Title: Healthcare (International Arrangements) Bill **IA No:** 13010 **RPC Reference No:** N/A **Lead department or agency:** Department of Health and Social Care **Other departments or agencies:** N/A	Impact Assessment (IA) **Date:** October 2018 **Stage:** Final **Source of intervention:** Domestic **Type of measure:** Primary legislation **Contact for enquiries:** eeacorrespondence@dh.gsi.gov.uk

Summary: Intervention and Options

RPC Opinion: N/A

Cost of Preferred (or more likely) Option

Total Net Present Value	Business Net Present Value	Net cost to business per year (EANDCB in 2014 prices)	One-In, Three-Out	Business Impact Target Status
N/A	N/A	N/A	Not applicable	N/A

What is the problem under consideration? Why is government intervention necessary?

The UK participates in reciprocal healthcare arrangements with Member States of the European Union (EU), non-EU Members of European Economic Area (EEA), and Switzerland. These arrangements allow UK citizens living and working in EU/EEA countries and Switzerland to access public healthcare on the same basis as domestic nationals. They also enable UK residents studying and traveling in these countries to access need-arising care (i.e. emergency care) in public hospitals through the European Healthcare Insurance Scheme (EHIC). Further, all UK residents are entitled to receive planned treatment in another member state, subject to pre-authorisation by the devolved UK health authorities (e.g. for England the relevant authority is NHS England). For these groups (UK pensioners, students, visitors and UK citizens receiving planned treatment) the cost of the healthcare provided is funded by the UK Government (with the exception of healthcare systems in the EU which require co-payment by the patient).

The majority of reciprocal healthcare for UK citizens within the EU has to date been enabled by EU regulations (883/2004 and 987/2009 and their predecessors), which set out detailed rules for who is eligible and reimbursement, and provide the legal authority for the Secretary of State for Health and Social Care to make overseas payments. The Secretary of State has limited powers to fund and arrange for overseas healthcare, or implement reciprocal healthcare agreements with other states. When the UK leaves the EU, the current EU regulations will no longer be part of our statute and we will need domestic legislation to provide for healthcare abroad.

The Healthcare (International Arrangements) Bill (the Bill) provides the Secretary of State with powers which are necessary to fund and arrange for the provision of healthcare overseas, after we leave the EU. The powers are required both in a deal and in a no deal scenario, and go beyond the EU sphere, to allow the Secretary of State to implement any new agreements on reciprocal healthcare which the UK puts in place with both EU and non-EU states.

What are the policy objectives and the intended effects?

The powers enable the Secretary of State for Health and Social Care to address the essential matters relating to healthcare overseas, including defining individual entitlements to healthcare and operational and administrative matters, such as data sharing where necessary to facilitate treatment. This also includes being able to reimburse other countries for healthcare provided to UK citizens, and to recover costs for healthcare provided to their citizens by the NHS.

These powers will ensure we are prepared whatever the outcome of EU Exit and are able to better implement new reciprocal healthcare agreements in future by:

- enabling the UK to fund and implement our future relationship with the EU on reciprocal healthcare;
- ensuring the UK is prepared if there is no deal later this year. It will enable us to implement reciprocal healthcare agreements with individual EU states, such as Ireland, or to make unilateral arrangements for UK citizens to have access to healthcare abroad.
- allowing the UK to strengthen its other reciprocal healthcare agreements or implement new ones with countries outside the EU as part of health and trade policy on the global stage.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

The Bill is one of a number of planned pieces of EU Exit legislation that will support the UK's withdrawal from the EU.

The EU (Withdrawal Agreement) Bill will allow us to continue the vast majority of existing EU reciprocal healthcare arrangements during the Implementation Period (and after the Implementation period for those people covered by the Withdrawal Agreement). The EU (Withdrawal) Act 2018's powers allow for the remediation of deficiencies in retained EU law.

However, neither supports long-term arrangements covering the general UK population after the Implementation Period. Nor do they provide the powers needed, in the event of no deal scenario, for the UK to give effect to complex bilateral agreements with EU/EEA countries to ensure continued access to healthcare for UK nationals living, working, studying or traveling to the EU/EEA. Lastly, neither would enable implementation of complex healthcare arrangements with countries outside of the EU.

The alternative option is to not legislate, however this is not a viable option. Not legislating leaves the UK without sufficient domestic powers to make unilateral or bilateral arrangements which would provide for continuation of the current approach to healthcare abroad. Legislation will be necessary to implement any reciprocal healthcare agreement that is agreed with the EU as part of our future relationship. In the event of a no deal, the UK Government would not have the power to give effect to bilateral agreements with member states, if agreed, and would be unable to put in place arrangements to provide for affordable access to healthcare for UK nationals already residing or studying in the EU.

In brief, the Bill will provide the Secretary of State with powers which are necessary, after EU exit, to arrange for the provision of healthcare abroad for UK citizens. The powers are required both in a deal and in a no deal scenario, and go beyond the EU sphere, to allow the Secretary of State to implement any new agreements on reciprocal healthcare which the UK puts in place with both EU and non-EU states.

