DÁIL ÉIREANN

ROGHCHOISTE SPEISIALTA AN TSEANAID UM AN RÍOCHT AONTAITHE DO THARRAINGT SIAR AS AN AONTACH EORPACH

SEANAD SPECIAL COMMITTEE ON THE WITHDRAWAL OF THE UNITED KINGDOM FROM THE EUROPEAN UNION

Dé Luain, 8 Márta 2021

Monday, 8 March 2021

Tháinig an Roghchoiste le chéile ag 3 p.m.

The Select Committee met at 3 p.m.

Comhaltaí a bhí i láthair/Members present:

Seanadóirí/Senators	
Malcolm Byrne,	
Timmy Dooley,	
Eileen Flynn,	
Robbie Gallagher,	
Tim Lombard,	
Vincent P. Martin,	
Michael McDowell,	
Joe O'Reilly,	
Niall Ó Donnghaile,	
Mark Wall.	

Seanadóir/Senator Lisa Chambers sa Chathaoir/in the Chair.

Business of Select Committee

Chairman: As we have a quorum the committee is now in public session. I remind members to ensure that their mobile phones are switched off. I ask them to mute their devices until they are contributing. I welcome everyone to the meeting. We have no correspondence to note. We need to adopt the draft minutes of our public meeting of 1 March 2021, which was the engagement with officials from the Data Protection Commission. Are the minutes agreed? Agreed.

Cross-Border Healthcare Directive: Discussion

Chairman: Today's meeting is on the cross-border healthcare directive. The witnesses for today's meeting are from the Department of Health, the Health Service Executive, Kingsbridge Private Hospital and the Defence Forces' representative association, PDFORRA.

I remind witnesses that the evidence of witnesses physically present or who give evidence from within the parliamentary precincts is protected pursuant to both the Constitution and statute by absolute privilege. However, witnesses who are to give evidence from a location outside the parliamentary precincts are asked to note that they may not benefit from the same level of immunity from legal proceedings as witnesses giving evidence from within the parliamentary precincts and may consider it appropriate to take legal advice on this matter. Witnesses are also asked to note that only evidence connected with the subject matter of the proceedings should be given. They should respect directions given by the Chair and the parliamentary practice to the effect that, where possible, they should neither criticise nor make charges against any person or entity by name or in such a way as to make him, her or it identifiable or otherwise engage in speech that might be regarded as damaging to the person or entity's good name.

Members are reminded of the long-standing parliamentary practice to the effect that they should not commit or make charges against a person outside the Houses, or an official, either by name or in such a way as to make him or her identifiable. I remind members that they are only allowed to participate in this meeting if they are physically located on the Leinster House campus. In this regard, I ask all members, prior to making their initial contributions, to confirm that they are on the grounds of Leinster House. Participants in the committee meeting from a location outside the parliamentary precincts are asked to note that the constitutional protection afforded to those participating within the parliamentary precincts does not extend to them. No clear guidance can be given on whether or to what extent their participation is covered by absolute privilege of a statutory nature. Therefore, if they are directed by the Chair to cease giving evidence in relation to a particular matter, they must respect that direction. There are ongoing Teams and ICT issues that are being worked on so I ask participants to bear with us if we encounter any glitches during the meeting. It is just one of the facts of life when doing things remotely.

Our witnesses from the Department of Health are Mr. Muiris O'Connor, assistant secretary, research and development and health analytics division, Mr. Jonathan Patchell, principal officer, international unit, and Ms Emma-Jane Morgan, principal officer, eligibility policy unit. We are also joined by Ms Catherine Donohoe, general manager, commercial unit, acute hospital services at the HSE.

I understand there will be one opening statement on behalf of the group. I thank all four witnesses for attending and invite them to make their opening statement.

Mr. Muiris O'Connor: Good afternoon. I thank the committee for inviting me to attend today. I am joined by my departmental colleagues, Mr. Jonathan Patchell, head of our international unit, Ms Emma-Jane Morgan, head of the eligibility policy unit, and Ms Catherine Donohoe from the HSE. It is our pleasure to be here to give the committee an update on the cross-border healthcare directive since the end of the transition period.

As we all know, the UK's withdrawal from the European Union has impacted across many sectors, including health. The Department welcomes the conclusion of the EU-UK Trade and Cooperation Agreement, TCA, in December 2020. The TCA, together with the withdrawal agreement which includes the protocol on Ireland and Northern Ireland, means that Ireland's key Brexit objectives have been achieved in the area of health and social care. The agreement provides a new framework for the continuation of access to healthcare for Irish people who are working, visiting, or residing in the UK and *vice versa*. The TCA has protected many of the health rights that existed prior to the UK's withdrawal from the EU, which will benefit residents in Ireland. I am also pleased to note that under the TCA, patients who require planned and often very specialised healthcare, as was provided for under the treatment abroad scheme, will continue to access that care in the UK.

Members will be aware that there has been a long history of cultivating and utilising our shared health services to enhance the health outcomes for everyone on this island. It is useful to outline here that North-South co-operation in healthcare continues to be delivered. For example, cross-Border health services such as the cardiology and cancer treatments in Altnagelvin and paediatric cardiology and related maternity services in Dublin will continue to operate on a cross-Border, all-island basis. A new EU programme, PEACE PLUS, is being developed to continue to build on the work of the current PEACE and INTERREG programmes. There was confirmation from both the EU and the UK, at an early point in the Brexit negotiations, of their enduring commitment to PEACE PLUS, which is a positive. A memorandum of understanding signed by the Chief Medical Officers of Ireland and Northern Ireland on 9 November 2020 provides a formal framework to manage the transfer of patients between jurisdictions in cases where critical care capacity has been overwhelmed in either jurisdiction. This is a concrete example of continuing co-operation in the pandemic.

Notwithstanding the extensive and welcome continuation of access to health services in the UK, one direct consequence of the UK's withdrawal from the EU is that the EU cross-border directive, CBD, no longer applies to the UK. This directive provides for the reimbursement to patients of the cost of receiving treatment abroad in another EU member state, where the patient would be entitled to such treatment in his or her home member state. Since its introduction in 2014, cross-border directive has provided access to health services in Northern Ireland, in particular for persons in this State. In 2020, almost 7,850 CBD reimbursements were made in respect of treatments accessed in the UK, which represents 90% of all treatments accessed by Irish residents under the CBD across the EU. Of those cases accessed in the UK, 98% of the treatments reimbursed were accessed in Northern Ireland. These are treatments obtained from private providers. However, as the CBD is EU legislation associated with the Single Market, the provisions of the CBD no longer apply to the UK, including Northern Ireland, since 1 January this year. This outcome was certainly not one desired by the Irish Government, and therefore mitigating measures have been put in place to address this loss of access.

First, the HSE has put in place transitional arrangements for certain patients who have a le-

gitimate expectation of continuing to access care in the UK under the current provisions of the EU CBD scheme. This includes provision for reimbursement of healthcare costs by the HSE to persons who fall into certain categories, such as patients who can provide evidence that they had treatments booked prior to December 2020 for treatment in 2021.

Second, on 28 December 2020, the Government approved the implementation of a new Northern Ireland planned healthcare scheme. Persons resident in the State have since 1 January this year been eligible to be reimbursed for accessing private healthcare in Northern Ireland by the HSE, provided such healthcare is publicly available within Ireland. It is intended the new scheme will operate for 12 months on an administrative basis initially, and along similar parameters to the cross-border directive, with the drafting of a general scheme planned to take place on a statutory basis. This important step, taken by the Government, provides both new and current patients with certainty around their ability to continue to access care in Northern Ireland and be reimbursed for it by the HSE.

In conclusion, despite Brexit the Irish Government has ensured that persons resident in Ireland can continue to access and be reimbursed for the cost of healthcare obtained from private providers in Northern Ireland. The Northern Ireland planned healthcare scheme will provide certainty for patients if they cannot continue to access private routine and scheduled healthcare in Northern Ireland, particularly in light of the ongoing impact of the Covid-19 pandemic on access to non-Covid 19 care within the State.

Both the EU and UK trade and co-operation agreement and the Northern Ireland protocol provide for substantial continuity in the provision of health services between Ireland and the UK and the Government will maintain and build upon existing healthcare co-operation through these frameworks. We are very happy to take any questions or provide any further detail that the committee might require.

