



HOUSE OF LORDS

European Union Committee

8th Report of Session 2006–07

Cross Border Health Services in the European Union

Report with Evidence

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(Q) refers to a question in the oral evidence

(p) refers to a page of written evidence

FOREWORD—What this report is about

This Report makes available the oral evidence provided by the Rt. Hon Rosie Winterton MP, Minister of State for Health Services to EU Sub-Committee G on 25 January 2007 relating to cross border health services in the European Union.

Cross Border Health Services in the European Union

1. This Report refers to issues raised by the EU Commission's Communication "Consultation regarding Community Action in Health Services"—SEC (2006) 1195/4. The Commission's document addresses the present unclear situation, in which Community law provides patients with rights to cross-border health care, but there is need for a clear, practical framework in which greater individual choice can be reconciled with the sustainability of health systems overall. Some of the practical issues raised are the need to clarify: the terms and conditions under which cross-border healthcare must be authorised and paid for; whose rules apply; and what happens when things go wrong.
2. We recognised that the issues raised in the context of cross-border health care are difficult and sensitive, and that both practical issues and issues of principle are involved. We therefore invited the Minister of State for Health Services Minister—Ms Rosie Winterton MP—to speak to us about the subject. In this Report, we make available for the information of the House, the oral evidence she gave to us.
3. An opening statement made by Ms Winterton as part of her evidence covered the following key issues (Q 1):
 - the problems with the current legal position that might usefully be addressed by Commission proposals;
 - the UK Government's views of how the Commission's proposals might best be framed to address these problems;
 - any concerns about possible legislative proposals that the UK Government would not find acceptable; and,
 - whether a framework for non-regulatory co-operation between Member States could help to support the legal framework and, if so, the sort of issues it could most usefully cover.
4. In answering questions from the Sub-Committee, the Minister's evidence went on to cover the following topics:
 - the position of other Member States and the Commission in relation to the UK Government's views (QQ 2–3);
 - the extent to which future progress in clarifying the issues of patient mobility depends upon political or legal decisions (Q 4);
 - the impact of patient mobility on the provision of health services in the UK (QQ 5–6);
 - practical issues relating to patient mobility (QQ 7–11);
 - the confidentiality of patient information (Q 12);
 - mobility of doctors and quality of care for patients (QQ 13–15);
 - different definitions of healthcare across the EU (QQ 16– 20); and,
 - liability for negligence (QQ 21–22).

5. The meeting with the Minister helped to improve our understanding of the significant and sensitive issues, of both a legal and political nature, that need to be resolved in order to find an acceptable way forward in this case. In particular, we recognised the point she made that there is a need to get the framework for European Health Services right so that it can provide a fair and transparent system for people seeking health care and, at the same time, ensure that it does not undermine the UK health service.
6. We look forward to seeing the responses of the Government, of other Member States and of other stakeholders to the Commission's consultation; and we will look further at these issues when the Commission publish firm proposals.
7. Copies of our correspondence with the Minister, before and after our meeting on 25 January 2007, can be found in the Appendix. In our letter to the Minister of 8 February 2007, we release the Commission's consultation document from scrutiny.
8. The full transcript of the Minister's oral evidence is printed from pp 1–8.

APPENDIX: CORRESPONDENCE

Letter dated 26 October 2006 from the Minister of State for Health Services to the Chairman of the European Union Select Committee

Communication from the Commission: Consultation regarding Community action on health services SEC (2006) 1195/4

I attach an Explanatory Memorandum on the European Commission's communication on health services. This communication is a consultation document on the possible EU-level action on health services. It picks up on the development of European Court of Justice case law on patient mobility over the last ten years which culminated in the Watts judgement of 16 May 2006, which confirmed that the case law patient mobility does apply to tax-funded healthcare systems like the NHS. However the case law—which currently applies to the UK and, in certain circumstances confers on NHS patients the right to be treated abroad at NHS expense—has left areas of legal uncertainty, for example on exactly how Member States can manage such cross-border health care.

Another motor behind this work is the removal of healthcare from the scope of the Services Directive. This cross-cutting Directive—which, in its original version, contained an article on the reimbursement of costs for cross-border patient mobility—was unsuitable for addressing the specificities of the healthcare sector. However, the removal of healthcare from the scope of the Directive—which we successfully argued for—has led the Commission to try to address some of these specificities through the work on health services.

The Department of Health sees potential advantages in health services legislation, not least in building a consensus between EU Member States and the EU institutions on how European Treaty articles apply to health care services. The consultation and debate that will follow offers us an opportunity to engage with other Member States and the Commission to influence the debate towards our thinking in this area.

The Health Council has already been active in this controversial area, where significant legal uncertainty remains. In June all 25 Health Ministers agreed on a statement of Values and Common Principles (a copy of which is attached) which framed the area where it thinks EU-level work should focus. The central point of this statement is that, although there are shared values across European health systems, there are very significant limits to the amount of harmonisation that could or should be attempted.

I would be delighted to come and speak to your Committee on these points, should you wish.

Letter dated 15 January 2007 from the Chairman of EU Sub-Committee G to the Minister of State for Health Services

Commission Consultation—Community Action on Health Services SEC (2006) 1195/4

Many thanks for offering to visit EU Sub-Committee G at 10am on 25 January to talk to us about the Commission's Consultation on Community Action in Health Services.

I thought it would be helpful to write to you in advance setting out how I feel the session might most profitably be structured.

We felt that your offer to visit the Sub-Committee, made in your letter to Lord Grenfell of 26 October, provided us with a valuable opportunity to add an additional informative, initial, stage to the usual scrutiny process.

We recognised the complexity and wide ranging implications of the issues relating to the Community Action on Health Services proposals, and we welcomed your suggestion that you should visit the Sub-Committee to go over the key issues with Members, in a little more depth than can be done in an Explanatory Memorandum.

