

THURSDAY 23 OCTOBER 2008

Present

Howarth of Breckland, B (Chairman)
Kirkwood of Kirkhope, L
Neuberger, B
Perry of Southwark, B
Trefgarne, L
Young of Hornsey, B

Memorandum submitted by PA Consulting Group

Examination of Witnesses

Witnesses: **Mr Andy Mullins**, Partner and Head of Health, **Mr George MacGinnis**, Managing Consultant, **Dr Stephen Black**, Principal Consultant, and **Dr Chris Austin**, Principal Consultant, PA Consulting, examined.

Q1 Chairman: We are very grateful to you for taking the time to come. You will probably have gathered that you are the first of our witnesses, so you are going to be, if you like, setting our thinking going in relation to all of this. We think it is an extraordinarily important inquiry because I doubt whether some of the issues have been really fully explored anywhere as yet, so we see it as our responsibility to make sure we do look at the issues in some depth. If we do not get through everything today, we are very happy for you to send supplementary evidence or further answers to any questions that have not been reached. As you know, today we really do want to look at the conceptual issues around this Directive and we are looking for help in that, so perhaps you would begin by saying briefly who you are.

Mr Mullins: My Lord Chairman, can I start by saying thank you very much for inviting us along to give evidence and to contribute to the important work of the Committee. We are delighted to be invited and the reason why we contributed to this in the first place was that we see this as a particularly important issue for health organisations throughout Europe. Perhaps

it might help, as you say, for me to say a little bit about who we are and to introduce my colleagues. PA Consulting is a British management and technology consultancy firm with global reach. We have some 2,000 employees around the world based down the road just in Victoria. Those 2,000 employees all own a little bit of the business, so we are a bit like John Lewis in that sense, so we are employee-owned. We have a long track record and a history of delivering change successfully across the public and private sectors and our work in health is perhaps one of the most significant areas that we are involved in, so each year we will be involved in something like 100 different assignments in the UK, Ireland northern Europe and, more recently, the Middle East. Our work ranges from supporting governments in looking at the design of complete health systems, on the one hand, to working with individual hospitals, clinicians and managers to help improve the care that they deliver to patients. It is with that background and that interest that we come today to offer our views. We do not have all the answers to some of the things that, I know, you will be considering, but we certainly have some views and we hope that that will contribute to your thinking and debate. With me today giving evidence are Dr Stephen Black, Dr Chris Austin and George MacGinnis. My name is Andy Mullins, a Partner with PA and I lead on PA's work in health in the UK.

Q2 Chairman: Do you want to make a short opening statement?

Mr Mullins: If I may, I would be delighted to, yes. After many years of uncertainty, we think this Directive clarifies the rights of patients to choose their healthcare provider, irrespective of where they live in the EU. It is proposing to underpin this choice with the patient's right to reimbursement for the care that they receive as well as some protection around quality and safety. In that sense, the Directive provides leadership that has been long-needed in the area of cross-border health while also giving Member States some room for interpretation and implementation. There are some areas that we would welcome, but there are also some areas that we are more cautious about and, if I may, I would just like to outline

those for you now. Specifically we welcome five areas. The first area is the clarification of entitlement to treatment in accordance with the legislation and standards that apply in each Member State, so, for us, that seems to be a key point. The second is the requirement for minimum standards around the monitoring of healthcare providers' complaint systems and so on. The third is the clarification that patients only seek reimbursement for treatment to which they would be entitled in their home system and that prior authorisation systems may be introduced by the Member States for hospital care. In our view, that is essential for stability for individual hospitals or indeed for some Member States' systems as a whole. The clarification that Member States are not obliged to treat a patient from another Member State if it were to be to the detriment of other patients with similar needs, we also think, is an important point which this Directive makes. Finally, in terms of the areas which we welcome, the fifth one, we also welcome many of the cross-border co-operation ideas on healthcare, including recognition of prescriptions, clinical reference and technology assessments as well, but we will go on to talk a little bit about our worries around some of the comments on e-health in a second. One of the things that we did recently, in preparation for some of our thoughts around this Directive, was to survey 2,000 people through the polling organisation, YouGov, to get some of the general public's views around this particular Directive. You may be interested to hear, and I am sure this reinforces what you will already know, that the majority of UK respondents are strongly in favour of the right to access cross-border healthcare in the EU, some 58 per cent. Interestingly, and particularly when you hear the accents of my colleagues, there is stronger support in Northern Ireland and Scotland. We think that the difference may be explained by the longer waiting times for elective care in those areas. Interestingly, although the majority of respondents were in favour, 24 per cent said that they would not seek treatment in another EU country under any circumstances, which I think was a bit of a surprise to us; we did not think it would be quite as high as that.

