



Select Committee on the European Union

Home Affairs Sub-Committee

Corrected oral evidence: Brexit: Reciprocal Healthcare

Wednesday 15 November 2017

11.15 am

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Members present: Lord Jay of Ewelme (The Chairman); Baroness Browning; Lord Condon; Lord Crisp; Baroness Janke; Lord Kirkhope; Baroness Massey of Darwen; Baroness Pinnock; Lord Watts.

Evidence Session No. 11

Heard in Public

Questions 85 - 93

Witnesses

I: Damien McCallion, Director-General, Cooperation and Working Together; Bernie McCrory, Chief Officer, Cross-Border Health and Social Care, Cooperation and Working Together; Dr Anthony Soares, Deputy Director, Centre for Cross Border Studies.

Examination of witnesses

Damien McCallion, Bernie McCrory and Dr Anthony Soares.

Q85 The Chairman: Welcome. Thank you very much for coming to give evidence to us. One of the issues that has arisen during the evidence we have heard so far, and in the deliberations we have had, is the situation in Ireland and the implications of Brexit for healthcare and relations between Northern Ireland and the Republic of Ireland, so we are very grateful indeed to you for coming and giving evidence to us. Would you like, briefly, to introduce yourselves to us, partly for the record? I should say that this is a public hearing and we will send you a transcript to correct, if necessary, and to send back to us.

Bernie McCrory: I am the Chief Officer of Cooperation and Working Together. That is a partnership of the health services in Northern Ireland and the border counties of the Republic of Ireland. It was formed in 1992 to promote the health and well-being of the population, particularly those in the border corridor.

Damien McCallion: I am the Director-General of CAWT. I just recently started a number of months ago in this area. I have been on the board of CAWT for three years. The board of CAWT is comprised of chief executives from the NHS in Northern Ireland and senior equivalents in the Republic of Ireland. It is very much a partnership model. The framework it operates in is under the EU but it has also taken on certain responsibilities from the Good Friday agreement and other such agreements over the years. That is the background. The organisation is partially based between Northern Ireland and the Republic of Ireland. Bernie is employed in the north of Ireland; I am employed in the Republic of Ireland. It is very much based on a partnership model, I suppose, in order to improve, as Bernie said, the lives of people in the border region.

Just one point I would make in terms of the border region, which is important in opening, is that in both north and south, for reasons that are probably obvious enough, the most disadvantaged areas are the border corridor. It is very rural in the main, but the Troubles over the years have impacted in terms of people and their lives and, I suppose, also investment and so on to come into it, apart from difficulties for the island as a whole. The population of the total island is 6.5 million, which is small in relative terms—just a little bigger than Greater Manchester—but the border area, if you include all of Northern Ireland and the equivalent area in the south, is around 2 million. It depends on what you put in or out.

Dr Anthony Soares: Good morning. I am the Deputy Director of the Centre for Cross Border Studies, which is a not-for-profit organisation created in 1999, shortly after the 1998 Belfast Good Friday agreement. The centre provides research, training, information and management support to groups and organisations working across the Ireland-Northern Ireland border. The centre researches, develops and promotes co-operation across the Irish border in a wide range of practical areas—notably, capacity-building for co-operation, governance, education,

health, the economy and citizens' information, and works with a wide range of actors engaged in cross-border issues on the island of Ireland and in other parts of Europe and beyond. The centre has a specific and unique role in contributing to increased social, economic and territorial cohesion by promoting and improving the quality of cross-border co-operation between public bodies, and between public bodies, business and civil society; improving the capacity of people involved in social and economic development on the island of Ireland to engage in mutually beneficial cross-border co-operation; and addressing information gaps and other barriers that constrain cross-border mobility and cross-border co-operation through research, the provision of resources and other practical support.

Given the potential impacts on cross-border co-operation, the centre has been devoting increasingly considerable amounts of energy to the issue of Brexit, and we therefore welcome this opportunity to share some of our thinking in relation to reciprocal healthcare arrangements.

Q86 The Chairman: Thank you, that is very helpful. I should say, just on timing, we will need to finish at about 12.10 pm, which should give us enough time to get through the questions. Again, we are grateful to you for coming and giving evidence to us.

Perhaps I could ask the first question. Could you give us an idea of how well integrated the health systems are in the north and in the Republic of Ireland? Do you have any specific examples of services that are provided in the Republic of Ireland that are not available in Northern Ireland and vice versa? Do you have any idea of how many people depend on these cross-border services, as it were? It was very helpful to have the figures you have just given as to how many people are involved in the borders.

Damien McCallion: On the framework first, which is important from the CAWT perspective, the services have been developed. There are a number of areas that we have flagged in four categories. One is patients; people who work, travel, live or holiday across the border. It is estimated that about 30,000 people cross the border every day, so they live in one jurisdiction and work in the other. The first category is around emergency care and critical need, holidaying in the south or holidaying in the north, or working on either side on a daily basis. The emergency care that is provided today is under the EU treaties in terms of how it is dealt with.