Will the policy be reviewed? The policies implemented will depend on the outcome of EU Exit negotiations. **If applicable, set review date:**

Does implementation go beyond minimum EU requirements?	N/A

Are any of these organisations in scope?	**Micro** No	**Small** No	**Mediu m**No	**Large** No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded:**	**Non-traded:**	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it

Signed by the responsible SELECT SIGNATORY: ..... Date: .....

represents a reasonable view of the likely costs, benefits and impact of the leading options.

Summary: Analysis & Evidence **Policy Option 1** – Introduction of the Reciprocal Healthcare Bill
Description: The Reciprocal Healthcare Bill
FULL ECONOMIC ASSESSMENT

Price Base Year	**PV Base Year**	**Time Period Years**	**Net Benefit (Present Value (PV)) (£m)**		
			Low: Optional	**High:** Optional	**Best Estimate:**

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant	**Total Cost** (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate				

Description and scale of key monetised costs by 'main affected groups'

The powers provided for in the Healthcare (International Arrangements) Bill will allow the UK Government to pursue and implement a future relationship with EU/EEA on reciprocal healthcare arrangements.

Currently, the use of EU reciprocal healthcare entitlements by UK citizens in EU/EEA Member States and Switzerland cost approximately £630m in 2016/17. Payments to individual Member States are made on a monthly basis, within the timeframes set out in the EU regulations on social security coordination, including reciprocal healthcare arrangements. Payments are made in the local currency of Member States and the GBP equivalent amount is therefore sensitive to movements in foreign exchange rates within a given financial year.

In both a deal and a no deal scenario we are seeking to maintain reciprocal healthcare arrangements with EU/EEA Member States and Switzerland for the Implementation Period, during which the costs will be similar. In a deal scenario, the powers to maintain reciprocal healthcare arrangements during the Implementation Period will stem from the EU (Withdrawal Agreement) Bill. In case of a no deal scenario the UK Government would rely on the powers of the Bill to implement new bilateral agreements with individual Member States, with a view to maintaining access to healthcare for UK citizens abroad.

The longer-term costs of reciprocal healthcare arrangements are subject to the outcome of the negotiations between the UK and the EU and agreement on the relationship between the two parties including reciprocal healthcare arrangements. In this scenario, the UK Government will rely on the powers provided in the Bill to implement the future reciprocal healthcare arrangements between the UK and the EU.

Other key non-monetised costs by 'main affected groups'
This Bill provides enabling powers; no immediate impacts are on the face of the Bill as the exercise of powers in the Bill are subject to a number of uncertain factors, such as the negotiations within the EU, international agreement and the exercise of secondary legislation.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant	**Total Benefit** (Present Value)
Low	Optional		Optional	**Optional**
High	Optional		Optional	**Optional**
Best Estimate				

Description and scale of key monetised benefits by 'main affected groups'

This Bill provides enabling powers; no immediate impacts are on the face of the Bill as the exercise of powers in the Bill are subject to a number of uncertain factors, such as the negotiations within the EU, international agreement and the exercise of secondary legislation.

Other key non-monetised benefits by 'main affected groups'

UK nationals living, working, studying or visiting EU/EEA countries and Switzerland will have continued access to healthcare after the 29 March 2019.

Key assumptions/sensitivities/risks **Discount rate (%)**

The analysis assumes that future arrangements are broadly a continuation of the current EU ones that the UK participates in. Future arrangements will be subject to negotiation and agreement with other countries.

EU reciprocal healthcare rules are based on the principle of free movement which the UK Government aims to replace with a new mobility framework. Any reciprocal healthcare arrangement should facilitate this mobility framework and reflect the new economic partnership between the EU and the UK.

This analysis also assumes those UK nationals living abroad do not return to the UK to receive healthcare through the NHS.

The amount of £630m per year does not include new users of EU reciprocal healthcare arrangements, the impact of the general economy inflation, or the healthcare cost inflation[1].

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			**Score for Business Impact Target (qualifying provisions only) £m:**
Costs:	**Benefits:**	**Net:**	

[1] Annual increase in healthcare costs as a result of price increases of healthcare products

Reciprocal Healthcare Arrangements under EU Regulations 883/2004 and 987/2009

Background

What is reciprocal healthcare?

1. Reciprocal healthcare is an agreement between countries, whereby two or more countries become party to an international agreement by which they facilitate access of their citizens to their respective healthcare systems.

2. Providing individuals with access to healthcare abroad through a reciprocal healthcare agreement is generally seen in a positive light and mutually beneficial as it provides individuals with greater life opportunities, for example to travel or to work in another country.

3. The UK has multiple reciprocal healthcare agreements for example with Australia and New Zealand among others, as well as with the EU. Many of the current reciprocal agreements are modernised versions of long-standing historical agreements that were during the 20th century.

EU Reciprocal Healthcare

4. Reciprocal healthcare arrangements across the EU, EEA and Switzerland are facilitated by a system of provision reimbursement and cost recovery predominantly deriving from the following regulations:

    - Regulation (EC) No 883/2004 on the coordination of social security systems; and

    - Regulation (EC) No 987/2009 laying down the procedure for implementing Regulation 883/2004 provide for coordination of social security benefits, including healthcare, for people moving within the EU, and between the EU, EEA and Switzerland.

