Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Implementation of EU Cross-border Health Directive and Overseas Visitor Policy

27 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 Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Fearghal McKinney

Witnesses:

Ms Catherine Daly	Department of Health, Social Services and Public Safety
Mr Stephen Galway	Department of Health, Social Services and Public Safety
Mr Robert Kirkwood	Department of Health, Social Services and Public Safety
Mr Michael Williamson	Department of Health, Social Services and Public Safety

The Chairperson: OK, folks. You are very welcome. We have Catherine Daly, deputy secretary in the Department; Stephen Galway, primary care medical services branch; Michael Williamson, general dental services branch; and Robert Kirkwood, primary care medical services branch. I remind the witnesses that the Committee will structure the session into two parts. First, we want to deal with the implementation of the EU directive. After you have made your presentation on that, we will open it up to the Committee to ask questions. Once those issues have been dealt with, we will move on to your presentation on the overseas visitors policy, and I will then open it up to questions and answers. I will hand over to you, Catherine. I am not sure who is taking the lead.

Ms Catherine Daly (Department of Health, Social Services and Public Safety): I will. Thanks very much, Chair. We are very grateful to have the opportunity to provide further evidence to the Committee today on the EU directive on patients' rights to cross-border healthcare and on the introduction of new policies in relation to overseas visitors' access to free healthcare in Northern Ireland. Those are separate matters, but the legislation to introduce the policies is interlinked, and that is why we are bringing them together. The briefing provided to the Committee is in two sections: one covers the EU directive, and the other covers the overseas policies. As you say, Chair, the Committee intends to take this in two parts, so I will deal with the EU directive now, and, after questions, I will move on to the overseas policies. I am conscious that my colleague Heather Stevens briefed the Committee on this issue on 9 October. So, I do not propose to go through the detail to the nth degree. Rather, I will cover the key points in the direction.

It is important to highlight the key focus of the directive: patient choice. The directive covers both primary care and secondary care. Provisions for certain levels of reciprocal healthcare for European Economic Area (EEA) citizens have been in place for some time, but the development of an EU-wide directive was seen as being necessary to clarify the law and the rights of citizens across the EU. The directive that we will discuss today really only reflects existing rights under various EU treaties and principles confirmed by EU case law, and applies best practice in providing access to those rights. The main objective of the directive is really to clarify and simplify the rules and procedures that are applicable to patients' access to cross-border healthcare; provide EU citizens with better information on their rights; ensure that cross-border healthcare is safe and of high quality; and promote cooperation between member states.

The directive sets out the information that member states need to provide to patients from other states who are considering coming to another country to purchase healthcare. 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 cost of cross-border healthcare if they choose to seek such healthcare in another member state. The directive does not require the home state to prioritise an EU directive patient to the detriment of persons who reside in the home state. That is an important point. The home state 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 under their own healthcare service.

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 to the person here in Northern Ireland. The patient will have a right to claim reimbursement of costs up to the amount that the treatment would have cost had they obtained it here, or the actual amount of the cost if it is lower than the cost here. The principle of reimbursement cost assumes that patients pay the overseas provider upfront for their treatment and then claim reimbursement when they return home. The patient will also bear the financial risk of any additional cost that arises from that whole process.

The process of prior authorisation, where that is applied, is a mechanism by which individuals can get clarity about a range of matters that relate to patient care, including confirmation that the treatment is one that the health service here offers; that the patient is entitled to reimbursement, and the level of reimbursement; which elements of the care pathway are being funded; what the patient must do if there is a problem with the treatment; and so on. It is very important to have that clear guidance in place.

In relation to that, the Department introduced interim regulations, which came into operation on 10 May 2012. They provided for reimbursement and prior authorisation. Those regulations were subject to scrutiny by the Health Committee at that time. As I said, the regulations were introduced on 10 May pending transposition of the directive on 25 October. As well as reimbursement and prior authorisation, a key feature of the directive is the imperative on making information on rights and entitlements publicly available and easily accessible, as well as the conditions that will apply to reimbursement and prior authorisation. To that end, the directive requires the setup of what is termed a national contact point (NCP). NCPs are really bodies from which information about patients' rights and providers of services that are available in other member states may be facilitated. The intention is that a network of NCPs will be established around the European Union to facilitate that exchange of information between member states. The NCP for Northern Ireland will be located in the Health and Social Care Board.

Implementation of the directive is being taken forward on a UK-wide basis, with one exception for Northern Ireland, which relates to the EU directive on patients' entitlement to primary care. As I have said, the EU directive covers both primary and secondary care. In Northern Ireland, patients who wish to register with a GP practice must prove that they are ordinarily resident here. That requirement flows from the Health and Personal Social Services (Northern Ireland) Order 1972. It is probably a product of the fact that Northern Ireland shares a land border with the Republic of Ireland. In the rest of the UK, persons can simply register with a GP practice at the GP's discretion. Due to the ordinarily-resident requirement here and the land border with the Republic, which does not have an entirely publicly funded health service, we have taken a different approach from the rest of the UK. The rest of the UK tends to absorb the cost of primary care for visiting patients.

The EU directive allows for derogation. Our approach in that context is to allow EU directive patients access to general medical services — essential services only — on an ad hoc basis. They will be charged a fee for that access and for availing themselves of those services. GP out-of-hours services

will be available to visiting patients in accordance with arrangements between the Health and Social Care Board and out-of-hours providers. Dental services will be provided to visiting patients on the basis of occasional patients, and that means that incoming patients can receive ad hoc dental care and will be charged at the present rate for each dental service as outlined in the statement of dental remuneration. Visiting patients who purchase general medical services with a GP will be issued with private scripts.

Only 13 responses were received to the eight-week consultation on the directive, which ended on 13 September. The responses in general recognised the necessity for the legislation under EU law. No specific mention was made of the proposals regarding EU directive patients' entitlement to primary care services. That was not explicitly raised in the responses. Comments on the implementation of proposals will be addressed in guidance that will accompany the regulations. It is important to highlight the fact that this is the Department's preliminary implementation position. Clearly this is a new arrangement, and monitoring of uptake will indicate whether the approach that has been agreed at this point is necessary and transparent and whether any change in that position is necessary.

Our primary EU directive obligations will be introduced through the regulations that have been provided at tab 3 in the briefing, and the derogation in relation to primary care services will be delivered through the three sets of regulations at tabs 4, 5 and 6. That is a bit of a gallop through, and I know that this is a complex issue. The development of this has required a lot of work, and I hope that this gives the Committee a reasonably clear overview of the directive. We are happy to take your questions.

The Chairperson: Thank you.

Mr Beggs: I declare an interest as I have family members who are dentists, and that profession was mentioned during the presentation.