The second category is where patients choose to travel to the other jurisdiction, north or south, in order to avail themselves of a service. Numbers there would be relatively small, probably less than 1,000, but they can tend to be very specific and sometimes quite high-need in terms of the need of the patient.

The third category that Bernie might talk to in a second is where we have put in direct services between the south and the north, and the 25 years of CAWT have largely been largely focused on trying to directly provide services. Those are funded from two main streams: one is where the states themselves pay for them. The second, which we can expand on, is

where the EU regional development Interreg programme has funded quite significant investments in services. At a macro level, to give you the picture, we are literally in the middle of a programme at the moment, with projects commencing. The last round of funding would have dealt with about €30 million of funding across a wide range of areas: acute, mental health, disability, older people, primary care and emergency services. When those projects come to an end, the state makes a decision, either north or south, as to whether they are going to continue. In the last round of funding, to illustrate the positive benefits, 80% of those services were what we call mainstream, so they were made permanent and potentially expanded.

I will give one small practical example, which Bernie can talk through, of eating disorders, which were issues on both sides of the border. A service was introduced on both sides of the border. It did not involve patients travelling. It was a project that worked across both sides but provided in each jurisdiction. At the end it was mainstreamed and expanded, in fact, in many ways in the other jurisdiction.

The last category that we are looking at, which is where we are at the moment, is that of future ideas. The Interreg programme is very much focused on things beyond what the state should provide; if there are gaps or deficits, or innovative ways of providing services that you can work on. Hence, you would expect that a certain amount of those services might not be successful in terms of trial, and Bernie can maybe talk to those.

I would keep those four categories in mind: the emergency piece; where patients select to travel to one or other jurisdiction in the EU context; where we have put in direct arrangements between ourselves, some of which involved investments on both sides; and the future piece in terms of areas or ideas, and some of those have been agreed under the 1998 Belfast Good Friday agreement which provided for the North/South Ministerial Council to identify priorities for healthcare such as emerging planning, cancer health promotion and so on. Bernie might talk about some of the practical examples of that as well.

Bernie McCrory: There are quite a number of ways of delivering services. The first area that I would like to talk about is ENT services. In the Cavan-Monaghan area, there really were no ENT services. This was subject to EU funding. It would not have happened unless we were able to secure the funding. Essentially, patients had to go to Dublin. Children were waiting for maybe four years for their first appointment if they had hearing difficulties, with all of the problems that that would have thrown up education-wise and so on. There was a very robust ENT service in the Southern Trust in Northern Ireland where we had four ENT surgeons working on a rota. The EU moneys allowed us to employ two more ENT surgeons. The surgeons rotated into the south of Ireland, into Monaghan, where they did out-patient and day-case work. Then the patients travelled to Northern Ireland, to Craigavon and Daisy Hill Hospitals in the Southern Trust, to receive more complex surgeries that were not possible in a small rural hospital.

Just taking the 2016 figures, 155 patients travelled from the south of Ireland to Northern Ireland for complex surgery, but the consultants who travelled down to the Republic saw over 2,000 patients in both out-patient and day-case procedures. It has been mainstreamed and is hugely successful. It is a flagship and a good model for going forward.

We have maternity patients who wish to deliver their babies in Northern Ireland, travelling from very rural areas in the Republic of Ireland, in County Louth. Although they are small in number, it is none the less an important service. Similarly, with renal patients from that area, there is a renal-dialysis unit in Daisy Hill Hospital in Northern Ireland, and patients have to travel there twice-weekly to have their dialysis. Otherwise, very brittle and sick patients would have to travel to Dublin for it. It is an extremely convenient service for them.

The ambulance services are very important on a daily basis. They cross the border in either direction and they bring patients to the nearest A&E department. We also have routine ambulance collections and there is a memorandum of understanding between both ambulance services. We train them together. We have many examples of where patients' lives have been saved because of free and open access with no impediment when they got to the border.

The Chairman: Ambulances from one jurisdiction going to—

Bernie McCrory: Going north to south and south to north. Heretofore, before this agreement and before the border was open, ambulances would drive up from one side of the border, the ambulance on the other side of the border would meet them, and the patient would transfer. We have come a huge distance in 30 years.

We have oral and maxillofacial services. It is a very similar model to the ENT model but it happens between Donegal and the Western Trust area in Northern Ireland, where the oral and maxillofacial surgeons go across and do outpatients and some day cases in both Donegal and Sligo, and then complex cases come across to Altnagelvin Hospital. The key thing was that oral and maxillofacial services would have been lost to the west of Northern Ireland had the Health Service Executive not paid for an additional two surgeons to ensure the future of the service, so everybody would have had to go to either Belfast or Dublin.

