Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

EU Cross-border Health Directive: British Medical Association

6 November 2013

NORTHERN IRELAND ASSEMBLY

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

Witnesses:

Dr Tom Black	British Medical Association
Dr Alan Stout	British Medical Association

The Chairperson: I welcome Dr Tom Black, who is the chairman of the BMA's GP committee, and Dr Alan Stout, who is the deputy chair of the BMA NI's GP committee. I invite you to make a 10-minute presentation, after which we will have questions from members.

Dr Tom Black (British Medical Association): Thank you for the invitation to appear before the Health Committee. We are GPs, and 10 minutes is a very long time for us, so my presentation will only be one or two minutes.

General practice is under considerable pressure in terms of workload. That is our number one issue. We are running about 11 million consultations a year, 38 million prescriptions a year and many other things. We do not see capacity in the system to take on additional workload in terms of additional patients.

We recognise that we have a duty of care to deal with immediately necessary and emergency situations for people who are not our usual patients, and we see that duty continuing. However, as GPs for the population in Northern Ireland, we need to prioritise the needs of the 1·91 million patients under our care and prioritise their routine care and immediately necessary and emergency care within that. Obviously, we need to accommodate the EU directive, but we see ourselves restricting access to services to essential services only and using cost as a hurdle to limit demand in that respect. We are happy to answer questions.

The Chairperson: That was music to our ears, not because you stopped talking, I hasten to add, but normally we have much longer presentations.

The point that you make about prioritisation of current patient commitments is critical. However, when we looked at the directive, it talked about visitors being able to access things like "essential medical services", and it was not clear what that meant. There were also implications for access to GP out-of-hours services and, ultimately, who pays for them. Those were some of the issues.

We felt that, given the unique situation that we have in the North with our land border, there was a need to look at the directive. Nobody is suggesting that it is not worthwhile to do so, but there are practical outworkings of it that are not clear. So, I am interested your views on that. Who defines "essential medical services", how are they defined and, practically, how are those services administered?

Dr Black: "Essential medical services" has a very long definition in our contract, but essentially it refers to those who are sick or perceive themselves to be unwell. "Additional services", which are what we hoping to exclude from the directive, refer to things like cervical cytology, cervical smears and maternity services; things that are more routine and for which, to achieve quality of care, you would need continuity of care. So, there is no point in me doing your smear: I should know what your last smear was, and I should make sure that I do your next smear if I am going to protect you from cervical cancer.

So, "additional services" tend to be those extra services. For instance, you should not bring your child to me to get vaccinated if I am not your usual doctor. Why? I need to know whether you have had previous problems with vaccinations, and I need to make sure that you get your full continuity of care and full vaccination programme. As you know, there is a huge vaccination programme for children. I did yesterday's baby clinic, and I was spraying flu up some children's noses, putting rotavirus vaccines in their mouths, and jagging some in the arms and some in the legs. You are looking at, roughly, nine vaccinations per child. It is really complicated. Imagine doing that to people who were not your patients.

Moving on to the out-of-hours services, there is already cross-border work done on out of hours, and, obviously, if you are resident in another EU or European Economic Area (EEA) country and happen to be in Northern Ireland, you would only use out-of-hours services if you had an urgent or emergency problem, and that immediately comes under the remit of, "Yes, of course you will be seen".

There are some issues in the border areas, which I am sure you are aware of, Chair, where some patients are much closer to the out-of-hours services on the other side of the border. That applies in Fermanagh, Derry or Armagh. There are already arrangements in place for that and for costs to shift between the two jurisdictions. So, I do not see that we have a huge problem with out-of-hours or essential services, but the "additional services" is the area that we need to be careful of, mostly due to quality-of-care issues.

The Chairperson: To put it bluntly, will the directive hinder that prioritisation of the current patient list or requirements that you have?