The Chairperson: Thank you. First, in terms of clarification, I suppose that we are not the only region or place that is unique in having a land border.

Ms Daly: Not across the European Union; that is absolutely right. I highlighted that point because, as a UK member state, we have a different approach because of our land border with the Republic and the funding of health services differs between those two areas. That is the basis for our different approach here.

The Chairperson: I assume that there are other land borders that have, as you said, variations and not all publicly funded health provision. I am sure there are others.

Mr Robert Kirkwood (Department of Health, Social Services and Public Safety): Yes, there are. The directive itself allows each member state room for derogation, so they can look at their own individual circumstances and apply whatever derogation they feel is necessary and proportionate. Within the directive for Northern Ireland, in relation to secondary care services we are similar to the rest of the United Kingdom; it is only in relation to primary care services that we use the derogation. The reason for that is because of the land border with the Republic of Ireland. If we had provided a free primary care service similar to that provided to someone who was ordinarily resident here, no doubt people from the South would be up here in busloads. We had to look at it and see what is reasonable and what is proportionate.

In the Republic of Ireland, there is a consultation fee when you go to see a GP of, depending where it is, between €50 and €70. We engaged with the General Practitioners Committee in relation to that, and it seemed proportionate for us to introduce a charge in relation to primary care services. It also seemed reasonable for us to restrict our primary care entitlement for visiting patients to essential services only. That is the reason why there is the difference between Northern Ireland and the other three countries in the UK.

The Chairperson: OK. Specifically in relation to the dental services issue, the Department intends to allow visiting patients to access dental services as an occasional patient, as stated in the document, and they will be charged a fee. I am just interested in how you define "occasional patient". Following from that, will there be a limit on the number of times a non-resident could use a dentist in the North? Will a non-resident be able to use a dentist in the North to obtain a general check-up, for example?

Mr Michael Williamson (Department of Health, Social Services and Public Safety): Within the existing range of dental services that are available, there is scope for dentists to provide treatment to patients on an occasional basis. The majority of dental patients in Northern Ireland are registered with a dental practice, but some patients do not want to register. If you are registered with a dental practice in your home town but you are away on holiday or visiting somewhere else in Northern Ireland and you have a need for acute treatment, you can go to a dentist and be treated as an occasional patient. A more limited range of services is available on that basis.

There is no obligation on a dentist to register a patient from Northern Ireland. Because of that, we did not feel that it was equitable to allow patients from outside Northern Ireland to register as patients as well. There is a range of treatments, and it does include examinations. It is mostly around relief of pain, fixing temporary crowns or bridges — immediately necessary treatment. There is no limit to how many times you can access the service. However, as part of the implementation of the policy, the Department and the board will monitor the uptake of those occasional services to see whether there is a need to refine it in the future. Essentially, the decision on whether to accept the patient on that basis lies with the dentist. At the moment, we are aware that many dentists provide services to patients on a private basis, and they may wish to continue to do that.

The Chairperson: So is an occasional patient related to previous registration?

Mr Williamson: Yes. There are around 1·1 million people in Northern Ireland who are registered with a dentist. Other people will access services but are not registered with a dentist. This is really a mechanism for a patient to come into a practice and receive one-off treatment. They may well be encouraged to register, but they can decide that they do not want to, or, equally, a dentist may not have room to treat them.

The Chairperson: I am a bit confused now. With a visiting patient, how is it defined that that person is an occasional patient? Are there not differences in terms of registration in other European countries as well if there is an EU visiting patient? How does that process take place?

Mr Williamson: The way I understand it is that they can contact the national contact point in the boards. They will be given a list of dentists and assured that they are all registered with the Regulation and Quality Improvement Authority. It is then up to them to approach a practice to say where they are coming from and ask if the dentist is willing to treat them on that basis. So, they will not be registered with that practice. Also, there will also be a more limited range of services available to them than if they were registered patients.

The Chairperson: But how does the dentist or dental practice take that decision?

Mr Williamson: It is an individual choice for each practice. They can decide to treat them as an EU patient under that directive, and they will be able to receive occasional services. We set out the fees that dentists must charge.

The Chairperson: Even if they are not registered somewhere else?

Mr Williamson: Yes. We set out the fees, and that is what they will get. Equally, the dentist can decide to offer to treat them on a private basis and make a private charge.

Ms Daly: That is very similar to what is available to Northern Ireland people who simply do not register with a dentist. As Michael said, there are 1·1 million people registered with a dentist, so there are certainly 700,000 people, or close to that, who are not registered. That is individual patient choice.

Mr Williamson: As I said, we will monitor uptake to see whether there is abuse of the system.

The Chairperson: The decision around what is occasional and what is not just does not seem very clear. I can take your point about people living here, but if someone is not registered and lives elsewhere, what is the decision-making process if it is just down to the dental practitioner?

Mr Williamson: It is really down to the dental practitioner as it is. If I went to find a new dentist, I would have to approach a practice and ask, "Will you take me on?". They can either say, "Yes, I will register you as a healthcare patient" or "I have had a look at your teeth and I do not really think that I want to take you on, but I will provide you with occasional treatment or treat you privately". In the

arrangement between the boards and the dental practitioners to provide services, there is no obligation on dentists to accept a patient from Northern Ireland for treatment. We feel that EU patients should receive only the same occasional treatments that are available to somebody in Northern Ireland who is not registered.

Ms Daly: Basically, the dentist's decision will be down to their capacity to deal with additional patients.

The Chairperson: You could have an issue of people from other, similar countries saying, "I did not get access, and somebody else did."

Mr Williamson: Yes. It will be pretty much down to dentist choice. Unfortunately, some dentists may turn away patients. However, they will no doubt have very good reasons for that. They could be at full capacity. They could be working hard and just not have the room.

Ms Daly: That is where the role of the national contact point is absolutely critical for people from other countries who come to Northern Ireland for healthcare or occasional treatments at dentists. The national contact point will be able to give those people details of a range of practitioners or dentists that they could go to. I do not think that we envisage an instance of someone trying to access services here and not being able to avail themselves of them.

Mr Kirkwood: As Catherine said at the beginning, the whole ethos of the EU directive is patient choice — whether they want to come along or not — for everything, really; all primary care services, including general medical services and dental services. As we said, that is up to the individual doctor or dentist. However, if a GP's list is not closed but a GP is not prepared to see a visiting patient, there is provision in the legislation whereby the Health and Social Care Board can intervene and allocate the visiting patient to a GP practice. The NCP is based within the board, so that whole thing should come together quite nicely.

Mr Gardiner: How much money do we receive annually from overseas patients that make use of our health service? Secondly, has anyone worked out the additional healthcare costs that will arise when citizens from Romania and Bulgaria are admitted to the United Kingdom?

