Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

EU Cross-border Health Directive: Health and Social Care Board

13 November 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 Samuel Gardiner
Mr Kieran McCarthy
Mr Fearghal McKinney

Witnesses:
Mr Peter McLaughlin Health and Social Care Board

The Chairperson: I welcome Peter McLaughlin, assistant director of commissioning in the Health and Social Care Board (HSCB). Peter, I invite you to make a presentation of not more than 10 minutes, and we will then take questions from members.

Mr Peter McLaughlin (Health and Social Care Board): Thank you. The board's role in the implementation of the directive is twofold: first, it is to operate the submission and approval process and reimbursement for patients who wish to leave Northern Ireland to go outside the UK for treatment; and, secondly, it is to provide a national contact point. That means, in essence, to give advice and guidance to patients either wishing to go outside the UK for treatment or wishing to come to Northern Ireland from another EU state to access treatment.

In operating the first category, that is to say patients who wish to leave Northern Ireland and go elsewhere, obviously, the spirit of the directive is that an EU citizen has the right to seek planned treatment anywhere within the EU, and we are keen to observe that spirit.

There are a number of issues around implementation that we need to be wary of. The first is that the directive mentions, in passing, that people who need treatment can access it anywhere within the EU. The first issue for us then is how that need is established.

The board operates a process for sending patients outside Northern Ireland, called the extra-contractual referral (ECR) process. It occurs when, mostly, a consultant or, occasionally, some other clinician considers that a patient either needs treatment that is not available in Northern Ireland because of its specialist nature or treatment that is available in Northern Ireland but there is some clinical or other exceptional reason why treatment outside Northern Ireland is justified. In that instance, we would send around 1,300 people a year outside Northern Ireland for treatment, the vast majority of whom would be treated somewhere else within the United Kingdom. Around 8% to 10%

are treated outside the UK and most of them are treated in the Irish Republic; a tiny number are treated in other EU states, and an even smaller number are treated outside Europe altogether. Nearly always, the decision is driven purely by clinical justification.

The point about the ECR process is that we have the reassurance that, because a clinician is referring a patient for treatment, the patient has been seen and assessed as requiring that treatment. The directive does not provide for that reassurance because it does not prescribe the process. What we are anxious to do, in putting in place our prior authorisation process and indeed a reimbursement process, is to make sure that people who feel they need treatment have that need confirmed in some objective way by a qualified clinician. There are very tiny numbers of people who feel that they need treatment who do not actually need it. We are talking about very small numbers, nonetheless, any system we put in place has to be fit for the purpose of protecting people in that instance.

The second issue that arises for us in operating a process where people leave the UK for treatment is that there are a number of commissioning restrictions that the board has in place for certain categories of treatment. The one that most obviously springs to mind is our effective use of resources policy when it applies to cosmetic procedures: breast enlargements, scar revision, skin resurfacing and a number of other cosmetic procedures. In a tiny number of instances, we would complete, carry out, or authorise or commission those treatments, but the patient needs to meet certain thresholds. The test of those thresholds in Northern Ireland is applied by local clinicians. We just need to be sure that whatever process we put in place preserves the commissioning restrictions that we have identified.

A sub-category of that, in a sense, is that there are some categories of drug treatment that are new and untested and do not yet have NICE approval, and there is a danger that people will seek to access them and have the board fund them when we have not yet authorised them for commissioning use. That would involve a small category of patients. Nonetheless, whatever we put in place has to be fit to deal with whatever circumstances arise.

The final thing that we need to be clear about in operating the system for people getting treatment outside the UK is that patients do not always consider what happens after their operation. We have no issue with patients who, for example, need a knee operation and wish to go to France, Germany or the Irish Republic and seek that operation. However, major in-patient procedures require post-operative care, and patients may not always be aware of the nature or extent of the post-operative care required. We need to have the capacity or system in place whereby patients can access that information or at least be given a route to where they can read the information for themselves. More elaborately, when a patient comes back to Northern Ireland having had major surgery, there needs to be a system in place to pick up that patient and make sure that his or her post-operative needs are addressed.