5. The purpose of Regulation 883/2004, which covers social security, pensions, benefits and healthcare is to ensure that insured EU citizens do not lose their social security rights (including healthcare) when they move to another Member State. It facilitates the free movement of persons by coordinating (but not harmonising) the laws of Member States in the field of social security.

6. Under Regulation 883/2004 the branches of social security benefits in scope include “sickness benefits in kind” i.e. healthcare. The rules of the Regulation determine which EU Member State’s legislation applies. The competent member state is the one which has responsibility for an individual’s healthcare costs (other than costs that are payable by the individual). The individual is insured by (has some/all of their healthcare costs covered by) the competent member state. Competence is largely determined by where an individual resides and where they work, with further detailed rules covering certain specific situations. Individuals should be treated the same as nationals of the member state in which they receive reciprocal healthcare under the EU principle of equal treatment.

7. These rules mean that UK residents who are residing or staying in another state may obtain treatment as if they were a resident of the country in question. The range of medical services in EU countries may be more (or less) restricted than under the NHS, and in some cases patients need to make a contribution towards the costs of their care (co-payments), but they ensure good access to healthcare at reduced cost (and in some cases for free).

8. The Regulations also apply to EU-insured individuals using NHS-funded treatment when in the UK, and enable the UK to recover the costs of treatment from the competent Member State. To note, however, that as the NHS is a residency-based healthcare system it can be the case that an individual is eligible for free care, based on ordinary residence in a situation where, under Regulation 883, another state is competent for their healthcare.

9. There are currently three main groups of individuals covered by current reciprocal healthcare arrangements:

    a. Approximately 180,000 UK state pensioners and their dependents[1] living abroad (principally in Ireland, Spain, France and Cyprus) registered for the scheme. Individuals in this group benefit from healthcare provision in their country of residence upon registration of their S1 form.

    b. Approximately 1,300 UK residents per year[2] who are traveling overseas to receive planned treatment in other EU/EEA countries and Switzerland (e.g. returning in their home country to give birth). Individuals in this group are able to receive healthcare in other EU/EEA countries upon authorisation of their S2 form by health authorities in the UK (e.g. for England the relevant authority would be NHS England)

    c. UK residents visiting EU/EEA countries and Switzerland (e.g. on holiday, to study). People who are residing in the UK qualify for the European Health Insurance Card (EHIC) and 250,000 medical claims are resolved each year.

10. UK nationals who live and work in the EU can access healthcare when they pay the same local taxes and contributions as other EU nationals (and are not UK funded). However, under the S1 route we also fund healthcare for over 10,000 employees of UK firms / bodies working in the EU/EEA (including their dependents) ('posted workers') and 'frontier workers' who live in the UK but travel to work in the EU.

How much does it cost?

11. DHSC expenditure on healthcare provided to UK citizens in the EU in 2016/17 (through the aforementioned routes) is estimated at £630m.

12. Expenditure on UK state pensioners and their dependents accounts for approximately 75% of this, at an estimated £468m for activity in 2016/17.

13. Expenditure on 2016/17 activity for temporary visitors (those covered by the EHIC scheme, which includes some posted workers who rely on EHIC to access healthcare rather than an S1 form), and those seeking planned treatment in another EU country is estimated to have cost £156m. Expenditure on dependents of posted workers (account for the remaining expenditure).[3]

14. The income from provision of NHS services to EU-insured individuals is estimated at £66m for 2016/17 activity. The majority of this income arises from temporary visitors, EU posted workers in the EU relying on EHIC and planned treatment, at £41m[4]. Estimated income from provision of healthcare to EU-insured pensioners and their dependents in 2016/17 is £25m.[5]

[1] This estimate is rounded and is based on the latest available snapshot report of live registrations, as of 1 April 2018 obtained by the DWP Overseas Healthcare Team. This figure may include a number of S1 forms (entitlement to UK funded healthcare abroad) due to unreported deaths, returns to the UK and uncancelled forms. This figure includes estimates for the number of UK insured S1 Registered Pensioners in the Republic of Ireland which is an estimate based on the formula agreement between UK and Ireland.

[2] According to UK's return to the European Commission's Questionnaire from 2016 and 2017, for the EU Commission's Cross Border Healthcare annual publication

[3] DH Resource Accounting and Budgeting (RAB) exercise. Totals are based on estimates of the costs of European Economic Area (EEA) healthcare claims made annually for the purposes of provisions made in the Department of Health accounts in accordance with Treasury resource accounting rules. Estimates are for 2016/17.

[4] This also includes a minority of income from other groups covered by Article 93.

[5] Ibid

Table 1 – Estimated claims for reciprocal healthcare provided in 2016/17[6]

	Member State Claims (costs incurred by UK)	UK Claims (income recoverable by UK)
Article 93[7] Temporary Visitors (EHIC), planned treatment (S2) and other groups, inc some posted workers	**£156m**	**£41m**
Article 94 Dependents (of worker) in home state	**£6m**	**£0.1m**
Article 95 Pensioners and dependents	**£468m**	**£25m**
Total*	**£630m**	**£66m**

Figures may not match due to rounding

The problem under consideration

15. EU Exit means that our continued participation in EU reciprocal healthcare arrangements, as a part of the broader arrangement of social security coordination between EU member states, is subject to negotiation between the UK and the EU.