Senator Robbie Gallagher: Good afternoon everyone. We thank the witnesses for taking the time to be here this afternoon. I have spoken with Ms Donohoe a number of times on the phone about different cases and I take this opportunity to single her out for the work she does and the manner in which she does that work. She is an excellent public servant and so we have a bualadh bos on this end for her and her work.

This has been a very successful programme since its inception. It was a bit slow to get off initially but once it took off, the demand for the scheme has been phenomenal. Many people languishing for long periods on waiting lists found an avenue through the cross-border directive to access care, with 98% of them looked after on the island, which was a big advantage for those who had to travel.

We are well aware that people have accessed the provisions of the cross-border directive in all parts of the country, as far down as Cork and Kerry. I understand a few notable bus journeys were made from that part of the world in recent times. Ms Sandra Reilly from Cavan knows what I am talking about when I say that for people living along the Border, the process has been very successful, as the journey would naturally be short for accessing care. I compliment everybody involved in it.

As has been outlined in the initial contribution, a kind of interim scheme is now in place. Other members spoke at an earlier meeting about the importance of finding a replacement. It is vitally important to find a long-term replacement for the current scheme, which expires at the end of the year. I would welcome an update on where that is currently. I am hopeful that

we will have the details of the new scheme long before the year end. I would welcome that. It is important to realise that while we are still only in March, when a patient is contemplating getting care of whatever kind, the process of getting to a point where they decide to go cross-border for that care, getting an appointment, getting all the paperwork sorted, to being post-operation or procedure, takes a long time. Therefore, in order for people to have certainty in that regard, the quicker we get the details of the new scheme, the better. I know that there are representatives of the Defence Forces here today, and that Senator Wall has spoken previously on the importance of this particular scheme for them. They, too, are most anxious that a long-term replacement scheme is found.

While Ms Donohoe is on the line, I have a question for her. What changes, if any, would she recommend be made from the old cross-border healthcare directive, if I can refer to it as such, to be included in the new scheme, that were perhaps problematic in the old scheme? That is all. I thank the witnesses for their contributions.

Chairman: I will go back to the witnesses to respond, and then we will have the next speaker. I will leave it to Mr. O'Connor to direct between him and his colleagues as to who may want to respond to the different questions, if that suits.

Mr. Muiris O'Connor: I thank the Senator for his praise for Ms Donohoe. We are also very familiar with the great work she does.

I will ask Ms Morgan to respond on the update on the statutory scheme. Perhaps Ms Donohoe wants to respond with her observations on the similarities between the administrative scheme and the cross-border directive, as it applied before, and any sort of insights she might wish to share in response to the question.

Ms Emma-Jane Morgan: I thank the Senator for the question. As the Senator is aware, the Government took the decision on 28 December 2020 to implement what we now call the Northern Ireland planned healthcare scheme. The decision was taken to implement it for 12 months initially, on an administrative basis. Therefore, the focus between the HSE and the Department has been about bedding down the arrangements to put in place the administrative scheme. However, the Government very much intends to underpin the scheme with a legislative basis. Within the Department, once we have progressed the bedding down of the arrangements for the operations of the administrative scheme, we will turn our attention towards looking at the legislative basis to give it the statutory underpinning. That was very much part of the Government decision at the time, that it would have a legal basis to support the scheme. The 12-month basis is really about the administrative scheme being put in place initially.

Mr. Muiris O'Connor: We do hear what the Senator has said on the importance of lead-in time for health matters. I ask Ms Donohoe to speak on how the current scheme relates to the cross-border directive, and any observations she might have going forward.

Ms Catherine Donohoe: The similarities between the schemes are numerous. There are really only two specific differences between the schemes, one being the lack of statutory protections for the patient in the other country. However, that is to be expected, because it is not a UK-recognised scheme. The other difference is that patients will not have access to the public healthcare system in Northern Ireland. In general, we have had very good co-operation with all the providers in Northern Ireland, without exception. I have visited all of the acute hospitals providing healthcare in Northern Ireland. The paperwork is always straightforward and their attention to patient service is extremely good. Therefore, from the point of view of the patient

continuing to access healthcare in the private sector, this is a really good step forward for the patients.

Senator Mark Wall: I welcome the guests today. I thank the Chairman for facilitating this debate. It has already been very worthwhile for the committee.

I have a couple of questions for the panel. Do we have any socioeconomic data on the types of people availing of the scheme? It would be important to find out whether such data are collected by the HSE or the Department. I am referring to data on where the people are coming from within our borders and to the socioeconomic background of those availing of the scheme.

My next question is on what is happening with our EU partners. Are they supportive of the fact that we are now opting for a new scheme? I totally welcome the new scheme, which has been called the Northern Ireland planned healthcare scheme. Have there been conversations with our EU partners? Are they welcoming of the fact that the new scheme is being introduced, albeit for 12 months?

I welcome the initial percentages Mr. O'Connor has given us on the number of people going to Northern Ireland. Obviously it is much more convenient to travel to the North than to elsewhere in Europe.

On my last question, Senator Gallagher, who has been very vocal on this matter, has outlined that PDFORRA has a scheme that has benefited many members of the Defence Forces. Could Mr. O'Connor comment on how that scheme will work under the new system? What have been the benefits from the points of view of both the Department of Health and the HSE? We all welcome the fact that there is a new scheme. Does Mr. O'Connor envisage any problems with the PDFORRA scheme continuing under the new scheme?

I welcome the fact that the delegates are participating today. I thank them very much for the time they have given us.

Mr. Muiris O'Connor: I thank Senator Wall. I will hand over to Ms Donohoe at the end of my contribution so she can give any detail we have on the socioeconomic background of the beneficiaries. We do not have direct socioeconomic background data but Ms Donohoe has a good insight into the beneficiaries and their profile.

On EU partners, the EU has been very supportive regarding the challenges Brexit presents for Ireland. In showing its appreciation for the importance and delicacy of the interrelationships across the island, it was very accommodating of the concept of the common travel area between Ireland and the UK. Under the common travel arrangement, we were able to negotiate a basis for the continuation of all reciprocal healthcare rights with the UK, including Northern Ireland. That would have held up irrespective of the outcome of Brexit. Even if there had been a no-deal Brexit scenario, we would have been ready to ensure continuity because of the work between Dublin, London and Belfast over the relevant period on all reciprocal rights. The difficulty with the cross-border directive is that it was not operating between Ireland and the UK on a reciprocal basis. The UK, even when a member of the EU, did not engage with it. I am not sure what issue it had with it. I believe it concerned the roll-out of the Single Market and the rights of Europeans, as citizens, to access healthcare in any of the member states and to have costs reimbursed.

On the unilateral scheme that we have put in place, I would not say the reception was welcoming but it was very accommodating. One of the tasks that Ms Morgan and her team were

required to do in giving effect to the scheme was engage directly with the European Commission to ensure it understood our motivation here. The motivation was to ensure the continuity of healthcare services for Irish citizens and residents of Ireland to the greatest extent possible.

On the Department's perspective, clearly the scheme addresses and provides for the meeting of extensive healthcare needs of what could reasonably be considered an emergency nature. The conditions covered include conditions that generate a lot of discomfort for patients and conditions that deteriorate over time so we are very keen to ensure the most timely service for all Irish residents. We wish to provide all these services as best we can within our own jurisdiction and the cross-border directive provides us with good insight into some procedures people feel the need to go beyond our borders to access. It is something we are keen to sustain and, in the longer term, to provide for comprehensively and in a timely way. I ask Ms Donohoe to share the information we have on the socio-demographic background.

Ms Catherine Donohoe: On the socio-economic background, we do not collect that type of information simply because we would have no right to for the purposes of processing an application. However, when we talk to patients, my opinion is that the majority of them are from middle to lower class socio-economic groups. They do not have health insurance, in the main. They are probably almost all borrowing the money, either from credit unions, banks or relatives. The two main ones that come up are relatives and the credit union. That is where they are getting the money.

By way of explaining that, I will mention two typical patients. One would be a cataract patient. It could be somebody in their 70s or 80s living in a rural area with no access to services and usually on a waiting list. A patient like that would be waiting two or three years to get access to a cataract. Such a period out of one's life at 70 or 80 years of age has a huge impact on the quality of life for the span one has left. I am not trying to make derogatory remarks towards older people but we should appreciate the impact on older people in particular that lack of timely healthcare has. For somebody like that, once they have the cataract procedures, they are able to drive again so they become independent and can live their lives. It has a huge impact. The other typical person, particularly with Covid, tends to be, let us say, a carpenter who has a knee pain or hip pain. They are off work because of Covid so are using the opportunity to access healthcare while it is not interfering with the ability to work. Those are the two types of patients and they are not higher socio-economic group patients.

