Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Proposed Legislation on Overseas Visitors' Access to Free Healthcare: DHSSPS Briefing

4 December 2013

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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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 David McIlveen
Mr Fearghal McKinney

Witnesses:

Mr Stephen Galway	Department of Health, Social Services and Public Safety
Mr Robert Kirkwood	Department of Health, Social Services and Public Safety
Ms Heather Stevens	Department of Health, Social Services and Public Safety

The Chairperson: Folks, you are very welcome. You know the procedure here well. I ask for a 10-minute presentation, then I will open the meeting up.

Ms Heather Stevens (Department of Health, Social Services and Public Safety): Thank you very much for the invitation to attend. We very much welcome the further opportunity to address your concerns on this important issue.

Since the last meeting at which the Department gave evidence, we have engaged with the Law Centre about its concerns, particularly on failed asylum seekers. We wanted to clarify our position on that issue and explain that these regulations extend the benefits available compared to the provision in current law. Some failed asylum seekers are already covered under the new regulations, which exclude only failed asylum seekers who are not cooperating with the UK Border Agency.

In any case, those individuals, in common with everyone else who comes to Northern Ireland, are entitled to free emergency care in an A&E department or a GP's surgery. They are also entitled to the range of services that is exempt from charge under regulation 4. This covers a reasonably wide range of things, such as sexual health services and treatment for the various infectious diseases listed in schedule 1, including food poisoning, measles and mumps. So, a level of cover is being provided already to individuals who come within the requirements of the legislation.

We set that out in writing to the Law Centre, and we have made it very clear that we recognise that these are very difficult matters and that we are very prepared to engage with the Law Centre on the issues it has brought to the table. However, we will also need to engage with other stakeholders in that process. We recognise that the Law Centre brings one perspective, and the Department needs to engage with a wider range of individuals before it looks at the potential for extending the provision further.

The second point I want to make is that we have received correspondence from the Committee enquiring about two very specific issues. One was about the number of non-residents who were likely to be given free HIV treatment if the proposals went ahead, and the other was about the Republic of Ireland's policy on failed asylum seekers. The formal response is with the Minister for clearance. However, in relation to the potential increase in the number of people seeking HIV treatment, any increase would be extremely difficult to predict. The main flow is from the Republic of Ireland, where HIV treatment is provided for free. Some people, for various reasons, such as to protect their anonymity, are making their way to Northern Ireland. They are being dealt with by the Belfast Trust and, in particular, by the genito-urinary medicine (GUM) clinic.

Over the past few years, they have tightened up the work that they do to make sure that the people who approach them for services are entitled to free treatment. They have stepped up their processes for checking addresses to make sure that people are not just coming across the border to receive treatment and then going back. Over the past few years, they have really reduced the numbers of people they are treating. For example, in 2013-14, out of 27 people who presented themselves for treatment initially, the number was managed down to six. They are very exercised about this issue, and we are grateful to them for protecting the public purse.

On the second issue, about the Republic of Ireland's policy — and I am conscious that the Law Centre will also have picked this up — the important distinction for us to make is that provision in the Republic is discretionary. There is no statutory entitlement for asylum seekers there, so healthcare is provided on a discretionary basis to those in direct provision centres who are waiting on a decision. We have had it confirmed by the Department of Health and Children that those whose applications have failed are provided with emergency treatment on a discretionary basis. That is the answer to that question.

The third issue that I want to highlight to the Committee is the link with the EU directive. The reason that these regulations are so time-critical for us is that regulation 24 implements the derogation in Northern Ireland, which sets out that certain primary care services are available to European Economic Area (EEA) nationals at a charge. Without the provision being implemented, we will fail to fully meet our requirements to transpose the EU directive.

The fourth issue that I quickly want to highlight is primary care. That is currently excluded from the purview of these regulations, and the exemptions do not apply to primary care. It is fair to say that, when the Department consulted on these proposals earlier in the year, the proposal to extend the exemptions to primary care was included in that consultation. However, in parallel with the work to implement the directive, it became clear that this was not straightforward issue and that there is an interplay between the rights of people in relation to the directive and what these regulations are trying to accomplish. We considered that, rather than rush through a provision, we needed to take some further time to explore and investigate the ramifications of extending primary care in these regulations.