It will be entirely up to you whether you would like to set out your views in an opening statement on 25 January. However, I hope that you will take advantage of the opportunity to do so. This consultation relates to an important and potentially quite contentious area of policy, and it would be most valuable for Members to hear from you the Government's view of the key issues including:

- the problems with the current legal position that might usefully be addressed by Commission proposals;
- the UK Government's views of how the Commission's proposals might best be framed to address these problems;
- any concerns about possible legislative proposals that the UK Government would not find acceptable; and
- whether a framework for non-regulatory co-operation between Member States could help to support the legal framework and, if so, the sort of issues it could most usefully cover.

Following such an opening statement, Members will probably wish to take the opportunity to ask you a number of questions, and my Committee Clerk will certainly let your departmental officials have advance warning of these.

Following your briefing, I would foresee the scrutiny moving into the more usual pattern, with a follow-up letter from Lord Grenfell raising a number of questions for the future. It is also possible that the Sub-Committee will wish to conduct an Inquiry into this topic, but no decision on this has yet been taken.

Letter dated 8 February 2007 from the Chairman of EU Sub-Committee G to the Minister of State for Health Services

SEC (2006) 1195/04: Communication from the Commission: Consultation regarding Community action on health services

Many thanks for the oral evidence which you and your officials presented to EU Sub-Committee G on Thursday 25 January. We will shortly publish a Report to the House which contains a transcript of the session.

The meeting helped to improve our understanding of the significant and sensitive issues, of both a legal and political nature, that need to be resolved in order to find an acceptable way forward in this case. In particular, we recognise the point you made that there is a need to get the framework for European Health Services right so that it can provide a fair and transparent system for people seeking health

care and, at the same time, ensure that it does not undermine the UK health service.

We would be grateful if you could let us have sight of the Government's response to the Commission's consultation and, in the future, keep us informed of progress towards the formulation of firm proposals by the Commission for establishing a framework which provides greater clarity. In the meantime, we are now content to release this consultation document from scrutiny.

Attachments to letter dated 26 October from the Minister of State for Health Services

Statement on common values and principles

This is a statement by the 25 Health Ministers of the European Union, about the common values and principles that underpin Europe's health systems. We believe such a statement is important in providing clarity for our citizens, and timely, because of the recent vote of the Parliament and the revised proposal of the Commission to remove healthcare from the proposed Directive on Services in the Internal Market. We strongly believe that developments in this area should result from political consensus, and not solely from case law.

We also believe that it will be important to safeguard the common values and principles outlined below s regards the application of competition rules on the systems that implement them.

This statement builds on discussions that have taken place in the Council and with the Commission as part of the Open Method of Coordination, and the High Level Process of Reflection on Patient Mobility and healthcare development in the EU. It also takes into account the legal instruments at European or international level which have an impact in the field of health.

This statement sets out the common values and principles that are shared across the European Union about how health systems respond to the needs of the populations and patients that they serve. It also explains that the practical ways in which these values and principles become a reality in the health systems of the EU vary significantly between Member States, and will continue to do so. In particular, decisions about the basket of healthcare to which citizens are entitled and the mechanisms used to finance and deliver that healthcare, such as the extent to which it is appropriate to rely on market mechanisms and competitive pressures to manage health systems must be taken in the national context.

Common Values and Principles

The health systems of the European Union are a central part of Europe's high levels of social protection, and contribute to social cohesion and social justice as well as to sustainable development.

The overarching values of universality, access to good quality care, equity, and solidarity have been widely accepted in the work of the different EU institutions. Together they constitute a set of values that are shared across Europe. Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need,

regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU Member States; closely linked to this is the work in the Member States' systems on the prevention of illness and disease by inter alia the promotion of healthy lifestyles.

All health systems in the EU aim to make provision, which is patient-centered and responsive to individual need.

However, different Member States have different approaches to making a practical reality of these values; they have, for example, different approaches to questions such as whether individuals should pay a personal contribution towards the cost of elements of their health care, or whether there is a general contribution, and whether this is paid for from supplementary insurance. Member States have implemented different provisions to ensure equity: some have chosen to express it in terms of the rights of patients; others in terms of the obligations of healthcare providers. Enforcement is also carried out differently—in some Member States it is through the courts, in others through boards, ombudsmen etc.

It is an essential feature of all our systems that we aim to make them financially sustainable in a way which safeguards these values into the future.

To adopt an approach that shift focus towards preventative measures is an integral part of Member States strategy to reduce the economic burden on the national health care systems as prevention significantly contributes to cost reduction in healthcare and therefore to financial sustainability by avoiding disease and therefore follow up costs.

Beneath these overarching values, there is also a set of operating principles that are shared across the European Union, in the sense that all EU citizens would expect to find them, and structures to support them in a health system anywhere in the EU. These include:

- Quality:

All EU health systems strive to provide good quality care. This is achieved in particular through the obligation to continuous training of healthcare staff based on clearly defined national standards and ensuring that staff have access to advice about best practice in quality, stimulating innovation and spreading good practice, developing systems to ensure good clinical governance, and through monitoring quality in the health system. An important part of this agenda also relates to the principle of safety.

- Safety:

Patients can expect each EU health system to secure a systematic approach to ensuring patient safety, including the monitoring of risk factors and adequate, training for health professionals, and protection against misleading advertising of health products and treatments.

- Care that is based on evidence and ethics:

Demographic challenges and new medical technologies can give rise to difficult questions (of ethics and affordability), which all EU Member State must answer. Ensuring that care systems are evidence-based is essential, both for providing high-quality treatment, and ensuring sustainability over the long term. All systems have to deal with the challenge of prioritising health

care in a way that balances the needs of individual patients with the financial resources available to treat the whole population.

- Patient Involvement:

All EU health systems aim to be patient-centred. This means they aim to involve patients in their treatment, to be transparent with them, and to offer them choices where this is possible, eg a choice between different health care service providers. Each system aims to offer individuals information about their health status, and the right to be fully informed about the treatment being offered to them, and to consent to such treatment. All systems should also be publicly accountable and ensure good governance and transparency.

- Redress:

Patients should have a right to redress if things go wrong. This includes having a transparent and fair complaints procedure, and clear information about liabilities and specific forms of redress determined by the health system in question (eg. compensation).

- Privacy and confidentiality:

The right of all EU citizens to confidentiality of personal information is recognised in EU and national legislation.

