Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Materion Ewropeaidd ac Allanol
The Committee on European and External Affairs

Dydd Mawrth, 24 Chwefror 2009
Tuesday, 24 February 2009

Cynnwys
Contents

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Jeff Cuthbert	Llafur Labour
Michael German	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Sandy Mewies	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rhodri Glyn Thomas	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Dr Tony Calland	Cyn-gadeirydd, Cymdeithas Feddygol Prydain—Cyngor Cymru Former Chair, British Medical Association—Welsh Council
Dr Andrew Dearden	Cadeirydd, Cymdeithas Feddygol Prydain—Cyngor Cymru Chair, British Medical Association—Welsh Council
Andy Klom	Pennaeth, Swyddfa Comisiwn Ewrop yng Nghymru Head, European Commission Office in Wales
Mike Ponton	Cyfarwyddwr, Cydffederasiwn GIG Cymru Director, Welsh NHS Confederation
Chris Riley	Adran Iechyd a Gwasanaethau Cymdeithasol, Llywodraeth Cynulliad Cymru Department of Health and Social Services, Welsh Assembly Government
Paul Williams	Prif Weithredwr, GIG Cymru Chief Executive, NHS Wales

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

Lara Date	Clerc Clerk
Gregg Jones	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Annette Millett	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.10 a.m.
The meeting began at 9.10 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Sandy Mewies:** Good morning to Members, officials and everyone in the public gallery. As usual, headsets are available to hear the translation and for sound amplification, with the translation on channel 1, and the amplification on channel 0.

[2] Please make sure that you have turned off your mobile phones and any other

electronic devices such as BlackBerrys, because they interfere with the sound equipment. I have not been informed of any sort of emergency, so, if the alarm sounds and the ushers come in, we will follow their direction.

[3] I have not received any apologies and I can see that we are quorate.

[4] I am sure that Members will all be as saddened as I was to hear about the passing of His Excellency, Mr Jan Winkler, ambassador for the Czech Republic. He was at our meeting on 3 February 2009 and gave us a very interesting and informative presentation. I also had the very great pleasure of having lunch with him afterwards. I have sent a letter of condolence to his family on behalf of the committee.

[5] You will also wish to note that Christine Chapman, who represents Wales in the UK delegation to the Committee of the Regions, has been selected to write an own-initiative report for the Committee of the Regions on the future of the Lisbon strategy post 2010, which is excellent news for us. We can discuss that work with Christine when we look at the activities of the Committee of the Regions again, in the summer term.

9.12 a.m.

Yr Wybodaeth Ddiweddaraf am Weithgareddau'r Undeb Ewropeaidd/Comisiwn Ewrop yng Nghymru
Update on European Union/European Commission Activities in Wales

[6] **Sandy Mewies:** I welcome Andy Klom, who gave us an update on EU/EC activities on 9 October 2008 and is here to update us again. Welcome, Andy. If you give the update first, I will then ask Members for their questions.

[7] You will know that we had a very useful visit to Brussels the week before last, and I want to give special thanks to everybody who helped with that: Gregg, Des Clifford and WAG officials, and everyone else who was involved. It was a most useful meeting. I think that we got a lot of valuable stuff from it that we are still sifting through, and it really will inform what we do in future. So, it is over to you, Andy.

[8] **Mr Klom:** Thank you very much, Chair. I will pass on those kind comments to my colleagues in Brussels.

[9] We spoke about EU affairs in Wales in October. As you may recall, 2008 was a special themed year for the EU: European Year of Intercultural Dialogue. A lot of our activities here in Wales were focused on that theme, and they were still taking place in October and December. However, 2009 is a new year with a new theme: European Year of Creativity and Innovation. That is, however, being overtaken by the political priorities of the EU. The elections for the European Parliament will be held between 4 and 7 June, and the voting day here in the UK will be 4 June. Based on that, I will be making some comments and describing some of our activities over the past two months and looking forward over the next three months.

[10] January started with a special reception organised with the Czech presidency of the EU, with ambassador Winkler coming over to Cardiff. To my knowledge, that is the first time that a presidency of the EU has organised a function in Wales.

[11] Unfortunately, in January, we also had our evaluation of the Europe Direct initiative. As you may recall, a call for proposals was made in September 2008 and my office was engaged in activities over the course of 2008, fiercely lobbying different entities here in

Wales to attract interest, and maybe to initiate new proposals for different areas. As it turned out, nothing came of that. No new proposals came forward from Aberystwyth, Swansea or the Valleys. Some of those decisions were no doubt influenced by the credit crunch and particularly the Icelandic banking crisis.

[12] To make matters worse, of the five centres that we have in Wales, two are to close. The one in Newtown, which is run by the Wales Council for Voluntary Action, is doing so on a voluntary basis, in that the WCVA has taken the decision not to continue as a Europe Direct centre. It is my understanding that it would rather focus on the convergence programme. The South Wales Europe Direct Information Centre in Cardiff did not pass our evaluations and, therefore, the European Commission is closing it down. That means that, in the whole south-east and central-south part of Wales, there is no Europe Direct centre. The closest one will be in Carmarthen. That decision was based on an evaluation of Cardiff's proposals, which were deemed to be too university-orientated and geared too much towards an academic community, which illustrates the major challenge that the Cardiff centre was battling over the past three or four years, given that no public authorities in this part of Wales were giving any support to the centre and so the university had to do so on its own. Its constituency was very much the university. That decision has been taken but I am still discussing with colleagues behind the scenes whether anything can be changed. However, for the time being, new contracts are being drafted and will come into force from 1 April. That means that we will have just three centres in Wales: two in the north east, in Wrexham and Llangollen, and one in Carmarthen in the south west. Unfortunately, that follows the overall trend in the UK, where some 32 centres are being reduced to just 16, so slashed by half. That is in quite a contrast to other EU member states where the centres are doubling in number.

[13] Let us move on to February. Many activities have been planned for this month, particularly at the beginning of it, when colleagues in the European Commission visited Wales, Scotland and England to discuss the electronic tagging of sheep. Our colleagues from the directorate-general for health and consumer affairs and the European Commission's research centre also visited Llanidloes and Llandovery, which I assisted with. An EU role-play was organised by Aberystwyth University, in which I assisted, and the United Kingdom Permanent Representation to the European Union came over from Brussels to provide private insights into the different positions of players in such situations.

[14] Just yesterday, we held a major school event in Cardiff. For the very first time, Cardiff County Council was involved in a European engagement, organised by CiLT Cymru, Cardiff council, and a range of other organisations, including the British Council, with the assistance of the European Commission Office in Wales. Some 300 secondary school students from an area covering Cardiff, the Valleys, and all the way over to Carmarthen participated in that event, which was geared towards languages and employment opportunities.

[15] As for what is on later this week, tomorrow we will have a light-hearted European fashion show organised by the Europe Direct centre in Llangollen, and a Eurodesk award ceremony. Eurodesk is a joint initiative by the European Commission and the British Council, which held a Let's Celebrate Europe contest last year. As it turned out, the UK winner was a school from the Vale of Glamorgan in Wales: St David's school in Colwinston. Together with colleagues from the British Council, I will be there on Thursday to present the award.

[16] Moving into political territory, the European Parliament elections are the main political priority for this six-month term. On 3 March, my office in Cardiff is organising two meetings, one for potential stakeholders and one for the Welsh media, to brief them on the European Parliament campaign. You may understand that the European Commission is not primarily responsible for running the information campaign on the elections, as that is in the hands of the European Parliament, but there is an institutional promise between the European Commission and the European Parliament in Brussels to do all that we can to assist it in its

information campaign. We in Wales and other parts of the UK are working closely on that with the European Parliament office for the UK, which is based in London, and also the office based in Edinburgh, which also officially covers Wales.

[17] As I said, there are two meetings next week, for which we are providing the facilities. The first is to meet with stakeholders in Wales, including officials from the Assembly Commission's outreach and information section, to see how we can spread the word and better inform people of what is at stake—not in a party-political way but more in the sense of raising awareness and getting people out to vote. There is then to be a similar meeting with the Welsh media in the afternoon.

[18] Following that, a citizenship event will be held in Llandrindod Wells on 18 March, organised by the Welsh Local Government Association, in an attempt to offer more EU opportunities to potential constituents here in Wales beyond the realms of the convergence fund. That is one of the EU programmes available, and I will be participating with the WLGA to inform people of that.

9.20 a.m.

[19] We are also making a growing number of school visits, especially in the context of teaching the Welsh baccalaureate and the particular module called Wales, Europe and the world. Many of these visits are demonstrating to us and to our contacts in the field, Europe Direct centres and even Welsh universities, that there is tremendous demand for teaching material and expertise to cover the slot for that particular module. Unfortunately, there does not seem to be enough material or training available, and so Welsh universities, Europe Direct centres and we are being contacted to plug that hole. So, we go into schools to teach multiple groups for whole days to fill that gap.

[20] At the beginning of April, there will be a major event in Wrexham organised by the Europe Direct centre in Llangollen. It is partially supported by Glyndŵr University and, therefore, will take place on the premises of Glyndŵr University—in a circus tent. It is an initiative by the European Commission's director general for employment, social affairs and equal opportunities. The circus tent will be travelling throughout Europe this year, going from country to country, stopping briefly at various places to hold a fair and an event related to employment and work issues, and the possibilities for training, exchanges, the Erasmus programme and the Leonardo da Vinci programme. Eures, the job mobility portal, will also be represented. The circus test is coming to Wrexham in north Wales on 2 and 3 April, and we hope that it will be a successful event, especially at this time of economic concern.