Dr Black: The proposals from the Department, as I see them, would accommodate practical working in that I do not see a huge number of patients coming from across the border if they are going to have to pay a fee that is commensurate with the fee that they pay in the Republic of Ireland. I work a couple of miles from the border, and I get frequent requests to see Donegal patients in Derry privately. To be quite frank, I am too busy, and that is the response I give. I have 7,000 patients in my practice. We have four doctors and we are snowed under with work. The last thing I need is to be looking after other people's patients. There are plenty of doctors in Buncrana, Moville, Carndonagh etc to see them. I see the proposals from the Department as continuing that situation. If you are sick on the day in Derry, I will see you. If you want a routine appointment, please see your doctor in Buncrana.

The Chairperson: Finally, for clarification, one issue in the directive was around primary care specifically. It looked at patients accessing dental services as part of what is called being an occasional patient. Do you have a view on the definition of an "occasional patient"?

Dr Black: I, thankfully, know very little about teeth. The only part of the body that we do not look after is the teeth, so I will not step on the toes of those who do. I know that, in our local area, people mix and match, back and forth between both sides. It does not have the same continuity of care issue. It does not have the same risk or life-and-death decisions as medicine.

The Chairperson: Fair enough.

Mr Gardiner: Thank you, doctor, for your presentation. As a doctor, how many patients would you feel safe having in your practice?

Dr Black: The average list size is about 1,600 per doctor. That has been the situation for probably the last decade or so. Prior to that, it would have been 1,800. At the beginning of my career in general practice, about 25 years ago, it was probably 1,800 to 1,900. When it comes to chronic disease management and vaccination programmes, for example, this month alone I will vaccinate in excess of 1,000 patients in my practice —

Mr Gardiner: Is that 1,600 per doctor?

Dr Black: Per doctor, the way that it is structured at the moment.

Mr Gardiner: Do you feel at ease with that? Do you feel that is safe? Do you need more doctors, or more hands on deck, as the saying goes?

Dr Black: The workload that we have at the minute stretches us considerably. We were at the Department just before this, and we described how young GPs are in the office from 7.30 am to 7.30 pm. That is OK; GPs are expected to work hard. We are well paid, and we should work hard. However, there seems to be very little give now in the system. Yesterday, I did a flu vaccination clinic, then a baby clinic, then I made a bunch of phone calls, then I did a bunch of prescriptions and then I did a late surgery. I think, "OK. I'm old. I've grey hair. What else am I going to be doing?"

Mr Gardiner: Your halo is shining at the moment.

Dr Black: No. It is just work. Do not get me wrong, GPs love being busy; we love being needed. We have that complex you know. However, the younger doctors are struggling with the sheer pressure of the workload. The honest answer is this: we need more GPs, but I should not say that because we are not training them. If I say that we need more GPs, but we have not trained them —

Mr Gardiner: You say you need them but you are not training them. What can we do? What can the health service do to improve that?

Dr Black: We are training about 60 GPs a year at the moment. We used to train 75. England has increased its numbers hugely. We should probably increase ours more. In Northern Ireland, it is not a big struggle to attract some of those English trainees back — there was a locum in my practice yesterday who trained in England but came from Castlederg — so that is good. However, I think that we should be self-sufficient. We probably need to train more GPs. That is the long-term plan.

Mr Gardiner: Local GPs.

Dr Black: That is how you get by.

Mr Gardiner: Do you want to encourage that, because we do not have sufficient numbers?

Dr Black: If you invest in a local person who will stay in the local area for 30 years, you will get huge value from them. That is our experience. Saying that has probably broken a few laws.

Mr Gardiner: That is a good motto to work on.

Dr Alan Stout (British Medical Association): Two other dynamics play a part in this. One is the increasing demand from the population, and there is an ever-increasing demand from the population, for access to health care in general, be it general practice or hospital-based services. The other element, which overlaps with that, is that we have created a dynamic in the health service in Northern Ireland where everybody who comes through the door of a practice — we talked about this earlier — will now see a GP, simply because the funding mechanisms in Northern Ireland have not allowed us to increase the practice workforce to include counsellors, extended nursing roles, practice-based health visitors and so on, which can actually take a lot of the load off a GP. Our dynamic is going the opposite way; it is very much dominated by a medical model and the GP seeing everything that comes through the door.