We feel that those are the major issues that need to be addressed for people going outside Northern Ireland. We also need to consider the issue of prior authorisation. That is in the directive at the request of the UK Government. In essence, it states that patients should, or may, be required to seek prior authorisation from their commissioning body for treatment that requires an overnight stay in hospital or expensive medical equipment. It also states that if they do not do so and go away for treatment and come back and seek reimbursement, we cannot unreasonably refuse it, nor would we wish to do so. It also states that we have to have sound medical grounds if we wish to refuse reimbursement. The end result is that we are not really anxious or interested in putting in place a bureaucratic obstacle course for patients. Other than for those categories that I mentioned, we do not see any great benefit to our prior authorisation process except that it may simplify the reimbursement of patients if we already know that they are going elsewhere.

The other issue for us does not concern us directly except that we will be operating a national contact point, and that is what the mechanisms are for people from outside the UK wishing to access primary or secondary care in Northern Ireland. Detailed conversations are under way with the Department, which also need to take place with trusts and other stakeholders, so that those eventualities are covered. For example, if a patient comes here and wants to see a GP, what is the process and charging mechanism? If a GP wants to access diagnostics in a trust, what is the mechanism for that? If a patient from Spain comes in seeking a major in-patient procedure, what is the mechanism for that? The board will not be operating those mechanisms but we need to know about them in order to be able to advise people seeking advice and guidance.

The Chairperson: Thank you for that, Peter. By way of clarification, this is the Committee, effectively, going through its due process on the directive because it is reflective of the unique situation that we have in the North with a land border. One issue was the definition of "essential services". Visiting

patients may receive general medical services. Is the phrase "essential services" defined or clear enough from the board's perspective?

Mr P McLaughlin: The quick answer is yes. The slightly longer answer is that we accept and acknowledge that it is a matter for the Department in discussion with the Business Services Organisation (BSO) and general practice. The board needs to know about that and understand the potential impact that that has on the capacity that we have commissioned to treat Northern Ireland residents. Speaking personally, I am content from some of the conversations that I have been privy to, and meetings that I have had, that work is under way to define that as clearly as possible. In our anxiety to be fit for purpose, I think that it is important not to overestimate the potential impact of this. I acknowledge that we have a land border, but, since 1 April this year, for example, we have had five requests under article 56 for transfers from Northern Ireland. I would not know about people from outside coming in and seeking primary care. However, to some extent, the level of care that we need to take on this depends on the volumes we encounter.

The Chairperson: OK. I thought that I saw in the report that, under the E112, there are around 1,000 requests each year throughout the islands and around 40 from the North.

Mr P McLaughlin: That is not under article 56. There are actually two routes. The older one, which predates the current conversation and current directive, means that a patient can seek state care in another EU country if their wait for treatment locally is unreasonable given their clinical circumstances, or if there is some other pressing reason why it is legitimate for them to seek that care elsewhere. That is the S2 route. Unlike the S2 route, article 56 provides that — forgive me if this sounds bureaucratic — any citizen, regardless of whether they have to wait an unreasonable time, can seek treatment in the state sector or private sector outside Northern Ireland. So, about 40 Northern Ireland citizens per annum use the S2 route to seek state treatment elsewhere, but we really do not know what the volumes are under the article 56 route.

The Chairperson: Finally, on GP out-of-hours services, there was talk about visiting patients being able to access out-of-hours services in accordance with arrangements with the health board and out-of-hour providers. Is that clear? I suppose that I am trying to tease out the board's role in managing GP contracts.

Mr P McLaughlin: The BSO will manage the GP contracts. The out-of-hours service is funded by the health and social care system through, in part, the board. I think that we still need to tease that out; I am not an expert on it. The existing system is that if you are in Northern Ireland, you can access an out-of-hours opinion either in a very urgent or emergency situation. That seems to me to cover 99% of what the out-of-hours service will likely be used for, and that is already covered by our existing arrangements. I am not clear on the extent to which a lot more preparation or amendment to the system is needed to address whatever obligation we have under the directive.