As Health Ministers, we note increasing interest in the question of the role of market mechanisms (including competitive pressure) in the management of health systems. There are many policy developments in this area under way in the health systems of the European Union which are aimed at encouraging plurality and choice and making most efficient use of resources. We can learn from each other's policy developments in this area, but it is for individual Member States to determine their own approach with specific interventions tailored to the health system concerned.

Whilst it is not appropriate to try to standardise health systems at an EU level, there is immense value in work at a European level on health care. Member States are committed to working together to share experiences and information about approaches and good practice, for example through the Commission's High Level Group on Health Services and Medical Care, or through the ongoing Open Method of Coordination on healthcare and long- term care, in order to achieve the shared goal of promoting more efficient and accessible high-quality healthcare in Europe. We believe there is particular value in any appropriate initiative on health services ensuring clarity for European citizens about their rights and entitlements when they move from one EU Member State to another and in enshrining these values and principles in a legal framework in order to ensure legal certainty.

In conclusion, our health systems are a fundamental part of Europe's social infrastructure. We do not under-estimate the challenges that lie ahead in reconciling individual needs with the available finances, as the population of Europe ages, as expectations rise, and as medicine advances. In discussing future strategies, our shared concern should be to protect the values and principles that underpin the health systems of the EU. As Health Ministers in the 25 Member States of the European Union, we invite the European Institutions to ensure that their work will protect these values as work develops to explore the implications of the European Union on health systems as well as the integration of health aspects in all policies.

*EXPLANATORY MEMORANDUM ON EUROPEAN COMMUNITY
DOCUMENT SEC (2006)1195/4*

*Commission Communication on Health Services: Consultation regarding
Community Action on Health Services*

Submitted by the Department of Health 27 October 2006

SUBJECT MATTER

The Commission has published a communication on health services. This document forms a consultation on health services that will run until the end of January 2007.

Two factors have prompted this Communication. Firstly, the development of European Court of Justice (ECJ) case law on patient mobility over the last ten years has left some areas of legal uncertainty (for example, on the question of who has responsibility for the safety of patients being treated in other Member States). Secondly, the removal of healthcare from the scope of the Services Directive, which has prompted the Commission to look at a sector-specific piece of work. In its 2007 Annual Policy Strategy the Commission undertook to provide certainty over the application of Community law to health services and healthcare.

The Communication emphasises that Community action does not mean harmonisation of health systems, and that the organisation of the benefits that different systems provide must remain the responsibility of the Member States, in line with the principle of subsidiarity. The Communication focuses on two pillars: legal certainty where it is needed—notably in cross-border care; and support for Member States in areas where European action can add value.

Legal certainty

On legal certainty, the Communication notes that the ECJ has ruled that healthcare services must be regarded as services within the meaning of the relevant Treaty articles on free movement of services. Thus any requirement that a patient should seek ‘prior authorisation’ from their home health system as a precondition on the costs of their treatment being reimbursed is a barrier to the freedom to provide services; such barriers may be justified by overriding reasons of general interest (such as maintaining the financial sustainability of health systems).

Cross-border healthcare is considered in four distinct categories:

- Provision of services (e.g. remote diagnosis; telemedicine; laboratory services)
- Use of services abroad by patients
- Permanent presence of service providers from other Member States
- Mobility of health professionals

The Communication argues that wider European cooperation has great practical utility in facing the wider challenges that healthcare systems must cope with e.g. in some areas it may be more practical for citizens of one EU Member State to visit a nearby hospital across an internal border; smaller Member States may find it more efficient to share specialized facilities where they could not afford to maintain them on their own. The ‘open method of coordination’ is developing mechanisms for information exchange and peer review as a means of sharing best practice in a non-regulatory framework.

It also suggests that an analysis of the impact of the economic, social, and health impacts of cross-border healthcare is required. The consultation questions on the legal certainty that is required focus on four areas:

Minimum information and clarification requirements to enable cross-border healthcare

This could include clarification of where Member States may insist on a system of 'prior authorisation' for accessing treatment abroad; and where such authorisation must be given. It also refers to the information that patients and professionals need to make choice about treatments and providers in other Member States.

Identifying the competent authorities and their responsibilities

Clarity is needed over which authority is responsible for ensuring the quality and safety of services provided to people from other Member States; also the question of whose system of redress should apply. The question of ensuring successful continuity of care for patients crossing borders for treatment is also posed.

Responsibility for harm caused by healthcare and compensation arising from cross-border healthcare

Clarity is needed over who is responsible for ensuring patient safety in cross-border healthcare, and which clinical liability mechanisms apply in case of harm.

Ensuring a balanced healthcare accessible for all

The Communication points out that, although the volume of patient mobility is relatively low, there are some circumstances where it may be much higher, such as border regions or tourist resorts. Clarity is needed on the actions that Member States may take to ensure that treating patients from other Member States does not prevent the provision of a balanced healthcare system open to all.

Support to Member States

The Communication refers to certain other actions that may add value to the actions taken at Member State level:

European networks of centres of reference

The Communication refers to the possibility of concentrating resources or expertise for treatment of rare diseases, for example.

Realising the potential of health innovation

Sharing scientific evidence to spread best practice and avoid duplication of resources.

Shared evidence base for policy-making

Strengthening mechanisms to share evidence on techniques and outcomes of treatment.

Health systems impact assessment

Implementing a mechanism to consider the impact on health systems of Community action.

Options for action

The Communication notes that there are a wide range of possible actions, but that legal certainty would be best ensured by a binding legal instrument, as an interpretative communication will probably not be sufficient.

There are also various non-legislative options, including practical cooperation through the High Level Group on health services and medical care, and the open method of coordination.

MINISTERIAL RESPONSIBILITY

The Secretary of State for Health has lead responsibility. Ministers of the Scottish Executive and the Welsh Assembly have an interest relating to their responsibilities for health care provision. Whilst the Northern Ireland Assembly and Executive are suspended the Secretary of State for Northern Ireland has these functions.

