Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

EU Directive on Patients' Rights in Cross-border Healthcare: Departmental Briefing

9 October 2013

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Ms Pam Brown
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Fearghal McKinney

Witnesses:

Mr Bryan Dooley	Department of Health, Social Services and Public Safety
Mr Stephen Galway	Department of Health, Social Services and Public Safety
Ms Heather Stevens	Department of Health, Social Services and Public Safety

The Chairperson: I welcome Heather Stevens, director of service delivery; Mr Stephen Galway, primary care medical services branch; and Bryan Dooley, general dental services branch. We have apologies from Mr Kirkwood. The normal procedure is to invite you to give a 10-minute presentation and then to invite members to ask questions.

Ms Heather Stevens (Department of Health, Social Services and Public Safety): Thank you, Chair, for the opportunity to present these four sets of regulations to the Committee. First, I convey our apologies for presenting the regulations at this late date, taking into account that they have to come into operation by 25 October to meet the EU directive transposition deadline. We fully appreciate that that is far from satisfactory for you, and we apologise for it.

By way of explanation, we had to understand counsel's advice on several policy issues relating to our obligations in Northern Ireland under the directive, particularly in relation to primary care services, and I will explain our primary care policy under the directive shortly. We had to work through the complexities of that advice and the complexities of derogation and to take advice and discuss that with departmental solicitors and the other three nations of the UK, because we were looking at derogation. That resulted in the Department being unable to go to formal consultation on our implementation policies until 22 July, and that consultation closed on 13 September.

Members have a briefing paper, which is split into two areas: implementation of our obligations under the directive in relation to patients' rights to cross-border healthcare and the introduction of new policies in relation to overseas visitors' access to free healthcare in Northern Ireland. The legislation to introduce those two sets of issues is interlinked, which is why we are taking them forward together.

I will deal first with the EU directive and how it evolved. EU regulations on the coordination of social security systems that were most recently updated in May 2010 already provided certain levels of reciprocal healthcare cover for EEA citizens — by that, I mean EU citizens plus citizens of Iceland, Norway and Liechtenstein. Those arrangements apply to tourists who require necessary care when visiting another member state under the European health insurance card (EHIC); people living and working in Europe; or, in certain circumstances and provided that they have received prior authorisation, those who travel specifically in order to receive healthcare.

Taking into account those existing provisions within EC regulations and the development of EC case law based on individual cases, particularly as a result of the Watts judgement in 2006, the development of an EU-wide directive was seen as necessary to clarify the law, which had been piecemeal, and the rights of citizens across the EU. For example, in the Watts case, the European Court found that the application of rights under the EU treaty applied equally to NHS-style health systems, whereas the UK had previously argued that it applied only to insurance-based systems. It also found that NHS regulations were deficient on the criteria for the granting or the refusal of prior authorisation and reimbursement costs. It found that the guidance on the procedure for an applicant to follow fell a long way short of the requirement for a procedural system that was easily accessible to citizens. It also found that, in this particular case, Mrs Watts had faced undue delay in accessing the treatment that she required within the NHS, and that the UK's failure to grant prior authorisation in that case contravened the regulation and article 49 of the treaty.

The directive that comes fully into effect from 25 October this year, therefore, only reflects existing rights under the treaties and the principles confirmed by EU case law, and it applies best practice in providing access to those rights. Its main objectives are to clarify and simplify the rules and procedures applicable to patients' access; to provide EU citizens with better information on their rights; to ensure that cross-border healthcare is safe and of high quality; and to promote cooperation between member states. However, its aim is not to incentivise cross-border healthcare.

The directive sets out the information that member states must provide for patients from other states who want to consider coming to this country to purchase healthcare. Conversely, it also sets out the arrangements that a member state must provide to allow its own citizens to access their rights to reimbursement of the costs of cross-border healthcare if they choose to seek that healthcare in another member state. They may want to do that if they believe that that care is better, cheaper or more readily available.