Radiotherapy services are very important. A year ago in November, we opened the radiotherapy centre in the Western Trust area in the north, at Altnagelvin Hospital. That was co-funded and co-planned by both jurisdictions. Both health services contributed to the capital build and continue to contribute to the revenue spend associated with that. It means that patients in Donegal can go across, maybe within an hour, and have their radiotherapy in Northern Ireland; otherwise, they would have had to travel to Dublin or to Galway. In some cases, the case studies prove that patients such as young mothers would have opted for radical breast surgery rather than leave their families for four to six weeks'

radiotherapy in Dublin. Now, patients can go and come in one day, and be repatriated home.

Dr Anthony Soares: The Centre for Cross Border Studies would certainly say that there has been a remarkable and steady increase in co-operation between the health services of the Republic of Ireland and Northern Ireland, including through the provision of cross-border or all-Ireland healthcare. It is one of the success stories in terms of what has happened since the 1998 Belfast Good Friday agreement. Part of that success story, a marker of it and a contributor to it, is CAWT itself as an organisation, which has helped us in that regard. We should also acknowledge the support given by EU funding programmes in terms of the delivery of services and contextually, providing the necessary collaborative environment that allows the agencies to work on EU-funded projects together to get an understanding in order to be able to co-operate more successfully on larger projects.

Bernie has already referred to two prime examples of the increasing co-operation between the health services in the two jurisdictions. Two of those examples are based on memoranda of understanding or service-level agreements between the statutory health authorities on either side of the border. These have been championed by the two Governments on the island of Ireland and their progress followed by the North/South Ministerial Council.

In terms of the radiotherapy unit at Altnagelvin, we must be careful to acknowledge that as the work of the two Governments. They have taken the work forward, overseen by the North/South Ministerial Council. Another equivalent example is the All-Island Congenital Heart Disease Network. In terms of co-operation in the latter, among other things it has led to the transfer of urgent paediatric surgical cases from Northern Ireland to Our Lady's Children's Hospital, Crumlin, in the Republic of Ireland. Those are the two flagship examples, but healthcare co-operation is taking place across a wide range of important areas through a variety of bodies and initiatives on both sides of the border working collaboratively. Among them we have the North South Alcohol Policy Advisory Group, the All Ireland Institute of Hospice and Palliative Care, the child protection work programme, and the work being carried out on an all-Ireland basis on issues such as childhood obesity by Safefood, one of the implementation bodies created under strand 2 of the 1998 agreement.

I would like to point out that the question was about the absence of services from one jurisdiction or the other. Healthcare co-operation on an all-Ireland basis does not necessarily mean that there is a complete absence of a specific service in one jurisdiction or the other. It is more to do with the logistical difficulties that may be encountered by people in accessing a service within their own jurisdiction that may be more easily available to them across the border. Co-operation can also come about in order to sustain clinical excellence through the provision of an all-Ireland service rather than duplicating that service and offering it to a smaller

constituency within each jurisdiction. They then may not be able to achieve similar standards of clinical excellence and outcomes as those provided on an all-Ireland basis.

Finally, to a quick snapshot in terms of numbers, we can refer to the example of the cross-border cardiology service which allows 50 to 60 patients from County Donegal to access lifesaving care in Altnagelvin Hospital and the 385 places in that hospital's radiotherapy unit for patients from across the border. I do have numbers under S2 and EHIC and the patients' directive, but we might come to that later.

Q87 Lord Condon: You have already answered much of what I was going to put to you. Is there anything more you can say that will give us a feel for movements both ways across the border based on reciprocal healthcare? What are the numbers around EHIC, S1 and S2, and the patients' rights directive? Is there anything more you want to say now or you could submit to us, so that we really understand the scale of the movement both ways?

Damien McCallion: I have one observation. Anthony referred to the numbers a moment ago and will come back in a moment. For the direct provided services that are done outside of the EU arrangements but are still under the EU framework such as the cancer and cardiac services, the numbers may appear small, but they are at the most critical, lifesaving end. The 50 people in Donegal who are alive today would not have been alive 12 months ago before the service was introduced. That is where someone has had a cardiac arrest. For a West Donegal ambulance, it was four and a half hours to the nearest centre. It made no sense for the Republic to organise a service. It could not attract doctors to run a service in that area. With the urban centre in Derry, it was feasible to do that jointly. Cancer was very similar.

These are sensible things if you almost ignore the border and look at what makes sense in terms of "as best you can". Clearly, there is a border with different regulations, so a lot of detailed work has gone on to make them happen. That is one strand that is independent of S1, S2, EHIC and so on. I would not have numbers for S1, but maybe Anthony can talk to that. The numbers in S2 would be relatively small in terms of total volume, but again tend to be in the critical areas. In terms of volume areas, I would put a flag that that is possibly not the most critical thing. The priorities are around key services that would help sustain that.