Ms Daly: We have figures here for income from areas outside of Northern Ireland over the past three years. It was £772,000 in 2010-11, £736,000 in 2011-12, and £576,000 in 2012-13.

Robert, do you want to pick up Sam's second question on additional costs?

Mr Gardiner: Has anyone worked out the additional healthcare cost that will arise when Romania and Bulgaria are admitted to the United Kingdom?

Mr Stephen Galway (Department of Health, Social Services and Public Safety): At the moment, no, we have not. Again, it is a bit like the directive —

Mr Gardiner: You will have to get your skates on.

Mr Galway: It is about being able to quantify and monitor the position and trying to identify those patients. At the moment, there is no estimation of the amount of cost that there will be with those new accession states. We will monitor and review the situation and try to keep it under review.

Mr Gardiner: So, you have no feel for it whatsoever.

Mr Galway: At the moment, no.

Mr Gardiner: Back to the drawing board.

Ms Daly: It is absolutely clear that that is something that we need to do.

Mr Gardiner: Yes, I agree with you. I thought that you would have had it done by now.

Mr Kirkwood: I suppose that we cannot do it until the directive is transposed and we can look at the numbers of patients who are coming into Northern Ireland to get treated.

Mr Gardiner: Watch this space.

Mr Kirkwood: The other important issue is that, although your question is in relation to the inflow of patients, the directive also allows residents of Northern Ireland to go to other countries and benefit from that. It is a two-way process.

Ms Daly: This is, in a sense, a new arrangement. It brings together all the policies and put them into a very clear context. With that clarity and certainty, there are expectations about what that might mean for patient flow. There is a greater awareness of people's rights, so we may find more people going from Northern Ireland to other countries to access treatment, and more people coming to Northern Ireland. Clearly, there is no way that that is intended, and it will be operated where it does not displace any element of prioritisation in the health service here. Nonetheless, we will be monitoring this to see just what the rate of movement is and the direction, out or in, to see if there are any implications. That is why I say that this is the preliminary position for the Department in terms of the implementation of this directive. If we look at the monitoring and the analysis tells us that we have not quite got this right or that there is some adverse impact that we had not considered, we will take action to address that.

Mr Gardiner: You go back to the drawing board again.

Ms Daly: Hopefully not, but, if necessary —

Mr Gardiner: I hope not as well. I hope that you get it right the first time.

The Chairperson: There will be monitoring in place as well.

Mr McCarthy: Sam says that you will have to get your skates on. I think that you will have to have your wits about you when this comes into operation to make sure that everyone gets treated fairly regardless of where they go to or where they come from.

My question is in relation to our own local Northern Irish residents being able to access elective care in other EU countries. I think that you mentioned that, Catherine. Who will decide whether that person has a clinical need for the procedure and, therefore, has the right to have it reimbursed by the HSC Board?

Ms Daly: I will look to my colleagues to keep me right on this. This, again, is where the national contact point and the role of the board are absolutely critical. This directive is not about the fact that someone can go to another country and get something that would not be deemed to be clinically necessary here. Under the rules for reimbursement, it has to be something that is deemed clinically necessary. So, that would be a clinical consideration. There are some instances where a prior approval will be required for some treatments, and, again, the Health and Social Care Board will provide the information on the detail of those circumstances, but that is for things such as where an overnight stay in a hospital is required or there is use of potentially very expensive hospital equipment. Those sorts of instances would require prior approval by the Health and Social Care Board. So, there are arrangements in place. It is not about creating a whole range of new services that, if you think about how our health budget is distributed, would somehow reprioritise all of that. It is about patient choice, but that will only be for treatments that are deemed to be necessary and which would be provided here had the patient been here.

Mr McCarthy: Will it be down to someone on the board to make the decision on whether you can or whether you cannot?

Ms Daly: The board will have the detailed guidance on all aspects of the direction in that respect.

Mr Wells: Regarding primary care, the Department intends to allow visiting patients to access a GP for what you term essential health services on an ad hoc basis, and then they will pay a fee. What is your definition of an essential health service?

Mr Kirkwood: Currently, under the GMS contract, a GP or a practice is required to provide what are regarded as essential services; that covers more or less everything that a GP provides, bar additional services in the contract. Additional services cover things such as contraceptive services, vaccines and immunisations and minor surgery. Under the contract, a GP practice can pick up and provide those

additional services or not. In essence, all practices in Northern Ireland provide them. In a GP practice, there is a quality and outcomes framework (QOF), and if you are a patient with a practice, it will pick up things such as prevention of coronary heart disease, diabetes, hypertension, strokes and chronic obstructive pulmonary disease (COPD). All those issues are covered in the QOF, but they are for registered patients only, the idea being that you have to be a registered patient. I think that Tom Black went into a wee bit of detail on that in his evidence session. You have to be a registered patient in order for the practice to provide services under QOF and additional services, so, if we were to say in the legislation that visiting patients were entitled to all services under the GMS contract, that is what a visiting patient would be entitled to. However, it was not practical to do that, so that is why it is limited to essential services only.

Mr Wells: So the GP would be very clear in his or, as is increasingly the case, her own mind as to what is essential?

Mr Kirkwood: Correct. I have engaged with the General Practitioners' Committee (GPC) about what it thought was practical in the operation of the system. The GPC consulted the local medical committees (LMCs) and said that it would cover essential services. The other services that I mentioned are specific. If you are a registered patient and you have coronary heart disease, GPs will follow that up in a certain way and get paid for it. That is the sort of thing that would not be covered for a visiting patient.

Mr Wells: So you will charge a fee. What will the fees be?

Mr Kirkwood: We consulted the GPC, and the Department applied a robust methodology, and the consultation fee for the GP is set at £44. As I said previously, the fee for consultation in the Republic of Ireland is between €50 and €70, and we have applied a fee of £44, so there should not be a big incentive for people from the Republic of Ireland coming up to access a GP in the North of Ireland. On top of the £44 consultation fee, there is a set fee of £20 for treatment-room services. We did not feel it appropriate to try to break down treatment-room services and to price each one for the simple reason that we do not know at the minute what the uptake is, so going into that level of detail could have been a waste of time. On top of the treatment-room fee, there will be diagnostic test fees where a GP has to send something to a hospital for a test. The GPs will invoice for that.

Mr Wells: How will a GP know that the person has driven across the border?

Mr Kirkwood: The GP will, for a start, not have the patient on a registered list, so he will know that the person is not a patient. If someone wants to exercise their right under the EU directive, they will be required to ring a GP and say, "Listen, I have such and such a condition and I want to be treated in your practice". It will mainly be in relation to primary care for people living in the South of Ireland. It is up to the GP to consider whether he has the capacity to do it. When discussing this with the GPC, it was explained that there will be practices that do not have the capacity and do not want to treat EU directive patients; others, however, will see it as a means of making money. Hopefully it will work out that way.