Let me give you an example of the sort of dilemma we face. The EU directive gives access to only essential services, so a limited range of primary care is being made available to EEA nationals at a charge. If we extend the regulations, through this set of regulations, to include primary care, that will open up all primary care facilities to the range of people who are within the exemptions. So, you could see the situation arising whereby a failed asylum seeker would have greater rights to primary care than an EU national coming into the country. We are not saying that that situation might be where we end up, but it is certainly not something that should be done lightly and this needs a lot more consideration. We have been very open with the Law Centre about making the commitment to give the issue further consideration. We are very happy to give that commitment to the Committee as well because it is an important issue and extremely complex.

The Chairperson: Thank you, Heather. Just to clarify, in the first paragraph of the letter on page 2 it states:

> *"If a person does not qualify for s.4 support it would seem that they are either not destitute or they are not cooperating with UKBA, or both."*

It then goes on to say, further down:

> *"this provides an important safeguard to ensure that those failed asylum seekers, who are genuinely working with UKBA to return home, are covered."*

In the previous session, we were told that it is not a case of not cooperating in a number of those cases, because, in effect, individuals are presenting to the Home Office weekly and supplying their fingerprints and addresses. It is just that they are not on a particular scheme. What is your view of that?

Mr Robert Kirkwood (Department of Health, Social Services and Public Safety): That is true, yes. You can have failed asylum seekers who are not in receipt of section 4 or section 95 support under the Immigration and Asylum Act 1999. In Northern Ireland, there is no detention centre as such and failed asylum seekers are required to register with the UK Border Agency at Drumkeen House or register at a police station on a weekly basis. In a lot of cases, they are doing that. However, as far as the legislation is concerned, all failed asylum seekers are in Northern Ireland illegally. That is the whole ethos behind healthcare in Northern Ireland: to have an entitlement, you must be lawfully living in Northern Ireland.

Failed asylum seekers are not here legally. The legislation as it stands has gone, if you like, a wee step further, to extend entitlement to failed asylum seekers who are getting section 4 and section 95 support. Beyond that, there are failed asylum seekers who are signing at a police station or at Drumkeen House but who are not entitled to the full provision of healthcare in Northern Ireland. They are entitled to emergency treatment. It is not that they are not entitled to any healthcare.

The Chairperson: Do you accept that people are cooperating?

Mr Kirkwood: Yes, in certain circumstances. If they are signing at a police station or registering, you could say that.

The Chairperson: Do you also accept that, with your definition of the word "illegal" — which I may not share — there may be circumstances in which people are waiting on applications or submitting them?

Mr Kirkwood: Correct. The legislation, as drafted, provides for that. Regulation 9 of the Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2013 is divided into four paragraphs: the first allows for asylum seekers to be exempt; the second allows for asylum seekers who have made an application which has not yet been determined also to be exempt; and the third allows for section 4 and section 95 exemptions.

I accept that you have taken evidence from the Law Centre and that the legislation surrounding asylum seekers is complex. If you take evidence from other stakeholders, they might have a totally different view. To try to base a decision on entitlement for this category of failed asylum seekers is difficult. The reason why the legislation has not been extended further than that at the moment is the complexity of the issue and the fact that the Department has not engaged with other stakeholders such as the UK Border Agency. It has not yet fully investigated the ramifications of introducing a policy such as that recommended by the Law Centre.

The Chairperson: I accept that it is complex, but this has been in the public domain since January. I am playing devil's advocate, but 18 agencies now fully support what has been presented in the recommendation of the Law Centre. You are referring to other stakeholders who might not hold that view. Who are they, and why have we not heard from them?

Mr Kirkwood: I cannot say. The Department's intention is to investigate the issue further. One such stakeholder which springs to mind is the UK Border Agency. To introduce a policy such as that suggested by the Law Centre could totally go against the procedures that the agency is trying to implement.

The Chairperson: I suggest that, with an issue such as this, the agency may already have triggered a view on it. There is also the situation in Scotland and Wales to be considered.

Ms Stevens: The Law Centre's representatives spoke very powerfully about some very hard cases, and we would like to look into those much more fully in order to understand the distinction that it is

making between cooperation and non-cooperation. We want to talk to the UK Border Agency about why it is has defined section 4 and section 95 support in the way that it has done. So, there are other issues that we must investigate. We are keen to take the time to do it properly.

