Published 11 February 2019
SP Paper 468
3rd Report, 2019 (Session 5)

The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee
Comataidh Slàinte is Spòrs

The current and future operation of reciprocal healthcare schemes

Published in Scotland by the Scottish Parliamentary Corporate Body.

All documents are available on the Scottish Parliament website at:
http://www.parliament.scot/abouttheparliament/91279.aspx

For information on the Scottish Parliament contact Public Information on:
Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

Contents

Health and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/health-committee.aspx

healthandsport@parliament.scot

0131 348 5524

Committee Membership

Convener
Lewis Macdonald
Scottish Labour

Deputy Convener
Emma Harper
Scottish National Party

George Adam
Scottish National Party

Miles Briggs
Scottish Conservative and Unionist Party

Alex Cole-Hamilton
Scottish Liberal Democrats

David Stewart
Scottish Labour

David Torrance
Scottish National Party

Sandra White
Scottish National Party

Brian Whittle
Scottish Conservative and Unionist Party

Introduction

1. This report considers the arrangements for the charging of European Economic Area (EEA) citizens and non-EEA individuals when using NHS services in Scotland and for paying healthcare costs for Scottish citizens when abroad.

2. The report covers the current operation of the various arrangements in force covering accessibility and costs, whether changes and improvements should be made while also considering the potential impact of Brexit.

Committee scrutiny

3. The Health and Sport Committee's scrutiny of reciprocal healthcare schemes was conducted to inform our consideration of the Legislative Consent Memorandum (LCM) on provisions in the Healthcare (International Arrangements) Bill. [1]

4. That Bill, introduced in the House of Commons on 26 October 2018, is intended to allow the UK to maintain reciprocal healthcare arrangements with the EU and its Member States after Brexit, in the event of either a Brexit deal or no deal scenario. The provisions are not limited to arrangements with the EU. The UK Government states that the Bill would also allow the UK to strengthen existing reciprocal healthcare arrangements with countries outside the EU, or implement new ones. [2]

5. To inform our consideration we wrote to NHS boards and Paul Gray, Director General for Health and Social Care and Chief Executive of NHSScotland. Responses were received from all health boards and the Director General.

6. We also wrote to the Department for Work and Pensions (DWP). We did that given their current role as the body responsible for charging and cost recovery for NHS treatment received by individuals from Non-UK EEA as well as countries where other reciprocal healthcare arrangements exist. The DWP is also responsible for the administration and reimbursement of overseas healthcare for UK citizens using the 'S2' route.[i] A response was received from the Department of Health and Social Care to the questions put to the DWP.

7. At our committee meeting on 11 December 2018 we held an oral evidence session with Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland. The session explored a range of issues including eligibility for free

---

[i] The S2 form is a mechanism that entitles patients to state-funded pre-authorised treatment in another EEA country or Switzerland, with the treatment being provided under the same conditions of care and payment as for residents of that country. The S2 route relates only to state-provided treatment and costs are dealt with directly between Member States, with the S2 acting as a form of payment guarantee. This means that in the majority of cases, the patient is not required to pay anything themselves. Under the S2 route, Member States retain discretion as to whether to authorise planned treatment in another Member State except in cases where "undue delay" is relevant – i.e. where treatment cannot be provided by the NHS within a time that is medically acceptable, based upon an objective clinical assessment of the patient and their individual circumstances. Where this is the case, authorisation must be given.

NHS care, cost recovery and payment for overseas visitors as well as the operation of the European Health Insurance Card (EHIC) Incentive Scheme. Following this session Paul Gray wrote to us providing further information.

8. We published our report on the Legislative Consent Memorandum – Healthcare (International Arrangements) Bill on 19 December 2018. [3] We recommended that the Parliament agreed to a legislative consent motion in the terms outlined in the memorandum—

> "That the Parliament agrees that the relevant provisions of the Healthcare (International Arrangements) Bill, introduced in the House of Commons on 26 October 2018, relating to powers to make healthcare payments; healthcare agreements and data processing, in so far as these matters fall within the legislative competence of the Scottish Parliament or alter the executive competence of Scottish Ministers, should be considered by the UK Parliament." [4]

9. We also stated in our LCM report that the evidence we had received had raised a number of issues regarding the operation of the current schemes. This report explores these issues in more detail.