Mr Gardiner: We record our appreciation for the work that you do under pressure.

Mr Dunne: Thanks very much, gentlemen, for coming in this afternoon. Is it fair to say that we are getting the old message that GPs are reluctant to change? They are set in their ways, and they are difficult to move. They are unwilling to change their methods and processes. Is that fair?

Dr Black: We have the most flexible, most adaptable and highest quality of care in the world. We got our figures just last week for the quality and outcomes framework. You will be pleased to hear that, as usual, we came top in the UK. We have the best access to patients in the world; there are 6·5 consultations per patient per year, compared with 2·8 per patient per year in the Republic of Ireland, so it is only double. We are 20% above England. We are the most effective and efficient users of information technology. Our computers are far better than hospital computers. Thank you for providing those computers for us. They produce 38 million prescriptions per year. You will be shocked to hear that the total number of prescriptions per year in the United Kingdom has passed one billion. That is extraordinary. We work very hard, and we try to adapt. We are always a little careful about the quality of care. We seem to drag our heels. For instance, the Prime Minister in London wants us to do Skype consultations and the Health Minister in London wants us to do 60-second e-mail consultations. We think, "Wow that sounds risky". We try our best. If we appear to be slow at times, it is because we are looking at quality of care for patients; we are trying to do our best for them.

Mr Dunne: Under Transforming Your Care (TYC), surely you recognise that change is coming and is needed. Your methods and how you carry out your business will have to change.

Dr Black: We were with the Department officials this morning. We are fully engaged with TYC. In fact, we are the envy of the health service in London when it comes to how GPs are so engaged. We entered discussions this morning about how GPs can take back out-of-hours services. That would get us sacked if we were in Scotland, England or Wales, but GPs —

Mr Dunne: Would you take it back?

Dr Black: We will take it back, not as a person or practice but as a federation. In other words, a local area will take back GP out-of-hours services. We are setting up GP federations to accommodate that. We discussed with the Department how it has de-funded that over the past decade, and we said that maybe it would like to refund it to the 2003 level. That will be an ongoing conversation.

Mr Dunne: I should think so.

Dr Black: We are trying to be as positive and progressive as possible. We hope that the board and the Department keep up with us.

Dr Stout: With respect, we are the exact opposite of what you described. We have been instrumental in putting people forward from our own committee to be involved in TYC committees and to lead integrated care partnerships (ICPs). Tom just mentioned meeting the Department officials and actually bringing the solutions to them. The room that we were in earlier this morning is the only room in the whole of the UK in which we will be having similar conversations about general practice being prepared to change, taking a risk and providing the solutions.

Mr Dunne: In your evidence that you have submitted, you talk about price and the administration of charges. You are saying that the admin is going to be of great concern. That sounds negative; you do not want any additional —

Dr Stout: It comes down to who is going to be treated —

Mr Dunne: — load, if you want.

Dr Stout: It is about essential services and duty of care. To be perfectly honest, the duty of care of any doctor in Northern Ireland will be to see somebody who is sick or perceives themselves to be sick. Any financial transaction, wherever the patient has come from, will be very much secondary to that. I imagine that, in reality, the doctor will use discretion or might not even realise at the time that it is appropriate to charge the patient. The financial transaction is very much secondary to anything,

hence the admin will be a very small part of that. It is about maintaining the best services for Northern Ireland patients while trying to inhibit the unnecessary use of Northern Ireland services.

Dr Black: To reassure you, Mr Dunne, we always ask for money for things, but we never get it. The funding for general practice this year is pretty much the same as it was in 2005. There have been no inflationary uplifts, no pay rises, no increments; it is the same as 2005. I know, it is so sad.

Mr Dunne: What do you think about GP practices that close at lunchtime?