The Chairperson: OK. Thank you. You suggested that that area probably needs to be teased out.

Mr P McLaughlin: Yes, although I would not want to be alarmist. My perception is that it is not going to be a big deal, because the system is already fit for out-of-hours enquiries from almost any source.

Mr McCarthy: Thanks very much for your presentation. What do you see as being the greatest concerns about the proposed manner of the directive's implementation? What steps can be taken to mitigate any problems that you have with the implementation of the directive, which is vital?

Mr P McLaughlin: From the perspective of people leaving Northern Ireland to seek treatment elsewhere, as the senior manager responsible for the section that manages the whole process of patients accessing treatment, I am anxious that people do not find themselves in a mess because they have sought a shortcut for their treatment. They are not required to consult us, but if we specify certain conditions where they are required to consult us, there will be no great penalty, such as reimbursement or whatever, if they do not do so. We are anxious to ensure that people do not make a mess of things because they have failed to talk to us.

Indeed, you can go to see somebody in Germany or Amsterdam, for example, but we need to be able to provide individuals with information about the clinician, the hospital or whatever. I think that patients need to be aware that if they opt for treatment outside the UK, they do so at their own risk and not at

the risk of the health service. If something goes terribly wrong, it is their responsibility. We do not want that to happen, so we need to put in place as much support as we can.

The other issue, I suppose, is that we need to be alert not so much to fraud but to good governance. We have already had some limited experience of that. For example, the cost of translating an invoice in Polish can be more than the putative cost of the treatment stated on the invoice. If I do get, as we recently experienced, an unsigned letter saying, "I confirm that this patient paid €4,000 for the following treatment", mostly, there is no fraud in it. Mostly, it is just people not understanding how the process works, but we need to have systems that are fit for purpose and where we can demonstrate at any point that we are not paying out public money unnecessarily or inappropriately.

In respect of patients coming here, I suspect that the fact that you have to pay for your own travel and accommodation is a great disincentive for most people wanting to access treatment outside the boundaries of their own country, but, as has already been said, we have a land border. My greatest concern is our ability to communicate with people coming here and seeking treatment; but, at least, in the case of the Irish Republic, we share a common first language.

Mr McCarthy: So, you are open to a conversation with a patient who wants to go down that road.

Mr P McLaughlin: I would urge that.

Mr Wells: You say that the cost is not of any great significance, but one third of all the babies born in Dungannon at the moment are Polish or eastern European, which, clearly, represents a cost. Obviously, the standards of maternity here are higher than in most eastern European states. I do not think that, as a Committee, we are concerned that a great many people from Northern Ireland are going elsewhere, because we pick up the tab and it is a small number. The worry is about putting additional burdens on our indigenous health service.

Mr P McLaughlin: Under article 56, the patient has to pay. Our patients going to Germany seeking a knee operation — in fact, I will keep it simple. A knee operation in the private sector in the Irish Republic costs about €10,000. A patient will go there from here, pay the €10,000, come back, submit a receipt to the board, and we will pay them the local equivalent cost, which is £7,800. A citizen from another EU state seeking treatment under article 56 must be charged and must pay. At least, that is the preliminary advice that we have been given by the Department.

Mr Wells: In answer to a question for written answer, which, I think, Mr Allister asked, the amount of money coming in looked pitifully small.

Mr P McLaughlin: One has to be careful to differentiate between the people who establish residence in Northern Ireland, who are ordinarily resident and are, therefore, entitled to health and social care systems, like any other Northern Irish citizen, and those who come here specifically to access treatment under article 56 and who will be charged.

Mr Wells: They were only charged £835,000 last year, which is tiny.

Mr P McLaughlin: Article 56 was introduced only on 25 October. There are not a lot of people seeking access under article 56. It is important to differentiate between that mechanism and the fact that there are increasing numbers of people who were not born in the United Kingdom but who are now resident in Northern Ireland.