16. Table 2 below, presents a break down by Member State of where UK citizens receive healthcare under the routes described in paragraph 9. More than 90% of UK state pensioners and their dependents reside in Ireland, Spain, France and Cyprus. The use of EHIC by UK residents is highest in Spain, Poland and Germany representing approximately 70% of claims against the UK for healthcare use by UK citizens in the Member States.

Table 2 – Summary table of UK-issued S1 and S2 forms and EHIC use by UK residents, by Member State[8]

[6] Please note that these are estimates of the cost of healthcare provided by member states to UK citizens in 2016-17 (MS claims), or healthcare provided by the NHS to EU-insured individuals in 2016-17 (UK claims). They do not relate to actual payments made in 2016-17.

[7] Articles 93-95 essentially correspond to Article 62, Article 62(2)a and Article 63(2)b of Regulation 987/2009; the UK has not yet implemented a new finance system so continues to refer to Articles 93-95 for ease of comparison. Article 93 figures include claims under the former Article 22.1c (planned treatment) and Article 55.1c (industrial injury)

[8] The UK has waiver agreements with Denmark, Estonia, Finland, Hungary, Norway and Malta for EHIC claims. The UK do not seek reimbursement for the healthcare provided to UK citizens in these countries and similarly these countries do not seek reimbursement from the UK.

Member State of residence	Sum of UK Insured S1 Registered Pensioners and Dependents in the EEA and Switzerland (2018)[9]	UK-issued S2 forms (2017)[10]	Use of EHIC in EU by UK residents (2016)	Number of UK residents' visits to the EU/EEA (2017)[11]
Belgium	450	*25*	*2,700*	1,616,711
Bulgaria	900	*<10*	*690*	527,635
Czech Republic	200	*60*	*3,800*	576,602
Denmark	30	*0*	*0*	468,016
Germany	2,800	*90*	*22,000*	2,909,349
Estonia	25	*<10*	*0*	*N/A*
Greece	2,600	*10*	*2,300*	2,382,736
Spain	67, 000	*150*	*91,000*	15,871,874
France	41,000	*100*	*18,000*	8,861,670
Croatia	80	*<10*	*2,200*	*N/A*
Ireland[12]	45,000[11]	*40*	*N/A*	*N/A*
Italy	2,400	*50*	*5,200*	4,159,927
Cyprus	11,600	*0*	*2,800*	901,370
Latvia	35	*<10*	*100*	*N/A*
Lithuania	35	*25*	*900*	389,234
Luxembourg	50	*<10*	*100*	80,200
Hungary	400	*60*	*<10*	669,419
Malta	2,600	*<10*	*0*	518,645
Netherlands	250	*15*	*3,800*	2,659,846
Austria	600	*10*	*9,200*	589,809
Poland	450	*550*	*55,000*	2,672,386
Portugal	3,800	*<10*	*0*	2,875,595
Romania	35	*<10*	*35*	1,008,754
Slovenia	70	*0*	*750*	*N/A*
Slovakia	35	*90*	*5,400*	185,988
Finland	45	*<10*	*0*	158,613
Sweden	150	*10*	*3,200*	376,223
Iceland	<10	*<10*	*700*	*N/A*
Liechtenstein	N/A	*0*	*<10*	*N/A*
Norway	40	*<10*	*0*	304,855
Switzerland	300	*15*	*3,300*	955,303
Total	**180,000**	**1,350**	**233,000**	

[9] Figures based on UK's return to the EU Commission's questionnaire for S1 registrations for year 2017 and are rounded

[10] Figures based on UK's return to the EU Commission's questionnaire for approved S2 applications for year 2017 and are rounded

[11] ONS Travel Estimates: UK residents' visits abroad (2017)

[12] The figures for Ireland are based on estimates. This is because the UK and Ireland only exchange S2 forms. The reimbursement for the healthcare of UK state pensioners and care provided to UK visitors is based on an agreed formula between the two countries. The

[11] This figure does not include pensioner dependents

17. As set out in the White Paper on the Future relationship with the EU, the UK Government's ambition is to ensure broad continuation of the current EU reciprocal healthcare arrangements.

18. The UK government's ability to fund and arrange healthcare for UK citizens within the EU has, to date. predominantly been enabled by EU regulations (883/2004 and 987/2009 and their predecessors), which set out detailed rules for who is eligible and reimbursement, and provide the legal authority for the Secretary of State for Health and Social Care to make overseas payments. The Secretary of State has only limited domestic powers to fund overseas healthcare, or implement complex reciprocal healthcare agreements with other states. When the UK leaves the EU, therefore, it will be necessary for domestic legislation to provide the Secretary of State with powers to fund and arrange for healthcare overseas.

19. Subject to the successful conclusion of the UK – EU negotiations, the UK Government will be able to rely on these regulations to continue participating in the EU healthcare arrangements but this only during the Implementation Period until December 2020 (and after the Implementation Period, for people covered by the Withdrawal Agreement).

20. Following the end of the Implementation Period, the UK Government will need to have domestic powers in place to give effect to a future partnership with the EU that enables the UK to continue participating in EU reciprocal healthcare arrangements, as expressed in the Government's July 2018 White Paper13, in a proportionate way to the mobility framework that will be agreed between the UK and the EU.