There are a number of key points to note. The directive does not apply to social care, but only to healthcare that is provided by regulated providers. It does not require the home state to accept a directive patient or, indeed, to prioritise the needs of an EU directive patient to the detriment of people who reside in the home state. The home state also retains responsibility for deciding what healthcare it will fund on a cross-border basis, so the directive is not a way for citizens to gain entitlement to treatments that would not normally be available in their home state. In other words, if you can get it here, you can get it there, and the cost will be reimbursed.

So, under the directive, people in Northern Ireland will enjoy the right to seek healthcare services in another member state that is the same as, or equivalent to, a service that would have been provided here. The patient will have a right to claim reimbursement of costs up to the amount that the treatment would have cost, had they had it here, or the actual amount, where that is lower. That principle of reimbursement assumes that patients will pay the overseas provider upfront for their treatment and then claim reimbursement when they return home, and the patient will also bear the financial risk of any additional costs arising.

The directive allows for a process of prior authorisation, which will be required for the more complex or expensive healthcare treatments. That is the mechanism by which individuals can get clarity about a range of matters relating to patient care. It includes confirmation that the treatment is one that the health service here offers, so that the patient knows that they are entitled to reimbursement and the level of that reimbursement. It also provides clarity on which elements of the care pathway are being funded and what the patient must do if there is a problem later on. In fact, we have had this process in place since May 2012 under interim regulations, which came to the Committee for approval.

As well as reimbursement and prior authorisation, a key theme of the directive is the emphasis placed on making information on rights and entitlements publicly available and easily accessible. To that end, the directive requires the setting up of what is termed a national contact point (NCP). NCPs are bodies from which information about patients' rights and providers of service available in other states may be facilitated, and the intention is to establish a network of NCPs right across the EU in order to

facilitate the exchange of information. The NCP for Northern Ireland will be placed in the Health and Social Care Board (HSCB).

Crucially, implementation of the directive has been taken forward on a UK-wide approach, with one exception in Northern Ireland — I alluded to it earlier — which relates to EU directive patients' entitlement to primary care. In Northern Ireland, persons who seek to register with a GP practice must prove that they are ordinarily resident here. That requirement flows from the 1972 order and is probably a product of Northern Ireland sharing a land border with the Republic of Ireland. That contrasts with the rest of the UK, where persons can simply register with a GP practice at the discretion of the GP. Due to the different law here, our "ordinarily resident" requirement and also the land border with the Republic — which does not have an entirely publicly funded health service — we, in Northern Ireland, have taken a different approach from the rest of the UK, which intends to absorb the cost of primary care for visiting patients. The directive allows for that derogation, and so our approach is to allow EU directive patients access to general medical services — essential services only — from their GP on an ad hoc basis, and they will be charged a fee for doing so. GP out-of-hours services shall be available to visiting patients in accordance with the arrangements that are in place between the HSCB and out-of-hours providers. Dental services will be provided to visiting patients on the basis of them being occasional patients. That means that incoming patients can receive ad hoc dental care, and they will be charged the present rate for each dental service, as outlined in the statement of dental remuneration. Visiting patients who purchase general medical services from a GP will be issued with private scripts.

Only 13 responses were received to the consultation that the Department held over eight weeks and which ended on 13 September. In general, those responses recognised the necessity for the legislation under EC law. No specific mention was made of the proposals regarding patients' entitlement to primary care services. Comments that were made, however, related to the detailed implementation of the proposals, which will be addressed in the guidance that will accompany the implementation regulations.

I should point out that this stance is the Department's preliminary implementation position. Monitoring of uptake is required by the EU, and it will indicate whether this approach is both necessary and transparent and whether any change from that position becomes subsequently necessary.

In summary, our primary EU directive obligations will be introduced through the Health Services (Cross-Border Health Care) Regulations (Northern Ireland) 2013. Our derogation for primary care services will be introduced through regulation 24 of the Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2013; the Health and Personal Social Services (General Medical Services Contracts) (Amendment No. 2) Regulations (Northern Ireland) 2013; and the General Dental Services (Amendment No. 2) Regulations (Northern Ireland) 2013. Copies of those regulations are included in members' briefing packs.

