

Committee on the Future of Healthcare

Opening Statement

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22nd March 2017

Chair, Members of the Committee

I welcome this opportunity to meet with you today, and to set out some of my views of the Future Direction of Health Policy.

Introduction

We all know the challenges that we face in the area of health, and we know that those issues have been with us for many years. We also know that it takes time to give effect to reform in the health service and I believe there is a certain amount of reform fatigue, for a variety of reasons, one of which is certainly the absence of a long-term plan founded on the consensus necessary to give confidence in its delivery.

That is why I was so strongly supportive of the Programme for Government commitment and the commitment of all parties in the Dáil to establish this Committee to allow for the considerable advantages of having broad political consensus on the strategic direction of reform.

Of course, the Minister of the day has responsibility for setting policy and should be accountable to the Dáil. But if we could achieve consistency of approach at a high level over a long enough period of years, then I think that we could improve the situation for patients and the public, their families, and the many dedicated staff who work in our health services.

I await with great interest the outcome of this Committee's deliberations. As you know, there are certain issues, such as those related to system design and governance, and the finalisation of a five year HSE service plan, which I have deliberately not moved on until I have the benefit of this committee's work. However, I have been Minister now for the best part of a year and I have a strategic perspective on these and other major issues, and I would like to share this with you in the hope that it is of assistance.

The report of this Committee and the work that will follow it is a significant moment for our country. This is the last chance for a generation to get this right and we all know the compelling reasons why we have to make the most of this chance.

I will elaborate further on each of the priorities I believe need to underpin our future direction over the course of the speech but, broadly, they include:

1. Shift our model of care towards more comprehensive and accessible primary care.
2. Increase health service capacity, in the form of physical infrastructure and staffing, to address unmet need and future demographic requirements.
3. Exploit the full potential of integrated care programmes and eHealth to achieve service integration around the needs of patients across primary, community and acute care.
4. Strengthen incentives for providers to effectively respond to unmet health care needs by ramping up Activity Based Funding.
5. Empower the voice of the clinician and provide them with opportunities to contribute to the management of our health services.
6. Further develop Hospital Groups and Community Health Organisations, align them geographically and, as they develop, devolve greater decision-making and accountability.

7. Follow this with the provision of a statutory basis for Hospital and Community Health Organisations, operating as integrated delivery systems within defined geographic areas.
8. Once statutory responsibilities and accountabilities are devolved from the centre to Hospital and Community Health Organisations, dismantle the HSE and replace it with a much leaner national health agency. In the interim, reform the existing legislation within which the HSE operates to improve governance.

Overall Health System Performance

It is important to place Ireland's experience of health and health service delivery within a comparative international context and take a long range view. That is not to say that we can simply adopt another country's health service. But through comparison we can learn about ourselves; our strengths and our weaknesses. In the past attempts have been made by reputable international bodies with health expertise to rank health systems. The World Health Organisation undertook the most widely recognised such ranking in its World Health Report in 2000. Perhaps because the exercise was so hotly debated the WHO has declined to repeat it ever since.

Of the 191 member countries ranked by the WHO Ireland came 19th. This was well behind the highest placed country, France, and one place behind the UK our neighbours but well ahead of others such as Germany, Canada, Australia, USA and New Zealand. Any change in methodology would certainly affect these rankings and undoubtedly the passage of time and differences in performance trends across countries would also see changes if the exercise was repeated today.

In 2010 the Oireachtas Library and Research Service produced "*Benchmarking Ireland's Health System*". This report said that in relation to health status, in general, Ireland performs well when compared to other countries. There has been further very

welcome improvement since this report was completed. All told we have added over 5½ years to life expectancy over the last two decades alone. Men now live on average to 79 years which is above the EU average and women to 83 years which is at the EU average. Across the OECD only three countries have shown a faster rate of improvement in life expectancy since 2000 – Estonia, Korea and Turkey – with Ireland ahead of the gains made in the 30 other OECD members. This improving life expectancy builds directly on the particular progress made in Ireland on mortality from major causes such as cardiovascular disease and cancer – in line with national strategies over recent years.

On spending, the Oireachtas report of 2010 noted that from a relatively low baseline Ireland experienced large expenditure increases over previous years and this had led to concerns over the performance of the health system, the outcomes achieved and the economic sustainability of the sector. The period since this report in 2010 saw spending stabilise, and indeed reduce in some years, but we are now enjoying a period of expenditure growth and indeed pressure for further increases to address unmet need.