Dr Black: I do not like that. I like to see doors open and staff there from morning to evening. My colleagues in Fermanagh and rural areas would say, "That is all right for you, Black, because you have eight or 10 staff to answer phones and the door, and you have four GPs, so you can do a rota, but I'm on my own or, if I'm lucky, with one other member of staff in a village in Fermanagh". If those who have done 35 years in that environment say, "I'll close door, but I'll carry a mobile phone", I think to myself, "Do you know what? I would like you to stay there". If the patients can accommodate that and know that they are getting a good service, that is the answer. So, in general, I do not like doors being closed, but I can see that there are exceptions.

Mr Dunne: I appreciate that. That issue has come up in North Down, which I represent. We are talking about large practices that are closed. There is no GP activity, and you cannot make an appointment. That is disappointing. I find the lack of access being very much against the principles of TYC. We are trying to move towards treating people in GP surgeries instead of overloading A&Es.

The Chairperson: I just remind members that we are straying into different territory.

Mr Dunne: We do not often get this opportunity.

The Chairperson: After that presentation, I think that you got the job.

Mr Dunne: Finally, when somebody comes to register with you, they obviously need a medical card. Do you have any system to verify that medical cards are legitimate? Are people falsifying medical cards? Is that an issue?

Dr Black: We do not register patients for medical cards. In Northern Ireland, that is done by the Business Services Organisation on behalf of the Health and Social Care Board (HSCB). If someone comes to me and says, "I have just arrived. I would like to join the practice", I will go, "That's grand. What can I do for you today? Are you sick?" They will then fill in the forms, which go off to Belfast for a decision on whether or not they are due a medical card.

Some of my patients are cross-border workers. It is an incredible situation. A cross-border worker who works in Northern Ireland and pays tax here is allowed to be registered with me, but their family are not, and if they get seriously sick and lose their job, their continuity of care goes. I always try to do the best for the person in front of me, but, remember, if you are in front of me, and you do not have a medical card, the health service will not pay me for your treatment. We will not see sick people and then hope that you pay for them.

Mr Dunne: I thought that people would come with a modern flexible card in their pocket and register with a GP. Is that not the case?

Dr Black: With their medical card?

Mr Dunne: Yes.

Dr Black: Oh yes. They come in with their medical card and say, "I have a medical card already. Can I transfer it to your practice?".

Mr Dunne: But it is not necessary to have one to register with you.

Dr Black: Registering is not the same as being registered as a patient in Northern Ireland. If you are on my list, I will put you on my computer system. I will then ask Belfast to accommodate you as a

patient under the National Health Service (NHS). If they say yes, they will pay me, and if they say no, they will not do so.

Mr Dunne: So, it is verified at that stage?

Dr Black: Yes.

The Chairperson: I think that it is important to point out as well that that is a completely different issue from what we are looking at in the EU directive. I do not think that we should confuse the two issues.

Mr Dunne: With all due respect, Chair, I think that it is relevant. Thanks very much, gentlemen.

Mr D McIlveen: I will try to relate this to the EU directive. I know that we are straying into territory that is perhaps not what you came here to discuss, and you have my full sympathy on that.

Obviously, one of the issues is the pressure on the system. I think that that is the overarching issue and concern that we have. I suppose that one way to alleviate pressure is to ensure that patients go to the right place with their concern or issue. We can safely assume that people with very minor ailments who go to your surgery sincerely and genuinely seeking your help could receive help in other places before they have to put the burden on your practice. In the negotiations with Community Pharmacy, which is obviously in a prime position to deal with minor ailments and so on, one of its big concerns was the imbalance between the prescribing of generic medicines and branded medicines, which was a major contributor in some pharmacies almost going to the wall because they were making a loss on their branded medicines.

A number of community pharmacies came to us with their sob stories, and I say that respectfully. They would pick up the phone to a GP who had prescribed a branded medicine and say, "Look, we have a perfectly viable generic here that does exactly the same thing". However, a lot of the time, an almost messianic complex came from the other end of the conversation, with the GP saying, "I have prescribed what I have prescribed. Just you issue the medicines."

