen—for example, were to come to Scotland and have treatment. That is the point that I will write to the convener about. How, and on what basis, do we know that information? How many people have we counted? We should assemble that data for the committee.

Liz Sadler: Through the EHIC scheme, we know how many people have accessed care using a European health insurance card. An EEA resident who came to live in Scotland as a pensioner would be entitled to free healthcare, so it would be in their interests to make sure that they were registered for that free healthcare. The UK Government could then claim back the cost from their country of origin. A very small number of people are in that category—I think that we only have the number at UK level.

10:45

Miles Briggs: Another issue that I would like to pursue is the repatriation of the body of someone who dies while they are living abroad or when they are on holiday abroad. Are there opportunities to improve that process? In my time as an MSP, I have had to support a number of constituents to make that happen. Is there an opportunity to improve the repatriation process not just on an EU level, but internationally?

Paul Gray: As far as I know, that issue is not covered in the Healthcare (International Arrangements) Bill. Ms Sadler made the point about the importance of people also having the appropriate level of insurance, because the repatriation of a person's body is not covered by the EHIC scheme. If Governments here and elsewhere were to agree to have a mutual or reciprocal repatriation scheme, that could be agreed, but there is no such provision in the bill at the moment.

The Convener: A piece of primary legislation in a new area of law would be required.

Paul Gray: Yes.

Emma Harper: Is it correct to say that anyone who presents for healthcare in Scotland without a community health index number is traceable and that, therefore, we would know that someone from England who did not have a CHI number was not resident in Scotland?

Paul Gray: That is so, but I come back to the point about the extent to which GPs would insist on such information before providing treatment. I use GPs as an example; the same would apply if someone suffered an accident in the street and was taken by ambulance to accident and emergency. We would not focus on finding out who they were and where they were from until we had administered the definitive treatment that they needed, particularly if it was very urgent.

Emma Harper: In my experience as an operating room nurse, it is handy to have a CHI number, especially when cross-matching blood. It helps with labelling for labs and with communicating across the whole system. Are people assigned a temporary CHI number if they pitch up in an emergency room?

Paul Gray: Yes.

Emma Harper: Okay. I am trying to get my head round the traceability of people who show up for emergency treatment.

Paul Gray: I make it clear to the committee that I regard it as highly desirable that we know where people are from. The more background that we have on an individual, the better the treatment for them is likely to be. There are certain diseases that are prevalent in some countries that are not prevalent in others. Depending on the circumstances, having that knowledge will lead to better diagnosis, better treatment and better care.

However, as we have already established, our principle is that we must provide the treatment that is needed.

Emma Harper: I support that.

Keith Brown: I have two quick questions. The first is about the 15,000 figure for the number of Scottish pensioners who live in the EEA, which Liz Sadler said was extrapolated from the UK figure. I would be interested to know more about that. I would like to find out what information the Government has on that; I will ask the Scottish Parliament information centre about it, too. My intuition is that it will be the case that fewer people from Scotland, the north of England, Wales and Northern Ireland live overseas permanently than do people from the south of England. It would be interesting to know what the 15,000 figure relates to. It is also my intuition that there will be fewer people from overseas living in those parts of the UK, but it would be interesting to know whether that is the case.

My substantive question is about the point that Paul Gray made about the culture of the NHS. The fact that, for 70 years, the vision of the NHS has not involved having a cash register by a bed is important. It would be useful if, in the pursuit of consistency, the value of that was kept in mind at the same time that proper reimbursement was sought for services that are provided.

Paul Gray: We do not regard individuals as a source of income. Nevertheless, the NHS in

Scotland and I, as the principal accounting officer, recover such funds as may be available to us.

Keith Brown: In my view, it should be borne in mind when looking at the straightforward accounting of things that the NHS culture of treating people who need treated and treatment being free at the point of use has a value in itself.

Paul Gray: Indeed.

The Convener: Further to Emma Harper's question, it is my understanding that UK citizens who do not have a CHI number, are not registered with the NHS in Scotland and work in other parts of Europe might not be able to access care in England if they returned to England but might be able to access care free of charge in Scotland in that case. Has that come to your attention, or that of any of your officials?