The other thing that we noted as well is that the over-55 age group were also stronger supporters than other age groups. When we looked at the reasons why people would travel overseas or indeed just across borders, respondents felt that the length of wait was the key factor, and I mentioned earlier about increases indeed in Scotland and Northern Ireland. The second most popular reason was the reputation and the experience of the EU healthcare provider, so people would be attracted to go to an alternative provider if their quality or their reputation shone out. I will just briefly go through the areas where, I think, the devil is in the detail, if that is okay, and then I will pause.

Q3 Chairman: Well, shall we go into our questions and, if you think we have not asked about the issues that you want to raise, then we can come back or you can let us have that. You are going fast and we need to absorb the issues fairly steadily because we are going to be thinking in a matrix way, across all the issues with a number of witnesses, but that was very helpful. You have had notice of the questions in advance, and the thing which has spurred this on is of course what you have just mentioned, which is the legal uncertainty which has come from cases like the *Watts* case in Europe and the issues about equality and cost, and we are going to be asking you a bit about that, but in your written evidence you talked about those issues that need clarification. Would you expand on those comments? You have mentioned some of them in your list, but you may, from the rest of your comments, want to talk about how we are going to get that current uncertainty resolved and what we need to look at. Then, to what extent does the Commission proposal, because this is what we are really interested in, respond to those problems and what do you think the implications would be if we did not agree to such legislation?

Mr Mullins: We think there are two key areas that are a challenge. One is around the right to reimbursement, so, on the one hand, we welcome what the Directive is suggesting around clarifying reimbursement, but we are concerned that it does not go far enough, it is not clear

whether reimbursement will mean the patient paying up-front and then reimbursed subsequently or whether the provider or the payer organisation of the Member State will pay directly to the hospital of treatment. Our view, is that in either the Directive, or implementation guidance, our Government ought to seek to clarify this or there will be some groups of patients who will not be able to afford or take up, or exercise, that choice. The second area, which I think we mentioned in our original report, was around clinical oversight and the responsibilities for managing the patient pathway between Member State and the providing hospital. If we think about what happens right now when a patient moves between one provider and another, there is a dialogue between clinicians and the GP within the UK around the pathway that that patient needs to go through. So before that patient may be transferred, there is clarity around what follow-up care they may receive when they go back home and they are under the care of their GP. What is not clear in this Directive is the mechanics of how that will happen across the European Union. Our view would be that provider organisations ought not to accept patients unless there is a clear pathway, and they would have a moral duty, we believe, to ensure that that pathway was in place before undertaking any treatment. Providers will need to be clear about what they are responsible for and what they are not responsible for. Even if the provider were saying, “We will operate on your hip and will be providing, as part of our package, a period of physiotherapy in the three days after”, they should be seeking assurance that the necessary arrangements are in place when that patient returns home to continue with further recovery care. In the UK, that could be the responsibility of the GP and in other Member States that may well be the responsibility either of the insurer or indeed of the patients themselves, but, in terms of provision, we need to be clear about who is responsible for that. We think, this is an area that requires quite a bit more guidance.

Chairman: And leads to quite a complex administrative process.

Q4 Baroness Neuberger: I ought to declare an interest to start with as a Director of Voluntary Health Insurance in Ireland, plus previously Chief Executive of the King's Fund, but I am really interested in your written evidence where you are pretty clear that there is a real benefit to be had for patients in increased choice, and you then say quite a lot about what might flow from all of that. If we go right down this line, with all the caveats, as you have just said, where do you think we end up because you have already said, and it was extremely interesting about the YouGov evidence, that there is a very positive view about cross-border healthcare and that older people are particularly interested, and I think we know that because there are some procedures where we are already seeing some signs of that, so where does this go and how do we make sure it goes there properly?

Dr Black: When we thought about what the benefits of choice are, and this applies inside England at least and is improved by having access to other countries, the obvious benefit is that some patients will be able to get care that is in some way better than what they were able to access locally, so it might be more timely, it might be more convenient or it might actually be of a different quality. It is up to the patient to decide what they mean by some of those things and choice has the benefit that, as things change over time, the patients will respond by making different choices, so we do not have a government committee deciding, "This is what's good for you" and taking a long time to do it, but patients can change their minds and next week they will want something different from this week. However, that is not the biggest benefit of having choice in the system. We believe the biggest benefit is in the way it changes the incentives for hospitals. There has been some analysis inside the NHS and in many other places where, if we get the incentives right, then hospitals become much more responsive to the things that patients want. If patients can move away from their local hospital because the waiting lists are long or because they do not like the sorts of wards that hospital has or they do not perceive the hospital to be of a high quality, then that gives that