The second issue is overseas visitors' access to free healthcare.

The Chairperson: It might be better to deal with the first issue rather than taking them all together, just for clarity, if that is OK. Are you comfortable enough to take questions at this point?

Ms Stevens: I am happy to do that. Absolutely, yes.

The Chairperson: You touched on the fact that this has come to us very late in the day. We are being asked to look at a specific European directive that is going to be implemented in 14 days' time. It does not seem to have gone through the appropriate processes from this Committee's point of view. Our sense is that we should have been looking at this early in the year to allow the Committee to scrutinise it. What are your thoughts on that? Following that, what would happen if the transposition deadline for an EU directive is not met?

Ms Stevens: As I said earlier, we recognise that the Committee has a very short time frame within which to consider this, and we apologise for that. The issues in the directive and their specific implementation in Northern Ireland have been incredibly complex to work through. As we were the only part of the UK that was proposing to derogate, we had to be absolutely sure that it was the right decision and that we had fully explored the ramifications. It required taking counsel's advice, not from London. We were required to understand that and to go backwards and forwards to departmental solicitors and our stakeholders, not the least of which is the Health and Social Care Board, in order to

really understand what the ramifications of the derogation would be. We recognise that it is a serious issue to derogate from the UK position on an EU directive.

Notwithstanding that, you have our complete apology for the fact that this has come to you so late. We have also apologised to the Examiner of Statutory Rules because we realise that —

The Chairperson: So, what would happen if the deadline is not met?

Ms Stevens: If the deadline is not met, technically, the UK will face infraction proceedings and will be subject to a fine. That fine would be passed on to the country that caused the issue, which would be Northern Ireland.

Mr Beggs: Are the infraction procedures going to be a lengthy, drawn-out process? Are we at the final stage where we will face the fine? What stage are we at?

Ms Stevens: No. We have not indicated that we are likely to breach it because we have done so much work up to this point. We believe that, subject to the Committee's scrutiny and approval to proceed today, we can meet the deadline. We are not looking at infraction proceedings yet.

Mr Beggs: Europe has not yet contacted us issuing any threats, so we are at a very early stage. Sometimes, it is two or three years down the line before Europe gets to that stage; is that correct?

Ms Stevens: That is my understanding.

The Chairperson: Do we know of any other EU countries that are meeting the deadline or that will potentially not meet the deadline?

Mr Stephen Galway (Department of Health, Social Services and Public Safety): No; we do not have any information about other EU countries. We are just focusing on ourselves in respect of the UK. The other three regions — Scotland, England and Wales — are ready and have processes in place to meet the deadline.

The Chairperson: There is a unique set of circumstances here. We are dealing with issues in respect of the perceived land border, which have been reported in the media in the last week. There are very practical outworkings from this directive concerning, for example, visiting patients' entitlement to essential medical services. Even that is not clearly defined, and nor is what the fee would be. There are critical practical issues that require consideration.

Mr Wells: I share the Chair's concern. I do not know whether you read the report in one of the newspapers during the week that stated that there are 80,000 more medical cards in Northern Ireland than there are people. I am sure that there are some very good and logical reasons for that, but it is noticeable that the areas of most concern are those closest to the border. The allegation is that folk who are normally residents of the Republic are registering at Northern Ireland addresses in order to avail themselves of free visits to a GP, free prescriptions, free eye tests etc. Therefore, our situation is very different from England, Scotland and Wales, where that is not an issue.

We know that there is a problem. Given that you have sought a derogation as a result of the 1972 order, you have obviously spotted a problem. Normally, these directives are the "salty sausages directive" or something like that; they are of no significance whatsoever, and we just nod them through. We have nodded some through at a very late stage, but this directive is just so fundamental. We need to drill down and find out what will be the likely implications for the very hard-pressed budget if we enshrine this directive in legislation.