Eligibility for free NHS Scotland care

10. Eligibility for free NHS Scotland care was a key aspect of the current reciprocal healthcare schemes we explored.

11. Guidance issued from the Scottish Government to NHS board Chief Executives makes it clear that only those people who are not 'ordinarily resident' in the UK will be charged for using NHS services (with some exceptions, such as A&E treatment and treatment for certain infectious diseases).

12. However there are differences in approach for those not ordinarily resident in the UK depending upon if they are non-UK [European Economic Area] EEA residents or non-EEA residents. These are detailed below in Table 1.

Table 1- Handling of non-UK resident's treatment charges

Origin of individual seeking NHS treatment	Body responsible for charging and cost recovery	How are costs recovered
Non-UK EEA and countries where other reciprocal healthcare arrangements exist	DWP (UK Gov) includes: EHIC, pensioners, workers, planned treatment	By DWP on an EEA or reciprocal country basis
Non-EEA	NHS Scotland territorial health boards	By the health board from the individual receiving treatment.

Source: Scottish Parliament Information Centre (SPICe)

13. The UK has bilateral reciprocal healthcare arrangements with a number of other countries, for those visiting on a temporary basis. For example: Australia; Kosovo; Serbia; and New Zealand. [5]

Determining eligibility of individual from overseas to receive primary and secondary care

14. One particular area we explored is how eligibility to receive primary and secondary care is determined in practice by the NHS for an individual from overseas.

15. In relation to access to primary care the Director General explained that whilst the Scottish Government encouraged GPs to establish a person's country of origin it was not mandatory. [6]

16. He provided further clarification in a letter following his oral evidence session. He detailed that recent guidance for Healthcare Providers of General Medical Services in Scotland on "Patient Registration" was underpinned by two key principles:

> "No documents are required to register with a GP. The inability by a patient to provide identification or proof of address is not considered reasonable grounds to refuse or delay registering a patient.
>
> Anybody in Scotland may access primary care services at a GP practice without charge." [7]

17. We explored with the Director General what impact this approach to registration for primary care services would have on secondary care. We were interested in whether individuals not entitled to free secondary care services would be given it without further inquiries being made.

18. The Director General explained that, in a situation where a GP referred a patient for secondary care services, the onus lay on the receiving organisation to determine if that patient was entitled to free care. [8] NHS boards were expected to carry out their own assessment of patient eligibility, regardless of whether they had already received GP services. He also made the distinction that, whilst registration was a matter for GPs as private contractors, there was a statutory duty on NHS boards to make decisions based on the Charging Regulations. [9]

19. We asked all NHS boards how they identified (non-UK) EEA citizens using NHS services in their board area and how they identified non-EEA citizens not eligible for NHS treatment. Both groups being liable to pay for their treatment.

20. Some health boards stated they did not currently identify (Non-UK) EEA citizens indicating it was not cost effective [NHS Lanarkshire] to gather this data.

21. In relation to identification of non-EEA citizens some health boards responses to our request for information suggested the onus was on staff treating patients to inform the health records team when they identified a patient as a non-EEA citizen. Detail was not provided on the process and procedures for that initial identification by staff. [10]

22. Other health boards provided detailed information on how they discern eligibility using patient registration forms and NHS entitlement forms when individuals present for treatment.

23. Two specific means used to identify by several of the NHS boards were—

    - an individual patient registering with a home address outwith the UK
    - or a patient presenting without a CHI (Community Health Index) number.[ii]

    These issues trigger a further assessment of eligibility by the board. [11]

24. However, NHS Lanarkshire acknowledged in its written response that picking up cases of individuals who were not eligible for free treatment through Accident and Emergency registration or when an individual has no CHI number can be ineffective if an individual has been to a GP and been given a CHI number. NHS Lanarkshire added that it had not found a way to address this issue "The Board has worked in local communities to enhance this and Counter Fraud Services have also considered the issue at a national level but a comprehensive solution has not been found." [12]

---

ii CHI number is a unique 10-character numeric identifier, allocated to each patient on first registration within the system.