local hospital a strong incentive to fix those things or, at least in systems where the money follows the patient, the hospital will lose some of its income, and that is a very, very powerful incentive to drive up improvements in health. We think that is actually the largest benefit for the system of having patient choice. What is likely to actually materialise may actually not be hugely significant in terms of the volumes of movement because you do not need that many people to make a different decision to provide quite a strong incentive for a hospital, and our view, looking forward, would be that we probably would not see large movements at the whole-hospital level. What is likely to happen would be to particular departments or particular specialties where there are either short-term or long-term problems. For example, in the UK, there are some orthopaedic departments which have very long waiting lists. It is much better than it used to be, but they are still long and patients do not like that. Those patients in that speciality may be the sorts of patients who would choose to move to another country, so it may be that that effect would be relatively localised. In the long term, these things may actually balance out, so the incentive for that department to improve may well lead to having very short waiting lists in the future, in which case the patients will no longer be moving abroad, so the effects are not permanent, but will be things which may be self-correcting through the mechanisms and the incentives that choice actually creates. There are some big benefits in terms of capacity across the whole of Europe. If we have particular problems, particular shortages in some countries, then the ability of patients to choose to move may actually help use European-wide capacity much more effectively than insisting that all patients are treated in their local hospital or in their home country, so that is a range of different benefits that we perceive coming.

Q5 Baroness Neuberger: I might just pick you up because you talk a lot about the patient and the patient being able to choose, but in many cases it may well be the payer as opposed to the patient. It may be in response to patient comments on the quality of service received, but

it could be, and it would not apply so much to the NHS, but it would apply to other European countries, that a purchaser would say, “Actually, the sort of orthopaedics we’re getting here are rubbish. We’re going to send all our orthopaedic cases of elective surgery to Spain”, and that will be presumably because the patients have put the pressure on the system. Is that part of the benefit that you see, that it is not only the patients, it is how the payers respond to patient pressure?

Dr Black: I think the answer to that depends a little bit on the structure of the health economy in different countries.

Q6 Baroness Neuberger: Sure.

Dr Black: In England, clearly we have separation between the people who pay and the people who do the care, but we allow the patients to have a choice and that choice imposes pressures on the hospitals to do things differently. In other countries, that effect may work indirectly, but it may be that the people who are paying in France, for example, would put pressure directly on the hospitals rather than the movements of patients. I think the ultimate benefit is similar, but the detailed mechanism may be a little bit different.

Q7 Lord Trefgarne: There is a political dimension to all of this as well, it seems to me. Just following Lady Neuberger’s example, let us say that a great chunk of the British National Health Service was not apparently providing adequate orthopaedic treatment and people got it into their heads to send all the patients or to encourage all the patients to go off to Spain, I would imagine that the Spaniards would not be best pleased about all that. Let us take another example. In this country, we are apparently pretty good at doing angioplasties, and I declare an interest, I had one a few years ago. What happens if the Spaniards get it into their heads that people need to be sent here for angioplasties? It is going to cause problems, is it not, and how do we resolve that?

Mr Mullins: To take the angioplasty example, I think what we saw in the EU Directive with the statement around Member States not having to accept patients across borders if it is going to be a detriment, I think, is key here. It will be those specialist hospitals that are likely to attract additional demand particularly if they are world-class in Europe.

Q8 Lord Trefgarne: So they can turn these people away, and the Spaniards can?

Mr Mullins: And the mechanics of how we turn people away is going to be quite difficult and how you capacity-plan in that environment and manage the potential impact on the primary care trusts in England. How you do that is going to be difficult.

Lord Trefgarne: It could be a coach and horses through the whole thing, could it not?

Q9 Baroness Neuberger: And how do you define a ‘detriment’, to add to that?

Mr Mullins: Exactly, and there may be some further guidance required. There is an important principle to remember here if we are going to help find our way through this. We need to accept that medical decisions are local, not national, that the people, certainly within the framework we have in the UK, who make those decisions are GPs in line, in England, with their primary care trusts. What we must be really careful of here is that we do not put something in at a national or EU level that takes GPs’ decision-making powers away. They are the ones who are going to have to agree prior approval for travel overseas and we have to be careful that we do not agree something that takes that power away from them. That is the only way that we are going to be able to manage or gatekeep this flow of patients. How other countries are going to do it, I do not know.

Q10 Lord Trefgarne: This leads to the headline where a particular hospital says, “Sorry, we can’t take any more foreigners because we’re full up with our own people”.

Dr Black: I think there is an additional issue of practicality to bear in mind in that situation and it is partially to do with, if the patient at least is choosing or even in fact if the payer locally is choosing to send patients, why would they continue to try to send patients to an unwilling hospital which did not want to take them. As we have said, one of the reasons why people choose to go is because they get faster treatment. If too many people choose to go, the treatment can no longer be fast, so it actually sets limits and the mechanisms of choice may provide a very strong practical limit to how far these movements can actually occur, whereas, on the other hand, if we have spare capacity in a hospital for doing angioplasties, why not use that for Spanish patients? Why would we have spare capacity? It may be a good thing for the NHS as much as for the Spanish.