[21] In May, which will be getting close to the elections, we are celebrating Europe Day once again. Just like last year, we hope to engage in multiple events, including a Europe Day celebration in the south of Wales, in Cardiff, possibly even here at the Senedd. We are in discussions with the Assembly Commission to see whether it can be celebrated on your premises this year. Just as we tried to reach out to a different part of Wales, namely north Wales, last year, this year, we hope to go to Aberystwyth and hold a similar event to celebrate Europe Day at the National Library of Wales. There is also the Urdd eisteddfod just before the end of May. We hope to have a large presence there, together with the European Parliament, to make a final attempt in a very public way to inform people about the European Parliament elections.

[22] Then, the political process starts and we will all be influenced by that. There will be the elections, then the European Council decision on a new European Commission president designate, then, during the summer, the formation of a new European Commission, and, in the autumn, hearings and a vote in the European Parliament.

[23] **Sandy Mewies:** Thank you, Andy. That was extremely comprehensive. Do Members have any questions?

[24] **Rhodri Glyn Thomas:** Andy, i ba raddau yr ydych yn poeni mai dim ond tair canolfan sydd bellach yng Nghymru—dwy yn y gogledd ddwyrain ac un yng Nghaerfyrddin? Yr wyf yn falch fod Caerfyrddin yn canfod ei hun mewn sefyllfa allweddol o ran hyn, ond mae'n bryder nad oes canolfan bellach yn y de na'r de ddwyrain yn arbennig.

Rhodri Glyn Thomas: Andy, to what extent are you concerned that there are only three centres now in Wales—two in north-east Wales and one in Carmarthen? I am pleased that Carmarthen has found itself in a key position on all this, but it is a concern that there is not a centre in south Wales or particularly the south east.

[25] **Mr Klom:** Yes, I certainly agree with that assessment. It is also a particular concern for us, because Cardiff is the capital city and there is a large population concentration in this part of Wales. The centre in Carmarthen does great work and covers a large stretch of the west for us, but it cannot reach all the way to the south east. As you may recall, we have tried extensively to interest public organisations, including local government, universities, and others, in this initiative and to put in a bid. However, the financing was, relatively speaking, limited at a maximum of just €25,000 per year, and required a matching amount from the host organisation. We have always said that it is a long-term investment because it opens up a window on Europe that offers all kinds of opportunities: access to programmes beyond convergence, and access to initiatives that may not be financial but that still bring in gains for the host organisation.

[26] Carmarthenshire local authority understands that very well and has invested in its centre over the past two decades, bringing in the gains for that part of Wales. A similar approach taken by the local authorities in Wrexham, Denbighshire, and now Flintshire is providing support to the Llangollen centre in the north east. Unfortunately, we have not been able to convince other authorities, universities or public organisations of a similar size of the benefits. Some of the feedback that we received was related to the fact that potential partners were more interested in convergence funding and wanted to invest their time and effort in that. Some partners, such as universities, thought that the effort of applying for this small amount of money did not relate to the gains that could be made. Applying for funding under the European Union's framework programme for research was seen to be more interesting with a better pay-off. We tried to inform this committee of that process last year but, to our disappointment, we have not succeeded in making progress.

[27] **Jeff Cuthbert:** Thank you for that comprehensive introduction, Andy. Clearly, the biggest issue that is facing us right across Europe is the economic situation. In the build-up to the European elections I, too, want to see as many people as possible going out to vote, hopefully, recognising the positive role that the European Union can play.

[28] What are the commission and your office in particular doing to help to promote the positive aspects of European structural funds, for example? You have mentioned convergence funding, and I am not suggesting that that will solve our economic problems, but it can help. Is your office particularly concerned about counteracting to a degree the current phenomenon of people wanting to secure British jobs for British workers? There are 1.5 million British workers working abroad currently, and, although they are not all in Europe, they point to the value of the free movement of labour. Is your office concerned about promoting that principle so that it is seen in a positive light?

[29] **Mr Klom:** I will give you two short answers, if I may, as I think that there are two sides to your questions. The European Parliament has prepared and devised a campaign with the help of expert organisations that it has hired, and we are following that campaign fully.

That is why we are having the stakeholder and media meetings in Cardiff next week: to hear from the European Parliament what it wants us to do and to support those efforts fully. So, I have to apologise, but I hope to be able to give you more insight into that campaign in future, following the meetings.

[30] As for the other two items that you raised—the promotion of the value of Europe through the delivery of structural funds in Wales and the job mobility and job market issues—we have been communicating about those issues in Wales for years now but, unfortunately, coming across many challenges. People do not seem to understand the similarity between the hundreds of thousands of British citizens working in other EU countries and the hundreds of thousands of EU citizens working here in Britain. We know that there have been problems and tensions with the eastern European migrant situation, and so, over the past couple of years, we have been trying to assist and clarify that it is all part of the same game with the same set of rules. The benefits are there to be gained by all as long as you engage, take the risk of applying for work, and get the skills to be able to find a job elsewhere.

[31] In the same vein, on structural funds, over the past two years, we have been working with the Welsh European Funding Office during the launch of projects to communicate the fact that they are based on EU funding. EU taxpayers are paying for these projects, in conjunction with funding from Government and different stakeholders in Wales. There is a very strong EU aspect to the benefits being delivered here in Wales. One stakeholder organisation that we have invited to our meeting with the European Parliament next week is WEFO, within the Assembly Government. We hope that it can assist us and the European Parliament, within the limits of its political mandate and confines, to get a positive vote on Europe.

[32] **Sandy Mewies:** Mike is next, but please be brief.

[33] **Michael German:** I have two questions about your original presentation, Andy, and specifically about 18 March. Can you say a little more about the WLGA citizenship event? Is that referring specifically to Europe or is it a broader citizenship event?

9.30 a.m.

[34] I was also disturbed to hear that there is insufficient teaching material for the Wales, Europe and the world module of the Welsh baccalaureate. That should be something in which this committee should have an interest as well, because, of course, it is not just about the European Union—it is about the world; it is about all the remit that this committee has. Do you think that that is partial, in the sense that the shortage of material just covers the European Union aspect, or is it general, in that the whole module, as part of the Welsh baccalaureate, is under-resourced and not able to be taught properly because of lack of materials?

[35] **Mr Klom:** Very quickly, I will reply to your two questions. The 18 March is a WLGA initiative. It is trying to inform its partners here in Wales about the possibilities of actually applying for funding under an EU citizenship programme. My part in that is, of course, very much to raise the profile, to attract attention, and to try, once again, to communicate the message that this is another positive opportunity that Europe offers. Beyond, of course, the convergence funding there are many other programme initiatives that can be accessed. So, it is very much an information session. I cannot give you more details than that, but I can refer you to the right people.

[36] As regards teaching, that is very much my assessment, or my impression. We are being approached on a very regular basis with a huge demand for material; then, if we go to a school, it turns out that we are not just speaking to an assembly or to a debating club, but

being invited to teach eight consecutive classes, because apparently the teachers do not have the right training or expertise.

[37] What I have heard from the field is that Europe Direct centres are also being approached with the same demands both for presence and material, and even certain universities, where there is a European expertise, are getting exactly the same questions. So, it leads me to the conclusion—this is very much a personal impression—that there is insufficient material. We are providing as much as we can through the Europe Direct centres and through our office here but, as you know, that is just information brochures and material, often bilingual nowadays, but it is not proper teaching material.

[38] **Michael German:** Perhaps we can return to this matter, Chair. We have done it in the past.

[39] **Sandy Mewies:** We undertook quite a comprehensive study.

[40] **Michael German:** Yes, and maybe we ought to review that.

[41] **Sandy Mewies:** You have been producing some materials, which I thought were very good; perhaps other Members have not seen them. Yes, we will return to it. I think that it is important. I wonder if, in the meantime, I should write a letter to find out what is happening.

[42] **Jeff Cuthbert:** Chair, could I suggest that we make contact with the WJEC, which is responsible for this?

[43] **Sandy Mewies:** Jeff, I will look at options as to who this needs to go to. It might be more than one person. I have people in mind. Andy has given us his impression. I think that we need to find out what exactly is going on and why it is happening. So, I will undertake to do that myself.

[44] Thank you, Andy. That was most informative, as usual. You are welcome to stay.

9.33 a.m.

Ymchwiliad Craffu: Hawliau Cleifion o ran Gofal Iechyd Trawsffiniol—Casglu Tystiolaeth
Scrutiny Inquiry: Patients' Rights in Cross-border Healthcare—Evidence Gathering

[45] **Sandy Mewies:** We spoke at our last meeting to Bernard Merkel, and when we were in Brussels the week before last, we referred to it, and got some very interesting information, as I am sure we will today. Therefore, I welcome Paul Williams, Chris Riley and Mike Ponton. Good morning to you.

[46] Personally, I have been fascinated by what we have found out so far, and I do not expect today to be any different, having looked at your papers. Thank you, both Paul and Mike, for the papers. I am going to ask both of you to give a very brief introduction. Please assume that Members have read the papers; they will have read them. Chris, feel free to join in whenever you wish. Do not try to manipulate the microphones; they will automatically, by magic, come on.