The Oireachtas report noted that compared to many other countries Ireland has a relatively high percentage of the population who report having unmet need and that the main reason for this is the cost of health care. I believe this is confirmed by our own experience as Public Representatives. The biggest challenge facing our health services relates to coverage and access.

Over the past few months, I have made no secret of the frustration that I feel, and that I'm sure the Members of this Committee feel, at some of the problems our fellow citizens can face in accessing health and social care. I say health and social care, because problems of access are not confined to surgery or unscheduled hospital care. Access is also an issue in respect of community based services.

Strategic Direction

So, in line with the key theme emerging from this Committee's consultations, I believe we must find a way of bringing about significant improvement in access. We should do so without losing focus on other crucial goals such as patient safety, efficiency and cost effectiveness. And the overarching objective must be population well-being and disease prevention – what we refer to as the *Healthy Ireland* agenda.

In devising a strategic way forward, we must also have three other factors in mind. Firstly, every country faces challenges in this area. As we live longer, as technology changes, as new treatments are developed, and as people's living standards improve, the demand on our health service will probably always challenge the level of provision. At any given point in time, there will always be limited resources available. That is just a reality. But I think we all agree that we need to do better than we are doing at present. To do so we must have better systems in place to guide us in setting priorities and allocating finite resources. Over the next decade we need to get past the stage of constant fire-fighting to a place where we can have a mature debate about how to set priorities and where to develop our services.

The second point I would make is that we are not starting from a blank page. It is always tempting to sketch out the perfect system on a blank piece of paper. But health policy is not an academic exercise. It is about trying to develop, reform and build a system while at the same time providing services day in and day out to the people who need them. That is part of what makes this a unique challenge, and a very demanding one.

And the third point I would make is that there are many disparities in the way in which we, as citizens, experience healthcare. Health inequality is a major issue, and will become even more marked in the years ahead, unless we find ways to serve all of our people better. This will require us to pay greater attention to addressing differences in

access and outcomes as a central part of ongoing performance evaluation and to work with other sectors nationally and locally to address underlying social issues that impact on health.

Structures or Systems?

I mentioned at the outset that I have not moved ahead with structural change or changes in HSE governance in deference to the Committee's work. I am not a believer in structural change just for the sake of it and it has not proved a panacea in the past.

However, if our structures are not best serving patients then change they must.

I must stress that when I talk about HSE structures not serving patients or others in need of services I am not talking about HSE staff. In fact, staff are also impacted negatively by structures which place too many layers between health service leadership and frontline staff.

Just as important as the design of structures is how we bring them into operation. Improving a system while simultaneously delivering services places a premium on a planned approach. For example, this requires the development of the actual capability to discharge functions before they are transferred or devolved. A benefit of a ten year horizon is that it provides a context for carefully planning the evolution of structures so as to avoid unduly disrupting the primary focus on improving care delivery.

The key entities for managing service delivery which are now in place are Hospital Groups and Community Healthcare Organisations. These are at different stages and both require significant further development. This will bring decision making closer to the point of care delivery and provide a counter-weight to the over-centralisation of decision-making and accountability which impedes service responsiveness.

I am convinced that Hospital Groups and CHOs should be geographically aligned. Due to considerations of specialism and critical mass, hospital services generally require to be organised across larger populations than community services. Therefore, I do not believe that in this phase it is necessary to have the same number of Hospital Groups and CHOs but a Hospital Group should ideally cover the same geographic area as one or more CHOs. Having Hospital Groups and CHOs operating on this basis will facilitate collective performance and accountability arrangements based upon pre-agreed and shared goals, budgets and incentives.

The next stage would be to provide a statutory basis for Hospital Groups and Community Healthcare Organisations. Rather than do this separately, I think we should legislate for integrated delivery systems within defined geographic areas; what, for now, we might call Hospital and Community Health Organisations. What I am outlining here is a clear journey towards a more devolved, responsive and integrated delivery system, although I acknowledge it would require time and careful planning.

My Department is on the record as saying the current HSE Directorate governance arrangements, as set out in legislation, need to be reviewed. While this committee is developing a 10-year vision for the health service, and this may well result in significant change – including legislative change – in a number of phases, some more immediate improvement in existing national governance arrangements is merited. Subject to the Committee's report, I intend to ask my Department to come forward with proposals to improve governance arrangements for the HSE for so long as the HSE continues in its current form. This will include examination of the current vesting of governing authority in the HSE Directorate, including the fact that the Director General is responsible to the Directorate for the performance of his or her functions.