The other point that I would like to make about those who cooperate but who are not in receipt of section 4 and section 95 support is, I understand, that you have to be destitute in order to get that support. Perhaps the reason why people are not getting that support is because they are not deemed to be destitute. Potentially, there is then an argument that, as they have failed to gain asylum, they should be asked to pay. This is part of the consideration that we need to give. We recognise that we have to make difficult decisions about who is entitled to free health care.

The Chairperson: OK. A number of members have indicated that they want to ask questions.

Mr Stephen Galway (Department of Health, Social Services and Public Safety): I just want to add this point. At the start, Heather mentioned how the law is applied in the South. Asylum seekers there are given healthcare treatment in a discretionary manner. If Northern Ireland is seen to be making it a legal requirement that healthcare entitlement is available to all asylum seekers, failed or otherwise, that would set us apart from the South, with which we have a land border. That is the sort of implication or ramification that could lead to a potential influx. It is possible that we would have an influx of asylum seekers from across the border to access healthcare in Northern Ireland because it would be a legal entitlement here, whereas, in the South, it is discretionary.

Mr Brady: Thank you for your presentation. Just on that point, we have been told that, if someone is an asylum seeker in the South and comes North, he has to declare that he has been seeking asylum in the South and would be sent back. Is that not the case?

We are not a million miles away. It would not be unreasonable to suggest that there might be cooperation. Registers and records should be kept of asylum seekers in the South and in the North. We are not talking about Australia. I live three miles from the border. I just wanted to make that point.

In general terms, how do overseas visitors access a GP here?

Mr Kirkwood: In relation to —

Mr Brady: There has to be a distinction made between asylum seekers and others. We have heard a lot of detail today and it becomes even more complex. I imagine that a person does not become an asylum seeker willingly. He has to have good reasons for doing so. I do not mean to say that there was an implication but, with HIV, do people say: "I am going to become an asylum seeker because I can go to Ireland, North or South, and get treatment"? I cannot imagine that that is necessarily the case.

Mr Kirkwood: They would not have to do that, because we have provision made for HIV. You would be entitled to treatment whether you were an asylum seeker or not.

Mr Brady: I give that only as an example. There must be other complex reasons why a person becomes an asylum seeker. I imagine that, to be accepted as such by the British border agency, the Home Office or whoever deals with it, you would have to satisfy very strict criteria; it is not unreasonable to suggest that. Overseas visitors are different. Obviously, the E111 form is accepted throughout the European Union, and people can access —

Mr Kirkwood: Let me just explain. The E111 form has now been replaced by the European health insurance card, which entitles you to emergency treatment only.

Mr Brady: I understand that.

Mr Kirkwood: It does not entitle you to register with a GP.

Mr Brady: No, but that is a different issue and I accept that.

Mr Kirkwood: It is the same with overseas visitors and with the overseas visitors regulations. The Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2013 set out exempt categories for overseas visitors. Again, this is an issue that we must be strong on.

The regulations apply only to secondary care, not primary care. So, in relation to overseas visitors or any of the exempt categories within these regulations, there is only free secondary care. There is no entitlement to register with a GP practice. If you go back to the Health and Personal Social Services (Northern Ireland) Order 1972, for entitlement to primary care services, one must be ordinarily resident here. That is the criterion for registering with a GP practice.

It gets confusing because these regulations are entwined with the EU directive, under which we have given EU visiting patients an entitlement to come and access primary care, but, again, those patients do not have the full entitlement of registering with a GP practice. So the EU legislation and the overseas visitors regulations give no entitlement to register with a GP.

Mr Brady: If, for instance, someone is waiting for their asylum seekers case to be considered and needs to access a GP, would they have to pay up front or is that covered? It seems to me that we are talking about two different issues, the health aspect and the asylum aspect.

Presumably, people need to access primary or secondary healthcare only if they are ill. We were given some examples. One was someone with asthma, probably brittle asthma, and all that person needed from the GP, initially, was an inhaler. However, because they could not register, they could not get one. The person ended up in intensive care, which cost quite a lot of money. People seem to be jumping in and out of the system. Somebody getting treatment for TB will come out of the system, then cannot get treated, then go back into the system. Apart from anything else, it is public health issue.

Mr Kirkwood: There are two issues that the Department has to investigate further. First, and importantly, there is the issue that you raise on whether we should extend the exemption categories in the regulations to include primary care. Various issues have to be considered.