LEGAL AND PROCEDURAL ISSUES

Legal basis

As this is a Communication with no legally binding or effective provision, no legal basis is required.

Impact on UK law

As this is only a consultation document, there are no direct implications for UK law at the moment. However, it should be noted that the case law that this communication addresses currently does have an impact on UK law.

POLICY IMPLICATIONS

We intend to engage pro-actively with the Commission, Member States, and other stakeholders at an early stage of the development of this dossier, to achieve maximum influence in the process; in particular through ensuring the discussion looks at what we consider to be the key issues where clarification is needed. This engagement will be at Ministerial and official level, and will be ongoing during the coming months.

This consultation gives us the opportunity to highlight the areas of legal uncertainty that the current case law has created, and where greater legal certainty would be beneficial to health system managers.

FINANCIAL IMPLICATIONS

None

TIMETABLE

This consultation will close on 31 January 2007. The Commission's response to the consultation is expected in the first half of 2007.

Minutes of Evidence

TAKEN BEFORE THE SELECT COMMITTEE ON THE EUROPEAN UNION
(SUB-COMMITTEE G)

THURSDAY 25 JANUARY 2007

Present	Dundee, E	Thomas of Walliswood, B (Chairman)
	Gale, B	Trefgarne, L
	Greengross, B	Uddin, B
	Howarth of Breckland, B	Wade of Chorlton, L

Examination of Witnesses

Witnesses: Ms ROSIE WINTERTON, a Member of the House of Commons, Minister of State for Health Services, MR JONATHAN MOGFORD, Head of EU Affairs and MR SIMON BURKE, Solicitors' Division, examined.

Q1 Chairman: Welcome, Minister, once again. We are very grateful to you for offering to come to talk to us about the subject of the Commissioner's Consultation on Community action on health services which is clearly an important subject and very much in our remit. It has wide ranging policy implications both EU-wide and for the UK and we also understand that some of the legal issues are fairly complicated. Any briefing you give us today is going to be very useful as we carry out our scrutiny in this area. I wrote to you on 15 January and suggested that you might make an opening statement setting the scene for us and then we will open up to questions from members of the Committee. I hope that is a format which suits you as well. I am also happy to welcome Mr Mogford and Mr Burke and perhaps they will join in as seems suitable to you and to them. I have to make the usual housekeeping points. We have an hour for this session. The session is open to the public and will be recorded for possible broadcasting or web casting. A verbatim transcript will be taken of the session and this will be printed on the Parliamentary website and if we do any report it will of course be part of the report. A few days after this meeting you will be sent that transcript to check for accuracy. If you have corrections you wish to make that is absolutely fine but please make them as soon as possible so that we can put it out to other people. If we find at the end of our session that there are still subjects we have not discussed or things that you wish you had said and did not say or whatever it may be, supplementary evidence is always very, very welcome from our witnesses and that is the same for you as anybody else. Once again, the acoustic in this room is very poor; we have just been talking about it before you arrived. Your voice is very clear, Minister, so I am sure you will get across, but if you do not speak clearly we tend not to hear what is being said. I am now going to ask you, Minister, to get us going on this meeting.

Ms Winterton: Thank you very much indeed for the opportunity to come here today. For the record I should re-introduce Jonathan Mogford who is Head of European Affairs in the Department of Health and Simon Burke who is the government lawyer working on this issue. As I say, we do think this is a very important consultation on health services and European Union action. I think it might be helpful if I dealt with a little bit of the background because I know one of the issues you particularly want to cover is the current legal situation that might be covered by the Commission's proposals. I am sure you are all aware that health services were taken out of the Services Directive and we were, as a government, extremely keen that that should happen because of the implications that might have for our National Health Service. The current legal situation is that we have a number of principles that have been developed by the European Court of Justice which are based on the Treaty articles on the free movement of services, on the rights of patients to go to another European Union Member State specifically to seek medical treatment at the expense of their own health system. These judgments have created some legal uncertainty which is not helpful. The key judgment for the UK was the Watts case. Mrs Watts had gone to France to have a hip replacement rather than wait to have it done on the National Health Service and she is now claiming back the cost of that operation from the National Health Service. The decision as to whether Mrs Watts will have her costs refunded will be decided in the High Court in England, but the European Court judgment confirmed that the legal principles of patient mobility that had been developed in previous cases ruled before the European Court of Justice apply to the NHS as well as to health care systems based on a system of social insurance. These principles give National Health Service patients the rights in certain limited circumstances to go abroad specifically in order to

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seek medical treatment at the expense of the National Health Service. The application of the case law has highlighted some ambiguities. For example, it is not clear whether Member States can require a patient seeking non-hospital treatment in another Member State to seek authorisation from their local health care fund—ie in the UK this would be the local primary care trust—before going for treatment. There is also a lack of clarity over who should take overall responsibility for the safety and wellbeing of patients who go to another Member State. For example, there is not clarity over who should take responsibility for the wellbeing of a person who goes for treatment of their own accord. Who is responsible for medical complications that might arise from clinical negligence? Is that the redress system that would apply in the Member State to which they have gone for treatment or is it in our case the National Health Service? As I say, the main driver of the law has been these cases in the European Court of Justice but what we feel is that it is inappropriate for that to continue without some political input. This is a view that is shared by other Member States. What we did in the European Council of Health Ministers last year was to issue a statement of values and common principles which I think Committee members do have. What we were trying to do here was put quite an important stake in the ground from Member States which we think has helped shape the tone of the discussion. That set of values and common principles emphasised that Member States have the responsibility for managing their own health systems in the manner of their choosing and that any proposals at European Union level should respect that fundamental point. The Commission's communication, I think, is a logical development from everything that has happened so far. It does set out the areas where there are currently problems that need to be discussed and debated among the Member States and of course with wider groups like healthcare professionals, the European Parliament and patients' groups. We have carried out consultation on that; we are very keen to protect the UK's interests in terms of the discussion. A lot of the views that we have had so far have helped us to frame our response. In terms of the question that I think you are very interested in which is how the Commission's proposals might best be framed to address these problems, we intend to argue that legislative proposals could be useful provided that they are underpinned by certain key principles. Perhaps if I could set out some of these principles it might be helpful. First of all, we think that any legislative proposals should be proportionate and should not go beyond what is actually needed to resolve the specific problems that we currently have and we think it should provide a sustainable way of managing the issue of patient mobility. We believe