Mr Wells: What is to stop somebody walking in and saying, "I am not one of your registered patients, but I am from up the road. Treat me".

Mr Kirkwood: It is up to the GP practice. If you walked into a GP practice and asked to be treated, whether you were a patient or not, I doubt that the GP practice would say, "Listen, Mr Wells, we cannot treat you today, but we will give you an appointment for tomorrow". It will apply equally to an EU directive patient. They cannot just walk into a GP practice and say, "I want to be treated". They can walk in and say, "I want to be treated under the EU directive", and the receptionist or the GP can say, "That is all right. We have capacity to treat you. We have an appointment for Friday week".

Mr Wells: But how do you establish where I am from? Say I have walked across the border from Louth into Armagh and into a GP practice. There is still no mechanism to prove that I am not from County Armagh.

Mr Kirkwood: If you were from County Armagh, you would be ordinarily resident in Northern Ireland, so why would you —

Mr Wells: No, if I walked across the border from County Louth, how do you prove that I have done that?

Ms Daly: If there are individuals accessing the health service from the South, they will be required to make payment under the normal processes.

Mr Wells: But how do you prove that they are from the South in the first place?

Ms Daly: They will not be registered with the doctor. Do you want to pick that up, Stephen?

Mr Galway: They will not be registered with the doctor. The doctor will say, "You are not on my list, so do you want to be treated under the directive or do you want to register with the practice?"

Mr Wells: No, no. "I am from the doctor up the road in County Armagh." What happens if he says that?

Mr Galway: There would have to be a transfer from one practice to another for the patient to be seen by the practice that he is attending. He would be directed back. If you are from a practice in Armagh, you need to go and see your own GP. A GP would not see a patient from another practice who was not on their list.

Mr Kirkwood: People who are ordinarily registered in Northern Ireland cannot be with two GPs at the same time. You are either on the list or you are not; that is how a GP will know. If you say, "I am from up the road in Armagh", the GP would want to know what practice you were with and the registration process through the Business Services Organisation (BSO).

The Chairperson: We need to be careful not to confuse the issue with that of potential fraud, which has been dealt with through the Business Services Organisation. We need to be very clear that that is not what this is about.

Mr Beggs: You propose that the out-of-hours service would be free to visiting patients. You will charge inside normal GP hours, but it will be free for out-of-hours GP services.

Mr Kirkwood: No. There will be a charge for the out-of-hours service. Any healthcare service provided to an EU directive patient will be at a charge.

Mr Beggs: So you are proposing to charge for the out-of-hours service as well?

Mr Kirkwood: Yes.

Mr Beggs: OK. I thought that it was not going to be charged.

Mr Kirkwood: No.

Mr Beggs: So there is no incentive for people to abuse the system.

Mr Kirkwood: No, there is not.

Mr Beggs: How will the charge compare with the charge across the border?

Mr Kirkwood: It will be set at the same rate as a GP consultation. That is our initial implementation. It depends on whether it is used down the line. Personally speaking, I cannot see the out-of-hours service being used at all. It makes little sense for an EU directive patient to use the out-of-hours service, because they would be better using the European health insurance card (EHIC) and getting the service for nothing rather than being charged for it. It would be silly for an EU directive patient to ring an out-of-hours service and say, "I want to come across the border and pay you for it". They would be better saying, "I have a pain in my stomach, and I want to use my European health insurance card" to get the service free.

Mr Beggs: How will we stop that being abused so that lots of additional customers —

Mr Kirkwood: That can happen at the moment anyway. It will be the same principles that are in place at the moment to try to stop that.

Mr Beggs: Are there charges that follow from that?

Mr Kirkwood: No.

Mr McKinney: You referred to it being a preliminary approach, and you said that honour and transparency were necessary. When will your first review begin?

Ms Daly: We have not set a date for it, but we will work with the Health and Social Care Board on it. As soon as we complete the transposition of the directive, we will work with the Health and Social Care Board on establishing a reasonable period. It can give us information that we can analyse and which tells us something. I imagine that they will be quarterly or six-monthly, initially, so that we can see what the figures are. There will be analysis of a lot of aspects, such as the flow, the extent, the volume and the costs that have been set. Is it reasonable? Is it compensating the service for the full cost of its operation? We do not have those details at this time, but it is something that we will be moving forward with the Health and Social Care Board in the programme of work.

Mr McKinney: Is there a duty on the GP to report all transactions?

Mr Kirkwood: Yes, in the regulations there is a duty on the GP to report the visiting patients to the board.

Mr McKinney: What is the strength of the duty? What happens if they do not report? In other words, is there a potential flaw in your monitoring if they do not report financial transactions and anything else?

Mr Kirkwood: The board will be required to have procedures in place in order for the GPs to —

Mr McKinney: Is that part of the plan?

Mr Kirkwood: Yes. The board has worked that up already in readiness for when the EU directive is proposed. We are in limbo until we can get the regulations made, but the board has worked on that. Similarly, the Department is working on guidance to accompany the regulations.

Mr McKinney: What does a failure to report meant?

Mr Galway: Do you mean some sort of sanction, for instance?

Mr McKinney: What will encourage them to report accurately so that your monitoring is robust?

Ms Daly: It is a statutory requirement; it is in EU law. We would look to the board, working with the BSO, to ensure that there are appropriate arrangements in place to address all requirements of statutory obligations.

Ms Brown: Thank you for your presentation. In paragraph 10 of your paper you state that a number of pieces of guidance need to be developed for the system to operate in practice, following the introduction of the legislation. When do you expect the new system to be up and running? Do the new rules apply once the legislation takes effect, or do people have to wait until the guidance is developed and the charging mechanisms are in place?

Mr Kirkwood: The system will be up and running as soon as we can make the regulations. If the Health Committee gave the go-ahead today, and approval for the regulations was given, the idea is that they would be made next week and come into operation the following week. That would probably be the second week in December. That is when the legislation would be in place.

When the legislation is in place, directions have to be in place directing the board. Transfer of functions directions must also be in place to transfer to the board functions in relation to prior authorisation. The transposition note, which sets out how we have transposed each article in the directive, goes to the EU Commission, and there has to be guidance in place. You cannot merely

transpose the directive without having all those in place by the date that the regulations come into place. Say, for example, that we got the go-ahead today, made the regulations next week, and they came into operation in the week commencing 9 December, all those documents and directions that I referred to would be in place by then. They are ready to go, except for the guidance, as a wee bit of finalising needs to be done to it. Depending on how we get on today, it will be ready to go by the week commencing 9 December.