Mr Brady: Primarily, there is the human aspect.

Mr Kirkwood: Yes, but say, for example, we extend the provisions in the regulations to cover primary care for visitors. At the previous Health Committee meeting, members were talking about health service fraud and people coming across the border to access healthcare. If we extend the provisions to include primary care, there would be no reason for health service fraud. People would come across the border, stay here for a couple of weeks and register with a GP.

Mr Brady: With respect; I represent a border constituency. In my view, health service fraud is not as prevalent as the press, media and others might suggest. I say that from personal experience.

Mr Kirkwood: I accept that.

Mr Brady: It is hyped up. I also think that there is a difference between asylum seekers and overseas visitors, because overseas visitors may be in a position to pay, or whatever, but when asylum seekers are coming in and out of the system, while waiting for decisions, that creates huge problems for them. I think therein lies the difference.

Mr Kirkwood: Maybe "overseas visitors" is an unfortunate term, but the overseas visitors regulations also include human trafficking. I know that it gives you a mental attitude of it being somebody who is just coming along here for a visit. That is not the case. It covers other categories, similar to asylum seekers.

Mr Brady: I accept that.

Mr Galway: On your point on widening it to allow asylum seekers access to primary care, Robert is saying that that is one of the key issues, along with looking at asylum seekers and whether the provision and entitlement should be extended to failed asylum seekers so that they all have access to healthcare. Those are the two key issues. If these regulations, as drafted, are approved and accepted, we will give a commitment to the Committee as we have already done to the Law Centre. In the new year, we will sit down and discuss those two issues with the stakeholders and look at the implications of how we can make further amendments to deal with that, what implications it would have for healthcare and how we can address those.

Mr Brady: I will finish on this. The issue is this: even if they are failed asylum seekers, they are still here. If they are ill, they still need healthcare, primary or secondary. That is the issue.

Mr Galway: If it is emergency medical treatment, they are entitled to it.

The Chairperson: There are a number of points to get through. I ask all sides to be succinct.

Mr McCarthy: Thank you very much for your presentation. We are discussing a very complex issue. I am sure that we all agree that we want to ensure that whoever comes to our country gets the medical service they need and not have to wait until some disaster takes place. That is what we are all about. To follow on from Mickey's comments, some submissions received by the Committee suggest that these regulations will allow free access to GP services for certain categories of overseas visitors, such as failed asylum seekers who are on government support schemes. Is that the case?

Mr Kirkwood: When they say "government support schemes", they mean people who are supported by the UK Border Agency under section 4 and section 95. Although there might be a terminology used in some of the correspondence, that is what "government support" means.

Ms Stevens: It is also not primary care. We have to be very clear about that. It is restricted to secondary care.

Mr McCarthy: OK. That is OK, Chair; thank you.

Mr Beggs: You said that primary care would not be provided. We have been given very clear illustrations from someone who suffered from asthma and somebody else who suffered from diabetes that, ultimately, when they became very ill and required accident and emergency treatment, there was a considerable cost to the health service. Do you accept that there are cases in which it would be much wiser to provide some assistance earlier?

Mr Kirkwood: Yes. As I said, that is one of the issues that we will be looking at when we introduce a policy. That would be on the plus side. It is the Department's overall policy that people should be treated in the proper place, and, in a lot of circumstances, that would be in a primary care setting. As you quite rightly say, the regulations, as drafted, do not provide for that. However, because of the complexity of the issue of extending it to primary care, we are saying today that we are prepared to investigate the pros and cons of that issue fully and then bring a recommendation to the Minister on the way forward.

Ms Stevens: That is absolutely right. There are benefits to be gained from that, and there are definitely cases where —

Mr Beggs: There are benefits for the patient and the health service?

Ms Stevens: Absolutely. However, that has to be weighed against the potential cost of opening it very widely.

Mr Beggs: Looking at the lessons from elsewhere, might there be some merit in having some discretionary support so that you are more agile and able to react to situations quickly when you see that there are very obvious areas that you should be supporting to create benefits? Are discretionary payments perhaps one way to enable you to react much faster and to create benefits for all?

Ms Stevens: That might be one solution that we could look at.

Mr Kirkwood: The important thing is that, at the minute, under the present legislation, this is not discretionary. Everybody has full entitlement to emergency treatment, and that includes failed asylum seekers. There is no discretionary element there. It is a full entitlement.