[47] Afterwards, I will invite Members to put their questions to you as a panel. So, Members should indicate whether it is a panel question or directed specifically to anyone. Paul, perhaps you would like to begin.

[48] **Mr Williams:** Good morning. First of all, we respect the rights of the individual but also the importance of providing comprehensive care for everybody in Wales. Our aim is to provide high-quality healthcare for the citizens of Wales and to ensure that, overwhelmingly, they choose to receive their care here, to have good local services of a high standard.

[49] The directive at the moment does not reflect the priorities of the Welsh Assembly Government, which, in health terms, are to reduce waiting times to a total of 26 weeks by December 2009; the reorganisation that is taking place at the moment, which reflects the 'One Wales' objective to replace internal markets with a whole-systems approach; bringing acute, community, primary and social care together; having integrated care pathways; partnership working; and reinforcing the importance of public health both at the national and the local level through the local health boards. So, the directive, at the moment, is something that we are responding to as opposed to its being part of our main policy thinking. As drafted, the directive is likely to benefit some but, possibly, to the detriment of others. This is because it will potentially generate costs that are not incurred at the moment, and we are not clear whether the system overall will be better or more sustainable. Obviously, that is what we need to explore.

[50] The situation is fluid and, to some extent, unpredictable. We have a draft, which is an initial proposal and still in discussion between the commission and the European Parliament and member states. However, the Government of Wales strongly believes that it has to take responsibility and an interest in the development, and try to influence the directive so that it benefits the people of Wales. As you know, the formal lead for the UK rests with the Department of Health, and we are working very closely with our colleagues there and in the devolved administrations.

[51] **Mr Ponton:** I agree with the principles and issues that Paul has raised, so I will not go over those.

[52] The NHS confederation is a membership organisation; the members are health organisations. We represent their interests and, obviously, try to influence policy. I think that some of you will at least know of, and perhaps have met, people from our European office. The European office is funded by strategic health authorities in England and primarily deals with English members. They have obviously provided us with the brief that you have and, of course, will support us in Wales in terms of the issues that come out of this directive.

[53] Principally, we are glad that some principles will be agreed out of this. The confederation, along with the Department of Health and the Assembly, are concerned about issues of sovereignty of the NHS in Wales, in particular, but in the United Kingdom and, of course, we will be working very closely with the Assembly Government in trying to influence the Department of Health.

[54] **Sandy Mewies:** Thank you. Chris, do you want to add anything? I see not. Rhodri, you have indicated that you have a question.

[55] **Rhodri Glyn Thomas:** Mae gennyf ddau gwestiwn ond maent yn ddau gwestiwn cwbl ar wahân. A ydych am i mi ofyn y ddau gyda'i gilydd neu ar wahân?

Rhodri Glyn Thomas: I have two questions but they are totally separate questions. Do you want me to ask them together or separately?

[56] **Sandy Mewies:** Ask the first one first and then if anybody wants to come in on that they can.

[57] **Rhodri Glyn Thomas:** Mae'r

Rhodri Glyn Thomas: The first question

cwestiwn cyntaf yn ymwneud â'r pwynt gododd Paul ynglŷn â blaenoriaethau'r gwasanaeth iechyd yng Nghymru a blaenoriaethau Gweinidog y Cynulliad, sydd yn sylweddol wahanol i flaenoriaethau adran iechyd San Steffan. Yr ydym yn rhan o'r aelod wladwriaeth, felly i ba raddau yr ydych yn credu bod blaenoriaethau'r gwasanaeth iechyd yng Nghymru yn cael eu hadlewyrchu yn y trafodaethau yn Ewrop? I ba raddau yr ydym yn llwyddo i sicrhau bod pobl yn sylweddoli ein bod yn symud i gyfeiriadau gwahanol yng Nghymru, a bod y ffordd yr ydym yn ceisio ymdrin â'r sefyllfa yn wahanol yng Nghymru? Sut y gallwn sicrhau bod hynny yn cael ei adlewyrchu yn y mesurau a ddaw o Ewrop? Gofynnaf y cwestiwn i Paul, ond efallai fod gan Andy rywbeth i'w gynnig hefyd.

involves the point that Paul raised about the priorities of the health service in Wales and the priorities of the Assembly Minister, which are quite different to those of the Department of Health in Westminster. We are part of the member states, so to what extent are the priorities of the health service in Wales reflected in the discussions in Europe? To what extent do we succeed in ensuring that people realise that we are moving in a different direction in Wales, and that the way in which we are trying to deal with the situation is different in Wales? How can we ensure that that is reflected in the measures that come from Europe? I am asking the question of Paul, but Andy may have something to add as well.

[58] **Mr Williams:** Thank you. I think that I touched on this to some extent in my introductory remarks.

9.40 a.m.

[59] Wales has clearly decided to abandon the internal market. We have the prospect of quite a well developed market in England, with plurality of providers, so one could argue that it could be a more attractive proposition, in terms of patients flowing into England with additional capacity.

[60] The issue for us will be that, if the flow is marginal—so far, the indications are that it may be marginal—that is something that we could easily cope with and absorb. If, however, the flow becomes significant, it could well destabilise the situation in terms of money flowing out of Wales into other providers in Europe, with a detrimental effect on capacity or the possibility of sustaining capacity here in Wales.

[61] Coupled with that would be the additional administrative burden associated with running a system with a significant number of patients choosing to move and then having to put the various mechanisms in place to deal with that.

[62] **Mr Ponton:** One thing that struck me in thinking about this is that one of the key policy issues is choice in England, voice in Wales, where we are developing public services to be fit for purpose and, therefore, to be absolutely the principal provider. In England, there is this issue of the pluralistic health community but also the ability of people to choose from providers. So, they may be more open to this in England, in some ways.

[63] Health issues are also generic, so we must be aware of that. Although our systems are changing, they are addressing the same sorts of issues. We must not be too blasé about it in Wales in terms of how we are developing our system, because there may be some health issues that will fall into the bracket of people wanting to search for care in other countries.

[64] **Sandy Mewies:** What is your second question, Rhodri Glyn?

[65] **Rhodri Glyn Thomas:** I will come back to my first question and perhaps try again. We all know what the differences are between the priorities in Wales and in England. The

question that I was asking was to what extent is that known in Europe, in terms of the discussions about this directive and the impact that this directive could have on the health service in Wales, as Paul referred to. We are part of a member state and, therefore, the lead in the discussions is the Department of Health in Westminster. What concerns me is that they may not be aware in Europe that, in Wales, we are dealing with things in a significantly different way to the way in which the department in England is dealing with things.

[66] **Mr Riley:** As you say, the member state is the United Kingdom and the Department of Health has the lead on this. In those circumstances, clearly our Minister and officials here want to make sure that the UK position represents the four countries and not just the position of, say, the Department of Health. We work very closely with the Department of Health and with Scotland and Northern Ireland on individual issues as they come along. In the case of this one, we will be talking to them about what is in the directive, about how it impacts on our separate arrangements, and drawing out issues as they regard, for instance, Wales or, particularly in the case of this one, Northern Ireland, which has an open border with another member state.

[67] So, the particular issues do come up in the discussion on the individual issues. How far they are generally known in Europe is a different issue, but one that perhaps the European office of the Assembly Government would be promoting more.

[68] **Sandy Mewies:** Andy, do you want to say anything on that?

[69] **Mr Klom:** Just to clarify that we are aware of the fact, of course, that the UK delegation, in discussions in council and parliament, does comprise four different sections. We are well aware, of course, of the internal dynamic in that discussion to represent a UK position, not just on this particular topic but on many topics, such as electronic tagging of sheep. We recognise that there are sometimes divergences between different parts of the UK, but the position that we accept is the one presented by the UK team in council.

[70] **Sandy Mewies:** I know that there are a lot of questions, so please keep it short.

[71] **Rhodri Glyn Thomas:** The second question—and I will avoid mentioning the electronic tagging of sheep—was about the administration of this issue. You said in your paper, Paul, that since the directive came into force, comparatively few numbers have actually taken this up—I think that you referred to about 550. There is this whole question of the gatekeeper: who should decide? I think that that is a very important question. Is there any possibility of a derogation in terms of the UK? I think that Bernard Merkel, when he was here, actually gave us some hope that there was a possibility of having that gatekeeper role.

[72] I am also worried about aftercare, when they come back here, because consultants tell me that that is a problem. If they have to cater for somebody who has had an operation in a different country, where they have a different way of operating, how do they cope with that aftercare when they come back here?

[73] **Mr Williams:** I think that the principle of prior consideration is one that we will need to press very hard. I think that it will maintain the gatekeeper role and ensure that there is a dialogue with potential patients before they take the step, so that they are aware that the care may not be as comprehensive as we would provide in Wales. There will be issues, obviously, about standards and making sure that there are quality measures. However, we think that this will be done by prior consideration and by explaining to patients that they may not enjoy the same degree of aftercare. I did mention social care, although it is not always part of the integrated pathway; we are working very hard to ensure that we have an integrated care pathway. This is why we want to ensure that we make our service as attractive as possible, so that very few patients want to go to Europe for treatment. They may well, therefore, have to

think about providing additional provision for themselves for the sort of aftercare that they might enjoy as part of a normal package in Wales.