Dr Anthony Soares: When you are talking about cross-border flows, data is always really difficult to come by, to access and to be provided. I can offer some numbers, although you might have access to them already. This is information provided by the NHS Business Services Authority to the Northern Ireland Assembly Research and Information Service. If you want a copy of the document, I can give it to you. It states that in 2016, 660,329 valid EHICs were in circulation in Northern Ireland. The Department of Health in Northern Ireland advised the same source that 81 applications had been approved under the S2 scheme from 2011-12 to 2015-16. The department also advised that from 2013

to 2016, 99 applications had been approved for reimbursement of cross-border treatment under the patients' directive, with 26 applications pending approval at that stage. This was in 2016, when the data was provided. Furthermore, perhaps as an illustration, data obtained by the Centre for Cross Border Studies shows that, of 28 applications for reimbursement under the directive received by the Health and Social Care Board in Northern Ireland between April and June 2016, out of 28 applications, 61% were for treatment in the Republic of Ireland.

If we turn to the other jurisdiction, in evidence to the Oireachtas Joint Committee on Health in March of this year, officials from the Irish Department of Health stated that 237 in-patient treatments were undertaken in 2016 under the directive, with 213 of those taking place in Northern Ireland. In the same year, a further 1,501 out-patient and day cases were reimbursed under the directive, with 479 going to Northern Ireland. This is just an indication of the data that is available.

Lord Condon: Rather than ask you to go through it line by line now, if you could submit that to us it would be very helpful.

Damien McCallion: As another observation, Lord Condon, there is a lot of movement of people between the north and the south. In terms of emergency departments, as Professor McKee said earlier, the vast majority of that is simply lost in the wash, to put it mildly. I live in the border area and I have often been in the ED in Sligo with young children. You know from the accents that people are holidaying, and equally in the other direction. There is an element of that. In terms of numbers, we will supply them. In terms of CAWT, there are probably as many people availing themselves of directly agreed services as there are in terms of the reciprocal EU EHIC and so on.

Bernie McCrory: I would like to add one point from a staffing point of view. Quite often, you would not be able to attract a consultant in a particular speciality if you did not have the population. The combined population allows us to provide services that we would not ordinarily have if we were doing it on a back-to-back basis.

Q88 **Baroness Massey of Darwen:** I am not sure where this question goes, but I think it is important. I want to link it with another question from later on, so it might save a bit of time. I have a paper by Dr Janice Thompson about health and social care in Northern Ireland and EU competence, action and support. It lists a whole set of areas—acute services, sexual health services, children and family services and eating disorders, which were mentioned earlier. I notice that two of them are now finished. I wonder if you have any evaluations of how those services improved outcomes for children that you could send. I do not want a reply, but please send them to us if you have them. This links somewhat to my question, which is about which groups are most affected.

The Chairman: We are coming to that.

Baroness Massey of Darwen: I want to cut it out because they are

linked. Could you send us information about which particular people are affected, residents, students, disabilities, etc? Perhaps do not go into that now, but write to us. It is a long and complicated issue.

Bernie McCrory: We have an evaluation of the particular services that were developed as a result of Interreg IV funding, and among those that you mentioned we certainly have an evaluation to send you.

Baroness Massey of Darwen: That would be brilliant. Thank you.

The Chairman: That would be very helpful indeed. If there are things that you do not have time to talk about now but could send to us, it would be very helpful and we have the full picture.

Damien McCallion: Going back, Lord Jay, to the point at the start, Interreg funding is time bound, so it typically takes three to four years. Decisions then have to be made if you are going to sustain it, so you have to think about that up front. You do not want to put a service in and then have to withdraw it. In the last round, following the evaluations, 80% of the services were mainstreamed by both sides of the jurisdiction. In the south that was challenging at the time. We were in our austerity period, so to say our economy was shrinking would be somewhat of an understatement, but 80% of those services were mainstreamed. We can send the evaluations through, and they are very diverse.

The Chairman: That would be very helpful.

Q89 **Lord Watts:** Your figures for cross-border were based on reciprocal payments. We have heard in previous sessions that that system is not the most effective. In the relationship between northern and southern Ireland, do you have a system that works? Is it a fairly comprehensive, well-worked system that charges both ways?

Dr Anthony Soares: I could not comment on the quality of the system, other than to say that when trying to get the breakdown of figures to give us a really clear idea of the separation between S1, S2 and the directive, the response from chief statisticians was that it would be an enormous amount of work and that the data is not readily available. I am just saying it is difficult to access the specific data. I have to repeat: it is an issue for all sorts of cross-border flows. It is only when issues come up that all of a sudden Governments or departments want to know the figures. Previously, they did not seem to have any particular interest. Now, all of a sudden, lots of people are interested in these figures and they do not necessarily have them.

Damien McCallion: Lord Watts, we have very specific data where we have direct arrangements because we are tracking it. The data that Bernie can provide gives very accurate figures around cardiac, cancer, ambulances and all those services because direct agreements have been facilitated through CAWT. As Anthony said, the wider EHIC and open access is more challenging because you are relying on the different hospitals and so on to submit the returns. I think Professor McKee alluded to some of the issues across the European Union on that earlier.