I have no problem whatsoever with people from the Irish Republic availing themselves of care in Northern Ireland provided that the health and social care authority in the Republic pays the bill. That leads me to this question: how much payment is made, at present, for ad hoc services? I know that there is a well-established practice for renal units, cancer units etc, and a bill is sent. However, is there evidence that we are picking up much from people who happen to take ill in Strabane or somewhere and drop in? Is it the case that there are a lot of grey areas and this will only compound those?

Ms Stevens: There are a lot of grey areas. The derogation specifically tackles the problem that we are seeing at the moment, in that it provides that it is not legal to claim a Northern Ireland address and seek free treatment here. Treatment is available, but it must be paid for.

To address the Chair's earlier point: the guidance that will accompany the regulations has all the detail of the tariffs that will be chargeable. Tariffs for the secondary care system have been in existence for some time, so we will just replicate those in the guidance. Tariffs for primary care services have had to be calculated. We have been working with the Northern Ireland General Practitioners Committee (NIGPC) and the Health and Social Care Board to come up with realistic and sensible tariffs that reflect the amount of work that will be taken. For example, an EU directive patient would not ordinarily have a 10-minute appointment as a domestic patient would have and might require a 15-minute appointment because their details will not have been known to the doctor in advance. We envisage a tariff of £45 being in place to meet that cost. So, in parallel with the development of the regulations to implement the directive, a lot of work has already taken place to develop the detail of the guidance. That is what most of the comments in the consultation were about. As you said, it is about the practical outworking of this policy.

The Chairperson: Our scrutiny role relates to the directive as opposed to the guidance.

Mr Wells: Is there any evidence that anybody is paying at the moment? Are we getting a flood of money from people who are hopping across the border and, for example, getting a consultation with a doctor or a prescription? The evidence from the Department indicates that about £110 million is coming in but that the vast bulk of that is for contracts with health boards in Donegal, Louth or wherever. How much money is being thrown at the Department? If we have a directive that makes cross-border healthcare a legal entitlement, will we not just encourage a continuation of the practice?

Mr Galway: There is evidence of people from across the border accessing services, particularly at hospitals such as Daisy Hill, and so on. However, a large proportion of people use their insurance from the South to pay for services, and they are happy to do that. For those people, it is more a case of wanting to access the standard and quality of services that they will receive in the North rather than use the services in the South. There is evidence that people are paying for the service.

It may not be as easy to identify at GP level, where it is about getting immediate access to a GP when you need one. We operate some cross-border pilots. There are North/South pilots operating in two border areas at the minute.

Mr Wells: Were you not suspicious about the house on the border with 18 medical cards and two beds? Did that not ring a few alarm bells?

Mr Galway: It definitely did. As Heather said about the derogation, we want to be seen to have a set charge for accessing GP services at primary care level. In England, Scotland and Wales, they are just going to absorb that cost. We could not afford to do that here. The reason for the derogation is to set that fee to try to alleviate any additional pressure caused by people accessing services under the directive. Therefore, yes, those issues do cause concern. The counter-fraud unit of the Business Services Organisation (BSO), as part of the board, is actively working through that process to try to alleviate those issues.

Mr Beggs: You said that you had worked out costs for a range of services. Will those costs be published so that everybody has access to them and is aware of the value of the service that we all receive, and so that those who might seek to use our system will be able to determine whether they might be likely to get approval from their own health authority or will have to pay separately?

Ms Stevens: Absolutely. One of the key drivers behind this is for that information to very publicly available. It will be held by the Health and Social Care Board. The national contact point will also have that information and information on the services available in the other member states to show the comparative costs.

Mr Beggs: Are the different funding models in Northern Ireland compared with other parts a contributory factor to your looking for a derogation on primary care and GP practices? Do our GPs get paid more for having more patients? Are there things that incentivise GPs to add patients from elsewhere? In what way does the current funding model work?

Mr Galway: The funding model is based on an agreed formula with NIGPC. The size of a GP's patient list is taken into account, yes, but patients who are accessing primary care services under the directive will not be on a GP's list. Those patients will access GP services on an ad hoc basis.

Mr Beggs: Somebody who has a medical card registered under a rogue address will presumably be able to access the services.