Chairman: I think we will come back to some of this, and certainly this leads into the next area very clearly because we are wanting to look at equity and all of this does take us into the equity question.

Q11 Baroness Perry of Southwark: Yes, indeed. Just to make a bridge in, as they would say on Radio Four, there are tertiary referrals, and this has been quite a risk for many years, has it not? I was a Governor for some years of Addenbrooke's NHS Trust and of course that includes Papworth, and we had a lot of tertiary referrals from hospitals at Papworth and going back 10/15 years I think that had been happening. Is this not something which might happen where you get areas of extreme specialism, so to speak, and very high-profile specialism where there are tertiary referrals from hospitals, and this would be hospital consultants, not patients making a choice?

Dr Austin: I am speaking from a background of being a clinician myself, having only recently come into the consulting industry. Previously I worked at a foundation trust here in London in a sub-speciality area of medicine - diagnostic and interventional radiology. Certainly some of the things that we experienced, even within our own department because of

the sub-specialisation that is taking place have led to these kinds of phenomena and behaviours among patients within the UK itself. It is actually even extending outwith those borders internationally because of the reputations of the different procedures that we are actually doing. Obviously, there is a balance that you have to strike here and I think the Directive does put some caveats into it, although I agree with the comment that what is meant as a “detriment” to the actual services that are being provided locally needs to be clarified. What is also essential though is to recognise that these centres of excellence need to have the capacity to develop themselves and grow. In my experience within a couple of years at my particular hospital, I started to see the kind of ebb and flow of very skilled clinicians not just within the UK, but from abroad who were being attracted to the practice and bringing patient groups with them. I think that the Directive should not necessarily curtail that kind of ebb and flow; that is what happens in academic institutions, in universities across the globe and we do not want to put barriers on universities, saying, “This shouldn’t happen”. If a facility which has that expertise and that sub-specialisation can brand itself well, it should have the potential to build that capacity, and that capacity, as long as it is generating income and good outcomes clinically, will attract and generate more individuals who can come and do the work. Obviously, there will be other capacity issues about beds and nurses and things that have to be considered along the way, but I do not think the Directive should put up barriers for that kind of sub-specialisation, that sharing and development of centres of expertise.

Q12 Baroness Perry of Southwark: That does raise the equity issue of the patients who might wish to buy their way into one of the areas of high expertise. I know that you have highlighted in your written evidence the issues of equity that arise. Could you explain the concerns that you have and what solutions you think might be offered?

Mr MacGinnis: Most of our concerns were actually about the mechanism of the way it would work in supporting people who were in other ways disadvantaged from being able to

pay for that, but I suppose I would just like to come back to the sense of how we got to this question today. I think there are some underlying principles that are quite important in understanding this queuing and rationing system, firstly, the bit about clinical need, and it must be an absolute thing, that this is not some bureaucratic right to join a queue, to get a place and then find the queue all filled up, but clinical governance over who has priority, and then that critical issue we pointed out earlier, that the provision of care to people across borders should not be to the detriment of the home population, and that is a clinical judgment, in my view, and must always be central. The side-effect actually is probably that waiting lists become the mechanism by which the flood of angioplasties is prevented from happening in one place or another, but I do take your point and I think that is actually not easy to govern and may be subject to other influences and interests at the local level, but that clinical judgment, I think, needs to be at the core of it. In the other areas, what we were concerned about more was whether this Directive would actually provide another means of having a two-tier NHS, those who had a cash reserve and could travel and those who could not.

Q13 Baroness Perry of Southwark: Travel or top up.

Mr MacGinnis: Well, a degree of top-up probably is unavoidable if there is a core operation for which the NHS would have a tariff and would have paid for anyway, so going and having extensive rehabilitation that was above and beyond anything that you could get on the NHS might well be an option for people who choose to top up and travel overseas, as it would be if they paid private medical insurance, so I think there are some of those mechanisms there. Possibly of more concern is actually whether the way that the payment mechanism is implemented actually serves as a further barrier to people who do not have a cash reserve, so we thought it was very important. The proposal enshrines pre-authorisation and we would go a stage further and would want to see that pre-authorisation with a payment mechanism which, for the NHS-funded elements of it, did not touch the patient. We actually think there

may be some side-benefits in terms of some of the other issues that you have addressed questions on if the NHS retains the payment control because that then gives you an ability to do a little bit more in judging quality and ensuring that you get documentation or whatever back, so we think that is there. Then there are a few even further issues, if you delve into that, around travel, accommodation, subsistence, particularly for people for whom the NHS pays, and I think this actually then does become a rather difficult issue and I am not going to suggest that there are any answers from our point of view, but I do think that it raises important equity questions. If someone would be entitled to free transport and support to exercise choice anywhere within the UK, then there are similar issues with this. Probably the overriding principle should be that that package should be contained within the UK tariff, so, if the medicine is cheaper and the accommodation adds to that cost, but is within the reimbursable limit, I think it would be fair if that was covered, but there is probably a multitude of sins in there and that actually creates quite a difficult mechanism for the NHS to actually get their mind round and govern.