However, with the development of stronger, more accountable and geographically aligned providers, the opportunity will arise to begin to more fundamentally consider organisational arrangements at national level.

The overall HSE project initiated in 2005 can be legitimately criticised in a number of areas, but the need for national arrangements for planning and sharing of expertise and services for a population of less than 5 million people cannot.

When the HSE was set up the Act establishing it had a schedule amending various other Acts so as to transfer a range of powers and responsibilities to it. There were over 40 other Acts amended covering over 230 different responsibilities. Further powers have been conferred on the HSE in the intervening period. Many of these statutory responsibilities could be transferred to Hospital Group and CHO level but others demand a national body for their proper discharge. We have gained much in recent years through national initiatives in areas such as the cancer programme, the integrated care programmes, the Fair Deal scheme, eHealth and many other areas. We need to retain such capability and avoid reverting to stand-alone geographically based organisations in the mould of the health boards.

However, the national health capability which takes the place of the HSE is likely to be a slimmed down body; one more equipped to lead than to directly control and, accordingly, with less management layers between the top and the front line.

There is also a question as to the respective roles of such a body and the Department of Health. In some countries of not dissimilar size, such as Scotland, the Department itself commissions services from regional providers but in others an organisation at a remove from Government and the civil service plays this role nationally.

The challenge in any set of proposals is to devise a clear set of principles and a framework of accountability which ensures better and more rapid decision-making and

responsiveness, but which also fully recognises the demands of parliamentary accountability.

Challenges

You are all familiar with the demographic and epidemiological challenges that Ireland faces. These challenges are common to the vast majority of developed economies. In the second half of the twentieth century medicine changed dramatically, but health systems and policies didn't keep up. Many of the diseases that were feared by our grandparents, such as TB or polio, and which consumed a large share of healthcare resources, were effectively defeated through a combination of vaccination and antibiotics. As a result, across the developed world, people are living longer healthier lives. In Ireland, this change has been accentuated by the fact that, in the 1960s, the rapid outward migration of our people during the 1950s was halted – so we are now facing a particularly rapid increase in the number of our citizens in the older age cohort.

As things stand, the annual increase in the number of people over the age of 65 in Ireland is approaching 20,000 and the overall number in this age group is expected to increase by over 36% between 2016 and 2026. What this all means is that the nature of the demands that the health service must provide for, has changed.

Today, the great challenge is the management of chronic disease - which is to say long term conditions which can be treated but not cured. In some respects, chronic disease is simply a feature of living longer, but in many cases the onset of disease is influenced by lifestyle factors including diet, exercise, smoking and alcohol consumption.

Because chronic diseases are often managed rather than being cured, this shift in the burden of disease requires a shift in the way that healthcare is conceived, provided and

managed. Whereas traditionally health services have been structured to provide episodic care, we now need a far greater emphasis on continuous care. This is why the World Health Organisation has placed so much emphasis on the development of person-centred and integrated care – care that is organised around patients, not just around groups of conditions or around health facilities such as hospitals.

Ireland faces particular problems in meeting this challenge, because historically our health system has been highly hospital-centric, with comparative under-development of primary and community based services. In effect, the challenge we face is to develop a new model of care, which is better suited to the needs of our population, now, and into the future. We need our hospitals to work more effectively, we need to develop primary and community care, and we need all components of the system to work in a more integrated and coordinated way.

Changing Model of Care

Many of the necessary features of the new model of care are already apparent and some are already being put in place.

Firstly, because chronic disease is related to lifestyle, we need to drive ahead with the Healthy Ireland agenda. As a country, we have made considerable strides in tobacco control, and there is growing consciousness of the need for healthier diets and taking more exercise. We now have a number of important strategies in place such as Tobacco Free Ireland (2013) – the first policy document to be launched under the Healthy Ireland framework; A Healthy Weight for Ireland - Obesity Policy and Action Plan 2016-2025 and Get Ireland Active – The National Physical Action Plan (2016).

But we cannot be complacent; we must drive ahead with implementing our strategic approach. This includes public health measures targeted at discouraging harmful levels of alcohol consumption.