PDFORRA's scheme is brilliant. It has organised with Kingsbridge Private Hospital - not that I support any individual provider in Northern Ireland - that the members of the PDFORRA medical assistance scheme, PMAS, have access to healthcare at the same cost that the patient will be reimbursed by us, so the patient does not have a shortfall. The patient borrows the money if they do not have the funds and, when they are reimbursed, because they have negotiated prices with Kingsbridge, they get full reimbursement and suffer no economic loss, nor does the HSE so it is win-win. Mr. Quigley will be on later and will give some case studies on how that has impacted their members

Senator Malcolm Byrne: I say thanks and hello to Mr. O'Connor, who I used to work with. I have two more general questions. We are looking at the question of Brexit more widely. One is about the import of medicines of medical devices from the UK or through the UK using the land bridge. Have Brexit and the challenges we are facing in our ports had any impact on specific medicines? Are there any concerns on the part of the Department or the HSE around specific medicines or medical devices? Are measures in place to address any potential shortages there? I know there was certainly some concern in advance of Brexit that this might happen.

Last week, the committee met the Data Protection Commissioner. I have expressed concerns that we will have a data adequacy decision quite soon. In the short term, it looks like the EU and UK will operate the same data regime. The concern would be if the UK diverges from the general data protection regulation, GDPR, or a GDPR-friendly regime around the sharing of medical data. This obviously is applicable where somebody living in the South might have his or her GP in the North, or *vice versa*. Are there any concerns on the part of the Department, particularly with regard to a scheme like this where there may be questions around data security and data storage? What measures should we put in place should we see a divergence in data?

Mr. Muiris O'Connor: I thank Senator Byrne. It is nice to see him again. I will take those questions. The import of medicines and medical devices was very close to our top concern in our preparations for Brexit and in our review of the implications of Brexit for the continuity of health and social care in Ireland. We did enormous work in the years leading up to Brexit. As the Senator knows, there were a number of cliff edges and we were ready for each of them.

Regarding the supply of medicines to Ireland, as the island beyond the island, an awful lot of our medicines came either from or through the UK. It was mostly the latter and came through in the form of the land bridge. We worked with our suppliers and the pharmaceutical industry in Ireland in the past while to look at the vulnerabilities that arose in that regard. Many of these were evident earlier this year. Thankfully, there was buffering of stock. We have never used the word "stockpiling" and we never advised stockpiling on the part of citizens, but we ensured there was a high amount of buffering in the pharmaceutical supply chains. That still stands to us. I believe there were approximately 12 weeks of supply for most medicines. We have monitored very closely the ability of the companies in question to maintain their stock levels and all is going well.

The products we were really worried about were the short shelf-life medicines that were not amenable to buffering. Those are radiopharmaceuticals that fuel the chemotherapy X-ray machines around our services. Compounded food products were the other area for which we had specific contingency arrangements in place. The radioisotopes are sourced from mainland Europe but come through an airport in the UK. We have watched those supplies. They have been completely unaffected by Brexit and the supply of radioisotopes has been unproblematic.

Compounded chemotherapy products, that is, nutritious medicine or food for very ill patients who may not be capable of eating, go off very fast because they are so high in nutrients. We had a dependence on the UK for those so we have watched that very closely.

We have worked closely with the Revenue Commissioners. I pay tribute to our colleagues in Revenue, who have been absolutely fantastic in responding to any issues and where anything got stuck. They worked with our medicines regulator and their counterparts in the UK to ensure no products were gravely affected. We were dealing with them on an almost case-by-case basis through January and February. As well as resolving the immediate issue, we were going back on each case to understand whether the logistical supplier, the pharmaceutical company or some aspect of the paperwork gave rise to the trouble. We have found that we are ironing out those issues.

We are feeling much better about medicines now. There has been significant rerouting of medicines, as has been the case with many other goods. Many of our shelf medicines are coming direct from Europe now. This is much more secure and bureaucratically tidier for suppliers. We are also looking at our own capabilities in compounded goods. This is important and a matter on which we are working and building up capability with the HSE.

On data, we are all holding our breath. The data adequacy agreement, in my assessment, is absolutely vital for the UK in terms of its ability to interface with Europe as neighbours. I would absolutely hope for a data adequacy decision whereby the European Union would deem the standards of data protection in the UK to be equivalent as they are now. Much of it depends on the UK's inclination to maintain that equivalence. Medicine is a very serious example of where deviation from regulations would give rise to difficulties in the future and give us real headaches. We await hopefully the adequacy decision on data, as well as the longer-term inclinations of the UK - it should be remembered that it is a major pharmaceutical exporter - to maintain alignment with European regulations and standards for medicines. We are watching this very closely. I will be able to give a fuller response as it unfolds.

Senator Niall Ó Donnghaile: I thank our visitors. I apologise for missing the start of the meeting and the contributions. I hope my initial question will not be too repetitive.

I am still not clear around the issue of cataract treatment and hip replacement, for example, under this directive. How does it apply to ordinary citizens in terms of retaining access to healthcare in the North? I would be grateful if that could just be touched upon again.

I am obviously coming at this from a different perspective in terms of any detail around reciprocal arrangements for people in the North who want to avail of healthcare in the South. What is the latest on that?

During the passage of the Brexit omnibus legislation, the Minister announced that citizens in the North would continue to have access to the EHIC, European health insurance card. While appreciating there will not be too many European holidays at the minute, I am just wondering, as we emerge safely out the other end of the restrictions, just what measures are in place to ensure that people know that they still have access to that entitlement. We have lost a hell of a lot of entitlements and rights in the North but this is one that we can retain. It is important that people know that entitlement is there and how they can access and avail of it should they be travelling once it is safe to do so.

Senator Joe O'Reilly: I agree with my colleague, Senator Robbie Gallagher, on the impact on the Border areas. We share the same constituency on the Border quite amiably and certainly so between elections.

The cross-border healthcare directive has been hugely successful. The participation levels established that. Ms Catherine Donohue nailed it in the kind of people she identified who are using it. That is a vital dimension.

I would like to see progress on the permanent replacement with no gaps between it. How will that be achieved?

The one way one will achieve a united Ireland - we all aspire to that in our different ways - is to establish areas of co-operation and normalisation of relations. Health is an obvious one. That is seen as part of it. It was mentioned that there is still co-operation with Altnagelvin Area Hospital. Will the witnesses comment on how this is going forward with cross-border healthcare? Quite apart from the cross-border directive, on direct input and co-operation in general in public health and hospitals along the Border, I note the point well made by Mr. O'Connor that in emergencies there is a contingency plan to share facilities. That is how it should be. That is great. However, I would be interested to hear how Mr. O'Connor sees ongoing co-operation developing, whether it could be a victim of Brexit, if so, how could it be remedied from the

point of view of our report, and if it will not be a victim of Brexit, if Mr. O'Connor can detail any of it. I thank Mr. O'Connor and our guests.

Mr. Muiris O'Connor: I thank the Senators. I will start by responding to Senator O'Reilly's questions on the general implications of Brexit for cross-Border health. I will go to Ms Donohoe for the issue of the continuity of access to services in the North and Ms Morgan on the ability of residents and citizens of the North to access services in the South and on the issue of European health insurance card, EHIC.

In response to Senator O'Reilly on the co-operation in healthcare and the implications of Brexit, Brexit, certainly on the face of it, presented many challenges for the continuity of care on a cross-Border basis, but in many other ways it has brought us even closer to our counterparts, both in the North and in the UK, because we recognise that under any circumstances we still are stuck together and we still are neighbours and always will be no matter what the wider political affiliations to the European Union will be.