21. In a no deal scenario, the Prime Minister has announced that the UK will protect the rights of EU citizens in the UK before exit-day14. In such an event the UK will look for EU/EEA Member States to reciprocate such assurances for UK citizens living in the EU/EEA and Switzerland through bilateral agreements that will maintain the reciprocal healthcare arrangements for a transitional period. The UK and Ireland are currently negotiating the continuation of such arrangements.

22. As the UK Government will no longer be able to rely on EEA regulations, the Bill will be necessary so that the UK government can pay or arrange for payment of healthcare outside of the UK, and give effect to bilateral agreements with Ireland and with any other Member State with whom the UK may secure a bilateral healthcare agreement, as well make necessary provisions in relation to data sharing to underpin these arrangements.

23. The most straightforward and clear way to allow for implementation of any such arrangements, be it as part of a future relationship or on a bilateral basis with Member States, is to introduce statutory powers for this purpose.

24. The Bill will also allow the UK to strengthen its other reciprocal healthcare agreements or implement new ones with countries outside the EU as part of health and trade policy on the global stage.

Why is Government intervention necessary?

25. The introduction of the Healthcare (International Arrangement) Bill is necessary to provide the government with the powers to ensure a smooth transition from our current relationship with the EU to the future one, which the UK Government aspires to include the continuation of UK's participation in EU reciprocal healthcare. The Bill will equip the UK with the powers necessary to address the discontinuation of current EU-based reciprocal healthcare arrangements and strengthen its other reciprocal healthcare agreements or implement new ones with states outside the EU as part of health and trade policy on the global stage.

[13] The Future Relationship between the United Kingdom and the European Union (p.35)

[14] PM Brexit negotiations statement: 21 September 2018

26. The regulation making powers in the [Healthcare (International Arrangements) Bill will enable the Government to implement any parts of a future agreement with the EU on reciprocal healthcare which are not dealt with as part of our withdrawal from the EU. As explained above [at page 2], neither the EU (Withdrawal) Act 2018, nor the EU (Withdrawal Agreement) Bill, provide the necessary powers.

27. The EU (Withdrawal Agreement) Bill (WAB) will incorporate into domestic law the reciprocal healthcare aspects of the Withdrawal Agreement, when this is concluded with the EU.

28. The UK Government is negotiating the terms of UK's withdrawal from the EU, which will be enshrined in the Withdrawal Agreement. As part of the agreement, the UK and the EU are seeking an Implementation Period to facilitate the transition to a future economic partnership. During the Implementation Period the UK will continue to participate in EU reciprocal healthcare arrangements. Subject to the negotiations concluding successfully, the rights of UK and EU nationals in the EU and the UK, respectively, will be protected beyond the end of the implementation period and for as long as they remain in scope of the Withdrawal Agreement.

29. Assuming the Withdrawal Agreement is concluded, the WAB will allow us to give effect to the continuation of key reciprocal healthcare arrangements during the Implementation Period, and for people covered by the Withdrawal Agreement, after the Implementation period.

30. However, the WAB is not intended to and will not support long-term arrangements covering the general UK population after the Implementation Period. Further, WAB will not be sufficient for the UK to make provision in the event the UK does not reach agreement with the EU, and wishes to arrange for healthcare overseas for UK citizens, either on a unilateral basis or by means of bilateral agreements with individual countries. Lastly, the WAB would not enable healthcare arrangements with countries outside of the EU.

What are the policy objectives and the intended effects?

31. The Bill is enabling legislation providing the UK Government with the powers to fund and arrange for healthcare abroad and to implement reciprocal healthcare arrangements with other countries, to ensure that the UK is well-equipped to address the discontinuation of current reciprocal healthcare arrangements with the EU, in both a deal and no deal scenario.

The UK's preferred policy position

32. The UK's preferred policy position with regard to future reciprocal healthcare arrangements is to seek a wider agreement with the EU that covers state pensioners retiring to the EU or the UK, continued participation in the EHIC scheme and cooperation on planned medical treatment.[15] The Bill would allow for the implementation of such an agreement.

33. The future relationship between the UK and the EU is subject to negotiations on both the continued participation of the UK in EU reciprocal healthcare arrangements as well as an agreement on the shape and scope of a future mobility framework. Reciprocal healthcare arrangements with the EU will need to support the agreed mobility framework.

34. In the event of no withdrawal agreement, or no future economic relationship agreement being reached with the EU, the Bill will be necessary to give effect to any bilateral agreements on reciprocal healthcare with individual EU countries, and to provide for healthcare cover for people in prescribed circumstances where the cost of their healthcare abroad is not covered under any future reciprocal healthcare agreements.

[15] The Future Relationship between the United Kingdom and the European Union, p.35

Rationale for preferred policy position

Life Options

35. EU reciprocal healthcare arrangements support the freedom for individuals to seek pre-planned treatment, visit or retire to other countries in the EU without the need to worry about the costs of their healthcare. This is particularly true for people with medical risk factors, including the elderly and those with long-term conditions, who might not otherwise be able to live or travel abroad as easily.