25. **It is important that regulations regarding entitlement to NHS treatment are applied fairly and consistently.**

26. **We support the principle that anybody in Scotland may access primary care services at a GP practice and receive A&E treatment without charge. However we are concerned that, because GP practices are not required to conduct checks on a patients' identification or proof of address, a GP may be referring a patient on for non-emergency secondary care services without it being established if they are entitled to access these services without charge.**

27. **We recommend the Scottish Government should re-examine its guidance for Healthcare Providers of General Medical Services in Scotland recognising the role of GPs as gate-keepers to providing access to secondary care. We believe the Scottish Government should give further consideration to whether changes should be made to the registration process for general medical services to ensure those who should be charged for receiving secondary care are identified.**

28. **NHS boards have a legal duty to adhere to charging regulations. However, we believe there may currently be instances where NHS boards' assessment process for patient eligibility to services may be resulting in inconsistencies in application.**

29. **NHS boards currently conduct their own assessment to determine who should be in receipt of free care and treatment. The responses from NHS boards suggest there are variations in their approaches and procedures to determine eligibility. We are concerned there could be instances where staff treating patients are asked to identify patients as a non-EEA citizen but without adequate processes and support to approach potentially sensitive and difficult discussions and this has its roots in the lack of effective identification procedures in primary care.**

30. **We recommend the Scottish Government conduct a review of the approaches and procedures NHS boards use to establish eligibility for free NHS treatment and establish a consistent and standardised approach. Boards are potentially losing out on significant revenue as we detail later in this report.**

Divergence in eligibility rules between England and Scotland

31. In certain circumstances, eligibility rules, for UK citizens working abroad for example in England and Scotland have diverged. NHS England revised their policy and guidance in 2015. Scotland continues to base its on Regulation 2(1) of the NHS (Charges to Overseas Visitors) (Scotland) Regulations 1989 as amended. Further amendments and guidance were introduced in NHS England in 2017. [13]

32. These changes to NHS England policy can result in someone from England who, for example, works abroad, being unable to access free NHS care in England, but is eligible to receive free treatment in Scotland when visiting.

33. We asked the Director General if he was aware of this policy divergence having an impact on people accessing NHS Scotland services. In his follow up letter to the Committee he stated that no figures were held for the number of people from Scotland working abroad who were subject to the provisions. In relation to usage by those not eligible to treatment in England he detailed—

> “there is no evidence to suggest that people who are originally from England are taking advantage of this arrangement to receive healthcare in Scotland when they are back in the UK.” [14]

34. The Director General also made a commitment to monitor the position.

35. **We welcome the Director General's commitment to monitor usage of NHS Scotland services by UK citizens working abroad. We ask the Scottish Government to provide further information on how it will conduct this monitoring, and the financial implications that arise from this divergent policy.**

Cost recovery and payment

Price tariff for NHS services

36. NHS Orkney in its submission to the Committee provided a price tariff for its services. The tariff breaks down the costs to those not entitled to free NHS care. The breakdown is provided by health specialty and on a per case or per day basis. [15]

37. No other NHS board provided information on how the charges it levied on individuals were arrived at.

38. **We believe it is important that where charges are levied there is a consistent and transparent approach taken to how these charges are determined across NHS Scotland. We recognise the cost of the provision of the same treatment may vary across NHS boards due to variables in the cost of delivery. We ask the Scottish Government how NHS boards set their price tariffs and what assessment is undertaken at a national level to determine that these are transparent, fair and consistent.**

Individuals from Non-UK EEA and countries where other reciprocal healthcare arrangements exist

39. As detailed in Table 1 income recovery from usage of NHS healthcare by EEA citizens visiting or resident anywhere in the UK and other countries where reciprocal healthcare arrangements exist is the responsibility of the Department of Work and Pensions (DWP).

The EHIC Incentive Scheme

40. The EHIC Incentive Scheme was established in October 2014 to encourage healthcare providers to record and report to the DWP usage of the NHS by EHIC card holders. Provision of this information allows the UK Government to recoup costs incurred under the EHIC scheme from other member states.

41. Healthcare providers across the UK collect and report information on Non-UK EU/ EEA nationals to the DWP via a dedicated portal, along with the cost of treatment. In return for submitting the information, the providers (boards) receive 25% of the cost of treatment.

42. In Scotland the Scheme is operated at NHS board level. NHS boards liaise directly with the DWP and receive reimbursement directly from them.

43. The Director General's letter of 4 December 2018 stated that £5 million worth of treatment, relating to 4,841 individuals, had been reported to the DWP by

participating boards since the scheme was set up (at the end of 2014). This had resulted in the reimbursement of £1.25 million to those boards. [16]

44. One issue that was highlighted during our scrutiny of the operation of the EHIC Incentive Scheme in Scotland was that not all NHS boards were currently participating in the scheme. The Director General estimated reimbursement of funds would double if all NHS boards participated.