Mr Beggs: I am looking at the cases in which failed asylum seekers are still here and have not left the country. However, the current system means that it is bad for their health and bad for our health service.

Ms Stevens: We could look at this as part of the review. However, as Robert said, it is not provided for at the moment.

Mr Dunne: Thanks very much for your evidence. I understand that there are discrepancies between England, Scotland and Wales. Have you looked closely at what is happening in the rest of the UK?

Mr Kirkwood: Yes. We have looked at England, Scotland and Wales. Our legislation, as drafted, mirrors the English approach. In relation to failed asylum seekers, Scotland and Wales provide healthcare —

Mr Dunne: Complete?

Mr Kirkwood: Yes, it is complete healthcare in Wales and Scotland. Our approach is similar to England's. As we said, in taking the issue forward, we will certainly engage with counterparts in Wales, Scotland and England to help inform the decision on the way forward.

Mr Dunne: Do you intend to do that?

Mr Kirkwood: Absolutely, yes.

Mr Dunne: The other point has been touched on. The government support scheme, as you termed it, seems a rather wide statement. We have heard evidence today about the ongoing cooperation that everyone seems to be giving to a certain level. How is that interpreted? Is it acceptable that you go into a police station or —

Mr Kirkwood: The issue of support is not governed by health legislation but by UK Border Agency legislation — the Asylum Act — and is outside our remit. The UK Border Agency considers whether somebody is entitled to support under its legislation.

Mr Galway: If we were to look at widening it, we could maybe look at what cooperation is.

Mr Dunne: To us sitting here, someone who reports to a police station or an office once a week is cooperating with the necessary agencies. That would be our interpretation.

Mr Galway: We need to look at how that is monitored and managed. We need to liaise with the UKBA to see what the implications are and how it controls that. For example, how is an individual then able to show evidence to a healthcare worker that they are cooperating? Those are some of the issues that we could thrash out with the UKBA and the Law Centre in the new year.

Ms Stevens: Another is finding out whether there are any barriers to obtaining section 4 and section 95 support that we are not aware of.

Mr Wells: It is interesting that something that could have been nodded through because of the urgency of the situation has thrown up so many issues. Never take an assurance from the Department that something is purely routine and just a matter of tidying up. It certainly has not been.

I have a couple of issues. First, what is wrong with the suggestion that we go down the road of the Welsh model but build in a commitment from the Minister to review it in one or three years?

Mr Kirkwood: That could be a proposal, but to go down the road of the Welsh model or the way that Scotland operates would require us to go back to the drawing board. We would have to consult all interested parties, come back to the table, bring it forward to the Health Committee, go through the procedure, decide the policy, take the policy to the Minister and get it signed off. With a fair wind, it would probably take two or three months to get that done. That is the time frame that we are talking about. We cannot go away today and say, "Yes, that is what we will do".

Mr Wells: However, you could decide to stick to your guns and introduce your review within one or three years to see whether the concerns that have been raised by other bodies are indeed occurring.

Mr Kirkwood: That is our desired way forward. These regulations are tied in with the EU directive legislation. Northern Ireland has failed to meet its transposition deadline. The rest of the UK —

England, Scotland and Wales — have the legislation in place. These couple of provisions within the overseas visitors' regulations are very complex. The area of primary care was removed as was the area of allowing free access to all asylum seekers. They are drafted as they are.

The ideal situation would be for the Committee could see the way forward and say, "Yes, we agree that you make the four sets of regulations, as drafted, and give an agreement to the Law Centre". We have done that. In fact, not only have we given an agreement to the Law Centre, we have given an agreement to our Minister and the Committee that we will fully engage with all stakeholders in January and February. If, at that stage, we feel that the Law Centre's recommendation is the way forward, it would be very simple to do a small amending set of regulations that could be in place within a further month.

Mr Wells: Implicit in what you are saying — this has come up several times — is a fear that expanding healthcare provision will encourage people to travel to Northern Ireland to avail themselves of it. However, failed asylum seekers have already made an attempt. They have already lodged an application for asylum that has been turned down or whatever. That person is already extremely well known to the authorities. This is not a person just arriving on the doorstep and saying, "I want to avail myself of the health service". The numbers are 21, 35 or 50, and all of those people are extremely well known to the authorities. So, how could that relaxation of healthcare provision lead to a dramatic increase in that number?