Q90 **Baroness Pinnock:** You have given us loads of really good evidence, which has been very powerful in reflecting the cross-border arrangements. You have partly answered this question already, but post Brexit, from your perspective, what are the big challenges or fears as to what will happen now?

Bernie McCrory: I referred earlier to emergency vehicles. We facilitate a lot of inter-agency emergency planning work with the British Army, the Irish Defence Forces, the Irish Air Corps and the RAF. We train together, usually once a year, to prepare for an emergency, be that an emergency in Ireland or for humanitarian relief abroad. We are now in a good state of preparedness to do that. If we had a hard border and emergency vehicles could not freely cross the border, that would be a huge impediment, particularly in areas such as the PCI, which has been referred to. It is about 90 minutes from the attack until you need to intervene with the patient. If there was any compromise at the border and a delay, it could have a huge effect. There are very practical examples where the border would certainly impede lifesaving treatment and perhaps preclude it from happening.

Dr Anthony Soares: Without prior knowledge of the precise contents of any future withdrawal agreement, it is not possible to offer definitive answers. Perhaps one of the crucial issues is the UK's withdrawal through Brexit risks exacerbating the overall peripherality of the border regions. It could undermine the current context for north-south cross-border co-operation. That includes where such co-operation leads to improvements in the provision of healthcare to people living in the border areas. Regardless of Brexit, co-operation on health between the Governments in Dublin and Belfast, when we do have a Government in Belfast, should continue as one of the areas under the North/South Ministerial Council and strand 2 of the 1998 Belfast Good Friday agreement. Co-operation in the area of health is part of strand 2 of the Good Friday agreement. The ease with which it can continue post Brexit will depend on a wide range of issues being resolved in order for healthcare provision in border regions not to be adversely affected. These include, but are not restricted to, the timely movement across the border of ambulances, patients and healthcare professionals, and, perhaps most important, the avoidance of divergence in terms of relevant policies, regulations and standards. A continued reciprocal recognition of professional qualifications is also an important issue.

The future nature of the border and the relative degree of friction associated with it post-Brexit will largely depend on how and if a resolution is found which can accommodate the UK Government's stated intention that the UK will no longer be a member of the single market or customs union. I would suggest that intention makes things rather more difficult in terms of maintaining the ease with which co-operation currently takes place and assists citizens living in the border regions in Northern Ireland and the Republic of Ireland.

Damien McCallion: We would be positive, based on the history of working together, in terms of trying to maintain it and there is a very

strong commitment to do so. In fairness to all the Governments involved, there is a commitment to the Belfast Good Friday agreement in terms of trying to find a solution. It is challenging in the context of the wider United Kingdom and things like the common travel area, the customs agreement and so on.

I would flag four things that we would work on with both departments, in terms of the Department of Health in Northern Ireland and in Dublin. One is around the workforce and issues about recruitment, regulation and so on. There are a lot of EU workers, both north and south. The island could have problems. There may only be problems in the north. There could be problems in the south. They are things that we are working on and trying to mitigate, so the workforce is one.

We have covered cross-border services well and is the second one. The third would be in terms of procurement and regulation on medicines, drugs and medical devices. The United Kingdom and the EU could diverge, which we can assume would not happen on any date of Brexit, whenever that actual date is. It is topical, having watched the BBC news last night. However, that could happen over time; what would the impact of that be? If a patient travels for cancer treatment in Northern Ireland and there is some divergence in the standards in some way, shape or form, and then they are travelling back for ongoing treatment in the south of Ireland, it is an integrated pathway. Those are the sorts of issues.

Lastly, EU funding has been invaluable in terms of trying to stimulate and encourage co-operation. While it is well established and embedded, at times the funding gives it a focus. It was €30 million in the last round. It is €50 million in terms of healthcare in the current round, spread across a wide range of areas with projects north and south. CAWT is an enabler to help the services, and community and voluntary groups, to work through that. In her statement in Florence, the Prime Minister committed around the PEACE funding. What PEACE funding means is there is a PEACE funding stream. On the margins, that would help some healthcare provision. However, the Interreg fund is the primary fund that has supported cross-border provision, but of course Interreg spreads across more than healthcare. How would that look? It would require a compromise if there was a commitment to continue. It would require a compromise from both the EU and the United Kingdom not just in terms of the money but also even in terms of having a partnership between an EU country and a non-EU country and so on. We would be hopeful that that might be something which could be considered as part of an overall agreement. The €50 million is over a five-year period, but it helps a very disadvantaged area. The whole purpose of Interreg funding is to help regions.

Q91 Baroness Janke: I would like your assessment of the current position in the Government's negotiations with the EU on reciprocal healthcare arrangements post Brexit and what changes, if any, you would recommend. Some of the issues that you have outlined are clearly the

outstanding issues that you would like to see resolved. Perhaps you could take a little step forward as to what you would like to see in terms of the proposals going forward.