Mr Dunne: Thanks very much for the presentation. Can you tell me what documentation a non-resident is required to produce in order to get such treatments in Northern Ireland? The rest of us feel as though we cannot go on holiday without our plastic EU medical cards. If our card is out of date, we panic to get it renewed before we go. What documentation does a non-resident need when he or she comes into a GP or dental practice under the proposed change?

Mr Kirkwood: Prior to coming along, there would be a requirement on the patient. The board and the Department will have guidance on their websites. If you want to be treated as an EU directive patient, you make contact with the national contact point first. Then the GP, dentist or secondary-care provider will be aware that you are being considered as an EU directive patient.

Mr Dunne: Those people will walk in off the street, and most of them will probably be in pain.

Mr Kirkwood: They will not be. If they are in pain, it is a different area from that covered by the EU directive; it is dealt with by EU legislation. However, that would be emergency, necessary treatment. That is what we were talking about earlier under the European health insurance card. That is when you would go. The treatment that people receive under the EU directive is prearranged.

Ms Daly: It is important to go back to the point about patient choice and the focus of the directive. It is about patients choosing to go to another area within the parameters of the guidance in their own —

Mr Dunne: So it is planned treatment?

Mr Galway: An example would be a patient in France, say, who needs a hip operation and who wants to avail themselves of services in Northern Ireland and have the treatment carried out here. They would get in touch with their national contact point and then the one in the board and look at the range of options and available services to have the treatment done here, as well as the cost attached to it. With EHIC you get free treatments; you carry it with you to avoid cost. The directive is for pre-planned patient choice. It allows patients to avail themselves of services elsewhere, where they feel that the service is better or waiting lists are shorter. They are prepared to pay for it. That is the difference.

Ms Daly: It is about patient choice and the requirement that they pay up front for those services. It is not as though there is an incentive for individuals here or in any European country to avail themselves of a service; they will be paying for it. A visitor from overseas might have an accident here, for example, and need to avail themselves of services. We will talk about that. That is different from the arrangements under the directive. It is important to keep the distinction between what the directive is about and other arrangements by which people need to avail themselves of healthcare services.

Mr Kirkwood: Although there is quite a bit in the directive about making the information freely available to patients — that is fair enough — the provisions that we are talking about under the directive have been in place in Northern Ireland since 2012. There has not been a big influx. All right; under the directive, there will be a bit of a push. Information will be available on websites and all the rest. I do not know whether that will create an outflow or an inflow of people. All I am saying is that, since 2012, under the interim regulations, the provision is already there if you want to go to France, for example, to get treatment. That has not created a problem so far.

Mr Dunne: If someone wants to register with a new doctor or dentist, what documentation do they need to produce when they walk into a practice?

Mr Galway: If someone walks into a GP practice and wants to register with that practice, they have to complete a form with the GP and fill out their details, such as name, address and details of previous addresses, inside or outside Northern Ireland. They will also have to provide documentary evidence, such as a copy of their passport. The GP will then sign the form and send it to the BSO. The BSO will go through the normal checking procedure to ensure that they are entitled to be an ordinary resident in Northern Ireland and on the GP practice list.

Mr Dunne: So the GP should verify their identification.

Mr Galway: The GP will attach all the details to the form and send it off to the BSO. The BSO will do all the checks.

Mr Kirkwood: And issue the medical card.

Mr Dunne: So people do not need to have a medical card for initial registration at a new practice.

Ms Daly: To register, they will have to have a healthcare number and a medical card. Stephen has more detail on this than I do, so I will pass to him. If someone is seeking to register with a GP and they do not have a healthcare number, that is when the "ordinarily residential" test is done to see whether they are entitled to avail themselves of treatment here.

Mr Galway: You would only have a medical card as such if you are in a practice having been "ordinarily resident" tested and checked by the BSO. If you want to transfer from one practice to another, you use the medical card. Everything concerning your medical records goes through the BSO. If you are completely new to Northern Ireland and have no medical card, you have to go to a practice, complete the form, provide documentary evidence of why you think you are ordinarily resident and submit that to the BSO through the GP practice for it to check and validate that the information is correct and that you are ordinarily resident. It is the BSO that makes the decision and not the GP.

The Chairperson: My final question is on something that you mentioned, Stephen. I am thinking about waiting lists. Where will somebody who wants elective care in the North be placed?

Mr Galway: They will not get priority. If there is a 12-month waiting list for a procedure, they will not get additional preferential treatment and go up the list; they will be told that the waiting list is 12 months and that they are welcome to add themselves to it.

The Chairperson: So they will be at the end of the waiting list.

Mr Galway: Yes.

Ms Daly: There is no intention to displace any prioritisation in our health system.

The Chairperson: OK. I will move on quickly to the next session. I do not know who is leading.

Ms Daly: Chair, I will give a brief introduction. The overseas visitor access to free healthcare relates only to secondary care, unlike the directive. Following a review of policies and legislation governing visitors' access to healthcare, the Department conducted a consultation on new policy proposals that bring us broadly into line with the rest of the UK. The consultation ended on 10 April. The Department decided to introduce new provisions in line with the EU directive legislation from 25 October as the amending legislation — the persons not ordinarily resident regulations — included a provision on the EU directive. That is where we talk about the interlink between the relevant aspects of the legislation.

By way of background, in line with the rest of the United Kingdom, Northern Ireland has maintained a policy of charging overseas visitors for secondary-care services — that has been the policy to date — with defined categories of treatment and persons free from charge when on a visit to Northern Ireland. The exempt-from-charge categories are set out in the Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2005 . The 2005 regulations, and the exemptions in them, do not extend to primary-care services. Therefore, unless someone is ordinarily resident here, they are not entitled to free treatment unless it is in relation to immediately necessary treatment owing to an accident or an emergency.

England updated, consolidated and extended its regulations in this area in 2011 with the result that there were variations between the regulatory framework here and that in England. Hence the review carried out here at the beginning of this year. We received 37 responses to the consultation. Generally, the comments were positive and welcomed the moves to update and clarify issues with the legislation. Only two proposals drew any main comment: proposal G, in relation to asylum-seekers, and proposal I, in relation to HIV. The policy proposals and the rationale for their introduction are set out at paragraph 9 of your briefing paper at tab 2. Most of the proposals are either technical or for

clarification purposes. The main proposals are proposal G on asylum-seekers, proposal I on HIV, and proposal J on the extension of the present exemption of charge categories for secondary-care treatment in a primary-care setting. I will say a little about each of those.