Mr Kirkwood: It could. I discussed this with the UK Border Agency. As we said, in the Republic of Ireland, it is discretionary in respect of failed asylum seekers. I am not saying that us making a provision whereby all asylum seekers, failed or otherwise, are entitled to free healthcare would or would not lead to a dramatic increase. What I am saying is that there is the potential for a failed asylum seeker down South to say, "Hold on. I will nip up across the border". It is not only from the South but from England. England has the same legislation as we are proposing. Failed asylum seekers who are not receiving UK Border Agency support under section 4 and section 95 are not entitled to free healthcare, so there is also the potential for people from England to come over.

Mr Wells: But that person will be well known to the authorities either in the Irish Republic or England.

Mr Kirkwood: It is the UK Border Agency that controls it. I just do not know how effective its control of that is.

Mr Galway: Anyone outside could see it that, if you go to Northern Ireland and apply for asylum, you will be entitled to healthcare whether you are granted asylum or not. That may be only one of a range of options that makes someone decide that that is where they want to go. They may decide not to go to another country — England, for example — because they know that, if they are a failed asylum seeker, they will not get access to healthcare. That is just one of the things.

Ms Stevens: There is another safeguard in there for failed asylum seekers who do not come under section 4 or section 95 support. They can apply again. People who are undergoing the application process will come under this, so that is an additional safeguard to ensure that people are brought within the exemptions.

Mr Wells: Surely the simple way round that is for only people who are "registered" in Northern Ireland, already known to our authorities and are signing on — to use that horrible phrase — off the Knock carriageway to be entitled to the full range of health services. Anybody who came in who was not known to the authorities in Northern Ireland would not be entitled to free healthcare. I know that it is a UK-wide Border Agency, but there is a specific office in Northern Ireland. Would that not be a way of solving it? That would mean that the 35 or 50 people who are here already and are known to the authorities are covered but that people cannot hop across the border, come across on the ferry or whatever.

Mr Galway: One of the options may be to define cooperation. It is not just that you are receiving assistance from the UKBA through some sort of benefit or payment but that you are attending and recording at a police station or UKBA headquarters. Defining cooperation may be one of things that we will look at.

The Chairperson: I would like something clarified. Jim asked whether an option may be to proceed in the way that Wales has done, for example. Robert, you indicated that that would be a major

undertaking because of the whole process of wider consultation and so on. However, you then seemed to suggest that, if the Department continues engagement with the Law Centre and thinks, at some point, that its recommendation were feasible, that would be fairly simple to do because only a small regulation would have to be amended.

Mr Kirkwood: Correct.

The Chairperson: Which is it?

Mr Kirkwood: It is both. To develop the policy, there are procedures relating to consultation, making the policy decision, and getting it cleared and signed off by our Minister. That process could take two to three months. Once the policy decision is made and we were to introduce the recommendation of the Law Centre, for example, it would be a question of making regulations and bringing those into effect. The procedure of drafting the regulations and bringing them into effect would take about a month. Does that make sense?

The Chairperson: One of the Law Centre's proposals is about the inclusion of secondary care.

Mr Kirkwood: Primary care.

The Chairperson: No, there are two proposals. The Law Centre is very clear. One is ultimately about looking at the whole option of primary care; universal care, if you like. The Law Centre recognised that the Department stated in the letter that it will engage. However, there is also a proposal of an amendment regarding secondary care. That is not all of the ask, obviously, but it is one of the options. If we were to do that, surely that would not require a big amendment to the process, which has been in the system since January.

Mr Kirkwood: It is not a big —

The Chairperson: So, it is not a big amendment.

Mr Kirkwood: From a drafting point of view, it is quite easy to do and take forward. However, from a departmental policy point of view, we have engaged with our Minister and agreed to further investigate the whole asylum seeker issue and the issue around extending the exemption categories in the current regulations to include primary care. It was made quite plain —

The Chairperson: We are not talking about primary care. We are just talking about secondary care at this point.

Mr Kirkwood: All right, secondary care —

The Chairperson: So, it is not a big deal to do it. I am sorry for labouring this, but I want to be clear.

Mr Kirkwood: What is not a big deal?

The Chairperson: To take the amendment that has been proposed. You know what is on the table.