Dr Anthony Soares: In the first instance, I will consider the Government's position paper on Northern Ireland and Ireland and what it proposes in terms of reciprocal healthcare arrangements. I must stress from the beginning that the Centre for Cross Border Studies, in terms of its analysis of Brexit, focuses on the official position papers and official positions of all the negotiating partners rather than commentary at the margins. We focus on the stated positions of the various parties. In the position paper, excluding animal health, health or healthcare are referred to on three occasions in the main body of the document. In two of those instances, reciprocal healthcare arrangements are linked specifically to the common travel area. The other reference is made in the context of strand 2 of the 1998 agreement where health is identified as one of the six areas of co-operation under the North/South Ministerial Council. However, no explicit correlation is made with the issue of access to healthcare provision.

The Government's position paper also highlights the question of citizenship in relation to the 1998 Belfast Good Friday agreement, and specifically the right of those in Northern Ireland to hold Irish citizenship. I am sure that you have heard this many times, but it is important to quote directly from the paper, "As long as Ireland remains a member of the EU, Irish citizenship also confers EU citizenship, with all the rights that go with this. This is as true for the people of Northern Ireland who are Irish citizens—or who hold both British and Irish citizenship—as it is for Irish citizens in Ireland." However, what it does not make clear is the position of such citizens in terms of their post-Brexit rights to access cross-border healthcare and any limitations that may result in differentiated rights in comparison with other EU citizens, especially where that implies accessing healthcare in an EU member state other than the Republic of Ireland.

The Government's earlier paper on the position of EU citizens in the UK and UK nationals in the EU states that it will seek to protect the healthcare arrangements currently set out in EU regulations and the right of UK nationals and EU citizens to obtain and benefit from the European Health Insurance Card. These objectives are, however, limited to UK nationals in the EU and EU citizens in the UK at the specified date. The issue of the rights of EU citizens in the UK is deliberately divorced from the position of Irish citizens and the common travel area. In the discussion around citizenship rights for EU citizens, it is divorced completely from the common travel area and the question of Irish citizens.

Returning to the proposals regarding Northern Ireland and Ireland, maintenance of the common travel area and its associated rights is one of its core objectives. Securing this objective would go a long way to supporting post-Brexit reciprocal healthcare arrangements between Northern Ireland and the Republic of Ireland as well as between the

Republic of Ireland and the rest of the UK. Bearing in mind the principle that nothing is agreed until everything is agreed in these negotiations, in order to secure the post-Brexit maintenance of the common travel area and its associated rights, including in relation to reciprocal healthcare arrangements, the UK Government need to ensure that their approach to other areas does not mitigate against this objective.

The CTA and the UK's reciprocal arrangements with the Republic of Ireland may pre-date EU membership, but the Republic of Ireland will remain an EU member state following the UK's withdrawal. Progress does appear to have been made in the negotiations in relation to the common travel area, but this could be undermined if progress is not made in other areas, including those not seen as immediately linked to reciprocal healthcare arrangements such as the ability of health authorities to procure services and goods on a cross-border basis. I will leave it at that at this point.

Damien McCallion: I do not want to go over the ground Anthony has covered in terms of the common travel area and its benefits. I will revert to the four last points I made on the maintenance of cross-border services being key. Those things are well established. There is a strong commitment to that and ensuring the frameworks that are put in protect it. The professional piece is a key piece, because without professionals in healthcare you do not have a service, but in my view there are ways of resolving that. There are already agreements between Ireland and other countries and the UK and other countries, so it should be within our ambit to resolve this as part of the process.

The area of medical devices, medications and so on is possibly a challenge post Brexit, and trying to build things into that may help to mitigate any future risk of divergence that could inadvertently impact on services which have been well established. Lastly, there is the challenge of the funding piece in terms of the Interreg programme, which has been invaluable over the last 15 years in terms of encouraging collaboration and partnership, not just in terms of people and professionals moving across the border.

I would add that some projects are effectively about taking a model and applying it to a number of jurisdictions. I will give one quick example. We have a community paramedic project that also involves the west coast of Scotland, which is in the Interreg area. All EDs in all countries are under pressure. This project is where, instead of people coming to EDs, community paramedics are trained to a higher skill level. They can then go out and try to work with other services to keep older people in particular at home so that they do not have to travel by ambulance to hospital.

The pilot project is in north Donegal, which is very remote; in Monaghan, which is remote; South Tyrone and the west coast of Scotland. Paramedics from Northern Ireland and the Republic of Ireland have been trained in the University of Glasgow. We were over there last week to meet them. The collaboration on information allows innovation to develop

and flourish, which is another important dimension. It has no economic piece and it does not necessarily have a strong regulatory piece, but it allows ideas to foster. I would personally say that, working in the south, it could have been years before we would have developed that without the initiative coming through.

Baroness Janke: Could we could have Dr Soares' evidence in writing? I did not quite get everything down.