I know that a lot of work has been done to try to address that, particularly in the past 12 months. From what we hear from the pharmacy side, GPs are starting to step up to the mark. However, do you think that there is still work that can be done to make sure that as much of the financial pressure as possible is taken out of the system? If there were more resources to deal with it at pharmacy level, or at whatever front line level, would that enable the issue not to occur?

Dr Black: Your general theme of the workload is correct. Lots of sick people need to be seen. There are lots of needs, wants, demands and expectations. We get great help from pharmacists, who are brilliant. They have far more people coming in through their doors. We do 11 million consultations a year. Pharmacists probably have 100 million people walking through their doors — certainly 20 or 30 million. Thank goodness for pharmacists. They are excellent at their job, and we get great support from them.

I am so old that I have been dealing with generic drugs for 20 years. When the generic prescribing rate was about 30% or 35%, we needed to increase it, so we took it to 40%, 50% or 60%. We are now at over 70%, and there is no gap now. We have actually gone too far. This year's prescribing budget is far less than last year's. Last year's was far less than that of the year before. Each year, we are spending less on drugs. You are sitting there and saying, "That is not what we are hearing". Each year, we are spending less on drugs. This year, it may be £410 million, which is a lot of money. That is money well spent, of course, because drugs are really good at keeping people out of hospital, keeping them alive and easing suffering.

The quick answer to your question about generic drugs is that we have gone too far. We are now prescribing generic drugs that are more expensive than branded drugs. We should pull back to probably 66% or 67%. We have overshot. The board fully recognises the fact that we have overshot. We have pressed the generic button for everything, because that was the religion. We should be a wee bit smarter and pull back to probably 67%.

Remember that the other drugs that are branded — that last 30% — are the ones that have been invented in the past 10 years. Prostate cancer is not curable, but boy, you can now live a long time with it. Heart attacks have reduced by 25%, strokes have reduced and so on. Those expensive branded drugs give us huge value in keeping patients out of hospital and alive longer. For every 10

years that pass, people live three years longer. For each of the past three decades, everybody lives three years longer. Mr McKinney, if I tell you that you will live for 10 more years, I am wrong. You will live for 13 more years, because, in 10 years' time, you will live three years longer. That is the value that we get from drugs. Sorry: long answer.

Dr Stout: It is impossible to let this pass without making the comment that members got the pharmacist side of the issue. The 70% that you quote is the generic dispensing rate as opposed to the generic prescribing rate. The generic prescribing rate is well over 90%. When patients go to a pharmacist with a prescription for generic medicine, they may be dispensed a branded product, perhaps because there is no generic equivalent. We will interrogate our computer systems, but the generic prescribing rate is as good as, if not better than, any other region in the UK.

Mr D McIlveen: Thank you for the answer. I appreciate what you said.

I think that there is an issue about mutual respect for each other's jobs. I do not think that there is any appetite in pharmacy to question, in an ethical sense anyway, what GPs and doctors are doing, and vice versa. However, you are here to represent the body of GPs within the BMA. Are you, as a body, of the mind that, if your members are contacted by pharmacists who say that they have a cheaper option, they should accept that those pharmacists are qualified and know what they are talking about and, therefore, allow that to happen?

Dr Black: Pharmacists are wonderful and know far more about drugs than doctors do. We are more than happy to accept that. However, if I have to sit in front of Mrs Doherty and say, "You are not getting the blue tablets this month. You are getting the white ones that were made in Greece" — I am dead. So there are exceptions when I will not prescribe generic medicines.

I return to Mr Gardiner's point. The demand is such that we are trying to keep up with it. In the next 10 years, I will not have enough GPs to keep up with it. The solution is very straightforward and simple: we need pharmacists in practice. We spend two hours a day now doing acute and repeat prescriptions. Those 38 million prescriptions take around two hours of GP time each day. Who should be doing that? Who is smart and more qualified? The pharmacist. Last week, we entered negotiations with the Health and Social Care Board to start to train pharmacists up into primary care providers to come into practices and start to do that work because they are better at it, it is more appropriate, and it frees up our time for more consultations. That is a work in progress. You are correct.