Promotes economic growth

36. Under EU reciprocal healthcare arrangements, many UK and EU residents are eligible for healthcare services across the EU without encountering financial or bureaucratic barriers. In reducing such barriers, the reciprocal healthcare arrangements help to support trade relationship and economic growth with EU Member States. For example, the presence of reciprocal arrangements could facilitate tourism. In 2017, there were 25 million visits from EU27 residents to the UK, spending approximately £10bn. This represents almost 70% of all visits to the UK by overseas residents. An estimated 28% of visits to the UK by EU27 residents were for business, as were approximately 9% of visits to the EU27 by UK residents.[16]

Personalisation and choice

37. Planned treatment under the S2 route (which enables people to travel to another EU country for qualifying, pre-approved, state-provided treatment) facilitates personalisation and choice. For example, mothers can travel to their home country to give birth or the NHS can authorise treatment in another EU country that would normally be provided by the NHS where there is a delay to provision domestically.

Cost-effectiveness of reciprocal healthcare

38. By 1 April 2018 there were approximately 180,000 UK pensioners (and their dependents) resident in the EU. The estimated expenditure on UK-funded healthcare delivered to this group during 2016/17 was £468 million.[17] Estimates suggest that average unit costs for treatments provided in the EU are lower than NHS average costs, however, these figures are not necessarily comparing the same treatments or frequency of treatments between the UK and EU/EEA countries, and are therefore not directly comparable.

39. However, it should be noted that under the EU reciprocal healthcare arrangements, the UK is also funding healthcare the costs of which would probably be met by individuals themselves in most cases. For example, in the absence of EHIC individuals accessing healthcare abroad would generally pay their costs either directly or through a health or travel insurance policy. In the absence of 'S1' reciprocal healthcare many people would still continue to live in and move to other EU member states and fund their own healthcare via social contributions.

40. Reciprocal arrangements also enable the UK to recover NHS costs from other member states in certain circumstances. The income from provision of NHS services to EU-insured individuals is estimated at £66m for 2016/17 activity. The majority of this income arises from temporary visitors (including posted workers) and planned treatment, at £41m[18]. Estimated income from provision of healthcare to EU-insured pensioners and their dependents in 2016/17 is £25m. Domestic legislation already enables us to recover income for the treatment of EU nationals who are not resident in the UK, however we currently rely on regulation 883 to recover costs from other member states when the individual is resident here. The Bill would provide that power once we have left the EU so these costs can continue to be recovered.

16 ONS (2018) Travel Trends 2017

17 Ibid; DWP Overseas Healthcare Team S1 liveload data (December 2017)

18 This also includes a minority of income from other groups covered by Article 93.

41. After EU-exit, EU nationals visiting the UK who are not ordinarily resident in the UK would be directly chargeable for any treatment provided in the NHS and, in the absence of any reciprocal healthcare agreement would have to pay for any care directly. Recovering the associated costs of care from a Member State rather than directly from the individuals (or their insurers) is preferable as there is a much higher recovery rate between countries' public authorities and reduces the administrative burden on healthcare providers.

Options under consideration

42. The two options considered in this IA are outlined below:

Option 0: Do Nothing (counterfactual)

43. Under this option the UK Government will not put in place all the powers needed to fund or provide for healthcare abroad, or give effect to any reciprocal health agreement that is agreed with the EU as part of our future relationship. Consequently, the UK will not have the power to fund or ensure access to healthcare for UK citizens traveling, moving or studying to the EU following the end of the Implementation Period.

44. In the absence of this legal basis and in the event that no withdrawal agreement, and indeed, no future economic relationship agreement is reached with the EU, the UK Government will not have sufficient powers put in place the complex funding and implementing provisions which are necessary to ensure that UK nationals already residing or studying in the EU have continued access to healthcare along similar lines.

Option 1: Introduce the Reciprocal Healthcare Bill

45. This option is to introduce new primary legislation to provide statutory powers to:

- fund and arrange for the provision of healthcare outside the UK (where appropriate);
- give effect to new reciprocal healthcare agreements with other countries (both EU and non-EU) or supranational bodies such as the EU; and
- establish a data processing gateway to enable the processing of data between authorised persons where necessary for purposes of implementing, operating or facilitating the operation of reciprocal healthcare arrangements or payments.

46. The Government's preferred option is Option 1, as the most straightforward and clear way to allow for implementation of the Government's preferred policy position, which will allow the Government the powers that are necessary to put in place reciprocal healthcare arrangements for UK residents and UK nationals abroad.

Rationale for the Bill

47. See section 'Why is Government intervention necessary', paragraphs 25– 30.

Who does this Bill cover?

48. The Bill enables the Secretary of State to:

- make, and arrange for payments to be made, in respect of the cost of healthcare provided outside the UK (Clause 1);
- to make regulations in connection with the provision of healthcare abroad (including making and arranging payments), or to give effect to healthcare agreements with other countries (both EU and non-EU) or supranational bodies such as the EU, depending on what is required after exit day (Clause 2); and
- lawfully process data where necessary for purposes of implementing, operating or facilitating the doing of anything under or by virtue of the Bill (Clause 4).

Risks and assumptions

49. It should be flagged upfront, that as the description above makes clear, this Bill is essentially an enabling measure, and contains few substantive provisions. It is therefore difficult to assess with any certainty what the impact of the Bill measures will be, given that the reciprocal agreements which would be implemented by means of the Bill are still being negotiated. Any policy that will be implemented using the regulation-making powers provided in this Bill will be subject to a new Impact Assessment.