I would describe the cross-border directive as perhaps the only aspect of the totality of the existing co-operation that required a special further arrangement. All of the rest of the continuity is protected in the Good Friday Agreement and it very much flourishes in the framework of the common travel area. It was not widely reported but, in May 2019, the Minister for Foreign Affairs and his UK counterpart signed a memorandum of understanding on the common travel area which included a reference to health. Between that time and December last, we worked intensively with counterparts in London and in Belfast to provide a basis independent of the European Union for the continuation of all reciprocal health rights and all the co-operation that existed. Under the common travel area, essentially, people on the island of Ireland and the island of Great Britain have the rights to travel, reside and work anywhere, and vote in each other's elections even. Particularly associated with the right to work are the importance of social welfare rights, and in the European framework health, rights are envisaged as part of social welfare rights. We have a basis for total continuity in co-operation.

Altnagelvin is absolutely secure and has a bright future. Our provision of emergency paediatric care to young infants from the North, from Crumlin now and soon to be from the children's hospital will continue to be on an all-island basis.

Something we were afraid of is that in our work to mitigate the implications of Brexit, we did not just want a pause, a freeze or to hold what we have because what we have in health is a trajectory of deepening co-operation. The Senator, from his neck of the woods, would see just how practical it is. It does not feel like international co-operation. It is community level health co-operation in most instances and it is thriving.

Peace Plus and the early commitment to it gave great reassurance around the Border area that there will be more investment from the EU, supported by London and Dublin, in that kind of co-operation. We probably know our London counterparts and Belfast counterparts better than we did before this, and the co-operation was excellent beforehand.

The cross-border directive, as I explained earlier, was one thing that was not reciprocal because the UK was not engaging with it and, therefore, it was not possible to encompass it in the wider agreement. We were not to know this but in the end we were very reassured about how comprehensively the EU-UK deal between London and Brussels provided for continuity in health and social care. We had meetings with counterparts in London and Belfast as recently as last Friday. We now have to exchange letters and clarify legally which pieces operate on

the basis of the European-UK deal and which pieces are in respect of the common travel area. In the future the common travel area agreement for full co-operation and reciprocal rights is enduring, irrespective of how the EU-UK relationship goes. We are very happy to be able to provide that strong assurance on that.

On public health, we are looking for areas to continue to co-operate, and public health is an obvious one. Cancer care is also an obvious one and there is much of modern health and precision medicine that requires scale of a level that neither the South nor the North has. The instinct to co-operate, therefore, is really strong. I will pass now or to Ms Donohoe who can speak on the continuity of access to cataract and the hip and knee procedures.

Ms Catherine Donohoe: The cross-border directive in respect of cataract and hip and knee procedures is continuing as normal. The new arrangement will have no impact on patients whatsoever and will ensure they have continued access from January of this year through to December and, it is hoped, beyond that in due course. There is no impact on patients. Patient access is being maintained.

Chairman: I thank Ms Donohoe. I will go back now to Mr. O'Connor.

Mr. Muiris O'Connor: Ms Morgan wishes to come in on the access that now exists for citizens and residents in the North in respect of accessing care in the South.

Ms Emma-Jane Morgan: On the question of the EHIC rights, which the Senator raised questions on in particular, the Senator is correct that we did have some Brexit contingency planning as part of the Brexit omnibus Bill, which is now an Act, to provide, in the event there was no deal and a loss of EHIC rights for our citizens in Northern Ireland, that the State would put in place a reimbursement scheme. I am pleased to say that it is not actually necessary for the Irish Government to implement that scheme because, under the trade and co-operation agreement, those rights have been maintained for the citizens of Northern Ireland. Everybody in Northern Ireland who currently has a European health insurance card is able to continue to use that card up until the date it expires. Once it expires, the UK Government is putting in place a new global health insurance card and people will transition onto that card. There was no need then for the Government to implement its contingency plans because of the maintenance of those rights under the trade and co-operation agreement. This scheme would have been inferior in many ways because it would have been a reimbursement scheme and people would have had to pay up front for costs. In this way, people will now just present their EHIC or their global health insurance card as normal, whenever they can travel abroad, and access healthcare in that way. They will apply for that in the same way in the North as they have done heretofore through the NHS.

Chairman: I thank Ms Morgan for that contribution. A couple of questions from Senator Dooley and me are all that remain now and I will hand back then to Mr. O'Connor and we will seek to finish up around the hour mark.

Senator Timmy Dooley: I thank the Chair, and I thank our three participants for the work they do on an ongoing basis and for their presentations today.

Do our witnesses think it is possible in any reworked scheme that we could do away with this necessity for people having to pay up front and be reimbursed later? Perhaps that is a departmental issue, but from a patient's perspective, it is a disincentive to some, and particularly for older people, to have to go through the process of borrowing what can be a large amount of money. I am aware that this is in the knowledge they will get the money back, but Ms Donohoe,

more than any of our witnesses because she deal with people, will be well aware how cautious elderly people are, especially that cohort form rural areas, which she has spoken about. They live by the premise that they never owe anybody any money and they try to ensure that nobody owes them money. It is a cultural thing and an age-related issue. However, it is a significant inhibitor because a number of people I have dealt with, notwithstanding the assurances they were given, were reluctant to the point they did not go ahead with it. Quite frankly, they did not want to engage with financial institutions. Some of them have very little interaction with financial institutions. They certainly did not want to be in a position whereby they would have to borrow that kind of money. Is there a methodology we could use or a simplification of the process? I know it would involve engaging with the service provider on the other side but it is normally accepted that if the State will pay for something it should be good enough from the service provider's perspective. I would like the thoughts of the witnesses on this. Perhaps it is for a different forum with regard to how it might get resolved but I would certainly like to hear their views.

Chairman: I have some questions. The witnesses have answered quite extensively on what the plan is for beyond the 12 month period. I was going to ask a similar question to Senator Dooley's. To pick up on what Mr. O'Connor said about the basis being there for total continuity, perhaps we do not want total continuity. Perhaps we want a slightly reworked system. Heretofore, we have been bound by the 2011 EU directive that put the scheme in place but now we have an opportunity to look at the drawbacks of the scheme, for want of a better phrase, and look to see how we can make it better and improve things.

Certainly my experience of dealing with people in my area is that there was a huge fear about borrowing to fund access to healthcare. We know that quite often what the State is willing to pay does not meet the full cost of the treatment and there can be a shortfall. Often, people do not know what that is going to be until they have embarked upon the process of engaging with the healthcare provider in the North. This is a disincentive to people accessing treatment. If one were to be very cynical it probably suits the Department and the State not to incentivise too many to take up this route because it is quite a significant cost to the health service. I hope it is not something that may be an underlying policy, whereby we do not want to encourage too many to avail of cross-border treatment.

We should look at streamlining it and making it a bit easier. We should not have a situation where politicians are bussing people to the North to get treatment. This shows there is a deficiency in the service. The reason there is such demand to go across the Border for healthcare is because our health service cannot cope with the demand that is here. Why can I purchase private healthcare in Northern Ireland and get reimbursed by the State but I cannot purchase it here in the Republic and be reimbursed in the same manner? We need to look at this, particularly because we know the colossal waiting lists that will be there after Covid. They are climbing all of the time. We are all very aware of this and familiar with it but at the end of the waiting lists are a lot of people who are really suffering and living in constant pain with a very poor quality of life. They also include many elderly people. I implore everybody working on this to try to rework the system and make it work for the patient not for the service provider. Really, the patient has to be put at the heart of this.

I want to touch on the need to provide certainty beyond the 12 month period. Senator Gallagher mentioned PDFORRA, the representative body for the enlisted ranks of the Defence Forces, whose representatives will come to our next session in the next hour. I am not sure which speaker described the medical assistance scheme in place as brilliant. The scheme has been

put in place to bypass the barriers the State has put in place to access cross-border treatment. This particular assistance scheme allows members of the Defence Forces to get money from the scheme to pay for treatment upfront. The State then reimburses the scheme and any shortfall is met by the scheme itself based on people paying an annual fee. If we are describing this scheme as brilliant when it is there to bypass the barriers we put in people's way in accessing healthcare we have a problem. These barriers should not exist. It is the ingenuity of people responding to the needs of those they look after to try to get them that healthcare despite the significant barriers the State put in their way. Let this be a lesson to us that we have an opportunity now to remove these barriers. One of the impacts is the uncertainty of this 12-month period. It is great we have a sticking plaster, if I could call it that, that kind of bridges the gap, and PDFORRA was looking to expand that scheme to take in family members, which is great because why not look after more people who need healthcare and keep them healthy? However, they are not in a position to expand because they do not know whether they can rely on access to treatment in the North beyond the 12-month period. Yes, they have acknowledged, as I am sure others will, that they can access treatment in Germany, France or other member states but, because the cost of travel and accommodation is not included in the reimbursement, travelling is not an option for many people, who can barely get the funds together to pay for the treatment itself.