Mr Galway: Yes. As I said, the role of the counter-fraud unit of the BSO is to actively pursue patients who access services with what seems like a valid medical card but is not. The unit will try to identify those people and cease their ability to access primary care services.

Mr Beggs: At some point, will there be a requirement for patients to provide other identification along with a medical card?

Mr Galway: That is not something that we have considered at this stage. The BSO may be considering that in its longer-term view of access. I understand that a new version of the medical card will be coming out, but I do not know how that fits in, what it will entail and whether there will be a photograph on it.

Mr McCarthy: The figure of 80,000 has been mentioned, which is a lot of patients. Whatever comes of this will affect those 80,000 patients. Have there been any discussions or debates on that issue between the Southern authorities and us? Has it been discussed with the Irish Government at the North/South Ministerial Council? It is a border issue that will affect a lot of people.

Ms Stevens: We do not have that information. We are not privy to the work of the BSO and the conversations that it might be having in its investigation of fraud and potential fraud. We are conscious that the figure of 80,000 can be made up in a range of ways, not all of which involve fraud. It may be that individuals have changed address and have not updated us, or are students who reside elsewhere. There is a lot of unpicking to be done before we reach a figure for fraudulent activity. The Minister will make a statement to the Assembly on the whole area of fraud next week.

Mr McCarthy: To your knowledge, there has been no discussion between the Dublin Government and ours?

Ms Stevens: I could not say whether there has been. I am not aware of it.

Mr McKinney: I return to the issue for which you apologised at the start. I acknowledge the fact that the Minister wrote to the Committee in July. Given the amount of work involved, what was the earliest point at which you could have alerted the Committee that this was coming down the track, which might have mitigated an apology?

Ms Stevens: That is a very difficult question to answer, because we were involved in discussions on the derogation right up until the consultation.

Mr McKinney: Yes, but could you have alerted the Committee to the potential for derogation?

Ms Stevens: I dare say that we could have done.

Mr McKinney: What was the earliest point at which you could have done that?

Ms Stevens: I will have to ask my colleague.

Mr Galway: If we had been aware of it, we could have done so prior to the summer. Perhaps in May or June of this year we could have notified the Committee.

Mr McKinney: Did you think of alerting the Committee earlier, given the amount of work that you say you have been involved in since?

Mr Galway: At that stage, we honestly did not. We have apologised for that. We focused on getting the consultation material together and had not thought that an advance warning to the Committee about the derogation or the delay —

Mr McKinney: I might be splitting hairs, but you have apologised for coming late. You did not apologise for not coming early. Is that something that you should consider?

Ms Stevens: Absolutely. We take the point completely.

Mr McKinney: OK.

The Chairperson: I want to add that the consultation was conducted in July and August. I think that you said that you received 13 responses. That is not really surprising, given that it was during the summer, which is not the best time for consultations.

Reference was made to the GP out-of-hours services. Might that potentially result in, for example, visiting patients using the out-of-hours service to access treatment that they might otherwise have to pay for, had they consulted a GP during normal working hours?

Ms Stevens: No. The only thing that will be available free is urgent and immediately necessary care. If that is the case, the out-of-hours service will refer such patients to an emergency department. Otherwise, such patients would be referred to a GP during normal hours.

The Chairperson: I suggest, Heather, that your references to urgent and essential medical services require more teasing out and greater definition. I want to know how you arrive at the definition. Moving on, there are four regulations involved in the changes to the existing legislation governing overseas visitors. You said in your initial comments that it is interlinked, but is it a separate piece of work?

Ms Stevens: It is a separate piece of work, but regulation 24 of the 2013 regulations refers to the EU directive. The overseas visitors' entitlement obviously covers countries that are beyond the European Economic Area. That runs wider than the EU, but there is a provision in those regulations that deals with EU directive patients. Would it be helpful if I outlined what that set of regulations does?

The Chairperson: The issue that I am picking up, and perhaps the consensus that I am getting to, is the need for more time. If we are fulfilling our responsibilities, there is a scrutiny role here. If the piece on overseas visitors is linked, we look at that separately as well.