45. Using the figures provided, if all boards participated we estimate the average money coming back to boards could be £710,000/year.

46. The Director General stated in his written response that six health boards had opted not to participate in the scheme. He listed the boards as NHS Dumfries and Galloway; NHS Forth Valley; NHS Greater Glasgow and Clyde (NHS GGC); NHS Fife; NHS Lanarkshire; and NHS Western Isles. [17]

47. The correspondence we received from those boards who were not participating in the scheme explained this was because the costs of administering the scheme outweigh the potential income.

48. Following receipt of the Director General's response NHS GGC stated that it was now participating and had provided data to the DWP along with the breakdown of cases and costs. It indicated that whilst the board had been collecting data on EHIC holders since 2014/15 it had not been submitting the data to the DWP and therefore not receiving the income (25% of costs). [18]

49. In subsequent evidence received from the Director General he confirmed NHS GGC had now recorded EHIC Incentive Scheme Data for November 2018 and had reported activity to the value of almost £120,000 in November and a further £88,000 in December 2018. The Director General confirmed that the DWP would accept retrospective claims for healthcare cost reimbursement. He stated he was "concerned that it has taken the Board so long to participate" in the scheme but the board had now assured him that "efforts will continue on the back-track exercise and that processes have been put in place to record and claim EHIC activity on an ongoing basis." [19]

50. The Director General was asked why he believed NHS GGC had now decided to join the scheme. He explained that the NHS board had recently appointed a new chair and chief executive who had been considering governance arrangements. He also added "To be frank, being asked by the committee why boards were not doing so will have prompted some boards to think about it." [20]

51. At the oral evidence session the Director General indicated that he was due to meet with NHS board Chief Executives and he would be asking why the remaining five boards were not participating in the scheme. He told the Committee in relation to NHS boards usage of the scheme—

> "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." [21]

52. **The Committee's consideration of the current operation of the EHIC Incentive Scheme has highlighted that a number of NHS boards are not currently participating in the scheme. We note that following our request to NHS boards for information on scheme usage NHS GGC has since chosen to participate in the scheme. We welcome this change in approach by the NHS board, especially as the board was collecting the data required for the scheme.**

53. **We recommend the Scottish Government take steps to ensure all boards are recovering money that is owed to them under the EHIC Incentive Scheme. We estimate the average money coming back to NHS boards, if all participated in the scheme, will increase substantially.**

54. **We welcome the comments made by the Director General that following our scrutiny of the EHIC Incentive Scheme he is now calling for greater consistency across boards and further justification from those not participating in the scheme. We request an update on the progress the Scottish Government has made since December 2018 to achieve greater consistency in the operation of the scheme including specifically whether the five outstanding boards have now joined the scheme.**

55. **If there are boards that continue to consider the scheme too administratively cumbersome when compared with the financial benefits we ask the Scottish Government whether consideration has been given to centralising the system at a Scottish Government or regional NHS board level to reduce administrative costs. Also, whether reductions in costs can be achieved through the use of technology which could be used to both assist in identifying those who should be charged and in receiving payment.**

Individuals not resident in the EU/EEA

56. As detailed in Table 1 income recovery from usage of NHS healthcare by individuals not resident in the EU/EEA is by the health board directly from the individual receiving treatment.

57. NHS boards provided us with information on treatment cost totals per year, how much of the costs were being recovered and their methods of doing so.

58. Boards detailed that they used various means to recover debts. If unsuccessful they might instruct debt recovery agencies or seek assistance from the Central Legal Office in NHS National Services Scotland.

59. Several of the health boards highlighted that debts over £500 can be reported to the UK Home Office and non-payers can be refused entry visas or extensions of stay. The information on outstanding debts is provided monthly to the Home Office.

60. The information we received from NHS boards highlights that boards vary in their ability to recover debts from overseas patients. NHS Lothian stated it had a balance

of £530,309 outstanding over the past five years out of £4,455,879 worth of treatment provided. NHS Western Isles recovered all of its debt, albeit a much smaller amount, £37,800, over five years. NHS Lanarkshire detailed that it had invoiced non-EEA individuals for £134,979.87 from which only £41,892.78 had been recovered. They stated the remainder has either been written off or remains outstanding. [22]

61. SPICe calculate the amount outstanding to boards from non-EEA individuals treatment that has not been paid over the past five years is £3,233,546. [23]