Secondly, because chronic disease is continuous, care and management of patients with these diseases must also be regular and continuous. It must begin with better information and self-management, but must also be provided and supported to a far greater extent through primary and community care. I know this is an area that has been discussed in detail as part of the Committee's deliberations. The Programme for Partnership Government seeks to achieve a decisive shift of the health service to primary care with delivery of enhanced primary care in every community. It is not a politically contentious point because both Government and opposition have all supported this goal over recent decades. However, successfully implementing such a strategy is not straight forward.

Comprehensive Primary Care

As we look to develop more comprehensive and integrated primary care we need to consider the challenges which experience has shown us we are likely to encounter.

Achieving a high level of team-working across diverse professionals with different employment and contractual relationships, priorities, cultures and approaches has proven to be challenging. It has not always been easy to combine the efforts of salaried HSE staff and GPs paid through capitation for medical card holders and fee per visit for others. Coverage and eligibility have also been issues. For example, how can the role of primary care in population health, disease management and hospital avoidance be fully realised when the State's financial support is predominantly concentrated on paying for access for the one-third of the population with the lowest incomes? Also in introducing improved primary care facilities we now have examples

of very successful Primary Care Centres, but we have faced problems in some areas with GPs locating in such centres.

While these challenges are closely related to our existing organisational, contractual and eligibility arrangements, all health services seeking to promote primary care face the twin challenges of achieving successful team-based, multi-disciplinary working and enhancing the status of primary care professionals within the overall health service.

Let me be clear, despite these challenges, augmenting primary care services is central to any successful strategy to address healthcare needs and promote population health. I will be very interested to see the Committee's considered views on how the vision of enhanced, more integrated primary care can be achieved and the challenges in doing so overcome.

We can build upon important developments in the primary care arena in recent years. These include the extension of eligibility for GP cards to under-6s, the development of the Diabetes Cycle-of-Care and on-going investment in the physical infrastructure for primary care. Over the next ten years, however, we will have to expand the scope of our ambitions about what can and should be delivered in a community and primary care setting. This will involve investment in personnel, buildings, diagnostics, and training, as well as expanding the scope of eligibility for primary care services on a phased and prioritised basis, taking account of resources and available capacity within primary care.

As you know, we are at the early stages of negotiation of a new contract for GPs. That is an important piece of work, but by no means the only element of the transformation that we have to effect.

My Department will shortly be launching a consultation paper on the future development of community nursing. In line with the recently concluded proposal put to the INMO and SIPTU, we are also planning to introduce new advanced nursing posts operating across primary care and acute hospitals. These initiatives have the potential to support the delivery of multi-disciplinary care, including active case management, through the introduction of greater nursing expertise in the community that up to now has been located solely in hospital settings.

We are also undertaking a significant programme of work in the area of home care. We will launch a public consultation process in the coming months to allow those who have views on this issue to have their say, including older people themselves and their families. We need to provide much better access to home care. We will be seeking to bring as much certainty to this access and the associated financing arrangements as we currently have for nursing home care.

We also have to look at how services which are currently hospital-based can be deployed in community settings. The HSE continues to develop the Community Intervention Team model.

The national maternity strategy which is being rolled out through the National Women and Infants Health Programme, places emphasis on services being provided in the community, greater integration of community-based and hospital-based services through the development of maternity networks, and appropriate risk assessment to ensure that patients' needs are met in the appropriate setting.

Acute Hospital Services

Hospital Groups will enable better configuration of hospital services with benefits in terms of safety, quality, access, cost and sustainable medical staffing and recruitment. Hospitals working together will be able to support each other, providing a stronger

role for smaller hospitals in delivering less complex care, and ensuring that those who require critical emergency or complex planned care are managed in larger hospitals.

The evidence for how hospital services should and can be organised in a manner that achieves quality and sustainability is being confronted by health systems the world over. Medical technology and practice and global competition in the training and retention of highly skilled health practitioners are all reshaping hospital services.

And yet as politicians we have on many occasions been hesitant in interpreting and reconciling these unavoidable factors with the existing understanding and expectation of the public we serve.

We cannot simply rely on clinicians to explain to the public how the reality of hospital care is changing and set to change further; not just in Ireland but in every health service committed to achieving – above all else - excellent patient outcomes. The Committee had the benefit of hearing from Professor Tom Keane who contributed so much to the progress we have made in cancer care. Professor Keane gave very well deserved credit to the political leaders that initiated and provided crucial support for these reforms. Such credit is overdue because those same political leaders were at the time the subject of unrelenting criticism in this House and outside.