It seems to me there is a recognition that we are sitting with a unique set of circumstances. Therefore, there are practical workings out of that that we, as a Committee, have a responsibility to tease out. I suggest that we come back to this piece of work. I think that we are legally entitled to do that, and there is a responsibility on us to fulfil our duty.

If Committee members are in agreement with that, we can look at scheduling with the Department at the earliest possible date. However, under the circumstances today, at this late hour, it would not be right or proper for us to proceed. We certainly cannot give the consent that we are content with the regulations as things stands. Therefore, if members are comfortable doing that, we will reschedule and come back to this. We will also separate out the piece on overseas visitors and take a look at that. Are members agreed?

Members indicated assent.

Mr Gardiner: Do you have figures for those who live in the Irish Republic and come over here for treatment?

Mr Galway: We do not have anything with us at the minute. We will see whether we can obtain those, but I am not sure.

Mr Wells: I am glad that Sam asked that question, because next time —

Mr Gardiner: I have not finished yet, OK?

Mr Wells: Sorry, Sam.

Mr Gardiner: If there is a house in which two people are living but perhaps 14 or 15 others are giving it as their address, I want to know about that, too — all built in. There seems to be an irregularity, and the Department is running away from it. You will have to face up to that. Money is coming out of our coppers to treat people from other countries.

Mr Brady: I, too, apologise for being late. I am sorry that I missed the presentation. I do not know whether you have dealt with this issue. The E111 form presumably comes in under EU directives. How does that apply to people from the Twenty-six Counties, because they are obviously part of the European Union? Is that applicable?

Ms Stevens: Yes, it is. There are reciprocal arrangements across all EU countries for services that you require urgently, so that applies —

Mr Brady: Is that invoked? Jim talked about there being a couple of million more medical cards than there are people. Everybody has a unique medical card reference number. I deal a lot with social security queries, and I cannot access any information for people without a national insurance number. That number is unique to each person. Two people could have the same name and date of birth but not the same national insurance number, because the number is artificially created.

Has it ever been factored into all this that if somebody applies for medical assistance for whatever reason, they have to quote that number? If I ring the Social Security Agency, it goes through a security check with me. I have to provide dates of birth and postcodes. The issue seems to be that people willy-nilly walk in and get medical treatment without any checks being made to determine whether they are entitled to it.

Ms Stevens: Those are good points that will probably emerge as a result of the BSO's fraud investigation, after which the Department will consider what needs to be done as a result.

Mr Brady: Everybody gets a card now before his or her 16th birthday. That does not apply to Jim or me, because they did not the technology then. We had to physically apply for ours. It seems to be a relatively easy thing to do. When national insurance cards originally came out, there was a magnetic strip on the back. No one is going to go the expense of putting that on the card if they are not to be used for storing information. That seems to be a way in which to deal with this issue. Last week, we talked about £250 million worth of fraud, which is a huge amount of money. Presumably, that is the outer limits of the figure, but it just seems that there are simpler ways in which to deal with this issue to avoid all the problems. That is just a suggestion.

Mr Wells: To follow up on that, now that we have agreed that you will be coming back, I wish to know the present extent of the usage of our health service by people who were not born or are not living in Northern Ireland and, more intriguingly, how much we are being paid for this. I have been to Daisy Hill's out-of-hours service in the early hours in the morning, and the place is packed, with half of them drunk— the usual problem. I cannot believe that the staff have the time to register people who have come across the border and make certain that there is a billing address, and all of that. I think that they are just treated. Therefore, there is no income coming to the health service. I suspect that there is a very small amount coming in at the moment. However, once you enshrine those rights in a European directive, what is going happen? To contradict what Mickey said, these are not people who are fake; rather, they are genuine citizens of the Irish Republic who are using a friend's address here to register for a medical card. That is what is going on. Therefore, a person presents himself as Mr Smith, has a card and is registered, and the doctor is under an obligation to treat the person for free. There is no question of billing. The fact that that has been highlighted this week places an onus on us to make certain that we do not accentuate the problem.