Proposal G introduces a specific exemption for charges for refused asylum-seekers who are supported under sections 4 or 95 of National Asylum Support Service (NASS) support and who are co-operating with the UK Border Agency. Most respondents welcomed that proposal with some suggestion that, as refused asylum seekers represent a very small proportion of the population and due to admin difficulties in identifying asylum-seekers in receipt of section 95 or section 4 support, we should amend this proposal to provide free healthcare to all failed asylum-seekers in Northern Ireland. The Department considered that it would be prudent to consider fully the ramifications of extending free healthcare to all asylum-seekers. Therefore the amending legislation restricts the entitlement to failed asylum-seekers in receipt of section 95 or section 4 support who are cooperating with the UK Border Agency.

In relation to proposal I, in taking account of the public health and clinical arguments, the Department has decided to introduce an exemption from charge for full HIV treatment bringing us into line with the rest of the United Kingdom. This extends to the current policy for exemption from charge in relation to HIV diagnoses and counselling only. Of the 14 respondents who commented on this proposal, 13 agreed with the introduction of an exemption from charge for full HIV treatment. Clearly, greater costs may occur from full HIV treatment exemption from charge. It needs to be balanced against the potential reduction in costs of not having to treat someone in hospital for AIDS as well as all aspects of public health issues around that.

Regarding proposal J in relation to extending the present exemption of charge categories for secondary-care treatment into a primary-care setting, following further discussions with the Department we considered that it would be prudent to give this proposal and its ramifications further thought before implementation. Therefore, the regulations do not include that provision. As mentioned earlier, regulation 24 of the 2013 regulations introduces provisions in relation to primary-care services for visiting patients under the EU directive. That is a very quick run-through. I am happy to take the Committee's questions.

The Chairperson: OK. I should have said at the start of the session that there is a briefing from the Law Centre on this policy on page 21 of members' packs. There have been letters supporting the position of the Law Centre received from a GP, Dr Agnew; the Northern Ireland Council for Ethnic Minorities; the Belfast Migrant Centre; the Northern Ireland Community for Refugees and Asylum Seekers; the Human Rights Commission; and the Children's Commissioner. They are all tabled in the items booklet. Correspondence has also been received from the Royal College of GPs. The Law Centre wrote to the Committee this morning listing 16 organisations that support its position, including the BMA and Women's Aid. Those letters are included in members' packs.

Mr McCarthy: Catherine, you might have answered this if I heard you right. There were 14 responses, and, of those, 13 said that they were in favour of free HIV treatment.

Ms Daly: Yes.

Mr McCarthy: My question is "What was the attitude of the board?", but I think that you said that the board is satisfied and has listened to that.

Ms Daly: Yes. That will be implemented in the regulations to meet the full cost of full HIV treatment.

Mr McCarthy: So this is one case in which the board listened to those consulted. That is good.

Mr McKinney: What are the public health benefits of providing free HIV treatment for all patients?

Ms Daly: This is about prevention — again, I will look to my colleagues to provide further detail — under the public health agenda. Providing full treatment ensures that all aspects of the condition are addressed so that there are not longer-term ramifications and potential spreads. There is a whole range of public health issues. Quite simply, if we look at this on a value-for-money basis, we see that the cost of doing it outweighs the potential cost of providing longer treatment in the longer run.

Mr Galway: What happens if it is not free? If people attend, say, the initial consultation for diagnosis, which is currently free, and find out that they are going to be charged for that, they probably will not go back to the clinic and will be out among the public. If you are not able to identify the patients, you cannot control the spread of the disease as such. The public health view seems to be this: provide the treatment and let them have access to the medication. That is expensive, but it limits and controls the spread. If patients are in contact with the clinic, the clinic can monitor and control their condition.

Mr Kirkwood: Another important issue is that treating pregnant women with HIV prevents crossover to babies. The treatment is very advanced, and, in some 97% of cases, it prevents crossover of HIV to a child. Providing free treatment has a knock-on effect because a baby will not be born with the virus and will not, therefore, require care, so there will be savings.

Mr McCarthy: While it is in my mind — I forgot to ask Catherine this — are you in a position to let the Committee know what those 14 organisations are?

Ms Daly: Absolutely.

The Chairperson: You can share that with us.

Ms Daly: Yes.

Mr Wells: I suppose that we are going back to some earlier issues. The number of asylum seekers is small, and they tend to be relatively young people who will probably not have a huge call on the health service. The HIV/AIDS issue is a bit more difficult, because it can cost up to £300,000 a year to treat somebody with that condition. Again, the most likely people to present themselves for treatment are those from the Republic of Ireland. The briefing paper states that you will pursue those people and check up on them, but what is to stop someone from the Republic coming into Northern Ireland and getting that very expensive treatment in the long-term, thus being a burden? That equates to 10 heart bypasses. I am not saying that the treatment is not justified; it certainly is, because it is a very serious condition. However, you would like to think that if the person is from the Republic, the HSE, or whatever it is, in the Republic should pay the bill. How do you stop that happening?

Mr Galway: The main GUM clinic, which is in the Belfast Trust, is working very closely with the Health Service Executive to try to identify which of its patients are from the Republic of Ireland. They want to show patients that, under these proposals, less free treatment is available here than it is down South. It is about anonymity; an individual does not want to access services that are local to them, so they are coming up here. However, we are trying to pursue and direct those patients back into services in the Republic of Ireland by working with the HSE. If there is a cost, we will try to work with the executive —

Mr Wells: I can certainly understand why somebody from the Republic would prefer to be treated up here because, unfortunately, there is still a stigma attached to the condition. I am just interested to know how you will make absolutely certain that the procedures are correct. This is serious money; if 10 people came up, it could cost £2 million or £3 million, so we have to make absolutely certain that the procedures are correct to ensure that the bill is sent down to Dublin for payment.

Ms Daly: That is absolutely right. I am not taking away from the costs at all, because they are significant. However, the overriding and dominant factor is the public health interest, given that charging could have adverse impacts, as Stephen highlighted. The predominant element is the public health interest. That does not mean that we will not look to ensure that all appropriate processes are followed and, when appropriate, any charges are recovered.

Mr Wells: When the charges are particularly significant, is the pursuance more rigorous? When you have a really expensive procedure, do you make a special effort?

Ms Daly: It would absolutely have to be proportionate and relative.

Mr Wells: Also, I presume that someone from Northern Ireland can go to a specialist hospital in Dublin for similar treatment and have some anonymity — is "anonymity" the right word? I hope that it is right; "secrecy", perhaps — that he or she would not get up here. Do we know if there is a flow in the other direction?

Mr Galway: I am not certain about that. I would need to check and come back to you on that.

Mr Kirkwood: I do not think that there would be a flow the other way, because there would probably be an associated charge.

Mr Beggs: Presumably, if someone down South has limited means and has a medical card, the treatment is free. We are talking about people who may have assets, and it would be worthwhile for them to come up here for a free service, thus avoiding drawing down their assets. Could we face that?