I believe this Committee through its Final Report has an important opportunity and a duty to explain these developments so that future Ministers for Health have greater support than heretofore to do the right thing.

In the era of “new politics”, without such support the change necessary to deliver ambitious improvement in our health service as envisaged by this Committee risks being severely hindered. The recently completed report on the Northern Ireland health services – *Systems, Not Structures* – summed the challenge up as follows:

“The choice is not whether to keep services as they are or change to a new model. Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.”

I believe the setting up of the Committee was a vote for the former.

Public/Private Provision

I talked earlier about the importance of comparative analysis of the strengths and weaknesses of the Irish health service. The extent to which public and private is interwoven in our health system is one of its most distinct and sometimes controversial aspects. Our publicly funded hospitals deliver care to both public patients and private patients.

As far back as 1999 in the White Paper on Private Health Insurance the potential drawbacks to this mixed system were of concern. Nevertheless, the White Paper identified certain advantages to the coexistence of public and private practice in public hospitals including:

- it helps to ensure that medical and other professional and technical staff of the highest calibre continue to be attracted into and retained in, the public system;
- it promotes more efficient use of consultants' time by having public and private patients on the same site;
- it facilitates active linkage between the two delivery systems in terms of the dissemination of current medical knowledge and best practice;
- as accident and emergency services are primarily provided by the public hospital system, it enables patients to avail of private healthcare when admitted to public hospitals on an emergency basis;
- it represents an additional income stream to the public hospital system.

In the intervening period, concerns about the allocation of scarce public hospital resources to private patients have grown. Partly this is attributable to the heightened concern about access for public patients generally. It may also be indirectly influenced by the growth in private health insurance coverage from 1.5 million people (or 42% of the population) in 1999 to 2.1 million people (or 46% of the population) in 2015.

Over the intervening years there have been proposals to eliminate private practice in public hospitals entirely on the one hand and, through mandatory competitive private health insurance, extend private insurance to everyone in the population. Whatever the direction of change, it requires careful consideration as it is likely to have very extensive implications for hospital costs and resourcing together with contractual and remuneration arrangements for hospital consultants. Other more detailed aspects of current arrangements are worthy of consideration including the misalignment of financial incentives as between public and private patients. At the moment public hospitals receive a block grant for public patients and a per diem rate for private patients.

Movement to Activity Based Funding for public patients will see public activity remunerated on a per case basis. It would make a lot of sense in this context to introduce a case-based charge for private patients and to equalise the tariff for public and private patients based upon the efficient economic cost. This would eliminate any incentive to the hospital to accommodate more private patients. Full alignment of incentives would also require a movement away from fee-for-service payments to hospital consultants for private patients towards an annual remuneration inclusive of both public workload and the permitted and planned level of private activity.

I offer these as examples of how the detail of any change proposed in current arrangements will need to be thought through carefully because of provider issues and

not least the fact that almost half of the population have private health insurance and very many people with such insurance currently receive their care in public hospitals.

Responsiveness

Wider consideration of incentives suggests, I believe, that the introduction of stronger provider incentives for responsiveness and productivity can assist in addressing the widespread concern about access issues.

A strength of our primary care system compared to some others is that generally there are not delays in accessing GPs, albeit there can be issues in some rural communities and in deprived urban areas. The responsive nature of General Practice owes something to the strong financial incentives under the capitation-based choice of doctor scheme for medical card holders and the fee-for-service for private patients. In contrast the traditional block grant approach to hospital funding entails very weak financial incentives for productivity.

I hope the Committee will concur that Activity Based Funding should continue to be used to promote stronger performance incentives for acute providers. Much of the technical work is now in place to allow Activity Based Funding for hospitals to be significantly ramped up over the period ahead, with further work potentially undertaken to incorporate measurement of quality and appropriateness.

Integrated Care Programmes

A crucial aspect of quality and appropriateness is integrated care. As we change hospital services and strengthen primary and community services, we will be challenged to ensure that services are designed around patients, rather than around the institutions that provide them.

Across the world, health services are grappling with the question of how services can be integrated, so that patients' needs are managed holistically, and in as seamless a manner as possible. This won't be easy to achieve – there is no magic wand for

integration. But we are working to find the right path for the future. In this regard, I want to mention the Integrated Care Programmes.