Dr Black: I was going to add a very short comment because there are some myths around who benefits from having a choice. I think the original work on this was done by Professor Julian Le Grand, and he argues that the middle classes are very good at getting choice, even in systems which do not notionally allow it, so they get it, but actually choice for all patients, especially if it does not involve them having to pay any of their own money, is actually very empowering for the people who currently do not get much choice, lower socio-demographic groups, and in fact they marginally want it more than the middle classes, according to public surveys.

Q14 Baroness Perry of Southwark: Can you name a survey that showed that?

Dr Black: Not directly, but I think the work will be work done by Professor Julian Le Grand, who was the Government's Health Adviser under Tony Blair.

Mr Mullins: We could perhaps provide that as supplementary evidence.

Baroness Perry of Southwark: Because some of the evidence, I know, in education is that, where people are offered choice, the lower socio-economic groups tend to be the ones who least want to exercise it, but it is the sharp-elbowed middle classes who do.

Baroness Neuberger: On the point of the lower socio-economic groups, was there not also evidence that suggested, and you actually cited the YouGov survey, that older people are stronger supporters of cross-border healthcare than other age groups? Is it not the key to some of this that older people feel disempowered in some health systems across the EU and therefore, look for choice elsewhere? Again, would you have some of the data on that because that could be very useful, which would tie together with the information about socio-economic groups?

Q15 Chairman: Just to add to that, in a previous inquiry which we have just undertaken on organ donation, it was quite clear that people from minority ethnic groups found it far more difficult to access healthcare of all sorts and, therefore, there were issues around organ donation. It would be really interesting to know what would happen to those groups in this market.

Mr Mullins: We would be very happy to submit the data that we have collected through the YouGov survey and that may help to answer the question. I cannot promise that it absolutely will, but we will certainly provide the data that we have.

Q16 Baroness Perry of Southwark: On the issue of equity, you have raised in your written evidence the question of whether the NHS should give more priority to using its resources to help reduce the existing health inequalities within the UK than to ensure that cross-border healthcare is available to all. In the light of your extremely expansive experience with the UK

health sector, do you have any feeling for the majority of opinion amongst health professionals and patients on that subject?

Mr Mullins: Sometimes you write things in reports and you think, “Actually, that’s quite inflammatory”, and we perhaps did that deliberately! We may have presented a slightly false choice there because I do not think any health professionals, managers or clinicians actually sit down on a day-to-day basis and say, “Am I going to tackle inequalities or am I going to send this person overseas?” Having said that, I think the sentiment that we were trying to get across is that there is a very real danger that, if we do not get the implementation guidance right for this Directive, it could distract managers and clinicians disproportionately towards the few people who want to exercise their choice in this area and away from the important work that they do day to day, and I think that is really the sentiment we meant, so I do not think there is a danger really that the money that is involved in this, given Dr Black’s comments about the numbers involved here, I do not think that is the issue here.

Q17 Chairman: The issue really is about the undermining of the clinical judgment that we were talking about earlier.

Mr Mullins: Yes.

Q18 Lord Trefgarne: I would like to raise two related topics. The first is a question of prior authorisation, on which you have already touched in your remarks, and, allied with that, the question of eligible conditions, where, it seems to me, the eligibility can be determined at the prior authorisation process on occasions, if not always. You have expressed support for prior authorisation as a concept at least, but what are the drawbacks to such an arrangement and what are the implications of excluding non-hospital care from the prior authorisation which is, I think, what the Commission have in mind?

Dr Black: I think there are two big issues with prior authorisation. The downside of it and the downside of having lists of approved conditions is that it could be quite bureaucratic, it could involve a lot of paperwork and a lot of delay in the process of getting people care. That may not be such an issue, depending on how you actually set up a prior authorisation system, but I think it is very important to understand why prior authorisation is necessary and it comes in if you compare different healthcare systems around the world. The ones which seem to get things right, which end up with reasonable amounts of control over both clinical quality and their budgets, are the ones that have incentives lined up so that somebody has to worry about whether we are doing too much or whether we are paying for too much, so the systems that work least well, like large parts of the North American system, have no primary care gatekeepers and, if anything, they dramatically overtreat the population and that leads to runaway budgets for healthcare and patients getting so much treatment that it actually harms them, and there is very solid evidence that that is true in North America. If you read some material produced by, for example, the Dartmouth Atlas project, we could refer you to that. Now, prior authorisation is necessary because it is the primary lead, certainly for the NHS, to put the incentives in the right place to stop runaway spending and indeed to actually act in the clinical interests of patients who will sometimes say, “I want this treatment”, even when a clinical judgment would say, “This is going to harm you rather than benefit you”. For both those reasons, we think that what the NHS does, which is it effectively has GPs acting as gatekeepers to hospital care, that system is essential and we do not want to undermine that by what we do in allowing people to go abroad and go to different European countries.