Paul Gray: It is not an issue that presses on us. In any case, we treat patients from England under reciprocal arrangements, particularly across the border between Scotland and England. I am happy to follow up your question to see whether there is any evidence of what you indicated, though. I can see in the abstract how that might happen, but we would in any case not routinely deny people treatment if we thought that they needed it.

The Convener: Absolutely, but that is not the suggestion. I merely wanted to establish whether there were any anomalies between the different levels of eligibility in different parts of the UK that might be impacted on by the bill, or carried forward into it.

Paul Gray: Sure. Thank you.

David Stewart (Highlands and Islands) (Lab): First, best wishes to you, Mr Gray, and thank you for all your work over many years. I echo my colleagues' positive comments in that regard.

I want to touch on contingency planning. Miles Briggs, among other colleagues, mentioned the 15,000 Scots who live in the EEA, outwith the UK, and we know that that figure was taken from the UK figures. Have you done any analysis of the possible effect on the Scottish national health service of a scenario in which the reciprocity of health treatment under the S1 route ended? I remember the previous cabinet secretary talking about the number of extra beds that would be required if those 15,000 Scots came back. You said earlier that you do not know whether individual Scots living in Spain come back for one-off treatment, but you will know if reciprocity ends and those 15,000 Scots need healthcare in Scotland. Has any detailed planning been done on that?

Paul Gray: The bill that is before us, which the Government has indicated that it regards as exceptional, is a core part of our contingency planning. Shirley Rogers might want to say a little more, because she has been leading for us on the consequences of Brexit for healthcare.

Shirley Rogers (Scottish Government): It might be helpful for the committee to hear of the breadth of planning that is under way around anticipating healthcare requirements. It also links to Mr Brown's question about what we are planning for and how that works.

At the moment, we are planning for a no-deal scenario on the basis that if that is as bad as it is, anything that is not that will allow us to recast our planning assumptions. We are planning on the basis of the supply of medicines, medical devices and clinical consumables; reciprocal healthcare, of which this is an element; workforce and all the impacts around the potential supply and our existing EU 27 workforce; mutual recognition of professional qualifications, which are the arrangements under which we are able to use medical and other professionals who have qualified in EU 27 nations; research and clinical trials; legislative deficiencies; contingency planning; readiness of NHS boards and social care bodies for operational impact; interdependencies with critical supplies, particularly food and fuel; and communications.

That illustrates the depth and breadth of the planning that is currently under way for EU withdrawal.

David Stewart: That was very useful, but I want to press you on a specific point. Obviously, in the current climate, it is very difficult to know what the next steps will be, certainly after yesterday's fiasco in the House of Commons. However, let us assume that we do not have reciprocal healthcare. If the 15,000 Scots who live abroad need healthcare and have to come back to Scotland for it, how many more nurses and beds and how much more spend will be required?

Shirley Rogers: We do not have that information, because we do not know the extent to which those 15,000 people are unwell. If the reciprocal arrangements turn out to be an issue and they have to come back because they need a particular surgical operation, but they recover from it, the answer to your question might be zero. If, on the other hand, those patients have long-term, on-going conditions, we will obviously need to factor that in, but it will depend on the nature and severity of the disorder from which those patients are suffering. We are working up a range of scenarios, but I do not have a percentage for you at this stage.

David Stewart: But your department is looking at the detail of a potential scenario in which there is no reciprocal healthcare.

Shirley Rogers: Yes, we are doing some scenario-planning work on that.

David Stewart: Okay. I will move on. I think that Mr Gray has already mentioned this, but I want to get it on the record. You will be aware of the new EU directive on patient rights and cross-border healthcare, which provides an enhanced S2 route. In other words, if I required a hip operation, I could go to the EEA, get the job done either in the private sector, in an unplanned way, or in the public sector and then charge it. That directive has been brought in only recently, although I note for the record that it is directive 2011/24/EU.