Mr Kirkwood: The proposal is that all failed asylum seekers would be entitled to free secondary healthcare. It is not a big deal to do the amendment.

Ms Stevens: We would need to take it to the Minister. I think that we would still want to investigate the cooperation and all those other issues. I suppose that our concern is with the time constraint that is on us because of the link with the EU directive. So, although one month or two months is a reasonably short period in legislative terms, it is a very long time as far as our implementation of the directive is concerned.

The Chairperson: I accept that, but the directive came to us extremely late in the day.

Mr Kirkwood: Absolutely.

The Chairperson: I think that it was 11 or 14 days before it was it was supposed to be enforced.

Ms Stevens: We recognise that.

Mr McKinney: I have a specific question, but given the way the conversation has gone, I will follow up on some points. Given that you suggested this afternoon that you need to look at it further, it strikes me that there is more homework that either has not been done or that needs to be done. You are suggesting that we shut the door now — to put it in a pejorative sense — and do the work later. If that were the case, can you assure me that we would not see some horrific cases, as my colleague Kieran McCarthy pointed out, over the severe winter that is coming, when the chances are that some of those failed asylum seekers may be living outdoors? As a result of your proposal, would we not find ourselves facing one or more of those horrific cases?

Mr Kirkwood: First, you said about closing the door. In making the regulations, we are not closing the door but opening it. That is for the simple reason that the provisions in the proposed regulations extend the current provisions for failed asylum seekers. If the regulations as drafted were made, the provisions would benefit failed asylum seekers.

Regarding your question about what would happen if there was severe winter, as I said, anybody is entitled to emergency necessary treatment. Any of those young people who are in urgent need of medical treatment will get it.

Mr McKinney: Not if we take my colleague Mickey Brady's consideration of, for example, someone with asthma. That person might find themselves not only ill but maybe reluctant to access even emergency services. We could end up with a catastrophic situation.

Mr Galway: Under the proposal from the Law Centre, that would not change until we looked at the aspect of opening up primary care. The amendment deals with the extension of secondary care for failed asylum seekers. Therefore, that situation would not benefit. The example of someone with asthma that was mentioned earlier would only apply with the widening of access to primary care. That would allow someone access to a GP to get the medication they need to avoid them having to go into hospital later. At the minute, the amendment only satisfies that looking at widening primary care.

Mr McKinney: Going back to the process point that I am making, could we not invert the process? That would allow you to do your homework that you have agreed to do, look at the wider considerations from the Law Centre and then take the major considerations separately.

Mr Kirkwood: We could do that. To do so would mean parking the legislation as drafted and not making the regulations. There are other proposals in that legislation on human trafficking, HIV and extending time limits, all of which are beneficial policies. If we took your suggestion, we would have to park the legislation. The asylum seeker aspect in the proposed legislation gives further benefits to asylum seekers than the current legislation. Your approach would see us parking the legislation and not making it until we look at the ramifications of those two areas: extending it to primary care; and extending it to all asylum seekers, whether failed or not.

As I said before, there is a time frame to consult on that policy and go through that procedure. The time frame between the policy and making the legislation is around three months. So, to do as you suggest would mean that there are people who would benefit from the regulations as drafted who will not benefit. My proposal would be to make the regulations as drafted, which would enable the EU directive to be taken forward and fully transposed. The legislation would be in place, which would assist asylum seekers, those seeking HIV treatment and other categories of visitor.

If the Committee was receptive to the idea and told us to go ahead and make the four sets of regulations, they would be made next week and come into operation week commencing 16 December. Then, to be realistic about it, it would be some time in January and February when we would engage with the stakeholders, including the Law Centre, that have an interest in asylum seeker policy and the extension of provisions into primary care. We would then decide whether we want to extend it to all asylum seekers and see what the full ramifications would be of extending it to primary care. When we know that, we could make a recommendation to the Minister one way or another. If there is a need, if we go down the road of extending it to primary care or giving it to asylum seekers, I can draft amending legislation and have it in place in a month.

Mr McKinney: My concern in that context would be that the imperative to look at this would be removed.

Mr Kirkwood: A commitment has been given. The letter that was copied to the Health Committee today that went to the Law Centre was cleared by our Minister, and in it, there is a commitment given. We have given a commitment to the Minister that we will get back to him on those policies, so it is not something that will sit until the summer.