Those are not so much questions but more statements and giving my own two cents on where we are at. I want to finish by thanking all four of the witnesses for taking the time to come to speak to the committee. This will form a significant and important part of our report when the committee comes to make its report before the summer recess. It is one of the areas that will be of most interest to the average citizen, who will be looking at the impact of Brexit across the country. I thank the witnesses and hand back to Mr. O'Connor.

Mr. Muiris O'Connor: I thank the Chairman. This session has been very valuable for us and we would regard it as a direct input into our thinking and into framing the scheme on a statutory basis. To deal with the administrative basis and, as the Chairman said, the sticking plaster, Brexit ran very close to the cliff edge in terms of the high-level negotiations, as we all know. We had a huge programme of work across this and many other areas to mitigate all the risks that arose. One of the reasons it is not on a statutory basis, as well as the compressed preparation time we had, is the very substantial complexity that arises in putting a scheme such as this on a statutory basis. I cannot give specific answers to the question of whether the payment upfront can be done away with, but I can assure the Chairman that all operational and policy matters will be considered.

As a Department, we absolutely empathise with the seriousness identified by Senators in regard to the waiting times that arise here. Like them, we are concerned about the further deterioration in waiting times that is almost certain to arise from Covid. However, putting a scheme like this on a statutory basis gives rise to matters of equity. Procuring outside of the European Single Market gives rise to WTO tendering issues and other issues. Absolutely, we will have to get stuck in on this really early, and we will be taking input on it as we go. We recognise the need for certainty.

While it is a scheme we support, it is regrettable that it is investment that is not improving facilities in this country, and that is something we are very keen to address through Sláintecare implementation and other mechanisms. We would pay a lot of attention to the services that people are seeking through the cross-border directive and the new Northern Ireland scheme to ensure we are also making the correct investments in those services in our own jurisdiction.

I thank Senators and I very much welcome all of their thoughtful questions. As I said, they

have raised many issues that we will be processing in working with our Minister and the Government on the statutory scheme in the immediate period ahead.

Chairman: I thank the witnesses for being with us this afternoon. We are finished right on the button, which is great. I thank the witnesses for their engagement and we look forward to further engagement with them on those issues. We will now go into private session.

The select committee went into private session at 4 p.m. and resumed in public session at 4.02 p.m.

Chairman: We are back in public session for the second part of the meeting. I must outline the issue of privilege again for the witnesses. I remind witnesses that the evidence of witnesses physically present or who give evidence from within the parliamentary precincts is protected pursuant to both the Constitution and statute by absolute privilege. However, witnesses who are to give evidence from a location outside the parliamentary precincts are asked to note that they may not benefit from the same level of immunity from legal proceedings as witnesses giving evidence from within the parliamentary precincts and may consider it appropriate to take legal advice on this matter. Witnesses are also asked to note that only evidence connected with the subject matter of the proceedings should be given. They should respect directions given by the Chair and the parliamentary practice to the effect that, where possible, they should neither criticise nor make charges against any person or entity by name or in such a way as to make him, her or it identifiable.

This is the second session on the cross-border treatment directive and I welcome the witnesses Mr. Mark Regan, chief executive of Kingsbridge Private Hospitals; Mr. Martin Bright, deputy secretary general of the Permanent Defence Force Other Ranks Representatives Association, PDFORRA; and Mr. Damien Quigley, PDFORRA. I thank the three witnesses for giving their time to be with us this afternoon to discuss the implications of Brexit, the loss of the cross-border treatment directive and what that might mean for healthcare on the island of Ireland.

I invite Mr. Regan to make his opening statement.

Mr. Mark Regan: As the only Irish hospital group with hospitals on both sides of the Border, one in Sligo and one in Belfast, Kingsbridge Healthcare Group was uniquely positioned to facilitate the flow of patients in both directions when the cross-border directive was operating up to December last year. The volume of patients travelling from the South to the North dwarfed the volume travelling in the reverse direction. There was a host of reasons for that, including, but not limited to, the exchange rates and the lower cost of private surgery in Northern Ireland than in the Republic of Ireland, which ultimately resulted in lower financial shortfalls for patients. That is an important point I will return to momentarily.

Typically, we find that clinical outcomes are directly proportional to any delay between the date of a referral through to the date of treatment, if it is in any way protracted. While the Irish State does not have the capacity to treat every patient on a waiting list, obviously, the continuance of this scheme beyond December 2021 would allow for many more patients to access treatment in a timely fashion.

It is of note that the cost to the public purse of patients accessing the scheme is similar to that if they had accessed it within the HSE. Any gap or shortfall, while minimal, is picked up by the patient and not the State. The shortfall relates to the procedure only and not travel, which

is excluded from the scheme. On that basis, accessing the scheme through Belfast means they are availing of a lower-cost surgery and thus a lower shortfall, as well as minimising the cost of any additional travel by staying on the island of Ireland. While patients can use the scheme for any consultation, scan or surgery that they can get within the HSE system, the majority of patients by volume present to be assessed for ophthalmology, orthopaedics, gynaecology, urology, neurospinal and ear, nose and throat, ENT, services.

While Kingsbridge offers support and education schemes through a one-to-one service in its Belfast hospital, it is not always possible to know which patients are using the scheme and others who simply may be medical tourists outside this scheme completely and attending from just over the Border to come to Belfast for timely treatment through private treatment. Since the autumn of 2017, we estimate that of the total episodes of care, approximately 28,000 have come from the Republic of Ireland to Kingsbridge Belfast. The Border counties, that is, Leitrim, Donegal, Cavan, Monaghan, Louth and Meath, typically account for approximately 6,500 patient episodes. Total surgeries come to approximately 8,000 and there were approximately 10,000 first consultations. It is also notable that approximately 1,300 patients have travelled from counties Cork and Kerry, showing that distance travelled on the island is not an issue or a barrier for them.

It is crucial to note that the scheme is used predominately by those with little or no disposable incomes and by those who cannot afford private healthcare in any fashion. The majority of the patients will use bank or credit union loans to cover the cost of surgery while they await that refund from the State. The average age is between 50 and 75 years, and many of them will rely upon relatives to support them in the journey to Belfast. This last point is of particular note when one considers that if the scheme is not passed into Irish law before December this year, they will be forced to travel to mainland Europe if they wish to avail of this type of scheme. This has implications for increased cost, which is not refunded, and would be an additional burden to the family to support the patient travelling through an airport system.

It is also of note that numerous medical colleges advise against flying in the days and weeks post surgery, unless accompanied by a medical team. The other option is to wait on the public system in Ireland but the table I have provided to members today will give some examples of why this becomes a problem. I will not got through these as it is available to the committee online. In essence, however, I have given figures around muscle decay becoming fatty infiltration while the patient waits. This is never recovered post-surgery with a host of problems. In hip replacements, patients can become addicted to pain relief. Even after the surgery they find it difficult to wean themselves off that. The actual surgery itself is technically more difficult whenever a patient has been waiting for three, four or five years and is down to bone on bone before he or she can have the surgery, and therefore the complications rate is also significantly increased. I have also submitted a list on cataracts to members that will raise similar points on the complexity and importance of getting early intervention within a year or so, and not three, four or five years, as we see with many of the patients who come to Belfast.

Chairman: I thank Mr. Regan for his opening statement. It made for quite sobering listening, and particularly the last part. I will now ask PDFORRA for its opening statement.

Mr. Damien Quigley: I thank the committee for the opportunity to speak on this very important matter. I am the national support officer of PDFORRA and a director of the PDFORRA medical assistance scheme, PMAS. I am accompanied by my colleague, Mr. Martin Bright, who is deputy general secretary of PDFORRA and another director of PMAS.

PDFORRA is the representative body for enlisted personnel serving in the Defence Forces and we have a membership of more than 6,300 across the Army, Naval Service and Air Corps. For a significant number of years, PDFORRA became increasingly worried that a high percentage of our members who had become injured in service to the State were unable to continue in service in the Defence Forces because of extended waiting lists for medical treatment in the public health system. Since 1994, new contract arrangements for enlisted personnel applied stricter health and fitness criteria for each period of re-engagement. Consequently, a member could be discharged and lose his or her job if medical treatment was not provided quickly.