Q92 **Lord Kirkhope of Harrogate:** Thank you very much for your explanations. What I want to ask you further on is this question of the role of the different legislatures. At the moment we have no Government in Northern Ireland, although hopefully that will be restored at some point. In the meantime, we have an anomalous situation where the civil service is effectively running Northern Ireland at the present time. These ongoing arrangements between Northern Ireland, the Irish Government and the UK Government are, I would suggest, very critical in trying to continue to have some kind of clear reciprocity across the border. We are moving forward through the Brexit process. When do you think the negotiations and discussions are going to take off, as it were? What is going to be the way in which they will operate, particularly in view of the fact that we still have everything based upon our EU membership facilitating the very things that you have been suggesting this morning?

Dr Soares: It is a matter of regret and concern that there is not an Executive in place in Northern Ireland at least to offer the potential for a common vision of how the reciprocal arrangements can be maintained post Brexit. It is important to have locally elected representatives who are close to the ground and know the situation. I do not mean any disrespect to elected representatives elsewhere. Local representatives are the ones who are in constant dialogue with their constituents. They know what the issues are, so it is a matter of regret.

Reference was made to the Northern Ireland Civil Service now having a very important role. I will just return to the North/South Ministerial Council. A work programme in relation to health and food safety was agreed by the outgoing Executive. There is nothing to stop that work programme going on during the current negotiations, and those negotiations taking into account what the work programme is about in terms of health and food safety.

In terms of the roles of other Governments—the UK and the Irish Governments—we would stress that, in terms of how these negotiations are approached by the two Governments, they should hopefully listen as much as possible to political representatives from all sides in Northern Ireland. The Governments should approach the negotiations with at the top of their minds the thought that they are co-guarantors—I will repeat the term—of the 1998 Belfast Good Friday agreement. Co-operation on health is in strand 2 of that agreement.

At the Centre for Cross Border Studies, in all our engagements with political representatives and policy-makers in all the jurisdictions,

whether they are devolved or central Government on these islands, but also with policymakers in Brussels, we are reminding everyone that the 1998 agreement is not an agreement that is simply there to resolve an issue in Northern Ireland. It is an agreement that binds all parts of these islands together. It has a dimension for Northern Ireland itself and it has a north-south dimension, but it also has an east-west dimension. All those parts need to be protected. The UK Government, the Commission and the various institutions in Europe stress repeatedly that the withdrawal agreement cannot undermine the 1998 agreement in any of its parts. Our position is that "any of its parts" means all three strands. It means the totality of relationships, the commerce and human flows that occur on a north-south and east-west basis within and between these islands. That is what must be safeguarded. Anything in the withdrawal agreement that undermines any of those flows will undermine part of the agreement.

Lord Kirkhope of Harrogate: In the context of leaving the EU, how does this sit? It was an agreement reached with the membership of the parties within the common arrangements of the EU. It is sacrosanct and guaranteed, of course, but in order for those guarantees to be maintained how can that be achieved in this basic context if we are not in the EU?

Dr Anthony Soares: That is a question for the UK Government. The UK Government will continue to be a guarantor post-Brexit of the 1998 agreement. They must bear in mind their approach to how they withdraw from the EU and how that will affect the 1998 agreement in all its parts. They must be frank with everyone in terms of the implications for the positions they adopt on how they affect the agreement. Specifically, the topic here for this Committee is reciprocal healthcare arrangements. How will their various positions in terms of the negotiations affect those reciprocal healthcare arrangements? They have to be frank and clear. That is what we need.

We, and I think also the Commission, are trying to get the UK to be more open about what the consequences are of the decisions that it is taking. Once you know what the potential consequences are, you start looking for solutions. However, we cannot find solutions until the UK Government and the other negotiating parties are frank about what the consequences are for the various positions being adopted in terms of the negotiations, including for reciprocal healthcare arrangements.

I have one last point. I know that the common travel area is mentioned a lot as being perhaps a solution to many of our problems. I will stress again that Ireland will continue to be an EU member state. The degree to which it can reciprocate those arrangements will be constrained by its membership of the EU and its obligations as an EU member state. There can be flexibility, but that depends on the UK's approach to the negotiations. At the moment, its intention to leave the single market and the customs union is posing a severe problem to co-operation on a north-south and east-west basis.

Q93 **Lord Watts:** What role are the Irish Government and the Northern

Ireland Executive playing in trying to find a solution to this? Are they having discussions among themselves or are they dependent on the outcome of the negotiations with EU partners? If that does not work, is anyone working on Plan B for a joint agreement between both sides of the border?

Damien McCallion: I will open this, and I am sure Anthony will have a view. From where we are sitting on the ground, we do not have full sight of the process you are describing, let alone the wider horizon of the UK-EU discussions. Both Departments of Health are working closely with providers in both jurisdictions, and in Northern Ireland with their counterparts in Scotland, Wales and England from a health perspective.