Q19 Lord Trefgarne: That ties up with eligibility, does it not, so that, while prior authorisation is being considered and no doubt mostly granted, at the same time the eligibility can be determined? The important thing is to ensure that the clinician faced with the patient

is not told to wait days or even longer while, first of all, the authority and then the eligibility is determined. That is the drawback, is it not?

Dr Black: Yes, and the advantage of having some list of approved conditions would be that the only person who has to do anything is the GP and, once they have made a referral, then everything else is fine. A very large amount of work happens in a fairly small amount of types of surgery or types of procedure, so, if countries can more or less agree this list, it takes out a great deal of paperwork and delay in the process.

Q20 Lord Trefgarne: And, if you have a condition on the list, prior authorisation is not required?

Dr Black: Well, I am not certain I would phrase it like that because you still have the clinical judgment as to an individual patient.

Q21 Lord Trefgarne: But, if the doctor is happy, then you are in business?

Dr Black: Yes.

Q22 Lord Trefgarne: But he cannot determine the eligibility?

Dr Black: It is very hard to write bureaucratic rules which determine clinical thresholds for treatment, you need some clinician involved in the loop, but the benefit of an approved list is no more bureaucracy beyond that point, no more paperwork. But it is not the patient deciding they need a hip replacement and then getting one automatically because it is on the list.

Q23 Lord Trefgarne: Eligibility has other considerations too. A patient might present themselves in France, saying, "I am eligible in England", but they happen to be foreign nationals and they are not eligible in England, and that might take a long time to sort out.

Mr Mullins: That is a very good point and I think it probably would.

Lord Trefgarne: It is not just medical eligibility, it is national eligibility.

Chairman: Having to prove eligibility will be quite a significant matter.

Q24 Baroness Young of Hornsey: All of this is extremely complex of course and, when we start to look at liability, we move into even more complicated areas, if that is possible. Now, you have indicated that the issue of clinical liability needs to be analysed very closely. Do you think that the draft Directive is helpful, useful or productive in that area and do you think it helps to give more certainty to patients and clinicians?

Mr Mullins: I think our comments in this respect clearly will not be from a legal perspective, but more from the managing, change and implementation aspects. I do not know, Chris, whether you had a view on that one.

Dr Austin: Again, as Andy is saying, we are not approaching this question with our legal hats on. In order to answer the question there is a need for detailed analysis particularly around the legal framework and focused on some of the indemnity issues and the requirements for insurance to protect clinicians who are offering treatments in the various Member States and that there is some kind of coherence across the board that recognises these packages. The way we have approached this question is to look at it from a management point of view and a business point of view and at the risks involved. From this context the process is really important, the process around ensuring that a patient can make the complaint, and that the process is transparent. Patients should know how to go through this journey - it can be a very complex journey for the patient and for the clinicians from that point of view. The process also has to be timely. The Directive does not necessarily need to say all of these things, but it needs to make clear that the process set out by a Member State meets these basic criteria so that, when this becomes an issue for individuals, they can have some kind of guidance of what to expect. I think the other thing to keep in mind with all of this is that, as the patient is going through the journey, there is an agreed consensus on how outcomes are going to be reached and how the compensation schemes are going to be reached. Finally, the

overriding principle here is one of ownership, who takes ownership for developing these processes and making sure that they are in place, and that there is some kind of agreement by the Member State that is going to be able to deal with the issue. Again, for us, it is not so much about the Directive saying, “This is exactly what you need to do”, but, because this is a process-driven thing, it is about making sure that the Directive says, “You have to make sure you do the right implementation and ensure that your processes are robust enough that patients can go through the system without legal wrangling between Member States disputing who is responsible and who is going to pay up”.

Q25 Baroness Young of Hornsey: I think this is probably another area which we will need to go into more deeply because it is not only about complaints about medical treatment of course, it is about a whole range of other issues as well that one might want to complain about. I will move on to my second question, which is not totally separate from this, but it is about the issue of language. Going through my mind is how do you make a complaint when you are dealing with several different languages, and of course across the Union there are 23 official languages and here in London we have many different languages. How are we going to cope with this? Who takes responsibility for providing services, like interpretation and so on and so forth?