that Member States' referral processes must be respected so where in the UK, in order to access a service, a referral is required from a GP, we believe that patients should need a similar referral from a British GP to access a service in another European Union Member State. We believe that determining what treatment is offered to individual patients is a matter for Member States to decide. If a person wishes to go to another Member State it would have to be for treatment that was available within the Member State and not necessarily for treatment that might be available elsewhere but was not available within the UK. Within that we also believe that Member States must be able to restrict the level of payment for treatment abroad to the cost of what would happen if that treatment was delivered in the UK. It must be the standard governance and systems of redress of the Member State where the treatment is carried out that would apply in terms of, for example, if anything went wrong. Member States should be able to prioritise their own citizens above citizens of other Member States who travel to them specifically to receive medical treatment. We believe that if these were the principles that legislation were based on, that would ensure that we could manage patients' mobility in a sensible and sustainable way. We also intend to say to the Commission that in any proposals it would be useful to place a duty on regulators to share information about healthcare professionals who cross borders to work as well as clarifying that Member States can require health professionals to be proficient in the language in which they are working. You are also interested in the legislative proposals that the UK would not find acceptable. We certainly would not support any legislation which merely re-stated the existing case law and we would not find it acceptable to support any proposals that complicated the current situation if there were an overly detailed legislative mechanism or any proposals which made it more difficult for Member States to manage their health system. We would also be very cautious about any overly ambitious proposals in the field of IT or e-health. In general we would not support anything which undermined the rights and responsibilities of Member States with regard to the organisation of their health systems which derive from the Treaty. I think you are also interested in whether a framework for non-regulatory cooperation between Member States could help to support the legal framework and the kind of issues that that might cover. We do have a framework for cooperation at the moment, for example the Commission's High Level Group on Health Services and Medical Care which does meet regularly to discuss issues of common interest. For example, there are centres where very rare diseases can be referred to and that is the kind of cooperation which we think could genuinely add to the work that

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is already carried out by Member States. We also think that frameworks that enable the direct exchange of best practice and experience between clinicians where policy experts in different fields or where stakeholder groups might be able to come together. A lot of good work has gone in on the area of public health and one area I was particularly interested in was mental health, again where people were able to share best practice and patient groups were perhaps able to exchange what were good patient experiences and so on. That has been useful. In general that is the approach that we want to take. We had a very good and helpful debate in the standing committee which I was glad to say that we got considerable cross party support from in terms of the stance that we are taking which we do feel is very useful in strengthening our hand in terms of the discussions about any possible legislation that might come forward.

Q2 Chairman: Thank you for that opening which was very comprehensive and very interesting as well. You have explained very clearly what the position of HMG is but how are you finding other countries? Are there other Member States who have very different approaches or do you think that the approach of this government is rather similar to the approach taken by other governments, in broad terms obviously?

Ms Winterton: Particularly because of the way the NHS works, being a tax funded system, we are very interested in this legislation. It is true to say that not all Member States would necessarily be as concerned as we are. However, in terms of signing up to the common values and principles, I think all Member States have shown that they agree that it is important for Member States to be able to run their health services and that has been a very important development for us in terms of saying that there is consensus around those values and principles which again has been very helpful in terms of giving an indication to the Commission as to where Member States are coming from.

Q3 Chairman: This is presumably a decision which would be taken by QMV if we got to that stage. Are there sort of camps because of the different ways of financing and running a health service or has not really appeared yet?

Ms Winterton: No, not really. It is more a level of interest but in general I do think we have consensus. There are no Member States really who are saying that they do not agree with this approach at all.

Q4 Baroness Greengross: I am fascinated and also questioning whether it is a political or legal decision. Thinking of some of the other decisions that we have been faced with here like the SiMAP/Jaeger cases for example, it seems to me that when you are talking

about the rights of an individual and a court judgment at a European level, this has been over and above any political decision that can be made. I think there are really big problems here if one is going to try to override these because we are not able to override them in other cases. There is a difference between what is labour law and what is NHS and so on. I just wondered if you or indeed your lawyer colleague might clarify for me how one could override the Court of Justice decision as we are not able to in other cases, and how an informal agreement could possibly be as binding as those court judgments are. I just do not understand that. My last point would be that you said that very rare diseases might justify going to another country and I have always thought that as we get more and more to establishing centres of excellence which cannot be in every city across Europe, there are bound to be cases where the centre of excellence could be in Brussels or for somebody in Brussels the centre of excellence could be in London, say, and that that would automatically, using helicopters or whatever, become much more routine than it is now. How could we, in the UK running the health service, argue with that sort of decision politically when they are legally established rights?

Ms Winterton: I will ask Simon Burke to come in in a second, but perhaps I could clarify that I do not think this is about overriding decisions; it is really about recognising that there are some ambiguities at the moment and in some areas there are perhaps seen to be contradictions. The Commission has said in its document that it thinks that the European Court had said that if you were going for non-hospital treatment you did not need to get prior authorisation, whereas we do not believe that that is what the Court said. We just want to establish what the principles are—that is where, in a sense, the political input comes in—because if we are not able to do that we will continue possibly to go along the line of individual cases being brought and a general policy on which all Member States basically agree which is that it is important for Member States to be able to run their health services. The implications if we do not put that legal certainty around it are that it becomes very difficult for the health service to operate because it does not know what it is supposed to be allowing in terms of people going to other Member States, there is not a referral process, there is not a process that everybody recognises should be followed. I think all our health systems need that clarity and it is simply clarifying the issues around which patient mobility should take place. I presume in future that might assist the European Court as well in making some of the judgments. With regard to the point about cooperation this was something that was raised at the standing committee about centres of excellence and would our centres of excellence have to go elsewhere. That is not really what we are talking about here. I

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think the example I was searching for at the standing committee and could not quite remember was something that we had cooperated on which was Bubble Babies which was a very, very rare treatment which was almost impossible to provide at national level and there is somewhere I think in Holland where there was a centre where there were facilities there, but it was so, so rare that even at national level it was not possible to provide that kind of support.