Mr Wells: I have to visit Daisy Hill Hospital late at night occasionally, usually to salvage a constituent who needs a lift home or something, and I notice in the A&E, which is always very busy, that there are a lot of accents, which indicates to me that the folk are not from Armagh or south Armagh; they are actually from Louth. They have come to enjoy the hostelries of Newry, something has gone wrong and they have got into a bit of difficulty, and they present themselves at A&E in Daisy Hill. Who checks that they are coming across the border? I get the impression that the doctors have so much else on their minds that they do not really bother to check and just treat folk no matter where they are from. I cannot see where the billing mechanism then arises?

Mr P McLaughlin: The first thing to say is that article 56 of the cross-border directive is concerned solely with elective care, that is to say, planned care. Emergency care is dealt with under a process called E111, where, if you are on holiday in France, for example, and you break a leg, you are entitled

to the same level of emergency care as a French citizen, and the UK Government ultimately pays for that in a reciprocal arrangement.

The other question you asked was, "Who checks that?" The trust and the hospital are responsible for checking that. It is not necessarily the doctor. You are quite right that he or she will usually be too busy, but when somebody accesses A&E or any other service in one of our trusts, the trust is supposed to have a process in place for checking their origin and their right to treatment.

Mr Wells: Is anybody actually auditing that to see if those checks are being made, particularly in border hospitals?

Mr P McLaughlin: I cannot answer that because it is not in my area of responsibility, but it is my expectation that the checks are being made.

Mr Wells: The sums involved indicate that it is a tiny amount, which leads me to believe that hard-pressed doctors are just treating the person as they should. There does not seem to be much in the way of paperwork.

The other issue is this: with the accession states of Romania and Bulgaria having free entry into Northern Ireland, all of the UK and the Republic from 1 January, has there been any estimation of that cost? In those countries, health care provision is extremely poor in comparison to most of the western states. Has anybody factored in the potential cost?

Mr P McLaughlin: Again, I cannot answer that from my own knowledge. I need to remind you that article 56, at least, is about people coming here with the sole intention of being treated, as opposed to citizens from other EU states who come here to work or live. I suspect, from your description, that the second category covers probably most of what you are concerned about. To my knowledge, very few people come here specifically to be treated and then leave immediately. It is, therefore, a different issue. Studies and research have been done on access to health and social care systems by non-UK nationals. I am aware that those are under way, but they are not something that I have any personal knowledge of.

Mr Wells: Finally, there is evidence that there seems to be a suspiciously large number of national insurance medical cards in particular parts of the border areas. Being uncharitable, one would almost think that people are borrowing a friend's address to get a Northern Ireland medical card to access treatment on this side of the border. The concentration seems to be in border areas, where there seem to be a lot of cards. Is there any evidence that that is happening for primary and secondary care in hospitals?

Mr P McLaughlin: I am not aware of any evidence. That is not to say that there is not any; it is just not something that I have detailed knowledge of. However, it is obviously a fraud issue and would be dealt with as a fraud issue.

The Chairperson: I think that we have to be very clear that that is a separate issue and is not specifically related to this directive. There are all sorts of issues in that area around people who are entitled to access health provision because they work here. I think that we need to be clear that this is about people who are not ordinarily resident here. It is about visiting people and how we deliver services.

Mr Beggs: You mentioned that you have had about five requests for treatment this year from folk from Northern Ireland who want to go elsewhere for their medical requirements. However, you did not have much information about the numbers of people coming the other way. Can you tell me more about why you do not have much information about the number of people who are coming into Northern Ireland to receive free medical treatment?

Mr P McLaughlin: There are, as yet, no systems in place that I am aware of to count people coming into Northern Ireland to seek treatment under article 56. It came into effect only on 25 October, so that is not terribly surprising. It is not something that the board, up to now, would have needed to count, because it would not normally be our responsibility.

Mr Beggs: You mentioned that there is a cost involved in translating an invoice. You almost gave the impression that you do not get it translated because it would cost more to do so than to pay it. Do you accept that it is important to know exactly what you are paying for and that it is all accounted for?

How is residency first proven, so that we do not have eastern Europeans fictitiously locating themselves in Northern Ireland to get private health care treatment in their own country? How do you prove that someone is resident here?