Dr Austin: Language is an important thing and it is essential that the Directive actually acknowledges how important it is in this kind of scenario. We know, as clinicians working in London, how important it is. It is important for lots of reasons. It is important for the patient, for the patient’s family and relatives and for the clinicians and the staff who are looking after them. So, whilst we think it is important to recognise it, we take a different stance in terms of what we think the Directive should say about language. We do not think the Directive needs to prescribe who provides it, nor who needs to fund it, and let me kind of explain my thinking around this. We are approaching this issue from the point of view that providers, who elect to

provide a service to a patient and agree in advance to taking that patient, need to provide whatever package of care is going to be essential for them to do the job appropriately. Now, if I put my clinical hat on, for instance, and put myself in a hospital in Paris and I choose to accept a referral from a patient coming from the UK, I need to ensure that there are certain things in place, otherwise I am putting myself in a liable position. If I do not have the services to communicate with my patient, to communicate with the referring clinician appropriately and in my language to understand the problem, I am not going to accept the duty of care and say, "Okay, come on over". We think that it is the provider Member States that really need to be thinking about this service.

Q26 Chairman: What about the commissioners? What are their responsibilities, the commissioners of the service, the people who are referring? It is all very well for the person who is going to provide the service, but what about the GP or the health authority? Earlier, we were talking about the pathway through the service. I wondered what you thought the responsibilities for the Commissioner would be for setting out the pathway and making sure that all these things are in place, including the language?

Mr Mullins: I think you raise a very good point and one of the angles we thought about when we were putting these answers together is that, if we think about the system of choice that Steve described earlier, patients are less likely to choose providers if they are not going to provide the full range or package of services that are going to be helpful to them, and this is a challenge around information which is a separate issue, but providers are going to have to say, "Yes, not only will we operate on your hip, but this is how we are going to look after you. This is the quality of care and the hotel services that we can provide for you, how we might support your family and friends, if they are with you, and indeed, if you do not speak our language, how we will support you doing that". Now, if those things are not clear and advertised, then I would suspect, when we talk about the PCT's role and the GP's role, the GP

is less likely to advise and support a patient to take that choice. Firstly, if they do not know that it is there or they are unsure, and I am sure the GP would not do it, but most patients still, I think, would heed what the GP says.

Q27 Chairman: How sure are you that GPs are going to have the expertise to actually make this analysis, bearing in mind some of the recent investigations into GP practice?

Mr Mullins: I am not sure, nor am I sure that they will necessarily always have the time to do that. It is difficult enough for supporting the offer of choice in this country alone, let alone between countries.

Q28 Baroness Young of Hornsey: It is partly a matter of process, is it not, but it is also, as you say, about information because we talk very blithely, I think, about choice, but then there is choice and there is real choice, is there not, and, if you are not in possession of all the facts and information and able to interpret and understand the implications of that, then what kind of choice is it? I think this is a really important area that we need to think about quite clearly and, as you say, the commissioning as well.

Mr Mullins: I entirely agree with you. One of the things that our short analysis showed is that people would make a choice on a small number of factors, whether it is waiting times or indeed location or the quality of follow-up care. It is some of the hygiene factors, if I can put it that way, around it which may actually outweigh their preference for some of those choices. In the absence of real information patients may make a choice they later regret and that is a thing we have to be wary of.

Baroness Young of Hornsey: I suppose there is an element of risk assessment for the patient in that.

Q29 Lord Kirkwood of Kirkhope: Within the Committee's rules, I am bound to advise you that I become a member of the GMC on 1 January 2009. I want to ask you about aftercare because it is a very important question, and this might be best done by a note because we are a little bit constrained on time, but, from your experience, can you sketch in the numbers that we are talking about here? Is there any data about what is happening at the moment? What is your estimate of what the demand might be? I think there are small percentages, but they could be big numbers, and it would be enormously helpful for the work of the Committee, as we start this process, if we could just get a handle from your background and not just about the statistics, the numbers of people and the flows that are extant at the moment, but could you estimate where this might lead? If everything that could go right did go right, in five or ten years' time would you be anticipating big flows across these boundaries? It may be that the best way of doing this is maybe to do a note, but could you just say a word about that for the benefit of the Committee before I ask questions about aftercare?

Dr Black: I would not like to commit to any numbers without going out and looking at some analysis that we can conceivably do with current NHS statistics, but I think a general comment would be that I would not think that the overall flows over time would be very large in a sustainable way because, as I said, they are probably quite narrow patient groups, quite narrow subsets of patients, and those people will choose for a bit and then maybe, when things change at home, they will choose to come back to England. We may be able to answer some questions by looking at how patients have chosen to move from hospital to hospital in England where there should be emerging statistics which tell us a little bit about that exercise, but I think we should probably look at the statistics and reply with a note.