The HSE is currently developing a number of ‘integrated care programmes’, which are focused on piloting new ways of working within the health service. The Integrated Care Programme for Older People has put in place a number of local initiatives to address specific issues related to the care needs of older persons at a number of pilot sites. The Programme places a strong focus on community-based multi-disciplinary care, with the goal of facilitating the older person to lead an independent life, with dignity and at home and avoid hospital admission where preventable.

The Integrated Care Programme on Chronic Disease is developing four projects which include Asthma, COPD, Heart Failure and Diabetes models of care, again focusing on multi-disciplinary teams delivering more effective risk assessment and case management.

As insight is gained from these projects, translating those lessons into the broader health service will be one of the big concerns of the next decade.

The Integrated Care Programmes are a great example of the benefits of clinical leadership in reshaping our health services. As a society, we greatly value clinical judgment, in relation to our own personal health and that of our family. It flows from that value that we must ensure we empower the clinical voice within the health service and facilitate a greater clinical role in management. Clinicians in management roles should not be the exception to the rule but rather one of the legitimate options for management of our hospitals and health services. This will involve development of a range of opportunities and pathways for clinicians to get involved in management at different levels and to develop their leadership skills and interest.

eHealth

A huge amount of the work done in the health service consists of collecting and using information, and yet the health service is a long way behind other sectors of society in how it deploys information technology. Again, we are making progress in this area – particularly on key enablers like the Individual Health Identifier and the Electronic Health Record.

There is now a clear strategy and programme of work in place and a growing sense that, with the right level of support, we will deliver on our ambitions.

Capacity

I would like to refer to the issue of capacity. I have repeatedly made clear that increasing capacity is a priority – that includes physical capacity, the staffing capacity to support that, and harnessing untapped potential in the system.

My Department is currently managing a large capital programme, much of which involves the necessary replacement and upgrading of existing buildings, rather than adding to the capacity of the system. That is an unfortunate consequence of the age of our health service facilities and that overall challenge will remain with us for the period ahead. While managing that problem, we also have to address the question of what is the level of capacity required into the future, which is why my Department is currently working on a capacity review.

Unlike previous reviews, the Capacity Review will extend beyond acute hospital beds, to look at issues like the provision of additional capacity in primary and community care.

I strongly believe this is the right approach and that it is also in tune with the Committee's emerging thinking. We need to have a view on capacity, but it cannot be divorced from the need to shift the model of care, that is more integrated and continuous, person-centred, and delivered at the lowest level of complexity consistent

with patient safety. It is within this context that the capacity review will be undertaken.

I am also on record as saying that there is no point in increasing physical capacity if we don't have the necessary staffing. I would like to acknowledge the intensive efforts of staff, management and the HSE, who, on a daily basis, work to ensure that those in need of services receive high quality care.

I am acutely conscious of the challenging staffing environment our health services are facing. There are many initiatives currently underway to improve staffing levels throughout the country and we will continue with these efforts. Increasingly we operate in a highly competitive market for attracting and retaining many health professionals which are in short supply globally. This is obviously relevant in assessing both pay and tax rates. But it also means we must enhance the attractiveness of the work environment with ongoing learning and career opportunity.

In return we should expect approaches to flexibility and change which are comparable to those demanded of health professionals in other health care systems, both public and private. I believe all of this will be required to achieve the vision set out on the establishment of the Committee.

Whatever our direction of travel, the capability of our health workforce – health professionals, administrative staff and managers – will be essential to the success of the Committee's proposals.

Conclusion

To conclude, I appreciate I have covered a wide agenda at some length but this is reflective of the breadth of issues affecting the future of healthcare in Ireland. The work of the Committee to date has highlighted the considerable consensus around some of the key building blocks, and I think we can all accept that this will require transformational change. The challenge for the Committee now is in determining the implications of each of its recommendations, what can be achieved realistically in the time period and in what sequence. This involves prioritisation and, where progress will be resource-dependent, consideration of cost. This is no small ask, but through success you will provide the reference point for successive governments and Dálaí in implementing real change in how the public experiences our health services.

I wish the Committee well in its final deliberations and, once again, would like to offer my continued assistance and that of my Department as you finalise your work. I want to sincerely thank the Chair and the members of this committee for the non-partisan and dedicated way you have gone about your work to date and for the opportunity to present my views to you today.

ENDS