62. **There is currently variation between NHS boards in their ability to recover the costs of care and treatment by individuals not resident in the EU/EEA. It is difficult to determine without conducting a detailed consideration of specific cases if the reasons why costs are not recovered is due to the individual circumstances of a case or whether there are inconsistencies in the approach taken and resources used to recover costs from individuals.**

63. **We recommend the Scottish Government conduct an assessment of each NHS board's, performance, criteria and approach to cost recovery. This should include an assessment of whether there are instances where costs should and could be recovered. We also recommend this assessment consider whether a more centralised system to manage NHS reporting and recovery of costs would deliver a more consistent approach across all NHS boards. We ask the Scottish Government to report to the Committee on progress on this matter.**

Healthcare of UK nationals abroad

64. Another aspect of reciprocal healthcare we considered was with regard to UK nationals abroad.

65. Currently the EEA Member States and Switzerland co-ordinate the provision of social security, including healthcare, under EU Regulations 883/2004 and 987/2009.

66. The Regulations include rules on the reimbursement of healthcare costs between Member States in the following circumstances—

- For visitors using the European Health Insurance Card (EHIC) for all necessary care during temporary stays in another Member State;
- For state pensioners and their dependants who have moved abroad, the state that pays their state pension is responsible for paying the costs of their healthcare – known as the S1 routes; (these procedures are carried out by the DWP on behalf of Scottish pensioners and their dependants)
- For a person undergoing planned medical treatment in another Member State, costs are paid by the Member State that has referred them – via either the S2 scheme or the Patients' Rights Directive. The EU's reciprocal healthcare framework has 32 participating countries (the 28 current Member States of the EU, the three EEA/EFTA states – Norway, Iceland and Liechtenstein – and Switzerland).

67. The Director General advised that reciprocal healthcare cost recovery applies at EEA state level and is funded by the UK Government on a UK-wide basis. [24] He also stated in correspondence that the UK Government pays around £630 million per annum to other EEA countries for reciprocal healthcare they have provided for UK nationals. It collects around £50 million for the NHS healthcare provided for non-UK EEA nationals in the UK.

68. Liz Sadler, Deputy Director of the Planning and Quality Division explained the reason for the large differential in figures—

> "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." [25]

69. The figure of £630 million can be broken down further, with £468 million of this being for UK nationals who reside in the EEA, the remainder being for those using their EHIC cards or going to the EEA for planned treatment (£156 million for 2016/17). [26]

70. We sought clarification from the Director General on the number of Scots using the S1 Scheme. Whilst in oral evidence he quoted the figure as 15,000 Scottish pensioners he clarified in follow up correspondence that this was an estimate. He explained that the Department of Health and Social Care and DWP had advised they could not separately identify state pensioners from Scotland that were

participating in the S1 scheme while residing in other EEA countries (or Switzerland) so the figure of 15,000 was a reasonable estimate. He provided detail on how this calculation was arrived at—

> "by using a historical estimate of the total cost of £48 million to fund the S1 scheme for Scots, and by dividing that sum by the amount paid for each pensioner on an annual basis at the time (£3,200), we have been able to estimate that around 15,000 pensioners from Scotland are participating in the S1 scheme." [27]

71. Another area explored with the Director General was the possible effect on the NHS in Scotland if reciprocity of health treatment under the S1 route ended following the withdrawal from the EU. Specifically, how provision of healthcare for returning UK state pensioners, originally from Scotland would be provided.

72. Shirley Rogers, Director for Healthcare Workforce, told the Committee the Scottish Government was conducting some scenario planning for such a situation as part of Brexit preparations. [28]

73. The Director General sought to assure us that whilst a number of UK state pensioners from Scotland may be likely to return following the EU withdrawal the Scottish Government did not consider this would place an unmanageable burden on the NHS or social services in Scotland. He explained that the numbers were expected to be relatively small; not all expats would want or need to return to the UK (or Scotland); or require acute healthcare or social care on their return and those returning would be spread across Scotland. [29]

74. The Director General did suggest that the implications may be felt more over the longer term—

> "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." [30]

75. The Director General went on to emphasise the importance of the UK Healthcare (International Arrangements) Bill. This Bill addresses some of these concerns as it seeks to maintain reciprocal healthcare arrangements with the EU and its Member States after Brexit, either in a Brexit deal or no deal scenario. He stated—