Appraisal of Option 1

50. Given that the future relationship of the UK and EU is subject to negotiation, and any costs/benefits arising from future policy changes in a negotiated or non-negotiated exit may potentially be examined in a new IA, a quantitative assessment of negotiating options is not presented.

51. Any impact will stem from the policies that this Bill will enable the UK Government to give effect to and implement. The policies outlined in previous sections will depend on the outcome of the negotiation between the UK and the EU on the terms of UK's withdrawal from the EU and whether there will be an agreement or not, including on a future relationship.

52. Examples of the type of impacts which could arise under future policy options are briefly discussed in the following section. At this stage however, it is not possible to set out in detail the scale of the impact the use of the powers in the Bill will have – this will only be possible once the outcome of negotiations and any policy changes resulting from a negotiated or non-negotiated exit are known.

Direct Impacts

53. Should the current reciprocal healthcare arrangements cease, without the UK taking mitigating action under the Bill, we could expect to see a number of direct impacts on the public, public sector and economy. There could also be direct impacts on the public, as some UK expatriates and visitors may no longer have the same access to healthcare as under current arrangements[19].

    It is not clear how member states will choose to support UK nationals who live in, work in, or visit their country to access healthcare after EU Exit in the absence of any reciprocal healthcare arrangement. The UK hope that member states will be willing to support UK nationals to access healthcare and the Bill will support us to implement bilateral agreements that would help do this. However, in the absence of any agreements a reasonable working assumption is that member states will apply the same rules to UK nationals that they apply to 3rd country nationals.

54. If UK citizens in the EU are treated as 3rd country nationals (i.e. they cease to have rights of movement and access to services in EU Member States, and are treated like citizens coming from non-EU countries) some may face additional financial costs or difficulties accessing healthcare services, with potential implications for their health and wellbeing.

55. Based on DHSC analysis of the registered S1 forms as at the end of April 2018, most EU expatriates have been residing in EU Member States for more than 5 years and as a result would be eligible for permanent residency that would entitle them to healthcare access. However, beyond the duration of stay in a Member State, each country has different criteria that British expatriates will need to satisfy to be granted permanent residency (for example, in Spain individuals are required to have been registered with the police authorities for 5 years prior to their application).

56. Where UK citizens are granted permanent residency, they will be able to access the healthcare system of their country of residency and be treated as domestic nationals. However, this does not exclude them from facing direct financial costs should a Member State require financial contributions from its domestic nationals either in the form of co-payments, payments towards a public/private health insurance scheme, or both.

[19] This will be dependent on the EU country the individual is resident in or visiting.

57. For example, in Spain, domestic nationals of state pension pay into the healthcare system through taxes and there is no additional cost for them in order to access the healthcare system.

58. Where UK citizens are not eligible for permanent residency, in some countries there will be the option to voluntarily opt in public health insurance schemes, but this will again be subject to different requirements in each Member State and may entail additional costs. For example, in Spain there is a public health insurance policy available to individual residing in the country for less than 5 years but this costs €1,900 per year for those aged 65+ and €700 for those <65 years old[20] and does not cover prescription costs. There will be cases where individuals will be required to purchase private health insurance policies to meet their healthcare costs, of which the cost will vary by country and by the risk appetite in each country's insurance market.

59. The fiscal impact of the cessation of reciprocal healthcare arrangements is unclear as this will depend on a wide range of behavioural reaction by the UK expatriate community in the EU. While the cessation of EU reciprocal arrangements will mean a saving of the EEA healthcare budget, it is unknown the extent to which UK citizens will opt to return and receive healthcare in the NHS. This will have an impact on domestic healthcare and adult social care expenditure. But Government's tax receipt would also increase in such a scenario, as the income of those expatriates will be spent in the UK. Whether this would offset the additional NHS and Adult Social Care expenditure is unclear, as UK citizens in the EU have different income levels.

60. The Bill provides the UK Government with the means to continue with UK – EU reciprocal healthcare arrangements as part of a future relationship, and to mitigate the impact of discontinuation of the current arrangements in a no deal scenario. In the absence of the Bill, the impacts of discontinuation of the existing EU reciprocal health arrangements would be significant, particularly in a no deal scenario. l. Any policy changes resulting from the use of powers provided through the Bill will be subject to a new IA, where appropriate.

Wider Impacts

Behavioural response

61. Maintaining existing reciprocal healthcare arrangements may help to mitigate the impact of potential behavioural responses from UK-insured individuals[21]. Any loss of, or reduction in, healthcare cover could make retiring in the EU less attractive to UK pensioners. Should this happen, UK-insured pensioners currently resident in the EU may choose to return to the UK. Similarly, those previously intending to retire abroad may instead opt to remain in the UK.

62. As a result, there would be a cost to the health (and possibly to the adult social care system) for providing NHS and social care support to both returning citizens and those who choose to remain in the UK rather than migrating. This would have wider implications for the health and social care system in terms of capacity or waiting lists and would affect other public services, such as social housing. However, there could also be benefits to the UK economy and public sector through increased tax receipts and consumption.