Mr Burke: The case law in this particular area on what is called patient mobility and the Watts case in particular in how it affects us, the Court was interpreting article 49 of the Treaty itself which is the principal article dealing with free movement of services covering the rights of persons to provide services and individuals to go and receive services. As it stems from the Treaty it is different in a sense from SiMAP/Jaeger which stems from an actual directive (I will touch on that further) where there is more flexibility of scope for Member States to reach agreement. As the Minister has said, there is clearly ambiguity flowing from these judgments in the sense of how this works in practice. The aim would be to clarify that ambiguity but also to apply the case law in a way which protects health systems. You can derogate from Article 49 rights in order to protect public health and the Court has recognised that in permitting Member States to have prior authorisation in respect of hospital care. It would be trying to reach an agreement in a way which protects health services and thereby public health which makes this case law manageable for the UK. You mentioned the SiMAP/Jaeger case law which was to do with an interpretation of the working time directive. That is an actual directive but the difficulty with that one is that several Member States are in agreement that they want to amend the directive to take into account to make the SiMAP/Jaeger cases more manageable, the difficulty is in getting agreement between sufficient Member States. On several occasions Member States have not been able to reach agreement because whilst many Member States want to rectify the position as a result of SiMAP/Jaeger case law they have differences of agreement on other articles in the Directive such as the opt-out where persons can opt-out of only working 48 hours per week. Whilst there have been attempts at horse trading to reach agreement it has not been possible at this stage.

Q5 Baroness Howarth of Breckland: I am a great fan of the health service but I want to ask you a consumer question here, a rather lay question about the impact. Although we have the values and principles which state that the overarching values are about universality meaning that no-one is barred access to healthcare that usually means in the priority system at the level it can be delivered within the rationing

system of the particular place it is going to, and I suppose looking at this in the European and legal context my concern is the impact on the healthcare system from the ordinary consumer point of view? Does it mean that if you are rich enough and informed enough to get a diagnosis that gets you to a centre of excellence in Europe and therefore gets you the treatment and gets you from undue delay (as in the Watts case) you are going to be able to be reimbursed from the UK health system which will increase the waiting list somewhere (because of the finite resources which we all accept are in the health service) for people who are less able to access alternative care. The impact on the health service is about the impact on individuals who are using the health service; the health service only exists for the individuals not in its own right. The whole system depends on professionals and managers being able to prioritise and manage their budgets and it seems to me that that is the key to this. Of course we would all wish to have universality and the principles as set out in the common values, but we do not attain that now, it is aspirational. I wonder how that practical reality is worked through and the difficulties it would really cause for our health service and the professionals trying to deliver an equal service were this to go forward.

Ms Winterton: I think you have absolutely hit on it there. One of the key principles underlying everything is that Member States should retain the right to manage their own health services. The other thing we want to make very clear is to say that it should be for an individual clinician to determine that somebody had an undue delay and it should be an NHS clinician who says there is an undue delay if someone were, in a sense, exercising their right to go to another Member State for treatment so that you can preserve the equity in that in terms of that if, as you have said, there are some people who just think that by demanding they go elsewhere and that has to be acceded to no matter what the impact would be elsewhere is not the situation that we want to see. We believe it should be an NHS clinician who would make the decision. I think it is also important to remember in this that in the wider healthcare reforms where people can go to other parts of the country and as the choice agenda widens up then there is obviously the ability to see whether that treatment can be found within the UK in the first place. I should say that we do expect the numbers involved here, if we get this right, would be in a sense relatively small. Even in terms of the present, I think in 2005 there were only something like 250 people who did go abroad for treatment. We want to be absolutely clear that we get the framework right so that it does not undermine our health service and so it as well a fair and transparent system that people go through and does not, as you quite rightly point out, make it

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unfair for other people who may not have the same ability to say that they want to go elsewhere.

Q6 Chairman: I was on the hospital board of a hospital right next to Gatwick Airport and we very frequently have patients literally dumping themselves on us with a baby just about to arrive. Actually you know pretty well when your baby is going to arrive and if you arrive at an airport about to produce a baby you have done that deliberately on the whole. Then the problem was how to get the money back. Are you thinking about systems for ensuring that money does flow between the various healthcare systems because that was a real problem?

Ms Winterton: There are rules about overseas charging at the moment and NHS care is for people who are ordinarily resident within the UK. Obviously there is the EHIC (European Health Insurance Card) which applies if people are on holiday and so on. In terms of the current paying out from other Member States we tend to have kind of reciprocal arrangements through the European Health Insurance Card, although it is always very clear that people should be aware that what they are going to be treated for is what happens in that particular country, so if there is co-payment they still have to pay that part of it, which is why we always advise people to take out health insurance as well. Another area is obviously pensioners, for example, in I think Spain, France and Ireland where we do have a system of paying the health service there because people have retired there. I think that is about £600 million a year. The system we are envisaging here is that if a person did go to another Member State they would be reimbursed for the cost of what that treatment would be in the UK, not more. It would be for what it would cost here and that is why we are very keen that we do have a good system of patient information so that people are very aware of what is actually required of them in terms of the payment.

Q7 Baroness Gale: I want to look at some of the practical issues relating to patient mobility. One, which I think you have just mentioned, is the provision of information. You said there is a good provision of information but you also said earlier that it would be on the basis of GP referral, just the GP referring the patient. How would the GP have all the information that he or she would need and be able to give it to the patient? When they return home is there a continuation of care at home once they come back? The language barrier is obviously a big barrier to overcome for the patient and the staff in the hospitals again between the administrative barriers when the arrangements are being made between the two countries. If a patient is in a country and they do not understand the language there could be huge

problems there unless there is going to be the provision of interpreters, for example, to assist the patients. I think those were the four points I wanted to raise, the language, the continuation of care and the provision of information to make sure the patients are fully aware of everything.