We have already referred to the absence of the Northern Ireland Executive at the moment, but I will comment on the south of Ireland. There is a connection into the overall negotiation in terms of the consequences from a healthcare perspective, and I know that colleagues in the Department of Health in Northern Ireland are similarly relaying that through. There are probably two lines in which that strongly needs to happen. One is from a health perspective. One is, as Anthony has just alluded to, the wider overall context of decisions on the big pieces around customs, the movement of goods and people, and the common travel area that have an impact on health, which can often be forgotten. In an all-Ireland context, it has been one of the successes over the last 15 to 20 years. The risk is that things happen inadvertently, as these things often do in negotiations, which could damage that—maybe not up front, but possibly over time.

Within the jurisdictions, which is all I can comment on in terms of within the government departments, there is a very significant process. The south has run a process. I think that 13 different public consultation workshops were run with regulators and political parties from all sides of the border. I attended the one on health myself. They tried to tease through the issues. They are reasonably well crystallised now, and as the discussions go on it is about the possible solutions.

I will close on the second part of your question. In terms of alternatives and contingency planning, a lot of work is going on. Someone described it to me recently as, "Hopefully it will be like the year 2000. Everyone did an awful lot of work and in the end it just passed by", but we will have to see. It is at a very difficult period at the moment. There is a lot of work going on. The connection of that in above that is not something that we could directly comment on, but I know that both in Northern Ireland and in the south of Ireland both departments are actively engaged in trying to assess the impact.

Lord Watts: Do the parties involved in this believe that if we crash out and do not have an agreement, the negotiations and discussions could provide an option for plan B from day one, or is that something that would have to be worked on after we crash out?

Damien McCallion: He is passing that one back, which is interesting. The challenge is that at the moment the scale of what we are looking at, speaking in a wider context, is vast. The sense I have is that the focus is on trying to find a resolution, assess the issues and look at what the consequences would be. That question will become valid as things unfold over the next six to nine months. A lot of work is going on behind the scenes that might help to inform what that would look like. This is not just about the D-day, be it a hard Brexit or a soft Brexit. It is also looking out and saying, "Are there things that could happen later that could potentially have a damaging effect?" If we do not deal with them in the context of negotiations, the risk is, we will have a wake-up day when something happens and we say, "Oh God, we never thought this could arise".

Bernie McCrory: The patients, the citizens themselves, will not be very happy if there is no agreement. It is fine if you have never had those services, but if a service that you have become used to is removed, I do not think the citizens would be happy about that. It is very natural for them to cross the border and receive services and I do not think they would accept anything less.

Dr Soares: I would like to point to the fact that the North/South Ministerial Council has a joint secretariat staffed by the civil service of the two jurisdictions. The civil servants have been doing a significant amount of work on the UK's withdrawal and its potential impacts. I am sure that the work will continue. I will underline what Damien has said in terms of the Department of the Taoiseach's initiative: the All-Island Civic Dialogue on Brexit, which is an enormous amount of work. It works through sectoral meetings as well as plenary meetings, bringing everyone together. Health was one of those sectoral meetings. Many of the issues have been examined, raised and identified.

It is disappointing that in Northern Ireland itself the discussions may not be taking place to the same degree as they are happening elsewhere, due to the challenging circumstances we currently have in Northern Ireland, whether between the political parties themselves in terms of their approach to the whole issue of the UK's withdrawal from the EU or the lack of an Executive. That is rather disappointing. From our position at the Centre for Cross Border Studies and our work with other organisations and officials, we are looking at the various scenarios, including the possible scenario of no deal and the UK simply crashing out.

I would emphasise that whether it is in terms of healthcare or other areas, the need for cross-border co-operation was there before the UK's referendum on EU membership. That need is there as the negotiations take place, and that need will continue to be there post-Brexit, whatever that Brexit is. It is not whether we should continue co-operation in terms of healthcare and other areas, it is about how we undertake co-operation in the future. That is the challenge. We can supply you with information. The Centre for Cross Border Studies has repeatedly come up with suggestions on how the structures could be put in place, depending on

the various scenarios, to support cross-border and north-south co-operation going forward post Brexit, but it will take a commitment from the UK Government in order for that to take place.

I would like to make one last point, just as an example. Unfortunately, policymakers sometimes forget that there is a border—this is previous to Brexit. They forget that there is a border and that there is a need, in terms of the people living at the border, for local authorities and service providers to be able to co-operate. Policies are sometimes designed just up to the border but not really facilitating co-operation across the border.

One very recent example of that is the Conservative Party manifesto for the last election. I am sure it was with the best of intentions, but perhaps a bit of forgetfulness. The shared prosperity fund is a suggestion for how EU Structural Funds are to be replaced. No mention is made of that prosperity fund being used to support cross-border co-operation. Structural funds are absolutely crucial to supporting cross-border co-operation. Anything that replaces those structural funds has to take into account the ability of those living in Northern Ireland to co-operate across our border with the Republic of Ireland.

The Chairman: You have been extremely patient and answered a raft of questions. All of you have also pointed out that what we are talking about here are the implications for people and their health and safety, which is extremely valuable to us. Thank you very much indeed for giving evidence to us. We are very grateful.