This problem is not uncommon due to the intense and physically demanding nature of military service. Injuries and accidents happen and are part of life in the Defence Forces. In order to keep their jobs, those concerned relied on the military medical services and public health service for prompt treatment. The military medical service only provides GP and primary care, while the public health system, because of very long treatment waiting lists, is unable to provide medical treatment quickly enough.

Unlike commissioned officers, enlisted personnel are not provided with free private medical care and are not in a financial position to pay for expensive private health treatment. In the foregoing circumstances, PDFORRA established the PDFORRA medical assistance scheme, PMAS, as a not-for-profit company limited by guarantee to facilitate members who required prompt medical treatment. This was to ensure their continued service in the Defence Forces or indeed on overseas service with United Nations. The scheme facilitates members in securing medical treatment, mainly in Northern Ireland, under the European Union cross-border healthcare directive.

The financial model used is based on the member who needs treatment seeking sanction from the HSE to receive the treatment and borrowing the necessary finance from the ANSAC Credit Union. These loans are guaranteed by PMAS. Once the treatment has been received the individual will get a refund of most of the costs from the HSE. Where the refund does not cover all the costs the member receives money from the PMAS fund to cover the shortfall. The PMAS fund was initially established by a loan of €150,000 from PDFORRA and is maintained and added to through member subscriptions.

The first PMAS member received treatment in Kingsbridge Private Hospital, Belfast in July 2018 and to date over 250 PMAS patients have been processed for treatment under the scheme. Membership of PMAS has risen to just under 3,000. It would be fair to say that the scheme has been a success in the short period that it has been active with many careers secured as a result, but also many important interventions for individuals in terms of ending pain, suffering and anxiety. The military medical service in particular sees the benefits of the scheme and refers injured members for treatment regularly. It recognises PMAS as a pathway to solving medical problems, reducing sick leave and retaining enlisted personnel.

The success of the scheme saw PMAS plan to formally increase its staff and to expand membership to include family members. However, Brexit and the Northern Ireland protocol have presented a challenge we did not predict. PMAS thought that the cross-border directive would still apply to Northern Ireland because it has a similar status to the European Economic Area, EEA, countries such as Norway, where cross-border healthcare takes place under the cross-border directive. For reasons that PMAS does not understand, this route appears not to have been pursued. Instead, a temporary and comparable scheme has been put in place by the Government in respect of residents of the Republic of Ireland seeking treatment in Northern Ireland. It is known as the Northern Ireland planned healthcare scheme.

The temporary nature of the new arrangements has led to PMAS putting off any expansion plans in respect of staff and family membership. It is our understanding that the Government scheme will only last for the remainder of this year and may then fall and not be replaced on 31 December 2021. In theory PMAS members will be able to go to other countries in mainland Europe for treatment. However, this is considerably more difficult from a travel perspective and, crucially, very much more expensive for the individual as a result of travel and accommodation costs. PMAS is not sure it can deliver such a service and further believes that members will not opt for such an approach. The net effect of this will be more medical discharges of enlisted personnel and, PMAS believes, more individuals voluntarily leaving the Permanent Defence Force.

PMAS previously wrote to the Minister for Health, Deputy Stephen Donnelly, seeking the continued operation of the cross-border directive in respect of Northern Ireland as part of the Northern Ireland protocol after Brexit. We have again written to the Minister for Health to ask him to give the Northern Ireland planned healthcare scheme a permanent status. This action will give our members the security they need in terms of medical treatment and career certainty.

I ask my colleague, Mr. Martin Bright, to give an outline of the experiences some of our members have had using the scheme.

Chairman: Absolutely. We would be delighted to hear from Mr. Bright.

Mr. Martin Bright: In the overall scheme of things I would like to give the members of the committee two short testimonials of what the treatment has meant for people. These are real people and the difference the cross-border hospital directive has made for them is life changing. PMAS has sent just over 1,200 members of the Defence Forces for treatment. We have successfully moved 256 people to surgery. Most of the surgeries are orthopaedic, which is a consequence of the robust nature of military service. Some other small surgeries are captured under the terms of the cross-border directive. However, we address anything that would be career ending and would stop people from serving. There is constant ongoing demand for the service. In the past two weeks alone, another 14 members have been referred to us by the military authorities for treatment.

I will give the committee a flavour of the impact the scheme has on people. First, a male member of the Defence Forces aged in his early 40s was waiting in excess of two years for surgery on his knee. He could not afford to pay for private care and could not save the money for treatment. His career was basically on hold as a consequence. He could not go oversees or attend his skills and promotions courses. He faced the medical board and discharge from the Defence Forces. Due to the cross-border directive, in tandem with PMAS, he underwent surgery. He has not only been retained in service, he has since been extended in service for the Defence Forces, has been promoted and has served overseas on two occasions, once in Syria with the United Nations Disengagement Observer Force, UNDOF. He is currently serving with the United Nations Interim Force in Lebanon, UNIFIL.

Second, a female member of the Defence Forces aged in her early 30s was undergoing IVF treatment when cysts on her ovaries were found that rang alarm bells. Urgent medical intervention was needed. Within seven days, PMAS, in conjunction with the cross-border directive, turned the member around. She received her treatment, has returned to normal life and, I am happy to say, is now well advanced in her pregnancy. She went through IVF and cancer and is now pregnant. That is the impact the scheme and the cross-border directive have on the real lives of the people in the Defence Forces we represent.

Chairman: I thank Mr. Bright. He provided an important context. It is important that we focus on the people who are affected, as opposed to always taking the more high-level policy approach. His remarks are very welcome. I thank the witnesses for their opening statements. We will now open up the floor to members of the committee for questions.

I wish to advise Mr. Quigley and Mr. Bright that witnesses from the HSE spoke in our first session. They will be pleased to know that PMAS was described by one of them as brilliant. They are getting high praise from the right places. Well done on the initiative.

Senator Robbie Gallagher: I welcome the witnesses and thank them for taking time out to be here. Mr. Regan and I have spoken many times down through the years. I always found him very helpful. He has experience of the current scheme. How does he think any new scheme could develop? What were the pitfalls, if any, of the old scheme that he would like to be addressed in any new scheme? That information would be important.

I have a question for Mr. Quigley. The merits of the scheme are beyond doubt. Everyone has sung its praises. I have spoken to many members of the Defence Forces who have used the scheme and the witnesses deserve great credit for setting it up. It has been a huge success. I speak for all the committee members in saying that part of the reason we have the witnesses here today is our commitment to ensuring that this EU scheme is implemented by the Government and that it addresses the needs not just of the Defence Forces but also of the general public. In the context of the extension of the scheme to family members, I know the credit union has an internal system. Would the witnesses envisage that any potential new scheme would have the capacity to be extended to family members, as well as to serving members?

Mr. Damien Quigley: There is fantastic potential in the scheme for our family members as well. The reason is that the model is quite the same whether one is in service or not. We have a fund of money which allows for shortfalls to be looked after. We can secure finance for people with ANSAC - Army Naval Services Air Corps - Credit Union. ANSAC was set up by PDFORRA and it has been very good at supporting us. There is potential to bring families on board, as well as ex-PDFORRA members, but we need that level of certainty. Towards the end of last year we were uncertain that this scheme was going to happen. It created a massive panic among our membership. Many people borrowed, jumped ahead of the queue and tried everything they could to get treatment for fear that the scheme would end. We hope that it would not be left to later in the year and that it would be flagged. We are very encouraged to hear the support we have received. It is heartening. We hope a determination is made early in the year to continue the scheme.

As regards family members, the press always gets that the Defence Forces were poorly paid, and the families suffer a great deal because of military service. We think it would be an excellent initiative to give back to family members, but we would need that level of certainty to be able to do so. We are hoping we will be able to get that. Again, I thank Senators Wall and Gallagher for their support over the past few months. It has been very important and we appreciate it.

Chairman: Does Mr. Regan wish to comment?

Mr. Mark Regan: I echo what Mr. Quigley said regarding the frenzy we saw many times last October and November when people thought this scheme was going to finish, with people jumping ahead of queues. There was a deluge forward to get this over with, and the stress that went with that. Then, in December, nobody was willing to take the risk and nobody got treatment. I cannot stress enough the urgency of trying to get this into law as soon as possible

to ensure stability in the scheme, not leaving it until after the summer and into the autumn to experience that again and the stresses it caused for many of the patients.