[74] **Sandy Mewies:** We are talking about prior authorisation now, are we not? Okay. I just wanted to clarify that for my own information. Jeff, you are next.

[75] **Jeff Cuthbert:** Thank you for what you have just said and for the written information, which was most useful.

[76] You make the point that most people clearly would prefer services close to home. That is, obviously, logically the case; people do not want to travel for treatment unless it is absolutely necessary. I understand the issues of how that could impact upon funding if there were significant numbers going abroad for treatment. Nevertheless, some people will want to take up these opportunities. The issue of health inequalities comes into play here. I would not want to see a situation where the people taking advantage of specialist treatment abroad as a result of this are the more affluent, the more articulate, those who have good access to information and who are, therefore, able to drive the system to their advantage. Not that I would be blaming them for that, but I would want to ensure that everybody, as far as possible, was aware of the opportunities to have treatment abroad if necessary.

[77] My first question is whose job is it to ensure that that is the case, that there is good information out there, that GPs in some of the more disadvantaged areas—Communities First areas, for example—are aware and are able to make this known to people if it is appropriate for them? I will leave it there at that point, but if there is time, may I come back with another question?

[78] **Sandy Mewies:** Yes, that is fine.

[79] **Mr Williams:** I think that that is a very good question. If one is promoting a free-market approach, potential users need to have good information. One of the implications of this will be that we will have to provide good information so that people are not just aware of the opportunities but also how they can access them. So, that will be an extra administrative burden that we will have to take into account.

9.50 a.m.

[80] **Mr Ponton:** In the context of Wales, of course, the new local health boards that will come into place in October will have responsibility for providing information to their local communities. That is written very clearly in the consultative papers that are out. Of course, they will also have a major role in ensuring that everybody in the system, including clinicians, has as much information as they should have. That will also be the centre, as far as I can see, of making the decisions about supporting or not supporting referrals to organisations in other places for healthcare. I think that the point is made in the papers that you have had that that is sort of a big deal, because we have to make sure that the information is accurate and available, and that decisions on care are very clear. So, this is a big responsibility.

[81] The other side of that is that there is also an issue here about payment. We must avoid building up large bureaucracies. What we are trying to do in Wales is to reduce bureaucracies and make the system slicker, so the issue about payment at the point of the delivery of care is one that we have to think about very seriously.

[82] **Sandy Mewies:** Jeff, did you want to come back on this particular point?

[83] **Jeff Cuthbert:** Yes. Is it clear whose responsibility or job it is—of a number of agencies—to make sure that the scheme, if properly implemented, is well publicised in all

areas?

[84] **Mr Williams:** Yes. If the directive is enacted, clearly, it will be Government, first and foremost, that is responsible. As Mike said, that would primarily be through the local health boards. They would be responsible for their populations.

[85] Your question is not just about having the information available so that potential patients are aware of the facility; there will be a whole range of other factors that patients will need to ask about. What are the standards available to me in the various countries? How is it monitored? What sort of indemnities would I have? How will you deal with my request? What will happen to my medical records? There is a whole raft of issues that then start to flow from this, which could generate significant administrative burden in order to have a comprehensive response to take those decisions.

[86] **Sandy Mewies:** William, did you want to come in on this point?

[87] **William Graham:** Yes. I am very grateful to Jeff for raising this issue. You will be aware that these arise almost out of desperation on behalf of the patient. Very often, those relatively few cases that are dealt with in England are extremely costly operations by their nature, in terms of the aftercare also. How confident are you that information provided to the patient to make that choice—where often it is much more an emotive decision than an informed one—is the correct information? Do they find these things on the internet, for example, and think, 'This is the solution to my problem', whereas the clinician may make a very different judgment? At the end of the day, there is an enormous cost implication in these things.

[88] **Mr Williams:** Under the present arrangements, particularly with the E112, the patient's inquiry should start with their general practitioner or consultant, but then it is a clinical decision on what constitutes undue delay. It is within that that there should be a proper dialogue. The procedures and systems and the circular are not there to block; they are there to be used effectively so that patients get the best information to take an informed judgment.

[89] **Mr Riley:** May I make an observation on both of those points? I think that, in a sense, there are at least three people who will be giving information. One of those is the GP, and your next witnesses will be in a position to talk about that. I think that the British Medical Association made certain observations on this directive in its reply, when it came out.

[90] The LHB will clearly be very important, and I think that the role of the LHB in helping people understand the gravity of the sort of decision that they will be taking is very important, because they do need to raise these issues about appropriateness of treatment, difficulties with travel, language, food, having relatives with you and aftercare. The provider will also give information. As drafted, the directive includes a heavy responsibility on the provider to provide information about the quality of care that will be provided. I think that the directive does try, as it were, to parcel out the responsibilities and make it quite clear who is responsible for what part of the process.

[91] **Sandy Mewies:** It is my understanding that it is the responsibility of the member state to provide the information as to what is available in other countries. Basically, that is it. I think that Mike and Paul have both touched on the point—and it certainly concerns me—that we have another bureaucracy being set up. I hesitate to say this, but you cannot rely on providers being 100 per cent accurate in what they say they are providing. That would have to be checked out, otherwise there is going to be a liability. It is a concern, is it not, that there will be a legal liability on those who provide this information? The member states are going to have to look at all the other parts of the union. They are going to have to examine quite

closely what is available and then come up with some sort of consistent document in quite a lot of languages.

[92] What I am trying to tease out now is how is regional Government—the Welsh Assembly Government, as far as we are concerned—going to be involved in that? Will the member state pass on all this information? Will it be the Welsh Assembly Government's responsibility to gather that information and provide it? What sort of liability would there be?

[93] As Members know, I do not, normally, intervene to ask questions myself, but I have another concern. Paul made a strong suggestion at the beginning that there are fears—and they are in these papers—that, while this may be a bonus for a few people, it will be detrimental to health services in general. I would like you to expand on that point.

[94] I am particularly concerned as to payment by results in England. The tariffs are totally different to the way in which we negotiate tariffs here. Will there be an impact because of that? Is it possible that there will be a stream of people who go for specialist dentistry to a particular country? Is that going to have a detrimental effect on the services that we provide here? I am thinking about the long term now. There is going to be a committee set up eventually, we were given to understand, to discuss all the detail of the issues. How will Wales contribute to that committee? That is how we will raise our particular issues. What do you think of the suggestion that perhaps a voucher system could be in use? There have been suggestions, too, that money would go to the patient to take where they want. How would the checks and balances work on how that was spent?

[95] I know that there were a lot of points there, but they are issues that I want to ask other people about as well.

[96] **Mr Riley:** I will pick up the first one, which was about the responsibility of the member states. The member state that is providing the treatment is responsible for assuring the quality of care provided on its territory. So, if someone from Wales is going to another country for treatment, we are not responsible for the quality of that treatment; the state that governs that system is responsible for governing the quality of care. We are responsible for making available to anyone in Wales who wants to go abroad the information that they require to understand how to use the system. That is the way that the member state responsibilities break down.

[97] **Sandy Mewies:** So the member state does not have to say, 'You can get this, this, this and this in the Czech Republic'?

[98] **Mr Riley:** What the individual is entitled to is no more than they are entitled to in their home country. So, in a sense, there should be no shopping list for people to decide that they want to go to another country for treatment. They should need the treatment in the first place. Hence the role of the gatekeeper and hence the importance of the prior authorisation arrangements to make sure people understand the process.

[99] **Rhodri Glyn Thomas:** It is not quite as easy as that, is it, because the health service here will, obviously, have to pick up on the aftercare? So, when you say that there is no responsibility for the quality—

[100] **Mr Riley:** Depending on the nature of the package, because they might—

[101] **Rhodri Glyn Thomas:** There is no responsibility for the quality unless you envisage people having to go back to wherever they had the operation for aftercare. If they have to be seen every six months after they have the operation, it is not feasible for them to have to go back to the other country every six months. So, in that sense, the health service here has to

pick up on that, so there is an element of responsibility for the quality of service on—

[102] **Mr Riley:** That is the aftercare provided in this country, for which we would obviously be responsible. If they went abroad for the aftercare, the other country would be responsible.

10.00 a.m.

[103] **Mr Williams:** I think that it is a re-entry problem, and how you re-enter the system.

[104] Before Mike comes in, I think that the other point is that it can be argued that markets are efficient, but they also tend to have fairly heavy transaction costs. I think that part of your question is about trying to understand and define what those transaction costs are. I mentioned some of them; I will not go over those.

[105] The other point that you touched on was destabilising the service if there was significant outflow. I do not think that it is just the money. Obviously, the money is one proxy to think about, in terms of having less money spread across the rest of the population, but it also could be in terms of scarcity of skilled workforce. Again, if there is a migration of scarce skills out of Wales to another country where things might apparently be more attractive, that could have a destabilising effect.

[106] **Sandy Mewies:** That is exactly the point.

[107] **Mr Williams:** So, I think that some of these issues will need to be explored very carefully.

[108] **Mr Ponton:** In terms of information at the level that we will have to provide, it seems to me that issues of quality and standards are very important. As we see, there is to be some attempt to try to get, at the least, information about the differences as well as what is available.

[109] Personally, as I have been reading this, I have thought that the commission has a responsibility for that. There should be some centrally driven mechanism for there to be some comprehensive comparison, not necessarily of how good or bad standards are but what regulations the Governments have put in place to protect users of the services and to ensure high standards of care in their particular circumstances.