Mr P McLaughlin: Your first comment was on translation. Let me reassure you that, regardless of cost, we translate every document. I absolutely concur: it is about financial governance and good management. It is just unfortunate that, sometimes, the cost of a translation of an invoice exceeds the cost of treatment. That is just the way it is.

On the second point, when we receive an article-56 request, we do check residency. We do a check, for example, against whether they are on the electoral register, whether they have a GP, how long they have been registered with that GP, whether they work in Northern Ireland and how long they have worked in Northern Ireland. There is no simple, absolute tick-box exercise to say that a person is a resident of Northern Ireland. We have to make a judgement call on the basis of the evidence that is available to us.

Mr Beggs: What checks occur when someone seeks to join a local GP practice? Could someone fly here, go down to the GP and get registered and fly home again to their own country with a medical number so that private medical care in their own country would be paid for?

Mr P McLaughlin: I do not know what checks are done before a person registers with a general practice. I am sure that I could find out for you.

Mr Beggs: I would be very interested to learn.

Mr P McLaughlin: I can think of a recent case, which we rejected, where someone seeking treatment in France was seeking to prove residency in Northern Ireland. We rejected it on the grounds that registration with a general practitioner took place within a month of the request for treatment. We simply said: "We do not accept that you have established residency". So, we do not simply accept claims of local residency at face value.

Mr Beggs: It would be useful if we could have details about GP registration and what requirements there are.

Mr Gardiner: Are there any clinical staff sharing arrangements between Northern Ireland and the Irish Republic?

Mr P McLaughlin: The quick answer is yes, although in relatively limited circumstances. I could not give you a comprehensive list, but I am aware, for example, that clinics are held in the North of Ireland on a partnership arrangement for certain specialist assessments. There is an ongoing relationship, which has been in place for some time, for emergency paediatric cardiac surgery in the Irish Republic. Other than that — *[Interruption.]* That was not my pacemaker. Other than that, I could not give you a comprehensive list, but things do evolve over time. There are situations where it does make sense for clinicians to cooperate.

Mr Gardiner: What way are payments made?

Mr P McLaughlin: In the case of the one specialist area I mentioned, which, frankly, I cannot remember the name of, it is done on a grace and favour basis. It is a reciprocal arrangement. In the case of paediatric cardiac surgery, there is a formal arrangement with the clinicians involved and the operating hospital in the Irish Republic. Payments are made.

Mr Brady: Thanks for the presentation. I represent a border constituency and live in Newry.

I am fascinated to learn that Jim can tell the difference between a south Armagh accent and a north Louth accent. Obviously he has been studying these things.

Two years ago, Daisy Hill had approximately 35,000 people through its A&E, and 3,500 of them were from north Louth or the South. Statistics are kept, and my understanding is that they are very accurate. For instance, in the renal unit in Daisy Hill, I think that six beds are reserved for dialysis. Those are all formal arrangements, so the number of people who would get through would probably not be that many. I do not spend as much time in the A&E in Daisy Hill as Jim does, obviously, but I know that statistics are kept, and they do seem to be fairly accurate. I just wanted to make that point.

Mr McKinney: We will hear later about the pressure on the system and waiting lists. If pressure is released elsewhere and externally, will that impact in any way on how this rolls out?

Mr P McLaughlin: Again, the quick answer is yes. One thing that we are anxious to establish, in conversation with the Department, is whether there are circumstances under which we can say, "Sorry, another EU national can't access the system because it is under pressure within Northern Ireland". We have not yet teased out what that would mean in practice, but it would not be unreasonable to look at things such as the average waiting time to get access to treatment. One thing that we will want to do is keep track of what kinds of treatment are being accessed and how.

The other issue, I suppose, is the putative citizen of France who flies into Belfast, walks into the Royal Victoria Hospital and says, "I want a knee operation". What are the systems? How does that individual access a knee operation? Do we say, "First, you need to be referred by primary care, as Northern Ireland citizens do"? Do we say, "Yes, here is a mechanism for you to do that but there is a six-month wait for a knee operation and you will be joining the end of the queue"? These are things that need to be teased out. Certainly it is our expectation that they need to be teased out.