63. With regards to EU nationals travelling to the UK, the use of reciprocal healthcare within the EU will depend on whether there will be any behavioural changes in travel trends between the UK and the EU. We will only be able to assess the scale of such changes, should there be any, most likely in the year following Exit when data on travel trends for 2019 becomes available.

Wider Impact on Business

[20] http://healthcareinspain.eu/living-in-spain/#convenioespecial

[21] Please note that a change in the migration intentions of UK citizens and/or UK nationals could occur under all scenarios, even where reciprocal healthcare is maintained, due to changes in other circumstances or rights in the UK or EU countries following exit (for example, the value of the pound could reduce spending power in the EU reducing the attractiveness of migrating or immigration regimes in the UK or EU could change).

64. As set out above, our preferred approach for reciprocal healthcare is for the UK to continue participating in the EHIC scheme and planned treatment, and ensure access to healthcare for UK state pensioners living in the UK, as outlined in the Government's White Paper from July 2018.

65. The wider impact on business may vary depending on the policies provided for in either a negotiated or non-negotiated outcome.

Travel Insurers

66. Under scenarios in which reciprocal healthcare arrangements are not maintained, there could be a direct impact to travel insurers. This is because EHICs essentially partially subsidise, but do not replace, travel insurance policies for temporary visitors within the EU. ABI estimates that travel insurance premiums could increase by 10% - 20%[22].

67. For those with a valid EHIC, the public costs[23] of any state-provided and medically necessary treatment will be covered by the competent state rather than through their insurance policy. It is also not uncommon for travel insurance policies to include an excess waiver for medical claims beyond this, where EHICs are used for medical treatment in EU countries.

68. In the absence of reciprocal arrangements for temporary visitors therefore, it is possible that the cost of travel insurance policies, particularly for people with medical risk factors, will rise, or coverage restricted. Insurers may also incur greater administrative and operational costs.

69. Whether or not these impacts arise, and the extent to which travel insurers will be affected, will depend upon the exact policy option realised for reciprocal healthcare.

Health Insurers (UK residents in the EU)

70. Under scenarios in which reciprocal healthcare arrangements are not maintained, UK-insured individuals resident abroad may need to access healthcare through other routes (or remain uninsured). Where individuals choose to purchase private health insurance, this would lead to an increase in business for private health insurance firms. However, these impacts will primarily accrue to EU-based insurers) rather than UK-based firms. In general, UK insurers only insure those who are resident in the UK, so the majority of individuals resident abroad will not qualify.

71. However, increases in private insurance may incur within the UK as well, in the case where the UK is not participating in EHIC and a proportion of UK residents may decide to opt for health insurance policies providing healthcare cover during traveling, instead of opting for short term travel insurance policies.

72. As above, whether or not these impacts arise, and the extent to which insurers are affected will be dependent on the exact policy option realised.

[22] European Union Committee – Brexit: Reciprocal Healthcare (chapter 5, paragraph 57)

[23] EHIC provides the right to access treatment on the same basis as a resident of the country, so the UK would only reimburse the costs that would normally accrue to the relevant EU state. Patients would still have to meet any co-payments etc in each country.

Health Insurers (EU residents in the UK)

73. Under some scenarios, there could be groups of EU migrants who are not covered by reciprocal arrangements or alternative public insurance schemes, but are not considered to be ordinarily resident. As is the case now, such individuals would be directly charged for NHS services, unless otherwise covered by private health insurance. Consequently, it is possible that some uninsured EU migrants opt to purchase private health insurance policies.

Employers

74. Currently, employees of UK companies who are posted for work in another EU Member State rely on either S1 or EHIC to access healthcare. In the absence of any reciprocal healthcare arrangements, it may be the case that employers will have to fund the cost of health insurance policies or healthcare associated costs, to ensure that their posted employees are able to access and healthcare and receive treatment, when necessary.

Indirect impacts

75. There could also be indirect business impacts. For example, if some EU nationals arriving after Exit day no longer find themselves eligible for free healthcare in the absence of reciprocal healthcare agreements, then it is possible that incentives for EU nationals to immigrate to the UK are reduced. However, there is limited evidence for “health tourism” or that it is a significant pull factor for immigration.

Monitoring and Evaluation of the Reciprocal Healthcare Bill

76. The Department of Health and Social Care is committed to monitoring the impacts of policies and establishing the extent to which objectives have been met. Any policy changes that are proposed to be effected by means of regulations under the Bill will give rise to a new Impact Assessment.

Summary

77. The Government’s preferred option is to introduce the Healthcare (International Arrangements) Bill (Option 1).

78. The introduction of the Healthcare (International Arrangement) Bill is necessary to ensure the smooth transition from our current relationship with the EU to the future one, which the UK Government aspires to include the continuation of UK’s participation in EU reciprocal healthcare.

79. Equally, in a no deal scenario, the Bill is necessary to give effect to bilateral agreements with individual EU countries and to provide for healthcare cover for certain people in prescribed circumstances where the cost of their healthcare abroad is no longer covered by EU arrangements.

80. More broadly, the Bill would allow the UK to strengthen its other reciprocal healthcare agreements or implement new ones, should it wish to as part of health and trade policy on the global stage.

81. The most straightforward and clear way to allow for implementation of the Government’s preferred policy position, in any EU Exit scenario, is to introduce statutory powers for this purpose.