You might not have this information in your head, Mr Gray, but do you have anything general to say on the matter? Have these provisions been used by Scots going abroad or, indeed, have other people from EEA member states come to Scotland for treatment?

Liz Sadler: We receive an annual return on the use of the directive, so we know that, on average, around 30 Scottish residents use it each year to travel for treatment at a cost of £50,000 a year across Scotland. The directive allows the cost of treatment to be covered up to what it would cost in Scotland; if the cost is higher, people get only the cost of the Scottish care covered, with additional things such as travel, hotel accommodation and so on not covered.

The directive is not part of the bill. We understand that the Department of Health and Social Care is considering the directive's future and how it should work, but we have no further details on that.

David Stewart: Given that the directive is not part of the bill, this right will cease for UK citizens if further legislation is not introduced.

Liz Sadler: That is right, and it was not included in the terms of the withdrawal agreement, either. It could therefore stop at the end of March.

David Stewart: It is not alone in not being included in the withdrawal agreement. I appreciate that other members might have different views, but I am not surprised at the low take-up of those provisions. Frankly, I do not think that the directive is generally well known.

My final question is on a UK Government issue, but Mr Gray might be familiar with it. I read in the press just the other day that, for non-EU migrants coming to Scotland—particularly to go into the health service, which is what we are all interested in—the NHS levy has doubled to £400 a year. As a result, a nurse on over £30,000 a year coming to Scotland from, say, Ukraine has to pay that levy to cover the costs of accessing health services in Scotland. Has that been subject to scenario planning with regard to workforce management? I know that the question goes slightly beyond the legislation that we are considering, but since I have Mr Gray captive—perhaps for the last time—I think that it would be useful if we could get an answer to that either today or in writing later. After all, the matter affects recruitment, and health service unions and professional associations have expressed a lot of concern about it. There is also the big cost to the employer, but that is another issue.

Paul Gray: We will write to the committee on that. It is an important question, and you should get a proper answer to it.

David Stewart: Thank you.

Sandra White: I have a brief supplementary, but first I want to thank Shirley Rogers for telling us about the amount of work that is being done, because it takes us to the nub of—indeed, the frightening part about—a no-deal Brexit.

David Stewart asked about the 15,000 people who will have to come back to Scotland from wherever they are if no reciprocal healthcare arrangements are in place. However, if there is no deal and no such healthcare, 10 times that number of people will have to come back to England from abroad. If we have reciprocal healthcare at UK level—and I know that the DWP is working on that bill, too—how will it affect healthcare in Scotland if people who cannot get such care in England happen to come up to Scotland? I know that that is just a scenario, but it is quite frightening when you think about it. If there is no reciprocal healthcare, we are looking at a tsunami—although I do not want to use that word—of people coming back.

Paul Gray: First, we would have to assume that they would all come back, although some might, having made their lives elsewhere and lived there for many years, choose not to and instead take out insurance arrangements. As Ms Rogers has said, we are doing various detailed scenario plans. The likelihood of 15,000 people returning en masse to Scotland is probably quite low, but it might well be that more people will be less likely to choose to live abroad in future if they think that the arrangements will be less favourable or they might have to take into account the insurance requirements that such a choice might attract.

That said, I do not want to miss the point that the bill before the committee has been introduced as preparation for addressing whatever scenarios might emerge. I am not making any presumptions about what the Parliament will do, but if the bill were to be given consent and its provisions adopted, that would resolve some of the issues that you have described.

The Convener: I thank Paul Gray and his officials for their evidence and for the offer to come

back to us with additional information. Just to put a further burden on you, I should point out that if the committee is to conclude its consideration of the LCM at its next meeting, we will require that relevant information to be with us by close of play tomorrow. However, I recognise that some of the things that we have asked you to provide are not directly pertinent to consideration of the LCM, but if you are able to respond on certain matters within that timescale, that will allow us to move ahead. We can hear in due course about the other matters that we have raised and which might require data, among other things, to be collected.

Paul Gray: We can certainly give you everything that we have by tomorrow night, convener.

The Convener: That is excellent. Thank you very much.

We now move into private session.

11:02

Meeting continued in private until 11:35.

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