[110] This discussion has proven to me that prior authorisation is absolutely crucial, because we are not going into this from a standing start. People do get referred to services in other countries, and the network of clinicians and the specialties know where care is that maybe cannot be provided here. The thing is that it is always going to be individualist, and I think that this is where Rhodri might be coming from. Decisions will be based on an individual's needs, but they will also be based on what is felt to be right and proper in terms of the service that we should be providing in Wales.

[111] In terms of how Wales can influence this debate, the key issues for this affect all of the respective countries in the UK—we have different systems developing, but the key issues about the process are the same. I think that, on one hand, we should not take that for granted, but be reassured by the fact that the UK as a whole has an interest in getting this right. No-one wants bureaucracy, and everybody wants to protect the patients' interests. Everybody wants to be aware of what the implications are, from follow-up treatment to the implications for patients having to pay for more than they expect, if they are going to pay for it.

[112] **Michael German:** I am going to ask a series of differently related questions, which

are about inflow, outflow and disciplines. You have given an indication of the number of people who currently go out. Do you have an indication of the number of people who currently come in? It is a two-way flow. Do you think that any particular specialisms will be under pressure, both inward and outward? For example, it is often mentioned that dentistry might be one such specialism.

[113] Related to that is the issue of prescriptions. Given the difficulties that we have had around the provision of very expensive drug treatments, particularly for cancer care, and the campaigns that have gone with them, is there potential for this directive influencing the decisions of patients when they might see, for example, certain cancer drugs being available in other countries and taking advantage of that? Does the rationale behind the prescriptions element of this directive make that possible?

[114] **Mr Riley:** On the first question, on inflow, I have tried to get numbers and it is quite difficult, because there is quite a complex set of inflows and outflows. One figure that I got was about 300 under reciprocal arrangements. That is the existing E112-type arrangements, and also the arrangements with Australia, New Zealand and other countries. So, it is quite small. That is within a year.

[115] How it would change would partly depend upon the position when the directive came in, what waiting times were like in this country, and all sorts of other issues. So, it is very difficult to forecast that, and I do not think that the Department of Health, which has more resources for this than us, has managed to do any better on that.

[116] On the second question, about the specialisms under pressure, again it is difficult to see. We imagine that it will be the elective area, but it would partly depend upon a relative judgment by individuals about what services in different countries were better or worse than those in other countries. There is no objective measurement of that at the moment. There is no way of making that judgment. So, the decisions may be made around other issues—where people would like to go for treatment, where they have relatives, and other things like that—rather than about saying, ‘I want a particular specialist service’.

[117] On prescriptions, the directive is very clear that it does not create new entitlements. The only entitlement that you have is the entitlement in your home country. Therefore, if you could not have a certain sort of treatment in this country, certainly on the basis of what the commission has said, you could not have that treatment by going abroad for it. However, there is some rather vague drafting in the document, which I have discussed with colleagues in London, which sort of implies that there might be an entitlement to get prescription treatment from other countries, which is their treatment rather than our treatment. I think that that needs to be clarified. However, the underlying principle is the entitlement in your own country.

[118] **Sandy Mewies:** How will that be clarified, then, Chris? We heard that, eventually, somewhere down the road, there is going to be a committee looking at the detail.

[119] **Mr Riley:** It may not be clarified through the committee; it may be clarified through the drafting of the directive. Obviously, the first thing is to see how much clarity they can get about the actual wording. Any subsequent work through a committee would be after the directive itself has been finalised. I think that Bernard Merkel told you that the whole process may take 10 years, but that does not mean that the directive will take 10 years. The directive will be out in a year or two, I guess, depending on the rate of passage through the legislative process.

[120] **Sandy Mewies:** One thing that we heard when we were in Brussels was that all this has been decided, that there is already case law on this, and that there is a feeling that this

should be laid down by directive rather than going through the courts. My own view on this, I would have to say, is that I still think that we will be going through the courts. I might be wrong, but I think that lawyers are saying, 'Hurrah, this is going to carry on'. What is your opinion? There will be additional costs because of that, if that is the case. My question to the three of you is: is this going to be of overall benefit to Wales or not?

[121] **Mr Williams:** If I start off, I think that there are two areas that could generate significant interest and work. The first of those is if we did not improve our waiting times. One of the specialties that Mr German mentioned is probably orthopaedics, with large numbers. Those waiting lists are improving; waiting times are improving. If they did not, I think that we would get significant pressure coming through the system and you could say that the directive would free up that flow.

[122] The other side would be, I think, on the very rare specialties or the very rare services that we would normally determine through Health Commission Wales. I think that there could be some pressure at the margins about different sorts of treatments and perceived better ways of doing it. You could then get into arguments with lawyers and doctors about precisely what is an equivalent service. So, I think that that could be an area that, as you quite rightly say, could end up being resolved in courts.

[123] On the other issue, on prescriptions, we just need to think about how we would have an interchanging, free flow of prescriptions as we understand them at the moment, which are different in the different member states, which comes back to your issue about re-entry or, in fact, patients coming into the UK with expectations about how their prescriptions might be treated. So, there are a lot of complicated issues around prescriptions that will need to be thought through.

10.10 a.m.

[124] **Mr Ponton:** There are quite a few wicked issues in this, are there not? The one that occurs to me is what people can expect from healthcare. We do not have a shopping list, as such, in the UK, or in Wales in particular, so it is very much about individual care. I know that we have had this issue about postcode prescribing and all the rest of it, but gradually, in Wales, we are trying to address that. Certainly, the restructured service will have a particular focus on trying to get consistency across Wales. I agree that, when it affects you and you think that you are entitled to care, you will do everything that you can to get it, even if it means going to court. Nothing is going to change that.

[125] We had a discussion about this the other day, and you can never say never. The economy now might mean that it is not so attractive to go to get your teeth fixed in Europe, but it could also mean that it is pretty attractive for people to come here to have certain things done. I think that we have to look very carefully at the alternative environment that we are working in as the years go by, because this will be in place and we will have to cope with it. This is never going to be, in our terms, 'tidy', I do not think, but what it needs to be is clearer than it is now. That is what we should work for from the directive.

[126] **Mr Riley:** Taking your two questions, I agree with Mike on the first one: will this, in a sense, kill the legal problem? The desire of the commission and of the Government is for this to regularise the position. Leaving it to the courts to make sequential decisions leaves everyone in a state of uncertainty, and the purpose of the directive is to provide clarity and a system that will work.

[127] As Mike said, you cannot stop people seeking a remedy if they feel that they are being unfairly treated. This, of course, began with interpreting the treaty in a way that I doubt any Government expected when they first signed it. So, lawyers may well find ways of

extending the jurisprudence.

[128] On the second point, as to whether it will be of overall benefit to Wales, that works at two levels, in a sense, the first of which is the overall negotiation. This is a very complicated negotiation: 27 countries, all with different systems, and the European Commission and the European Parliament are all looking for a solution. Obviously, what the UK is looking for—I think that that has come out from both our papers and the discussion—is a defence of our system; the system that we have set up with its checks and balances and its interrelationship between primary/secondary care, primary care and social services, and all those other elements. If you start snipping them up into little bits and taking bits from other countries, it may not provide a good service.

[129] In terms specifically of Wales benefiting, we are obviously working with the United Kingdom and we will continue working with the rest of the countries and the department to make sure that whatever comes out, as far as possible, reflects our interests.

[130] **Sandy Mewies:** Thank you. Does anyone else want to come back?

[131] **Rhodri Glyn Thomas:** Mae gennyf gwestiwn am y taliadau a'r broses o dalu am y driniaeth hon. Sut y byddai hynny'n gweithio o ran pobl sy'n mynd o Gymru i gael triniaeth mewn gwlad arall a sut y byddai'n gweithio i bobl sy'n dod i Gymru o wledydd eraill i gael triniaeth? Cyfeiriodd y Cadeirydd at hyn yn gynharach.

Rhodri Glyn Thomas: I have a question about the payments and the process of paying for this treatment. How would it work in terms of people who go from Wales to receive treatment in another country and how would it work for people who come to Wales from other countries to receive treatment? The Chair referred to this earlier.

[132] Un opsiwn fyddai rhyw fath o daleb y gallai rhywun ei defnyddio i gael triniaeth. Opsiwn arall fyddai bod pobl yn gorfod talu ymlaen llaw a hawlio'r arian yn ôl. Fodd bynnag, mae elfen amlwg o ansicrwydd yn hynny. Byddai hynny'n cael effaith ar bwy fyddai'n penderfynu mynd am driniaeth o'r fath—byddai, o reidrwydd, yn bobl sy'n gallu fforddio'r driniaeth ac sy'n gobeithio y gallant gael y taliad yn ôl. Fodd bynnag, mae goblygiadau o ran pobl yn dod i Gymru i dderbyn triniaeth a'r effaith y byddai hynny'n ei gael ar y gwasanaeth iechyd yng Nghymru a thaliadau am y gwasanaeth hwnnw. Yr ydych yn cyfeirio at hyn yn eich papur—mae cyfeiriad ato ym mhapur Paul, er enghraifft. Beth yw eich teimladau ynglŷn â'r ffordd orau o brosesu'r taliadau hyn pe bai hyn yn cael ei weithredu?