> "We fully appreciate that if reciprocal healthcare was halted or there was a hiatus because of a no deal situation, this could have adverse implications for the many thousands of Scots that live in, or travel to, other EEA countries. That is why the provisions in the UK Healthcare (International Arrangements) Bill are so important." [31]

76. The Director General also highlighted in his letter that assurances had been given that the UK Government is committed to working closely with the devolved administrations now and in the future to deliver an approach that works for the whole of the UK. He added—

> "There have been discussions between UK and Scottish Government officials about amending the Bill to include a clause whereby the UK Government must consult the devolved administrations and enter into a memorandum of understanding with them, before regulations that impact on devolved responsibility can be introduced. We have yet to learn if this will be formally adopted." [32]

77. **We recognise the importance of continuing as close as possible to the same arrangements for reciprocal healthcare as currently exist after EU withdrawal. As the Scottish Government has highlighted, many thousands of UK nationals, including Scots, benefit from EU reciprocal healthcare each year. Either as state pensioners residing in other EEA countries outside the UK or as travellers using the European Health Insurance Card, as well as those seeking treatment in the EEA (S2 route).**

78. **We also note that current arrangements for the cost of providing the £48 million to fund the S1 scheme for Scots is applied at a EEA state level and is therefore funded by the UK Government on a UK-wide basis. We therefore welcome discussions on the UK Healthcare (International Arrangements) Bill containing a clause whereby the UK Government must consult the devolved administrations and enter into a memorandum of understanding with them, before regulations that impact on devolved responsibility can be introduced. We ask the Scottish Government for an update on whether this clause will be contained in the Bill.**

EU Directive Patients' rights in cross border healthcare

79. Under current arrangements some people can be authorised by their NHS board to travel specifically to receive pre-arranged healthcare in a Member State. These arrangements have evolved over time, and have been subject to case law as people have challenged constraints on where they can receive healthcare. A new EU Directive, implemented in October 2013 clarified the position. [33] The premise under this Directive was 'If you are entitled to treatment here (e.g the UK) you can get treatment over there (i.e Member state)'. According to the UK Government guidance:

> "Unlike the S2 route, under the terms of the new Directive EU citizens who choose to obtain a healthcare service (including private and unplanned care) in another Member State can seek reimbursement of the costs, provided the healthcare service is the same as or equivalent to a service that would have been provided to the patient within the NHS in the circumstances of their case. The right to claim a reimbursement of costs is limited to the cost to the NHS of the same or equivalent treatment had the patient obtained that treatment from the NHS – or the actual amount paid by the patient where this is lower than the cost of the equivalent NHS treatment. A patient may receive treatment in the state-provided sector or they may access services in the private sector under the Directive." [34]

80. The Scottish Government told the Committee that around 30 Scottish residents use the Directive each year to travel for treatment at a total cost of £50,000 a year. [35]

81. The Scottish Government highlighted that the Directive had not been included in the terms of the EU Withdrawal Agreement or in the Healthcare (International Arrangements) Bill. The Scottish Government indicated that this right will therefore cease for UK citizens when the UK withdraws from the European Union. Liz Sadler told the Committee "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." [36]

82. **We ask the Scottish Government if it has requested a further update from the Department of Health and Social Care since December 2018 on the future plans for the Directive. We recommend consideration should be given to similar arrangements being made to replace the Directive regarding patients' rights in cross border healthcare.**

Annexe A - Minutes of meetings

31st Meeting, 2018 (Session 5) Tuesday 27 November 2018

Work programme (in private): The Committee considered its work programme and agreed to write to NHS boards, the Director General for Health and Social Care and Chief Executive of NHSScotland and the Department for Work and Pensions in anticipation of a Legislative Consent Memorandum in respect of the UK Healthcare (International Arrangements) Bill.

32nd Meeting, 2018 (Session 5) Tuesday 11 December 2018

Healthcare (International Arrangements) Bill 2017-19 (UK Parliament legislation): The Committee took evidence on the legislative consent memorandum from— Paul Gray, Director General Health & Social Care and Chief Executive NHSScotland, Shirley Rogers, Director of Health Workforce, Leadership and Service Transformation, Liz Sadler, Deputy Director, Planning and Quality Division, Ian Davidson, Head of Constitution and UK Relations, and John Paterson, Divisional Solicitor, Scottish Government.

Healthcare (International Arrangements) Bill 2017-19 (UK Parliament legislation) (in private): The Committee considered the evidence heard earlier in the meeting and agreed to consider a draft report at its next meeting.