Ms Stevens: We have given a serious commitment to look at it because we want to get this right, but we are concerned. There are benefits within it.

Mr McKinney: In that context, can we get an admission that you have got it wrong so far in timing and process? If this had been brought to us earlier, we may not be looking at this extra three months.

Mr Kirkwood: I quite agree. The Health Committee should have been brought along when the consultation went out and was completed and with the EU directive legislation and the overseas policy legislation. You should have been engaged before the consultation went out. When the consultation results came in, you should have been engaged, and these issues should have been discussed a long time ago. If that had been the case, I fully accept that we would not be where we are today. Unfortunately, we are, and all I am trying to do is find a realistic way and the best way to take the thing forward. We have missed the transposition deadline for the EU directive, which was 25 October. It is important that the EU Commission give maybe two months of grace to get the legislation in place. After that, there are infraction proceedings, and what we are trying to do is cut that off at the pass and get the legislation in place.

The Chairperson: We have one final question. Sorry, Fearghal, did you have another one?

Mr McKinney: I had some more issues, but I think we have reached a point.

Mr Brady: Just on Stephen's point that the North might become some kind of Mecca for asylum seekers seeking healthcare: there is no evidence from Scotland or Wales that the numbers have increased or that people are flooding across the border from England. In fact, from the statistics that we have, it appears that the Welsh numbers have gone down. I would imagine that the people who become asylum seekers under very difficult circumstances do not have some sort of a brochure that makes them think that they will go here or there because they might get better healthcare. I do not think it works like that at all.

I have another question to finish. I am suspicious — maybe I am just cynical by nature — because, once legislation is in place, it becomes increasingly difficult to change.

Mr Kirkwood: Primary legislation, yes; subordinate legislation, no.

Mr Brady: I am also on the Social Development Committee, so I am just trying to strike a balance.

Mr Kirkwood: This is the DHSSPS.

Mr Brady: The point I am making is this: is it possible that, before the legislation is transcribed or whatever, it can actually be amended, even with small amendments?

Mr Kirkwood: No.

Mr Brady: It cannot at this point in time. So, the Committee could not say that we will put forward an amendment.

Mr Kirkwood: Not at this stage.

Mr Brady: But you are saying that it could go ahead in January, February or March after consultation, which probably should have been done before. It is an inverse procedure.

Mr Kirkwood: It is, but, as I said, we are where we are. If we could get the legislation made, we could look at it in January and February. It is not a big problem to make a small amendment.

Mr Brady: It is now. My view is that, if you are going to do it, get it right the first time. That seems a simple enough point.

Mr Galway: We do take your point. It could potentially be done, but I think the issue, as we explained, is that we do not have the approval of our Minister to do that. We would need to go back. In looking at the drafting of the regulations, our Minister specifically asked us to look at the widening of the provisions in secondary care for failed asylum seekers. Taking that on board, we would have to go back. We could not just amend the legislation.

Mr Brady: It might not do any harm, because the Minister might be quite willing to listen to his officials.

Mr Kirkwood: But to go back to do that, we are going to have to consult with the various stakeholders. At this time of the year, it will be into January or February when you get the full consultation done to make the policy.

Ms Stevens: It is because of the link with the EU directive. I am sorry to keep coming back to it, but that is what is causing the time constraint. Ordinarily, we would take that away, do the work now and bring it back in due course, but it is just because we have the end of the year deadline from the EU Commission.

The Chairperson: I accept that there obviously has to be ministerial approval. I would like to think that there would also be an attempt to get Committee approval for it. We would be failing in our duties if we did not properly scrutinise it and take the time to take the evidence.

Thank you for the presentation today. No doubt we will be in contact.

Ms Stevens: Chair, can I ask when we might have an indication of the Committee's decision?

The Chairperson: I suppose that depends on the Committee. We are moving to try to get to some decision today.

Ms Stevens: Thank you very much. I appreciate that.

The Chairperson: We may need to reflect on that a bit more.

Mr Kirkwood: Chair, can I get clarification? After the meeting last week on 27 November, I was led to believe — correct me, if I am wrong — that the Committee was content with the EU directive side of our proposals and the way forward regarding the other sets of legislation.

The Chairperson: I think we were moving in that direction, but we still want to reflect on the entire piece. I think that would be useful. Thank you.