One option is some sort of voucher that people could redeem to receive treatment. Another option would be for people to pay beforehand and then to claim that money back. However, there is an element of uncertainty in that option. It would have an effect on who would decide to go for that kind of treatment—it would necessarily be people who could afford the treatment and who would hope that they would get that payment back. However, there are implications in terms of people coming into Wales to receive treatment and the impact that that would have on the NHS in Wales and payments within the NHS. You refer to this in your paper—there is a reference to it in Paul's paper, for example. What are your feelings about the best way of processing these payments if this was to be implemented?

[133] **Mr Ponton:** I can only speak from a survey that we undertook of our members across the UK. They felt that up-front payment was the lesser risk to the system itself and that vouchers have all sorts of issues related to them. Again, we go back to the point about pre-authorisation and the fact that that gives an opportunity for people who know the issues to explore them clearly with the patient and their family. There will be a lot of hidden costs; we have seen that. You are concerned about the implications on return for aftercare, so all that has to be considered very carefully. You could say that the voucher would be issued after that

type of discussion, and there is a suggestion, in the work that the confederation has done, that there are two sides to this. Those who choose to go overseas regardless would need to pay up front. If this is care that simply cannot be provided here, and is justified and agreed to, that falls into what we used to call the commissioning role, which is an agreement between one organisation and another to deliver care.

[134] Overall, one believes that, because of the E112 system—which I think is suggested by everybody is a good foundation for this; therefore, what we are talking about is care outside of that—the view of our members certainly is that that should be paid for by the patient and their family and then reclaimed.

[135] **Rhodri Glyn Thomas:** But there are implications to that, are there not, in terms of who could take up the option, because it would only be people who have the financial resources to do that?

[136] **Mr Ponton:** Very much, yes, but one assumes that those who really need care are going to get it, because the assumption in all this—and also through E112—is that people are going for things that are 'out of the system'. One has to be confident in that to make the type of assertions that I have, but that is what this is all about, as far as our reading is concerned.

[137] **Mr Williams:** I think that that is the interesting debate. If the intention is to make it equal to everyone, in fact, will the disadvantaged still be disadvantaged? Will they gain the information? Will they engage in the dialogue? The better-informed will probably be better placed in this situation.

[138] That comes back to my issue about the significant transactional cost in terms of making sure that people have good access, there is good dialogue and a full understanding of the implications. This is the issue that will need to be explored, because it will not necessarily end up with an equitable system. It may end up with fewer people who actually have a good understanding, who are articulate and who can press their case, enjoying access, and disadvantaged people not enjoying that access. If the flow actually increased, you could say that it will be the few who benefit and the many could lose out. That is the crux of the issue, I think, for us.

[139] **Sandy Mewies:** I do not know if this is what you are alluding to, but I know we have raised this before. Are we just introducing more inequality into the health service? Whatever you say or whatever I say, unless there are exemptions to allow people to have travel costs paid, there are still some people who, even if they can only get treatment in France or in Brussels and clinicians decide that they need that treatment, cannot access it. That could either be because they do not have access to the information, for whatever reason—perhaps for some people it will be a simple matter of going to see a solicitor and saying, 'Can I do this or not?'—or because they cannot afford the travel costs, or they cannot contemplate having major surgery done abroad without having family or friends nearby. Is there a danger of introducing a further inequality into UK healthcare?

[140] **Mr Williams:** I think that there is a danger that needs to be looked at with balance. What I call patient experience is important. Seasoned travellers might be very happy and competent to deal with the issues that arise during that patient episode, but others might feel quite vulnerable. How do you put checks and balances into the system to make sure that those people who might feel a bit vulnerable—they do not have their family with them and are not used to travelling abroad or different cultures and approaches—have a good patient experience?

10.20 a.m.

[141] **Mr Ponton:** In a survey that the confederation did, there is the inward risk of, for example, this issue of what people are and are not entitled to and how they get it anyway. Areas such as organ transplantation are the sensitive areas that could be affected by this. If we had people coming into Wales or the UK in general, then we have to be very careful that we do not disadvantage our citizens in terms of the care provided.

[142] Although another point is made in the papers that, as citizens of Europe, we are all part of the same community, I am absolutely certain that local people will not see it quite like that. In Wales specifically, we are going for much more equity in access and delivery of care and the individual's needs are paramount. So, if they are justified clinical needs, then I think that we are developing a service in Wales that would make sure that people get them.

[143] The devil is in the detail, so it is about how you get relatives over there with them and how you cope with the language barrier. At the end of the day, it is about whether we feel that that is what individuals need and we make it possible for them.

[144] **Sandy Mewies:** Thank you very much. I do not know whether you want to add anything further before you go, but if you feel that you want to add to the discussion, feel free to contact the clerk. I am sure that we will be coming to this. Every time that we talk to somebody there are a lot of wicked issues—Mike, you are absolutely right—that do need to be nailed down very firmly indeed. Thank you very much indeed for the contribution that you have made today. It has been very useful.

[145] **Mr Williams:** Thank you very much.

10.22 a.m.

Ymchwiliad Craffu: Hawliau Cleifion o ran Gofal Iechyd Trawsffiniol—Casglu Tystiolaeth
Scrutiny Inquiry: Patients' Rights in Cross-border Healthcare—Evidence Gathering

[146] **Sandy Mewies:** We are continuing with patients' rights in cross-border healthcare. I welcome Dr Andrew Dearden, who is the chair of the British Medical Association Welsh Council, and Dr Tony Calland, who is a former chair of the BMA Welsh Council.

[147] I do not know whether you have been listening to what has been going on, but I think that you know how this works. Thank you both for the work that you have done up until now. Perhaps you would like to make some introductory remarks and then Members will come in and ask their questions, if that is all right by you. Afterwards, we will send a copy of the draft transcript of the meeting to you, which you are welcome to check for factual accuracy. There may be other issues that you might want to comment upon, but it will be for factual accuracy. I do not know which one of you wants to start, but please go ahead.

[148] **Dr Dearden:** That is very kind; thank you very much. We appreciate the chance to come and raise a couple of points and perhaps answer some questions for you, if we can.

[149] I think that, generally, as the paper suggests, the BMA is quite supportive of anything that increases or improves patient choice. Our starting position is that anything that can get people the care that they need sooner or in a timely manner is something that we should be looking to and certainly working towards.

[150] In saying 'patient choice', of course, we need to be very careful that what patients are choosing is something that is safe for them to choose, and is something that we can safely

provide for them, and which then does not affect the care of other patients within, shall we say, the Welsh healthcare system at the moment. Certainly, one of the things that we would like to address—and I am sure you that will ask us about this—is looking at the standards that a patient might experience in terms of care; looking at the aftercare and the continuation of care, not just post a knee operation, say, but also pre-operation. The actual preparation for an operation is almost as important as the care after an operation, so we must be careful that we do not see healthcare as simply an event to be done.

[151] There are then also issues around IT. There are questions about the safety of data for the UK being made available in a much wider area, where perhaps access may not be as secure. There are certainly issues around communication and language. As a GP, I often get a letter written in Spanish about something that happened during one's holiday and, having absolutely no idea what the letter says, follow-up care is then quite difficult to provide.

[152] Generally, from our point of view, we are quite supportive of it. There are several issues, however, that we feel need to be worked through quite carefully so that we do not damage people or the healthcare system here in Wales. You have probably read the paper. Rather than taking up more time, I will turn to Tony to come in with a few points and then we will be open to answering any questions.

[153] **Dr Calland:** I do not have much more to add than that at this stage other than to remind people that when one talks of Europe one naturally thinks of going across the channel to France, Belgium, or Germany. We must not forget that, in Wales, we face Ireland, which is also in the European Union and much more accessible probably to the people of Wales than going across the channel. It might be something to just bear in mind.

[154] **Jeff Cuthbert:** Thank you for what you have just said and, indeed, the written paper, which was most helpful. I do not think that you were in the room when I asked questions of your colleagues, but it is about a matter that you refer directly to in your paper, which is health inequalities and the importance of trying to avoid them. You make the point that equality of access is guaranteed, and you say again that patient mobility must not be just for the wealthy and educated. I think that we would all agree with that; we would want to ensure that where this is taken up and is suitable for a patient it is not just for the more affluent and better educated, or those used to accessing and dealing with information, but that all people in Wales have an equal opportunity to take advantage of this.

[155] It was said by your colleagues earlier that GPs and the local health board and new organisations have a responsibility for ensuring that adequate and accurate information is made available to patients so that they can have a realistic choice. Do you agree? Do you think that GPs will be in the front line in terms of providing information? I am a type-2 diabetic and see my GP quite often, but if I were to ask him about his awareness of this proposed directive, is he likely to say that he does know anything about it at this stage? What is the role of the BMA here in ensuring that your members—the GPs—are aware of this and the implications that it could have?

[156] **Dr Dearden:** I have perhaps two or three points to make in response. I think that there is a real concern and danger here that doctors—and I will speak of 'doctors' as a whole for the moment—will start to become health travel agents. Just to give a simple example, yesterday, I had a three-hour consulting session, 30 minutes of which I spent purely on the phone trying to help my patients to manoeuvre around the health system. So, 30 minutes of a three-hour session was not actually spent in direct care but in helping them get through to where they needed to be. I could have seen three more people had I had that time for care. So, I think that we need to be very careful that we do not expect doctors who have an expertise in the delivery of care to be involved in the administrative accessing of care. For example, I would not expect a GP to organise an ambulance from wherever the person is to the hospital.