Mr Galway: No matter what healthcare system we have in place, there is always the potential for it being misused, at whatever level.

Mr Beggs: How will you monitor that to determine whether there is such a level of abuse so that we can use the £3 million or £10 million to treat our own patients, and private individuals do not benefit by not using their own system?

Mr Galway: The trust would work actively with the GUM clinic and its conditions to interrogate its list of patients who are accessing services. It is a very expensive treatment. The trust would try to identify whether patients are entitled to treatment — are they resident in Northern Ireland, are they asylum seekers, are they here legally? — and pursue people from the Republic of Ireland who are accessing services when they can get that service in the South.

Mr Beggs: Will the clinic continue to treat that person for free if that person so chooses?

Mr Galway: Ultimately yes, in that it is a public health issue. However, the trust would tell the patient that they can avail themselves of similar services in their own country and should not be accessing such services in Northern Ireland.

Mr Beggs: The issue would be if those patients do not wish to draw on their personal assets. Even if they had hundreds of thousands of pounds in their bank account, they could still choose to come up here and get free treatment.

Ms Daly: That is a risk. Part of the approach is to look at the wider issue to try to mitigate the risks as far as possible. We will always keep operational matters under review, but the public health interest is the major dominant issue.

Mr Beggs: We need to be careful, because many people with that condition could be drawn to our community to get the free service. There is a balance to everything we do.

Ms Daly: Absolutely. That is why we look to the trusts and the commissioners, working together, to ensure that the processes are in place and the arrangements are not exploited.

The Chairperson: HIV treatment in Scotland and Wales is referenced in the supporting documentation. Will you clarify the approach that Scotland and Wales have taken?

Mr Galway: England has gone down the route of free treatment for all, so Scotland is proposing to do the same — it may have already done so. Wales is falling into line with England, so it will be the same position. It will be a four-country-wide stance for provision.

The Chairperson: Fair enough.

Ms Brown: If the legislation comes into effect, how many non-resident patients with HIV are the trusts likely to be treating?

Mr Galway: I do not have the figures with me today, but I can get them for you. I will liaise with the trusts.

Ms Brown: That would be much appreciated. Thank you.

Mr Beggs: How easy will it be to amend the proposed legislation if, for some reason, things go wrong and large numbers are drawn in that we cannot afford? I am thinking in particular of people who would have to pay for treatment in Dublin but who might decide to come up here and get it for free.

Ms Daly: No legislation is easy to amend, but it is possible. I do not think that there is anything to stop that happening. If, through analysis or evaluation, it were deemed necessary to change the regulations, that could be accommodated.

Mr Kirkwood: It could take two or three months, unless we went down an accelerated route whereby you could have legislation in place within one month.

Ms Daly: That, of course, would be subject to all the due processes with consultation. If we moved from one agreed position to another, that would have to be subject to the full consultation process and all the associated elements.

Mr Beggs: As long as new primary legislation would not be required, I was thinking that you would be able to build in a secondary —

Mr Kirkwood: It would be subordinate legislation to amend the Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2005.

The Chairperson: Fearghal, did you have another question?

Mr McKinney: I think that it was covered.

Mr Dunne: Will you detail where such treatment will be carried out in the health service? Are you satisfied that the necessary resources are available to carry out such treatments?

Mr Galway: Yes. All treatment will be carried out in one clinic in Northern Ireland: the GUM clinic in the Royal Victoria Hospital in the Belfast Trust.

Mr Dunne: It is generally known as the infectious diseases ward.

Mr Galway: It will treat all HIV patients. At present, the clinic is able to treat current numbers. We will monitor and review the position, but we will have an ongoing liaison with the clinic on the impact of the legislation. We will see whether there is an influx or an increase in the number of patients accessing treatment. At the minute, there seems to be an assessment that —

Mr Dunne: Has it been verified that the resources are available?

Mr Galway: Yes. We have been liaising with the clinic, and it has sufficient resources to provide the services under the new legislation.

The Chairperson: I would like clarification on an issue around failed asylum seekers. The situation in Scotland and Wales is slightly different, but is there an estimate of how much it would cost to provide free healthcare? The documentation that we have refers to a very limited number of people. There are still issues with certain benefits and what constitutes a failed asylum seeker; I think that we are talking about 16 or 20 people.

Ms Daly: It is a very small number.

The Chairperson: Can you clarify that?

Ms Daly: We have had sight of the Law Centre correspondence, and we probably need to clarify issues about the proposals on asylum seekers. I think that the Law Centre correspondence referred to the regulations not covering asylum seekers who are not in receipt of government support. The regulations do cover asylum seekers. The exemption relates to failed asylum seekers who are not in receipt of certain support, and those numbers are very small.

Mr Kirkwood: As Catherine said, we had sight of the Law Centre's letter. The Law Centre must have read the legislation with the misinterpretation that the regulations covered primary care as well as secondary care. As Catherine said, they do not; they cover only secondary care services. The letter gets a bit confused on asylum seekers and failed asylum seekers. Regulation 9 of the amending regulations is split into four paragraphs. The regulations, as drafted, extend the provision for asylum seekers to what is in place with the 2005 regulations. It extends it to provide for failed asylum seekers who are being supported under section 4 or section 95 of the Immigration and Asylum Act. The only asylum seekers for whom the regulations are not allowing are those who are not cooperating and who are here illegally. At present, there is the question of immigration and the new Immigration Bill. The issue of abuse of asylum-seeker policies is a hot potato. In essence, the Law Centre is recommending free treatment for all failed asylum seekers. That includes free treatment for people who are in Northern Ireland illegally.

We spoke earlier about the costs of HIV treatment, whether it is proportionate and whether the health service can afford it. Before we go down the road of thinking about introducing free healthcare for people who are in Northern Ireland illegally, those issues and areas need to be bottomed out significantly. That will entail discussions with the Law Centre and other stakeholders who, as you said, have corresponded with you.

You asked how long it takes to make amending regulations, and there are provisions. There is a provision to extend the regulations into primary care, and there would be a provision to extend free treatment to all failed asylum seekers. If after a full investigation that would involve interacting with the groups that we mentioned and the Law Centre, it was decided to go down that path, it is a question of amending the proposed regulations that we need to make to transpose the EU directive.

Catherine said that there is a regulation in the Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2005 that relates to the EU directive. It is important that we get approval to make all four sets of regulations to transpose the directive. The issues around making the health service free to all failed asylum seekers, for example, need further consideration. We need further consideration of the new Immigration Bill that is being introduced and on other policies that England is introducing on migrants' access to the health service.