With regard to the initial question from Senator Gallagher about what we would do differently or what the shortfall was in this, so far there has been no perceptible difference in the scheme from last year to this year. It has worked largely the same. I worry that while I may have a list, and I alluded to two or three things that would potentially improve it, they also create an element of a barrier to accessing the scheme, which may be morally wrong but, as a societal matter, it is probably better that there are not hundreds of thousands using this and that it is maintained to a degree. That is challenging healthcare to try to get across that it is not being financially driven by access to finance, but making it perfect may well tip the scales whereby the entire thing collapses.

The shortfalls are a problem whereby patients gather the information on what they believe will be a shortfall and get approval from the HSE. When they have the surgery, however, they may find that the shortfall is slightly different. That is due to the coding that is used. Both institutions in the North and the South use different coding systems to describe the surgery. Perhaps there should be a tightening up of that whereby if one gets a pre-authorisation for a given code and that surgery is carried out, then that is locked in after the surgery so the patient does not get a shock when he or she comes out of surgery. That is what we have tried to do for the past five years in Kingsbridge in Belfast in order to make sure that there are no shocks. We want this scheme to be used as it is. It is not a money-making racket or about charging people more. It must be done morally and properly, and we must try to make it a free flow of information throughout. Finally, the exchange rate also causes a bit of a problem. That is likely to be the case in any event and is outside of our control. Nevertheless, I stress that the scheme has been a massive success for five years. Perhaps changing those ideals will tip it in the wrong direction and leaving well alone may well be the best advice.

Senator Joe O'Reilly: The Chairman's point that the scheme, while wonderful, indicates shortcomings and inadequacies in our health service that need addressing is a given. I congratulate PDFORRA. The scheme is a wonderful bit of self-help and a wonderful initiative. Like Senator Gallagher, I come from an area with a large PDFORRA presence. There is a large PDFORRA membership living in Cavan town and beyond. It is a very good initiative. The witnesses from the earlier session would suggest that there will be a continuation of the cross-border directive. I hope that the PDFORRA scheme will continue and that it will be extended to family members. I cannot see why that would not be possible.

As somebody who has many PDFORRA members as neighbours and friends and who knows many of its members throughout Cavan and Monaghan, I congratulate it on the initiative. It is great to take the initiative on one's own to deal with a problem. The association has done something about feeding the pig, rather than just weighing it.

Mr. Damien Quigley: I thank the Senator for the kind sentiment. We initially set a target of 3,000 members and we are very close to that target. If we had certainty that the scheme would continue, we would be in a position to employ staff and to roll it out to families. It would be a welcome development and our members would appreciate it. The medical officers of the Defence Forces have totally embraced the scheme and know about the benefits of membership of general. We know, through our committees and through a breakdown of every meeting we hold with other groups and so on, that bringing the families on board would be a fantastic initiative. We have been able to help family members as it is. We have helped probably in excess of 20 family members, who avail of the scheme in the same way but we do not source the finance for

them. They deal directly with their own credit union or bank but we have been able to get them the same rates. Mr. Regan and Kingsbridge have kindly reduced their rates for our members. Even though family members are not officially or statutorily on our books at the moment, which we hope they will be soon, a large number of family members avail of cross-Border treatment and of the reduced rates that Kingsbridge has offered. That has been very welcome.

Mr. Martin Bright: Mr. Quigley hit the nail on the head. It is an excellent scheme, and while it is our intention to roll it out to family members, unless it is put in place on a full-time basis it will not be possible and we may have to consider sending our members to mainland Europe for treatment. As Mr. Regan said earlier, we would not like to have to put people on a plane and send them to mainland Europe, to allow for surgery and the recovery time after that, and then to put them on the plane back. We really would like the cross-Border scheme to be retained.

Mr. Mark Regan: As Mr. Quigley said, I treat each patient as an individual so family members would be very welcome to us. Yes, we do respect that the PDFORRA aspect is looked at slightly differently but as the individual patient comes to us we treat them the same.

Senator Mark Wall: I welcome our three guests. It is very telling, as the Chair has said, that the previous speakers described the scheme as brilliant. Great credit goes to Mr. Quigley, Mr. Bright and PDFORRA for setting up PMAS. I was very interested in Mr. Bright's personal stories because at the end of the day that is what this is all about, helping people as often as we can, which is what we all set out to do in our daily lives.

My first few questions are for Mr. Quigley and Mr. Bright. How many of the Defence Forces personnel are waiting or are afraid to proceed with the scheme because there is only a 12-month lifecycle? Is there a waiting list of personnel? If so, how many people are on the list?

Mr. Quigley made the very important point that the commanding officers of the Defence Forces are very much behind this initiative. It is great to see buy-in by commanding officers and serving personnel and their collaboration to get serving personnel back into service as quickly as possible. Was that the case in the early days? Did the commanding officers always see the benefit of the scheme or is it only since hearing the testimonials, as Mr. Bright has described for us recently?

It was a great idea for PDFORRA to include family members. The initiative is what makes PDFORRA a great organisation; not alone does it try to help its members but it also tries to help family members. That goes to the core of what PDFORRA stands for in my personal opinion. Mr. Quigley mentioned that PMAS was started with €150,000 of credit union funding from the organisation's own credit union. How much money has been involved or is going through it at the moment? How much more investment has been received in setting up and administering the scheme?

Mr. Quigley has mentioned that very few people help out with the scheme at the moment and it is just himself and one or two others. Can he please let us know his vision for the future growth of the scheme?

Today, we have heard about the Northern Ireland planned system which sounds good. I have no doubt that we need to place it on a legal footing as soon as possible. Notwithstanding what has been said by the Chair, because it is very important that we acknowledge there are shortcomings in our health system and we all know them, PMAS offers its members a solution

to their problems. I have asked previous speakers whether they saw a problem with PDFORRA proceeding with PMAS to which they have answered "No" in addition to describing it as a brilliant system. Do the witnesses see problems with this continuing, aside from it not being on a legal footing of more than 12 months? Have they seen anything worrying in the paperwork for the new system aside from it just running until 31 December?

I thank Mr. Regan and the staff of Kingsbridge Hospital for the work that continues to be done. It is very telling that 1,300 people have travelled from counties Cork and Kerry to avail of services. I have to say with the greatest of respect that it is unfortunate that people must travel but that is what is wrong with the Irish healthcare system and, as the Chair has said, that is an argument for another day. I ask Mr. Regan to convey our thanks to all of the staff for the terrific work they have done for the people who have availed of the cross-border directive.

Finally, we have had a brilliant discussion and I want to put on record my thanks to PDFORRA and to all of the staff and Mr. Regan at the Kingsbridge Hospital.

Mr. Mark Regan: I have nothing specific to add as most of what has been said relates to PDFORRA but I will convey the Senator's appreciation to the staff who work tirelessly to make sure these patients are facilitated the same way as they would be at home.

Mr. Damien Quigley: On waiting lists, unfortunately because we can only allow secure credit for so many people at a time this creates a bottleneck at certain times. For this reason, the association made the decision late last year to lift some of the self-imposed restrictions and hope that things work out well. Doing that has been a good move and many more people have received treatment. As Mr. Bright said, 14 new members have also been referred for treatment in the past ten days or so. There is demand for the scheme.

Senator Wall is correct that the testimonials from individuals are what sells the scheme. People go back to Limerick, Cork, Kildare, Dublin or elsewhere and tell their colleagues around the barracks, on the Naval Service ship or in the aerodrome about how they have been treated, the class and nature of care and the speed of treatment. Shortly afterwards, a large number of people from the area in question will suddenly join the scheme and seek treatment. We try to process as many people as possible but if we had certainty, we could potentially grow the scheme much quicker. If we had full-time staff, we could process people through the system faster.

PDFORRA stood fully behind the medical assistance scheme and has even offered more money to support, invest in and grow it further. However, it is aware of the uncertainty with Brexit and all that went with it. The first thing the association did was provide a loan of €150,000. There are further funds available if PMAS needs them. For a representative association to do that has been excellent.

In the past couple of weeks, I have received emails from medical officers overseas, whether it be Syria or Lebanon, who have forwarded referral letters. The word is getting out. The medical officers see it now as part and parcel of the service and the treatment they can get and they recognise the benefit of it.