Mr McKinney: Of course, there are two ways of relieving the pressure: one is to stop people coming in, by virtue of them joining a longer list; the other is that our people will start choosing to leave. Is that a further possibility? Is there not a bit of madness in that?

Mr P McLaughlin: There is. However, again, we have to hark back to the essential spirit or intent of the directive, which is that an EU citizen is entitled to access medical care wherever they wish to do so. But it can throw up strange situations. We could find ourselves, for example, being asked by a citizen of the Irish Republic for a heart operation, when we are buying heart operations in the Irish Republic. That really would not make sense.

Mr McKinney: You touched on it earlier specifically around post-op, but what is the capacity for record sharing, particularly electronically?

Mr P McLaughlin: That still needs to be worked through. It is one of the issues that we have raised as requiring discussion with trusts and others. There are a couple of things there. One is the logistics. Are we talking about electronic care record transfers? What about translation of those? What about making sure that the person who is asking for it is entitled to receive it and vice versa? Indeed, what is the nature of the confidential information? All of that must be addressed. If a citizen is going to seek treatment in another EU state, we must make sure that the requisite medical information transfers backward and forward.

Mr McKinney: Because, of course, without the appropriate information, you could have some negative outcomes.

Mr P McLaughlin: Absolutely — and even with it. No matter what we say and no matter what guidance is issued, the first time that somebody seeks treatment in France and has a really bad experience, the system will be tested.

Mr McKinney: I have one other issue, around information and the national contact point. Can you give us some details about how that will roll out and how the patient will access information?

Mr P McLaughlin: As a marker, we have placed a small section on our website already. It simply says how you can seek treatment outside Northern Ireland. We have tried to present it in a logical way. By far the most common way that a Northern Ireland citizen will access treatment outside Northern Ireland is through our extra-contractual referral process. So we have said that there are ECRs, the S2 route when you want to seek state care elsewhere and have a clinically justifiable reason, and, finally, the article 56 route, which really is a matter of the individual's personal preference.

We will produce leaflets. The UK has established four national contact points (NCPs), one in each jurisdiction. The NCP in Northern Ireland will be in my section, because we have the ECR experience and contacts with other EU states. We are already in reasonably frequent contact with the other NCPs in the UK. We are keen for a network to be established once an NCP is established everywhere.

Mr McKinney: What constitutes a satisfactory contact point from the patient's perspective? Is it simply a presence on a website? Is it one or two staff dedicated to —?

Mr P McLaughlin: In the case of Northern Ireland, we will, at least initially, dedicate one or two staff. We will review that in light of the demand on the capacity. It might be as simple and as broad as someone asking where they can go to get a hip operation and what is it likely to cost, or it could be something very specific like," I have spoken to a doctor in Paris who can do my nose operation; is that OK?"

We have to tread a fine line. We cannot and will not advise the patient on which doctor or whatever is qualified to do that operation. What we can say is whether that individual is registered within the national regulatory bodies that that country has in place. We will supply that service to non-UK citizens who are seeking information from us. If they are seeking treatment from a private sector hospital in Belfast, we can say if that hospital is regulated with the RQIA and what the regulatory reports are and so on.

We can and will supply lists of registered practitioners. We have tended to focus on inpatient treatment that requires prior authorisation, but the directive allows an individual to seek other kinds of treatment without any form of prior authorisation and then simply present us with a request for reimbursement. So, for things like physiotherapy, dental treatment, occupational therapy or speech and language therapy, we will maintain lists of registered bodies in the UK and Northern Ireland. It is our expectation that other NCPs will do the same. I can see somebody saying, "I am going on holiday to Germany, and I want to seek physiotherapy." Our first route there would be to speak to the German NCP to establish what advice and guidance it can give our citizen.

The Chairperson: Thank you for that, Peter. As I said, this is us going through a scrutiny process. We will take on board the information that you have given us today. We will talk to departmental officials in two weeks' time. This has been useful today. Thank you.