The Chairperson: Without opening up a whole debate on that matter, I suggest that it is not as clear-cut as saying that people are here legally or illegally, because there are all sorts of issues about people who cannot return home.

Mr Kirkwood: People who cannot return home are covered. If they are cooperating with the UK Border Agency and cannot return home for some reason, they are entitled to the free health service. That is in the regulations. The only people who are exempt from entitlement to the free health service are those who are not cooperating with the UK Border Agency. In reality, those people are here illegally. The issue is whether we want to consider extending health services to those people.

Mr McCarthy: That brings me on to my final question. It has been brought to my attention that millions of pounds are outstanding to the health board from people who were not entitled to free healthcare. Can anybody confirm that? What is being done to rectify that? This EU directive will go some way, but in the immediate term, is it just filtering out? Are the bills adding up?

Mr Galway: I do not have the actual figure or the quantification of the debt level, but there has been a move in the past number of years. The Department issued a circular to the health trusts and the board stating that, if people turn up at a hospital for treatment, they are entitled to any necessary treatment immediately in A&E. Once they move out of that, they are chargeable patients. Irrespective of whether they are able to pay, they should be charged. If they cannot pay, there will be a debt, but it is a quantification for us as to the number of people who are using the service and accessing it. Each trust has private patient officers who try to identify patients who are accessing treatment, and there is now a new access to healthcare team in the BSO that is looking at coordinating all those activities across each trust to ensure that proper guidance and procedures are in place to identify and charge patients accordingly.

Mr Kirkwood: There is also the UK Border Agency, which has introduced, or is in the process of introducing, legislation. If someone is a debtor to the health service and owes £1,000, he or she is not allowed back into the country. An overseas visitor, for example, might go off to another country or get their treatment here. Maternity services is quite a good example. Women have their baby, there is a charge against them, but then they clear off home. If a woman tries to come back in, and there is an

outstanding debt — set at £1,000, I think — she will not be allowed back into the country. That is a provision, but it is UK Border Agency legislation.

Mr McCarthy: There is a debt somewhere.

Mr Kirkwood: There is a debt. That is a sanction against people who have not paid their debt, so it will help.

The Chairperson: For clarification: what is the situation with asylum seekers in Scotland and Wales?

Ms Daly: Scotland and Wales are different from Northern Ireland because they cover all asylum seekers and all failed asylum seekers. Nobody is exempt from that in Scotland and Wales.

Mr Galway: We have not ignored the issue completely. We have taken it on board. As Robert said, the draft regulations go a bit further and provide for those who are cooperating with the UK Border Agency. I have changed the draft regulations to widen the provisions, but we need to look at the implications and ramifications of going further than the provisions in Scotland and Wales. We need an in-depth analysis and understanding.

Ms Daly: On that final point, the issue can be quite complex and complicated. We need absolute clarity about what the regulations cover and a full understanding that it does not apply to all asylum seekers. In the category that Robert explained, it is a very small number of people.

Mr Kirkwood: As I said, we were copied into the Law Centre letter. Depending on today's discussions, it would be the Department's intention to write to the Law Centre to address the issues that it raised and explain that we made the regulations because there was a requirement to transpose the EU directive. However, we will take up the issues that you raise with the Law Centre and other stakeholders and look at the policies on asylum seekers and primary care.

The Chairperson: It would be useful to copy us into that correspondence.

Mr McKinney: I have a final question. It would be helpful to get a guesstimate of how much it would cost to provide free healthcare for that other category. Do you have any idea at the moment of what that would be?

Mr Kirkwood: It is a small number. That said, if the provision were there for free healthcare for all asylum seekers, the cost could mushroom out of all control.

Mr McKinney: Is that the case in England?

Mr Kirkwood: Yes. They costed it about a month ago, and it was in the millions of pounds. England is looking at the issue again. There was an article in the paper last week —

Mr McKinney: It was not the 'Daily Mail'; was it?

Mr Kirkwood: No, it was the 'Daily Star'. *[Laughter.]* The article was on how failed asylum seekers are using and abusing the system. All that a failed asylum seeker who is not entitled and is not cooperating has to do is reapply for asylum and come on to free entitlement until they are failed again.

Mr McKinney: Maybe we could get a wee bit more detail.

Mr Beggs: The proposal is to provide free healthcare for failed asylum seekers who are on government support schemes. Only if you are not on the scheme will there be no provision or support. What are these schemes? Why would someone not be on a scheme? I have not been made aware of them. Why would someone choose not to have the free healthcare that is available to everyone?

Mr Kirkwood: Various legislation sets out the schemes. It is covered in the Immigration and Asylum Act. To qualify for section 95 support, an asylum seeker must be destitute. The UK Border Agency gives section 4 support to:

"failed asylum seekers taking reasonable efforts to leave the UK but for whom there are genuine recognised barriers to their return home."

If a person does not qualify for section 4 support, they are either not destitute or they are not cooperating with the UK Border Agency. Section 95 support refers to asylum seekers who:

"would otherwise be destitute and this normally continues for those failed asylum seekers who have children".

Mr Beggs: Thanks for that. To what extent has your thinking been influenced by the fact that we have a very porous border? That is unlike England, Scotland and Wales. You have to take either a ferry or a flight to get to those places, but we have a porous border. Is it part of your thinking to do it differently from Scotland and Wales?

Mr Kirkwood: Our thinking is more on how England has approached the policy. England has allowed free health services for failed asylum seekers who are cooperating with the UK Border Agency and being provided with either section 4 or section 95 support.

Ms Daly: The border was not deemed to be a significant factor with this exemption. If it were, we would look at it.

Mr Beggs: How is it being dealt with in the Republic of Ireland? How we deal with it on one side of the border compared with another could have an influence on people's movements. How is it being dealt with across there?

Mr Galway: We are working on the basis of whether you are cooperating with the UK Border Agency, which does not exist in the Republic of Ireland. You have an identity card. You have something that shows that you are receiving section 95 or section 4 support . You can show that to a healthcare worker to prove that you are entitled. We are saying that, if you do not have that —

Mr Beggs: You are almost saying that your proposal is comparable to some extent, because you would have to be cooperating with the system down South as well.

Mr Galway: No, it is a UK issue. It is the UK Border Agency. How the Republic of Ireland treats asylum seekers will be different.

Mr Beggs: Is a failed asylum seeker down South entitled to free healthcare?

Ms Daly: Under the South's system?

Mr Beggs: If they are not cooperating with their system. Someone who fails there is likely to fail up here as well.

Ms Daly: You are asking whether there is a difference between what the South does and what we do. I do not know the answer to that. We will look at that and come back to you.

The Chairperson: Thank you all for that overview. It was useful. We will reflect on the information that you have given today and be back in contact.

Ms Daly: Thanks very much.