Regarding setting up the scheme, I must give great praise to Ms Donohoe, who was absolutely fantastic. She told us what the HSE expected, set down the guidelines and informed us of the paperwork and so forth. She is an absolutely fantastic advocate for patient care. We then met Mr. Regan and his team in Kingsbridge Private Hospital. We brought the director of

the medical corps at the time to meet them and he was more than satisfied that the hospital in Belfast provided the right level of care for our members. There was, therefore, buy-in from the start, which was very important.

Many thanks go to Kingsbridge Private Hospital. In the personal testimonials, we had a number of cases of people with potential cancers. As a result of Covid-19, especially last year, PMAS called in many favours from the hospital and said that these people had to get treated immediately. It is very worrying to go for a scan and be told one potentially has cancer but it is even more so when one is told the next appointment will be in five or six months' time. We have been able to use our scheme to have the issues of individuals in question addressed. As Mr. Bright outlined, one of the cases had a very successful outcome as a consequence of that. Personal testimony is what matters.

Chairman: I thank Mr. Quigley. Does Mr. Bright wish to add anything to that?

Mr. Martin Bright: The scheme has been running since July 2018. In those 32 months, some 1,200 members of PDFORRA have been referred for treatment. As I said, 256 of them had surgery and they have remained in service at a time when the Defence Forces has a recruitment and retention crisis. I am not going to make a political speech about that issue as that is a different hat for another day. The ability to retain this cross-border directive will keep people in a job and in their homes doing something they love. That is what we want. The issue needs to be addressed quickly so that we do not have this cloud hanging over us like we had previously. As Mr. Regan said, at the end of this year, everybody will be running up to Kingsbridge Private Hospital to try to get surgery in the event that the extension falls. The issue really needs to be addressed for people's peace of mind.

Chairman: I thank the witnesses. I have a couple of questions, since I think all the members have spoken at this stage. It is nice to hear praise for Catherine Donohoe going in both directions at both sessions. There seems to be a good relationship between the hospitals, PDFORRA and the health service, which is good because that benefits the patient. Mr. Bright is right that if we were to discuss recruitment and retention in the Defence Forces, we would be here all day and night and well into next week too. That is probably a topic for another day and another committee. He is right that anything we can do to keep people in their jobs and serving is worthwhile. PMAS is clearly doing that. It has directly helped nearly 260 people to stay in a job, which is a fantastic achievement for a scheme that is in its infancy. It has gone from strength to strength and has been a significant success. I give credit to the witnesses for having the ingenuity, foresight and vision to set it up and make it a success. These things might look easy when they are up and running but actually getting there is a difficult task. Finding a way, getting on with the job and doing it for themselves is typical of the Defence Forces, because if they waited for the State to do it, they would wait for a long time. It is indicative of the mentality within the Defence Forces of getting the job done, which is a credit to everybody involved.

My first question is for PDFORRA. It meets the cost of the shortfall. What has been its experience of what the State is providing through reimbursement compared with the actual cost? Is it finding that to be a difficulty or is that manageable for the organisation? We have heard loud and clear about the need for certainty and we impressed on the HSE in the last session that we really needed to know about this. It would be good to get a solution well in advance, unlike everything else related to Brexit that has run to a cliff-edge deadline, so that we can flag it to all stakeholders and know what is coming down the tracks after this 12-month sticking plaster. Why can we not get it done early rather than waiting to the last minute? The witnesses mentioned that there was a limit to how much credit PDFORRA can secure. Will they explain

why that limit is there? Is it self-imposed or is it imposed in conjunction with the credit union it is working with? Is that having a major impact on the people in the scheme waiting to get healthcare?

I was struck by the last part of Mr. Regan's opening statement in which he talked about the impact of patients waiting for longer than they should to get treatment. He referred to the impact of waiting for three years for a hip replacement. He touched on muscle decay, which is irreversible. It is unacceptable that our health service would leave people in that situation where they have had irreversible damage done because they have had to wait. By the time the patient gets to the witnesses, what has prevented them from going sooner? Have they not been able to afford to get the money together? Were they giving the health service in the Republic a chance to look after them? Why were patients waiting for so long before seeking out that help? Have the witnesses identified certain barriers that the committee needs to address in its report?

While I know that Mr. Regan is concerned that too many changes might push this over the edge, one of the points that I and others made to the HSE in the last session was that now we have an opportunity, we are not confined by the directive and we have an opportunity to reimagine all-island access to healthcare and maybe make some improvements and remove some of the barriers that are clearly there. The fact that we have PMAS, people getting buses to Northern Ireland and the demand for the service is because there are barriers to healthcare here in the Republic. What barriers have the witnesses seen to people accessing healthcare at their facility?

Mr. Mark Regan: The first and most significant barrier has been awareness of the scheme. I did a radio interview about two years ago. I was described as the Easter bunny and Santa rolled into one because what we were offering was too good to be true, since one could get healthcare and get most if not all of that money back. It seems like a scam and like it is too good to be true, but it is a reality. The initial barrier was that people did not trust it. It has now turned a corner and it has become mainstream, with the majority of Irish citizens hearing of it or knowing someone who has been through the scheme in one of the institutions. That has been the biggest barrier to it. Shortfall is a barrier for another percentage. I do not know what that percentage is but it might be 20% or 30%. It is relatively small. The biggest problem is people not trusting it. It is a Government-run, State-run scheme. That is changing and the barriers are disappearing. Hopefully, if this can get into law over the coming years, we will see a different attitude to this. Awareness and the shortfall are the two biggest issues.

Mr. Damien Quigley: On the question around finance, we have not just guaranteed finance to everybody. We need to impose a certain limit on ourselves. Our funding body, ANSAC Credit Union, has been good to us and we are growing our loan book month on month. There were difficulties in the past getting reimbursements. Thankfully, the HSE has got more staff on board and we hope to see reimbursements flow a bit more quickly. The sooner we get reimbursements in, the more people can use it and the more people get access to treatment. We hope that, as more people join, we can increase the amount of money we are prepared to borrow. With that, we need staff to process those people. It goes back to the certainty to move ahead and do it.

On shortfalls, 40% to 50% of our members, heading up, have typical military service injuries, whether it be knees or hips. Kingsbridge have sat down with us and agreed treatment rates which match the HSE reimbursement rate so that patients could have little or no shortfall. As we discover new types of procedures, operations and treatments people need, we sometimes uncover different shortfalls. For instance, a hip arthroscopy is one for which the HSE reim-

bursement rate is less than generous for the amount of work carried out. There is a significant shortfall in relation to that. There are other issues around shoulders, ankles and so on but we have built up that fund. First we knock heads with Kingsbridge to see if they can reduce prices to reduce the shortfalls. Then we have our fighting fund. We do not restrict access to treatment for members. If there is a big shortfall, that is what we have set up the fund for. It is so the patient gets the treatment, first and foremost.

Chairman: Does Mr. Bright want to add anything?

Mr. Martin Bright: That is basically it. Mr. Quigley outlined the vicious circle we are stuck in because of the pause we have, trying to get the cross-border directive extended past 2021. It is important to understand that Mr. Quigley runs this scheme on his own. We do not have any staff and we are afraid - that would be the right word to use - to employ staff to extend the scheme. Until it is addressed at its core, we will have to limp along.

Chairman: That brings to a conclusion all the members who have asked to contribute to this afternoon's debate. On behalf of the committee, I thank Mr. Regan, Mr. Bright and Mr. Quigley for their time this afternoon. It has been an excellent exchange of views and we have got a good feel for how the directive was working, what needs to be put in place to maintain the service provided to PDFORRA members and what is required in a hospital setting. It will form a significant part of our report which will be completed before the summer recess. We appreciate the witnesses taking the time to present to our committee and take questions. Everyone has found it useful and interesting. It is good, as well, to give a platform to both organisations to address the committee and push it out to the wider public. It addresses Mr. Regan's concerns around people knowing about the scheme. He referred to himself as the Easter bunny and Santa rolled into one, which sounds too good to be true because we have had such difficulties accessing healthcare in the Republic. It is a great scheme so we need to protect it and make sure we retain access to healthcare North and South for citizens across the island.

The select committee adjourned at 4.50 p.m. until 3 p.m. on Monday, 22 March 2021.