33rd Meeting, 2018 (Session 5) Tuesday 18 December 2018

Healthcare (International Arrangements) Bill 2017-19 (UK Parliament legislation) (in private): The Committee considered and agreed a draft report on the legislative consent memorandum.

3rd Meeting, 2019 (Session 5) Tuesday 29 January 2019

Healthcare (International Arrangements) Bill 2017-19 (UK Parliament legislation) (in private): The Committee considered a second report and agreed to further consider the report at its next meeting.

4th Meeting, 2019 (Session 5) Tuesday 5 February 2019

Healthcare (International Arrangements) Bill 2017-19 (UK Parliament legislation) (in private): The Committee further considered and agreed a second report.

Annexe B - Evidence

Written Evidence

- Letter from Paul Gray, Director-General Health and Social Care and Chief Executive NHSScotland - 4 December 2018
- Follow-up letter from Paul Gray, Director-General Health and Social Care and Chief Executive NHSScotland - 12 December 2018
- Letter from the Healthcare (International Arrangements) Bill Team, Department of Health and Social Care - 12 December 2018
- NHS Ayrshire and Arran - 4 December 2018
- NHS Borders - 5 December 2018
- NHS Dumfries and Galloway - 4 December 2018
- NHS Fife - 4 December 2018
- NHS Forth Valley - 5 December 2018
- NHS Grampian - 4 December 2018
- NHS Greater Glasgow and Clyde - 6 December 2018
- NHS Highland - 5 December 2018
- NHS Lanarkshire - 5 December 2018
- NHS Lothian - 4 December 2018
- NHS Orkney - 29 November 2018
- NHS Shetland - 3 December 2018
- NHS Tayside - 4 December 2018
- NHS Western Isles - 30 November 2018

Official Reports

Tuesday 11 December 2018 - evidence from the Scottish Government

1 Legislative Consent Memorandum on Provisions in the Healthcare (International Arrangements) Bill.

2 House of Commons Library. (9 November 2018) Healthcare (International Arrangements) Bill 2017-19 .

3 Health and Sport Committee. 12th Report, 2018 (Session 5). *Legislative Consent Memorandum - Healthcare (International Arrangements) Bill* .

4 Legislative Consent Memorandum on Provisions in the Healthcare (International Arrangements) Bill.

5 NHS England: *Reciprocal healthcare agreements for visitors to the UK*

6 Health and Sport Committee. *Official Report, 11 December 2018* , Col3.

7 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 12 December 2018.

8 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 12 December 2018..

9 Statutory Instruments 1989 No.364 (S.40) National Health Service Scotland. *The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989.*

10 NHS Forth Valley. Written submission.

11 NHS Ayrshire and Arran. Written submission.

12 NHS Lanarkshire. Written submission.

13 Department of Health and Social Care. *NHS visitor and migrant cost recovery programme* .

14 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 12 December 2018.

15 NHS Orkney. Written submission.

16 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 4 December 2018.

17 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 4 December 2018.

18 NHS GGC. Written submission.

19 Health and Sport Committee. Official Report, *Official Report, 11 December 2018* , Col 3. Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, *12 December 2018* .

20 Health and Sport Committee. *Official Report, 11 December 2018* , Col 12.

21 Health and Sport Committee. *Official Report, 11 December 2018* , Col 3, 12.

22 NHS Lothian. Written submission. NHS Western Isles. Written submission. NHS Lanarkshire. Written submission.

23 SPICe calculation based on written submissions from NHS boards.

24 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 4 December 2018.

25 Health and Sport Committee. *Official Report, 11 December 2018* , Col 14.

26 *Healthcare (International Arrangements) Bill Impact Assessment,* Page 7.

27 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 4 December 2018.

28 Health and Sport Committee. *Official Report, 11 December 2018* , Col 19.

29 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 12 December 2018 .

30 Health and Sport Committee. *Official Report, 11 December 2018* , Col 20.

31 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 12 December 2018 .

32 Letter from Paul Gray, Director General for Health and Social Care and Chief Executive of NHS Scotland, 12 December 2018 .

33 Directive 2011/24/EU – *On the application of patients' rights in cross-border healthcare* .

34 NHS England. *S2 and Directive routes:guidance for commissioners* .

35 Health and Sport Committee. *Official Report, 11 December 2018* , Col 19.

36 Health and Sport Committee. *Official Report, 11 December 2018* , Col 19.