Ms Winterton: That is a crucial part of this but I think we have to be very clear that in a sense patients need to realise that this kind of mobility does carry a certain amount of risk with it and that if somebody decides that this is what they want to do, if somebody says, “Well, I want to have my operation there for family reasons” or whatever, the patient does have to find out what is actually going to be covered. We need to be clear about what it would cost in this country to deliver that care but we have to be clear that if a patient chooses to do that they have to realise that it will be standards of medical care that apply in that particular country; it has to be the standards of redress that will apply if that is what they choose to do. It is important for the patient to realise that, that this is not like a situation where a Primary Care Trust (PCT) might be the provider of care. There have been some instances where PCTs on the south coast have purchased some operations from France which is where the PCT is, in a sense, taking that responsibility. This is a different situation because somebody is choosing to go to a different country. What we intend to say to the Commission is that we think that the providers who wish to provide a service to patients from other Member States (for example, if a hospital in Estonia says, “We would like to provide hip operations”) they would have to provide patients with information about what exactly that meant. What does the package of care that they are providing cover? Does it include aftercare? Will the healthcare provider have somebody there who does speak English so that the patient can understand the treatment? What will the patient do if something went wrong? We believe that that should be the responsibility of the provider who says “We want to sell our services”; they have to provide the information that goes with that so that the patient is fully aware of what is happening if they choose to take that route.

Q8 Baroness Gale: Obviously a decision would have to be made by the patient whether they wanted to travel abroad, but if the patient decides “I believe I can have this treatment in another country and I want the NHS to cover this cost” or, as you say, in some areas the PCT will actually buy that in, so it could be that the main responsibility will be on the patient seeking that treatment abroad and it is then up to that patient—not the GP or anyone else—to ensure that everything is in place for that person.

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Ms Winterton: It is for the GP to say that the patient needs a particular type of treatment. The gateway in this country is through the GP. You cannot just roll up to a hospital and say, “I think I need an operation”. The GP is in a sense the person who refers you on for the decision to be made that you actually need treatment. What we want to preserve within any legislation that might come forward is that the GP remains the gatekeeper in the sense of saying that that treatment was something that would be provided locally and was necessary. What we are saying is that if a patient really wants to go somewhere else then it is quite different from the situation, as I have said, where a PCT might purchase X number of operations somewhere else; it would then be the PCTs responsibility to make sure what the package of care is and so on.

Q9 Baroness Uddin: Minister, I just want to take on board what Baroness Gale has just said and also the point that Baroness Howarth raised with regards to consumer choices and information. It is obviously taken as read, those of us who are committed to the NHS, that we have a good standard of care. I was deeply thoughtful, not being involved in this Committee from the beginning but listening to everything that is going on about the inequality of access, that it is a handful of elite as you say—not your words, but mine—who will end up using the mobility or the access they may have and they will have choices, but do you foresee a sense of responsibility that the NHS have and how we might do that, about educating the wider public not just about the risks but also about rights and responsibilities about going abroad? Is there some communication? Are there materials available that are available to the wider public or is it simply the gatekeeper, ie the GP, who has it? My other concern was that, having worked in Community Health Council (CHC) for a long, long period and looking at consumers and complaints I remember often people were complaining about GPs not referring them to the right places in their own eyes. Is there a kind of second tier of gatekeepers in this context that also may decide and how do we educate the public on the benefits or disadvantages to the UK National Health Service of going mobile in this way?

Ms Winterton: This is one of the reasons why we do need clarity. At the moment we can issue a certain amount of guidance to the NHS on how to deal with some of these issues. If there were to be legislation then obviously we would want to be making sure that people did have proper information as to what their rights were and obviously that is something we would look at when there was proper clarity about it. When we talk about choice and so on, I think I would say that we do need to be clear that within the UK what we cannot necessarily do—it would be almost

impossible to do—is to take responsibility for everything that happened to somebody who chose to go elsewhere.

Q10 Baroness Uddin: The responsibility of the wider public or the users of the NHS rather than the Department’s responsibility. They have some responsibility if they are suddenly deciding or wanting to decide that they will go elsewhere seeking services. It is their responsibility rather than the Department’s.

Ms Winterton: I think it is our responsibility to make clear what the risks are. The benefits to an individual will probably be pretty obvious. They will say, “If I can go here and be with my family afterwards” or “If I go here I am going to get this done more quickly” then one presumes that is what they see as the benefit because that is why they are choosing to do it. It is quite a big choice frankly. Not many people really think, “I will just nip over to Estonia for whatever”; this is something that people will think about. Our responsibility is to make sure that they know that what they are getting and they need to enquire about that and they need to be aware of all the risks that are associated. I think it would be our duty to do that because that is where people, if they come back and say, “Nobody told me I was not going to get somebody to come and attend to me afterwards” or “Nobody told me that if something went wrong I do not have the same rights of redress as I have here” or “If the PCT paid for it does that mean they are now responsible for everything”; it is our duty to explain to people exactly what the risks are.

Q11 Lord Wade of Chorlton: In a way your answer to one of the questions has dealt with one of the issues I was going to raise regarding confidentiality and data protection because clearly if a person is having an operation abroad then their medical details would go with them if they wanted them to. Clearly this is an issue that has been addressed very much in the UK and we are very conscious of the fact that a person’s health statistics and figures about themselves and particularly genetic information is a very private matter and it should not be divulged to anybody else without their permission. I sat on the select committee that looked at this three or four years ago, looking particularly at genetic information then, a genetic database of information. The evidence we took was pretty clear. There is a lot of strong, emotional feeling by some people about this issue. In a way your reply to that is that if you decide to go then you have to take any risks where your information might be less confidential abroad than it is here. I do not know what your comments are on that.

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Ms Winterton: Obviously the principles of confidentiality and consent are paramount and I think all the Member States follow the principle that access to medical records should only be with the patient's informed consent. Certainly our view is that where there is any processing of UK health information outside the UK we would want to see the same standards as apply domestically.