Q30 Lord Kirkwood of Kirkhope: Yes, that would be very helpful and that is the best way of doing that, thank you. You talked earlier, Mr Mullins, about the patient pathway and I am

sure that that is absolutely right. Just give me six sentences on what you think a definition of ‘aftercare’ and ‘follow-up care’ would be.

Mr Mullins: Rather than try my layman’s approach, I am actually going to turn to the doctor on the team and ask him to do that one, if I may.

Dr Austin: To answer the first part of the question, we did not use the concept of ‘aftercare’ in our submission, but I think that came back to us in the questions. We are not making a differentiation between the two, but we are using the term ‘follow-up care’ in our document and we include that to be everything post-treatment, from the time of hospital discharge to the point when the best possible clinical outcome has been achieved.

Q31 Lord Kirkwood of Kirkhope: So that includes things that go wrong unexpectedly?

Mr Mullins: I think this is another area to highlight where we think will need some clarification. As you will know, one of the challenges of the introduction of the independent sector in this country has proved to be is: who does the rework if we get it wrong? Of course that has caused all sorts of implications and bad feelings sometimes when that has happened. If we are going to get the guidance right for this Directive, we are going to have to clarify those bits of the pathway as well, so not just if it works properly, but what happens when it goes wrong and what is the redress for that.

Q32 Lord Kirkwood of Kirkhope: Okay, but the key question really is this: supposing you were persuaded that you could not, within the context of the Directive, lock down the requirements for that patient pathway about which you spoke so eloquently earlier, do you think that the merits of doing all of this would be worth the trouble if you could not get that grounded properly in the legislation? If you did not have the confidence that that would be a seamless, joined-up process, is this something that we should think about in terms of not even bothering if you cannot do it?

Mr Mullins: If we cannot ground it, whether it is in the legislation or subsequent guidance or indeed within our own Member State, then I think we would certainly be worried because, and you will know better than I will, a proportion of those procedures will go wrong for whatever reason and, if we have not grounded what happens in those circumstances, then I think that is a worry.

Q33 Chairman: Unfortunately, we are running out of time and clearly the Committee could have continued to ask you a range of other questions, but there is just one more that I would like to ask and that is about co-operation between Member States, which you mention. Of course, we all believe in co-operation as a principle, but it is the practicality that is the difficulty, and we wondered if you would like to expand on some of the issues that you have identified in terms of practicality. I think some of us are particularly interested in e-health and the use of computers, bearing in mind the difficulties some of us have faced with computers in other situations.

Mr Mullins: I have to say you are not alone on that! With that in mind - and perhaps we can do a separate note - we had some thoughts around some of those points on co-operation. But particularly as it is e-health I will ask George to say a few words around that area because it is an area that he is expert in.

Mr MacGinnis: It follows on really well from the continuity of care argument because the exchange of health information in support of people moving is clearly something to be really welcomed. Breaking away from some of the paper cycles and some of the limitations on paper is equally important. What I have flagged is this is the area which is probably, in my view, the most far-reaching and radical element of the Directive and does raise for me some questions about how feasible it is and exactly what the nature of the powers being transferred are. Without really going into much detail, it is probably enough to say that inter-operability in health is an illusive and moving target. For instance, we have had all our GPs

computerised for well over a decade now. Only last year was the first time that some GPs could move electronic records when their patients moved to a new GP, and that goes down to the heart of these technical issues. Clinical safety is at the heart of the reason why that has not happened earlier. In solving this this is not a national or a regional problem; it is a global problem. If you look at the national programme, many of the products coming over have been developed elsewhere particularly in English-language countries and the size of the market suggests that. I think the home nations have had quite a good track record of engaging globally in getting the standards they needed to get their programmes delivered. Why is this an issue? Standards generally, while they make sense, normally come with a burden. There is a cost/benefit equation and by being very close to the people who are trying to implement them and commercialise some of this stuff that cost/benefit equation is being solved. I do not see the same mechanisms in Europe. I do not see the ability to back up a mandate of a standard with a payment mechanism that actually gets everyone's computers upgraded, or however it would manifest itself. Because we are earlier adopters in the UK, we probably stand to lose more than other nations might gain from disturbance to our various national programmes up and down the country, so I think it is a really worthwhile goal. It is an illusive target and I am really not sure that the European mechanism would have sufficient strength behind it and be consistent with subsidiarity to actually follow that through.

Chairman: Is there anybody else on the Committee wanting to ask any other questions? That being so, can I say that if you do have other things that you would like to send us, we would really welcome them. As you can hear, we are already immersed in some quite complex issues around this and you have helped us immensely. Thank you very much indeed.