Mr Beggs: Thank you for your presentation. I noticed in your written response to the Committee that the BMA is also concerned that individual GPs may find themselves liable if they provide a referral for a patient to receive secondary care in another EU member state. Why would that be any different from any current liability, including for patients who are resident in Northern Ireland and are local citizens?

Dr Black: Our duty of care includes ensuring that a referral is to someone who is registered as a medical practitioner, has received higher professional training for their specialty and maintains appraisal, revalidation and appropriate knowledge, skills and experience. If I refer a patient to someone in Altnagelvin Area Hospital or the Royal Victoria Hospital, I know who that person is straight away. Not only that, but somebody has checked his or her work. There are governance systems in those hospitals right up to the Health and Social Care Board and the Minister, which assures me that that is OK.

If I refer someone to Mullingar — just to pick a place that was in the news recently — I do not know whether it is a hospital or a clinic. Is it a private clinic? Who does it employ? What is their professional background? Should I go and check that? You can see the dynamic. We have raised concerns about the shift from outpatients into the so-called independent sector in Northern Ireland. That gives us great concern about our patients because we feel that the National Health Service provides patients with better care than an unknown in the independent sector. We have a professional duty to ensure that. If we refer patients outside the jurisdiction, there is a duty on us to assure ourselves that the hospital has the correct governance and professional standards. You can see the problem. To whom am I referring patients?

Mr Beggs: I can certainly see a difficulty if someone is visiting from Europe or further afield. However, can arrangements not be put in place so that it works both ways and knowledge is transferred?

Dr Black: Yes. At present, the system accommodates that. If I refer to the NHS in Northern Ireland, it very often sets up contracts with Scotland, England and the Republic of Ireland. However, someone is sent to check that entire systems are in place. It insists on National Institute for Health and Clinical Excellence (NICE) standards for patients who come from the UK. So yes, you can accommodate.

The Chairperson: The reverse of that is when somebody comes to you who requires surgery and requests your advice on going to France, for example, to have that operation done. Under this directive, are you required to give advice? What would be the process?

Dr Black: We get asked for advice on everything, Chair: "What A levels should I do?" The latest one is "Should I get my teeth done in Italy?" The answer strikes me as "I do not know, to be honest". If someone asks me whether he or she should go to a chiropractor in France, my honest answer is that I do not know.

The Chairperson: Are there implications for GPs under the directive of people accessing external provision or services?

Dr Stout: In another EU state?

Dr Black: We have patients going off and having private work done. We see them only when they come back after, for example, gastric banding in eastern Europe. We take a deep breath and say, "Oh right, so you are OK". If they had asked us in the first place — obviously, they did not because they knew what our answer would be — we would have asked, "Who will do the surgery?", "What kind of hospital is it?", "Have they good sterility?", "Have they good governance procedures?" and "What qualifications does the surgeon have?". Other systems are not like ours. You can be a surgeon or a GP without the rigorous training procedures in the UK. The Republic of Ireland is very similar to here, so I have little or no problem there, but eastern European countries are completely different.

Dr Stout: As Tom rightly says, we would be asked for advice in that type of situation; we would not make a referral in such a situation. We take clinical responsibility for the referral. By and large, our advice would be that we could not stand over a patient going to that place because of our lack of knowledge in those circumstances.

The other element of liability is that, if a patient is referred, we still retain responsibility for that patient and his or her condition until he or she is seen by the appropriate person. The liability issue also covers that. If somebody comes from the Republic, for example, and is referred to a local hospital or a hospital down South, we retain that liability until he or she is seen. We need to ensure that we know that he or she has been seen within an appropriate timescale.

The Chairperson: Our scrutiny work is ongoing. I know that we went off the subject, which probably shows how much dialogue we can have about GPs in general. The message that we are picking up is that the Department's proposals would, in your view, assist practical working. Thank you both for your time.