Q12 Lord Wade of Chorlton: If there was a situation where an NHS hospital wanted to send people abroad because they wanted to reduce their own waiting list or whatever—which has happened I believe in some cases—then that is quite a different issue than if someone decides under their own volition to want to go abroad because then I suppose they have to take the risk. However, if they were sent over then it would be the responsibility of the hospital that sent them I take it.

Ms Winterton: I would guess that even if a PCT had purchased care abroad, particularly as in what we were talking about earlier, they would still need the patient's consent to pass the medical records to another hospital. I think the same principles would apply.

Mr Burke: Our Data Protection Act is based on a European Directive and therefore every other Member State should have similar principles to our Data Protection Act.

Q13 Lord Trefgarne: Our discussion up to now and what you have been saying has concentrated very much on patients going from one country to another but is it not equally important that the Directive addresses the need for the professionals moving in all directions as well. I am thinking not only of the doctors but also all the other professionals in the health service, for example the technicians and the radiologists. Are we clear that the proposals that are now coming forward will have those needs in mind as well as the patients'?

Ms Winterton: One of the things that we think is that this could be quite a useful vehicle for making sure that this kind of information is passed systematically because there is a mutual recognition of professional qualifications which means that that does allow health professionals to move between Member States and should allow the passing on of information. We do think there is a bit of an issue about, for example, perhaps misconduct that is not systematically passed on and that this might be a useful vehicle to making sure that that does happen.

Q14 Lord Trefgarne: How is that going to work? There have been some famous cases where a doctor has come here—or, for that matter, gone elsewhere—who has been disciplined in some way and ought not to be practising.

Ms Winterton: I think what happens at the moment is that if somebody wants, for example, to register as a doctor they have to produce a kind of good character statement or standard of good character, but we are not entirely sure that that is necessarily as rigorous as perhaps it ought to be. I think at the moment the standard of good character may not include whether there has been a complaint and whether it was upheld or not upheld. I am not sure that that is passed on. That is the kind of thing we would like to make sure that there was greater clarity about.

Q15 Lord Trefgarne: You will be making these points.

Ms Winterton: We will make the point to the Commission that we think this could be a vehicle for doing that. We also want to clarify that Member States can require that health professionals should be proficient in the language that they are working in and again we think that that is something could usefully be addressed in these proposals.

Q16 Earl of Dundee: Across the European Union the definition of health care may vary quite a bit and it appears that one Member State's healthcare is another one's social care. Does this matter? If it does, what can we do about it?

Ms Winterton: I think it does matter. The case law itself actually indicates that it is for Member States to define what benefits their own citizens are entitled to. One of the things that we want to go back to the Commission with in our response is that one of the key principles that we think should underpin any proposal that they might come forward with is to reaffirm that it is the home healthcare system that should determine what treatment patients are entitled to. That is certainly one of the key principles that we think is extremely important again in terms of enabling Member States to be able to manage their own healthcare systems properly.

Q17 Earl of Dundee: Are you nevertheless happy enough that that will contain the ambiguity? I suppose the progress of cross-border health services will depend upon a mixture of coastal and political decisions and this progress may well be held up by an absence of consent or definition. I do not know whether the adverse impact of that upon political thinking there is not least its probably adverse effect on the interpretation of case law. Even if we begin to go country by country, do we not also need to advance or seek to achieve a greater degree of consensus across Europe about what we mean by healthcare?

Ms Winterton: I think the difficulty with that approach is that would we end up saying that if we harmonise what everybody believes would be healthcare treatment that would lead us down a line

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surely of saying that if we recognise a certain type of treatment in another country then automatically everyone in the UK would be entitled to it. Our principle is quite firm that we think that if we offer that here then that is what we will pay for elsewhere and if another country chooses to have a different treatment then that is up to them, but we cannot say that we have to import that here or allow UK citizens to go elsewhere for that because that would just lead to the problem that would mean that we were not able to manage things successfully. I suspect that we might find that there were other Member States who are not as prosperous as us who would find that extremely difficult as well because that principle for them would be really quite difficult to sustain.

Mr Mogford: That is certainly one of the big difficulties. The other one, the classic example, are some of the continental Europe countries that include things like spa therapies and what have you in their definition of healthcare and how that then gets translated is quite difficult.

Chairman: What a wonderful thing that would be. Rehabilitative care is something that the health service is not very good at.

Q18 Baroness Greengross: I used to have a great deal to do with older people in Spain and that is a real case in point. The basic health care that they get does not cover the home care which we might call social care but which is bunched together in this country quite a lot with community nursing and what have you. What has happened about paying for that? Is that part of the money you were talking about that we pay out or do they just not get anything? Is that going to develop at all?

Ms Winterton: What we pay for is what the Spanish system offers in terms of their healthcare.

Q19 Baroness Greengross: The voluntary sector does a lot but they cannot look after the thousands and thousands of British.

Ms Winterton: We pay for what their healthcare system offers.

Q20 Lord Wade of Chorlton: If someone goes to live in Spain but retains British citizenship, do we continue to pay for their healthcare in Spain?

Ms Winterton: We do with Spain, France and Ireland because there are so many people who have retired there and it costs something like £600 million a year.

Q21 Chairman: There is an interesting question here which is about liability for negligence and how that would be dealt with. We have been round the edges of it and I just wondered if you would clarify that point in the remaining few minutes that we have of your time.

Ms Winterton: This really touches on the issues that we have talked about in terms of patient information and making people aware that if somebody chooses to go elsewhere the NHS in a sense should not be expected to have a system of redress that would be the same as one might be entitled to in this country.

Q22 Chairman: If you are in Paris and something goes wrong with the operation, if you are going to make a complaint you must do it there and you must do it under the system which operates in Paris or in Berlin or wherever.

Ms Winterton: Yes, and that people understand that very clearly before they travel anywhere for treatment. The real issue that we want to see in there, if legislation does come forward, is that that is quite clear so that there is no ambiguity about it.

Chairman: Thank you very much indeed. Does anybody have a last minute question?

Baroness Howarth of Breckland: I would just say that this has been extraordinarily helpful.

Chairman: Yes, thank you very much indeed for coming. We have all learned a good deal and understand what we are talking about now a great deal better than we did before. We are very grateful to you all, thank you.