Mr Dunne: I apologise for being late. How will registering with a GP in Northern Ireland for those who are non-residents operate under the directive?

Mr Galway: At the minute, if you want to register with a with a GP or change your practice and move to a different GP, you go along to the practice and give it your details. The practice will fill in the appropriate forms and send them to BSO and the board. They validate whether you are ordinarily resident — whether you meet that test. There are certain conditions to be met, such as whether you have lived here for longer than six months; whether you have the means to live; and whether there is a reason that you are here working, or whatever. BSO and the board test all that information. If you do not meet the conditions, they liaise with the UK Border Agency at the Home Office to validate people

who have tried to gain access to primary care. They go through a rigorous process to ensure that people are fully entitled before they are put on a list at a GP practice.

Mr Dunne: Your briefing paper on the directive states:

"currently GP Practices may accept anyone they choose onto their list regardless of their status."

Mr Galway: That is the way in which it operates in England. GPs in England, Wales and Scotland decide whether they will accept a new patient, but that is not the way in which it operates in Northern Ireland. The Home Office has had a consultation out on the Immigration Bill, and it is looking at taking on aspects of the ordinarily resident test that we operate in Northern Ireland and applying it elsewhere in the UK to make it more stringent so that GPs do not have to take the ultimate decision.

Mr Dunne: Do you feel that it works fairly effectively?

Mr Galway: At the minute, based on the UK as a whole, it is probably one of the stronger —

Mr Dunne: Can people from the Republic register with a doctor here?

Mr Galway: They can register with a doctor here only if they have a Northern Ireland address — we have already highlighted that issue — and provide the appropriate evidence to support an application for registration with a doctor, and the BSO validates that.

Mr Dunne: Otherwise, they get treatment on an ad hoc basis.

Mr Galway: They get treatment, and it can be dealt with either privately with a GP or, under this directive, in a similar way, and there will be a consistent charge for any GP that they are accessing — £44 or £45.

Mr Dunne: That is the structure at the moment.

Mr Galway: Until the directive comes into place at the end of October, this is how it is applied at the minute: if someone is not registered with a practice and presents to a GP, that GP may decide to treat that person, but the GP will have to do so on a private basis.

Mr Dunne: Is it similar with a dentist?

Mr Bryan Dooley (Department of Health, Social Services and Public Safety): It is similar, in that you have to live in Northern Ireland and have an address here.

Mr Beggs: I want to pick up on the bit about "appropriate evidence". If someone has a friend here, that person can get an address here. What else do people have to provide to get a medical card?

Mr Galway: I am not wholly clear.

Mr Beggs: A medical card is the passport to all these free services. What do people need, other than the address of a friend?

Mr Galway: An application would need to show that they have a national insurance number, and there would be a range of aspects of information that the BSO would require and look at. If it were people who have just arrived in the country, questions would be asked about how long they have lived here and how long they plan to be here. There is a whole range of questions.
I do not have to hand the full criteria that BSO requires, but I can get that for you.

Mr Beggs: We are taking time over the issue, but it is important that we get it right, particularly for those who live in the Western Trust and Southern Trust areas. If their out-of-hours service gets swamped with people who want to avoid the €50 or €75 GP fee in the South by simply going to the

out-of-hours service in the North, the service available to local people will not be able to cope. Therefore, it is important that we get it right.

Similarly, I understand that it is €100 for A&E in the South if you are not referred by your GP. Again, there is a big financial incentive for people to avail themselves of the free service by simply going to the South West Hospital or Daisy Hill. That will mean huge pressure on services. However, one of the biggest concerns could be around prescriptions. As we have just learnt today from your written evidence, it could cost around £300,000 a year to deal with particular illnesses. If we do not get this right, it could completely throw the whole health budget in Northern Ireland. We need more time to make sure that it is the best that it can be.

The Chairperson: I think that you are fairly clear that the Committee's view is that it needs more time. We will reschedule. It would be appropriate to seek evidence from GPs, the British Medical Association and the board. It is critical that we get this right. Thank you for your time. The staff will be in contact with you to reschedule.