I would expect to be able to say, 'This person has this need. They need to be here' and someone should be able to organise that while I see somebody else. So, I think that we do need to be very careful that we are not using medical time to organise care in that way.

[157] The second thing that I think that we need to be very careful of is, again, the sheer amount of information that you could be asking a GP, or even a consultant, to access. For example, I know my consultants in the Cardiff area. If I were to be asked who the orthopaedic surgeons were in Newport or Bridgend, the chance is that I would not be able to name them, simply because I almost never refer to them. If that applies to Newport and Bridgend, you could imagine the difficulty if I had to have a list of people in Brussels, France, Germany, Italy and Ireland and then have enough information to give an informed choice to the patient.

10.30 a.m.

[158] It is not enough just to say that there is a consultant in Brussels. I have to be able to say to the patient, 'That person's expertise is knees. They are a very good people person'. Sometimes I will say to someone, 'Look, this person is technically excellent but you might find them a bit brusque', and if I explain that initially then people are prepared for that, but what they are looking for is the technical expertise. So, the sheer amount of potential information that a patient might want to access could be huge if you think of the European Union as a whole. There certainly does need to be an access point to that information.

[159] I would also make another suggestion. When someone comes to see me, I look at them and they say, 'I have a very painful hip, which is stiff'. I may send them off for an x-ray to see the extent of the damage. What I then need to do is ask my consultant colleague, 'Does this person now require a hip replacement?' The consultant will often say, 'We could try these three conservative treatments first and if they do not work we will move to this'. So, the GP may not actually be the best person in many cases to say, 'This now needs an operation'. Neurosurgery and spinal surgery are other examples.

[160] One of the questions is: is the GP best placed to decide when, in this case, an operation is needed or should we ask the consultant orthopaedic surgeon/neurosurgeon to look at it and say, 'Yes, this person now needs an operation'? At that point the patient would be put into the broader context of where that could be delivered. There is a danger that we use doctors to do administration work. The GP may not be able to make the decision that a procedure needs to take place. We do need to be very careful about the increasing amount of time and the sheer volume that this could use up. As a GP in Cardiff—and I consider myself reasonably well informed—once you go 20 miles away from my practice my knowledge of the physicians there becomes quite limited. What I tend to do is phone my GP colleagues and say, 'What do you think about so-and-so?'

[161] **Dr Calland:** Just to add to that, what would the BMA's role be? The BMA is an organisation that gives service to its members, and if there was a need for members to be better informed because of legislation then the BMA would have to provide a service to the members and give them information as to how they should deal with the new legislation. So, the BMA would have a role, but I do not think it is the BMA's responsibility to ensure patients get to the right place or in the right way. We have a service to our members.

[162] The other thing that I would be anxious about is where the medico-legal responsibility for a referral lies. As a GP, one will quite often get patients coming in saying, 'I have heard that Mr so-and-so is very good for doing a breast augmentation or a breast reduction operation. I want to go and see him'. It may be that that person would be at a clinic that one would not necessarily recommend but there are other surgeons who one may well recommend. Just because a patient wants to go to a particular surgeon does not mean to say that the GP should have to arrange that. I think that we would need some very clear rules and

a very clear framework so that GPs knew where they stood medico-legally if patients were going to require them to be part of a process that enabled them to go and see doctors in other countries, because GPs are not going to have the personal knowledge—as Andrew said—of the hospital. You build up a relationship with your local consultants over the years; you know they are good, they give the patient a good service and do a good job.

[163] If you are referring just to a hospital or clinic in wherever it happens to be, you would not necessarily know that. If things went wrong one certainly would not want to be caught up in the medico-legal process of being culpable, because it may just be that the patient might change his or her story about who asked for what when. Unless it had been clearly documented, it could put doctors in a position of jeopardy. I think that that if we are to have this type of system, that is fine, but we need to ensure that all the t's are crossed and i's are dotted so everyone understands the rules that they are playing under.

[164] **Sandy Mewies:** So, it is the underlying medico-legal issue of if you a GPs say, 'That person in France is very good' and something goes wrong, what responsibility do you have?

[165] **Dr Calland:** The question is: is there going to be a responsibility because I participated in writing a letter for you or in organising this or whatever else?

[166] **Dr Dearden:** If I may comment, that is reflected the other way as well, of course. When an operation is done, what happens if there are complications? Would the patient then have legal redress in the country where it took place or in the country from which they were referred to that place? There is the issue of who then is responsible for the physiotherapy for the knee replacement. Is it the NHS? If there are any gaps in between, who is responsible for that? There is a simple question about what happens if a referral letter gets lost. It is a very simple question, but in some situations I fax and send a copy and check to make sure it has arrived because of the importance of that letter arriving on the consultant's desk. It is more difficult the further away you get, and when I am asking the question in a foreign language.

[167] **Sandy Mewies:** That is very useful, thank you. Rhodri is next.

[168] **Rhodri Glyn Thomas:** Thank you for those comments. It has raised a number of questions about prior consent and the gatekeeper role. At face value, it seems to be the ideal answer: a medical practitioner takes a decision based on medical need. However, as you have explained to us, there are a lot of practical issues that are not addressed there. It would be very nice, Andrew, if your scenario of the GP or another medical practitioner taking the decision and then somebody else picking up the responsibility for practical arrangements were to happen, but we all know it does not happen in that way.

[169] There is also the whole question of the litigation culture that we have at the moment, and what happens if you are part of a referral process. Chris Riley tried to give us the impression that it was very clear-cut—if the operation happens in another country then it is its responsibility—but it is not as clear-cut as that by a long chalk. There are all sorts of problems.

[170] Chris suggested that this directive might get through the European Parliament within the next two years. Given those difficulties, do you think we are looking at that process coming into being in that timescale, or is it going to be a long, drawn-out process? We have been here before with an attempt to do this kind of thing and it has not succeeded up until now. Do you really think it is going to happen?

[171] **Dr Dearden:** Is it possible that it could happen? I think that the answer is 'yes'. I think that it could happen, but I do think there is a lot of work to be done between now and then, and I am not sure that 2010 will give us enough time to do that. If we look at how long it

sometimes takes to develop a single care pathway for a single disease between primary, secondary and community care within Cardiff, that could take three or four months to look at the gold standards, the patient's needs, to see what is available in the community and then design a care pathway so everyone is clear—including the patient—what it is he or she can expect at certain points and where transfer of care occurs. To consider everything that this could cover across boundaries, language, IT, different regulatory bodies, different practising standards, different litigation rules and laws, two years might be pretty optimistic in getting all those things together.

[172] What I would like to see when a patient comes to see me is that I, as a GP, suggest that maybe he or she needs to see a consultant. Let us use hip replacement for example, although I think that we need to be very careful that we do not just look at orthopaedics here, and I will give another example in a minute. I then send the patient to my consultant colleague. He says, 'Absolutely, you need the hip done'. The consultant then puts the patient on a waiting list to have the hip done. Someone then comes to the patient and says, 'Actually, you could wait three or four months and have it done here or you could travel to Brussels. Here is some information about the consultants, the surgeons, what they use, what hips they use, what the success rates of those hips are, the complication rates', all the information that you need not just to have choice but informed choice. The patient then discusses with their health travel adviser where he or she might then go. Then it is very clear that the patient can make a reasonable choice.

10.40 a.m.

[173] However, you could do something simple. For example, in Cardiff at the moment, if you have a small skin tag—that is, just an outgrowth of skin—the Heath hospital will not see you and take it off. The dermatologist will not take it off and the surgeons will not take it off. So, if there is no GP in your area who will take it off for you, this might suggest you would have the right to travel to Brussels to have done something as simple as that, which is not available in your local area. So, I think that we need to be very careful and not just focus on the very high end of these things. It could come down to simple things such as tattoo removal or fertility treatments, which may not be available here, or where the waiting list is so long that travel becomes an alternative.

[174] As an example, if we had people going to Rome for fertility treatment, where the ethical number of eggs being placed and the follow-up care is very different from in the UK, then that could have quite interesting impacts when it comes back to us. We have seen that transfer even within a private hospital within Cardiff. If an operation is done privately in Cardiff and the patient then needs ITU, he or she is transferred back to the NHS and the NHS then picks up the cost, because that private hospital simply does not have the facilities to provide that level of intensive care. So, the complication—which may be perfectly ordinary in that sense—transfers back to the NHS. One of the difficulties with this is that I think that we are being asked to look at something which has no attached costs at the moment, where we have no numbers by which we can actually measure the cost, and we have no idea of the knock-on costs. A simple example is someone who has a spinal surgery and ends up on ITU for six months. Who pays the ITU bill?

[175] **Sandy Mewies:** One of the reasons why we are doing this inquiry is to try to find out some of these issues. I am quite interested in your example of skin tags. Now, I would have thought that does not qualify under clinical need, whereas perhaps the case could be made with regard to a tattoo.

[176] **Dr Dearden:** Let us say it was in the place where a belt or a bra strap was, and every three months it was knocked off and the person bled, and the last time they bled was in a very embarrassing situation and the person was left with a reoccurring sore that was not healing

because of its location.

[177] **Sandy Mewies:** However, you are meant to offer treatments that you can get in your own home country, are you not?

[178] **Dr Dearden:** That is right, but if I went to Bridgend I could get it done.

[179] **Sandy Mewies:** Exactly, and that might be the place to go rather than Brussels.

[180] **Dr Dearden:** That is absolutely correct.

[181] **Sandy Mewies:** I am not being facetious. I am just trying to tease out these issues, because I think that you are right about the low end, which I think that none of us have really given a lot of thought to.

[182] **Dr Dearden:** I just use that as a technical possibility within what the papers currently suggest, and that is where I think that we need to be looking at what it is that we are actually thinking about providing. It does talk about producing a list of what could or could not be provided.

[183] **Dr Calland:** I think that one of the problems with this is it is easy to get it fixed in your mind that this is about hips, knees and all the simple surgical single-event issues that are easily quantifiable. However, it may not be. It may be that people go on the internet—maybe they have respiratory disease or diabetes—and they suddenly find on the internet that there is somebody in France or Italy who has some magic cure or treatment that will make their life easier.

[184] If there is not proper regulation around this whereby somebody is going to say, 'Yes, you can go' or, 'No, you cannot go', you are going to have people going all over the place. Over my career I have had people go to South America to have treatments for cancer. They went privately and did it and they believed in it, but if you are opening up a can of worms like this, in a way, you do need to have some very clear rules so that everybody understands exactly what is going to be available and what is not going to be available. I think that one of the difficulties at the moment is the way that the directive is worded, and the law around it, implies that everything is up for grabs and whatever you want you just go off wherever to get it and can expect your health service at home to pay for it.

[185] I think that Wales is particularly vulnerable compared with England for two reasons. In England, there is a purchaser/provider system built on a lot of unit cost care, so it is pretty well up to speed in having a pricelist, if you like, whereas Wales is now moving away from that completely into almost a no-cost-based type of system. In Wales, if this comes in, we are going to have to be running a system where you have a system of charges and costs and all the work that will go with that, when, in fact, that is an administrative system that is not necessary for the running of the health service in Wales. Also, because the NHS Wales cake is significantly smaller than the NHS England cake, the risk of destabilisation becomes greater if there are significant numbers of patients moving across.

[186] I saw on *The One Show* a few weeks ago a story about a busload of people going from Kent over to Brussels to get their hips done. That is fine, but if such travel catches on you are going to have charabancs from Wales trooping down the M4 or going up through Holyhead. It may sound ridiculous but, in fact, if that did start to happen it could have a significant effect on NHS Wales and those people that want to be treated in Wales.

[187] **Sandy Mewies:** Thank you. William and Mike have questions. I have 10 minutes to allocate to them, so bear that in mind.

[188] **William Graham:** Thank you, Chair. Knowing that heat and temperature are not the same thing, could I press you a little on your suggestions about redress and also a mechanism for claiming in compensation? You suggest that a concept of regulatory redress should be added to the proposal, also, in terms of a mechanism for the member state, recourse for claiming compensation to rectify a clinical mistake.

[189] **Dr Dearden:** Again, from a patient safety point of view, should a patient be the unfortunate participant in a mistake or even just the normal 1 per cent risk of an operation, then he or she needs some form of financial support in the future. Of course, the difficulty then arises that if we are talking about different countries there may be both different expectations and different entitlements. We could even talk about the benefit process being very different in those countries. Patients who, let us say, go to a country that perhaps we would not recognise as working to the same standards as ourselves—which may not have in place the same degree of medical insurance, for example, or even the NHS redress idea—may need to be forewarned that should there be a consequence they may not have the same access to obtaining financial support in the longer term.

[190] The second point is that, even with the most perfect surgeon, there will always be consequences such as wound infections or all the other complications that can exist. In a situation where someone does an operation and then, five days later, when the person has left the country and come back to, say, my surgery, the NHS could pick up a bill that it may have picked up anyway because, of course, it was done somewhere else.

[191] To give you an example from here in Cardiff, many of our patients with knee problems were sent to Weston-Super-Mare and operated on in Weston-Super-Mare in this country with surgeons registered by the GMC—not all British but, nevertheless, to the standards we would expect—and several years ago we had to review I think over 100 of those knees and some of them had to be redone. Now, that is not to say that knees are never redone by British surgeons but it is an example of the fact that sometimes taking people out of an environment is not a single cost but there are knock-on costs.

[192] So, if we were to find that if a surgeon or clinic elsewhere was practising in a different way from ourselves and in this country it would be an unacceptable level, we could find ourselves with quite a backlog that we would need to go back and review again. Maybe we should be considering some sort of balancing payment so that if your mistake incurs costs to my health service I should perhaps be able to seek redress from you.

[193] As Tony says, Wales is probably quite at risk from this proposal. We do not have the pockets that Treasury has in England, but we would pick up, for our size of population, equivalent risk. So, we would have the same risk but without the ability to manage that risk that England would have.

10.50 a.m.

[194] **Michael German:** You have talked mostly about the outgoing migration of healthcare. I would like to ask a little bit about incoming healthcare as well: what do you think the pressures might be upon yourselves? I am particularly interested in the issue that was raised earlier about prescriptions, that there is a lack of clarity in the directive at the moment that might lead to people seeking prescriptions that are available in country Y that are not available in country X. Could you shed some light on that?

[195] Then, finally, there is the inequalities issue that you raise, about prior payments and so on. You suggest that there might be other ways of ensuring there was equity in the system so that people would not have to pay cash up front for their medical treatment. Given your

experience, what would you say were the alternatives that you propose?

[196] **Dr Calland:** Certainly, on the prescriptions issue, I think that that is a very real difficulty. In the UK we have NICE, which, whether you like it or love it or not, does a very competent job in determining what is clinically effective. The arguments about it are around cost effectiveness but, nevertheless, it does produce a coherent list of drugs that should be available through the NHS.

[197] I think that the difficulty comes when you go abroad. You will not only have maybe the same chemical drug with a completely different name—and I am sure Andrew, like me, has had difficulties when people come back from holiday and say, 'I have been given these, doctor'. Of course, you do not have a clue what it is and then you have to spend quite a bit of time trying to find out what the drug is that the patient has been given.

[198] The French in particular tend to love prescribing tablets—certainly they prescribe about five times more per patient than we do—and I have had patients coming back from holidays in France with perhaps 10 different things for bronchitis, which is quite amazing, most of which they did not take. I think that there is an issue around the quantity of prescribing, the appropriateness of prescribing and the cost of prescribing; all of which, as you rightly say, is a bit fuzzy in the way that the directive is written. This country has a well-regulated and well-controlled prescribing habit among doctors and nurses in the NHS, and I think that it would be a shame if we lost that or had to give prescriptions for treatments that we, or NICE, would not see as necessary or very effective. So, there is a big issue there.

[199] **Dr Dearden:** Just in terms of the equity of the care, I would use the example of a patient who comes to me and says, 'I would like to see someone privately'. I can usually tell them the approximate cost of the first consultation. I can then tell them, 'Should you need an endoscopy it would cost roughly this' and 'If you needed a hip done it would roughly cost that'. So, the patient goes into that with a clear view of how much he or she can afford and can do, which is, in a sense, what I was describing before, which was the GP, the consultant and then your healthcare travel adviser. Once it is determined that someone needs a hip done, for example, then it could be said, 'Here is a range of places that you can go to. These are the costs that would be incurred to the NHS if you went and had these things done'.

[200] I think that one of the dangers here is that we would be referring people, and if we did not know how much something cost before we sent them, we would be very, very stuck. As an example, I was in Chicago and had conjunctivitis. I went to a hospital there and was charged $500—£350—for a 20-minute consultation. Fortunately, my insurance company did not complain about that, but had I known it was going to be £350, I would have reverted to using salt and water. So, in a sense, there is a question of unknown cost.

[201] In that sense, I think that there is also the question for this committee about the place of top-ups in this particular scenario. There would be something the NHS may or may not be able to provide and then, of course, if we are allowing top-ups to NHS care—and I certainly do not have an answer to this one; this is my question to you, and, since there is only one minute left, you cannot ask me about it—what about the question of top-ups when it comes to this European directive in seeking care somewhere else? Is that something that will be applicable or could be applied, because that throws us into a whole new set of questions.

[202] At 55 minutes, Chairman, I will stop there.

[203] **Sandy Mewies:** Thank you very much, indeed, for your contribution today. As I say, we are finding layer upon layer of things to look at here. If you feel that there is something that we ought to be looking at, please feel free to inform the clerk—organ transplantation is one of the things that has been mentioned this morning that had not really crossed my mind

previously—and if we can consider it we will. Thank you very much indeed, and, as I say, we will send you a transcript.

[204] **Dr Calland:** Could I just give you a list? IT, which is coding, governance and security, GMC-type regulation around the EU, chronic conditions and mental health, and what happens with private insurance.

[205] **Sandy Mewies:** Yes. We have thought about a few of those indirectly anyway. Thank you very much indeed for attending today.

[206] Thank you, everyone, for being here. I know that we have all been to places and we have places to go now. The next meeting is on 10 March 2009. Thank you very much indeed for attending.

Daeth y cyfarfod i ben am 10.56 a.m.
The meeting ended at 10.56 a.m.