DÁIL ÉIREANN

COISTE UM CHÚRAM SLÁINTE SA TODHCHAÍ

COMMITTEE ON THE FUTURE OF HEALTHCARE

Déardaoin, 23 Meitheamh 2016

Thursday, 23 June 2016

The Select Committee met at 10.30 a.m.

MEMBERS PRESENT:

Deputy Mick Barry,	Deputy Billy Kelleher,
Deputy John Brassil,	Deputy Alan Kelly,
Deputy James Browne,	Deputy Josepha Madigan,
Deputy Pat Buckley,	Deputy Hildegarde Naughton,
Deputy Jim Daly,	Deputy Kate O'Connell,
Deputy Michael Harty,	Deputy Louise O'Reilly.

DEPUTY RÓISÍN SHORTALL IN THE CHAIR.

Election of Chairman

Clerk to the Committee: Members are requested to ensure their mobile phones and any other devices are switched off or are on airplane mode for the duration of the meeting. It is not sufficient to put devices on silent mode. No apologies have been received.

This is the first meeting of the Committee on the Future of Health Care. The first item on the agenda is the election of the Chairman of the committee. I now ask for nominations for the position.

Deputy Billy Kelleher: I propose Deputy Róisín Shortall as Chairman of the committee.

Clerk to the Committee: Are there any other nominations?

Deputy Louise O'Reilly: I second Deputy Shortall's nomination.

Clerk to the Committee: As there are no other nominations, I declare Deputy Róisín Shortall elected as Chairman of the committee. We will suspend the meeting for a couple of minutes to allow the Chairman to take her seat.

Deputy Róisín Shortall took the Chair.

Sitting suspended at 10.39 a.m. and resumed at 10.40 a.m.

Chairman: I thank my proposer, seconder and all the members of the committee for their support for me to be Chairperson. The committee is taking on a big task and it will work to a very tight timescale. However, it is a challenging and an exciting prospect for us to take a step back from the daily and myriad issues that affect the health service and to consider the bigger picture in terms of the type of health service and system we believe is most suited to Ireland, how we can transition from the current situation of a two tier, quite dysfunctional service to a single tier, universal health service, consider the most appropriate funding model to achieve that and how we can model and phase the transition from what we have at present to what we believe will be a service that serves the people of this country much better than is currently the case.

We must be careful not to overlap with the Oireachtas Joint Committee on Health of which Deputy Harty is chairperson. As many of us know from past experience, that committee, which deals with legislation and day-to-day activities in the health service, has a clear oversight role in respect of the different agencies in the health service and receives many representations. The work of our committee is to take a step back, examine the system and take a more strategic approach to the current model and the type of model we wish to achieve for the delivery of a modern, reformed and inclusive universal health service. We must be mindful of that to ensure there is no overlap with the joint committee.

We must also keep a clear focus on the terms of the all-party motion under which this committee was established. I have asked the Clerk to circulate the motion so we can remind ourselves what it provides for. There are two key provisions in the motion. The first is to examine how we can achieve a universal, single tier health service based on health need rather than ability to pay, how to transition from the current situation to that new model and what is the most appropriate funding model for a universal health service.

The second and most pressing element of the motion is to examine how we can re-orientate the health service away from the hospital-centric type of system we have at present and push the focus clearly on primary and community care. We all talk about the urgent need to do that. A more community and primary care focused health service undoubtedly delivers better quality of care, better health outcomes and is better value for money but while we talk about it, we have not looked at how we can transition to that model. It is important that we get some advice on how to phase that transition. It is all very well to say it makes sense on many different levels to re-orientate the health service to the community and primary sector but doing that in practice and the movement of resources away from acute hospitals to the community require very careful consideration and clear modelling. It will more than likely require some seed capital to get that transition to happen. That is the other key element of the motion which we must bear in mind. There are two separate strands of work, in my view.

I am keen to hear members' views on how we might proceed. I also wish to consider the types of groups or individuals we might invite to appear as witnesses before the committee. I have received many representations already from different groups. There are umpteen groups in the health sector with genuine concerns but it is important we try to take a strategic approach to this and invite, as far as possible, representative bodies or groups such as representative patient groups and representative professional groups. We should also be mindful of the commitment in the programme for Government to use an evidence based approach to policy making and that will entail having close working relations with people who are experts in the field from an academic point of view, certainly bodies such as the Economic and Social Research Institute, ESRI, the universities and other recognised experts in the field. It need not be limited to people in Ireland. There is no difficulty with bringing people from abroad if we believe they might be helpful to the committee's work.

That is my view on how we might proceed. I am happy to hear the views of members.

Deputy Billy Kelleher: First, I congratulate you, Deputy Shortall. It is a challenging undertaking. There is no point in us sitting here and thinking that we will be able to facilitate everybody among the public who has views and opinions on health care and the health systems in this country. It is important that when we extend invitations we should do so to people to give their expert views rather than let the committee be used as a lobbying forum for vested interests, of which there are many and many of which have good intentions. If we are to be true to the spirit of the motion, we are talking about developing a strategy for health care over the next ten years. That will require a great deal of work, much detailed research, and resources and supports for the committee. During my time as my party's spokesperson on health, I have learned that there is a huge body of work available in reports that have been produced both nationally and internationally. A great deal of research has been conducted by independent groups and experts, so we should be able to draw on what has been done already in those reports. The committee would have to be resourced for that purpose.

On the broader issue, the motion recognises the severe pressures on the health system and refers to the need for consensus at political level. That will always be a challenge and there is no point in saying otherwise. There are already varying views in this committee on how we fund health care in general, who pays for it, who has accessibility, who has priority in terms of clinical need and working from that. That will require shifts in people's minds, on all sides and none. We should approach it with an open view, listen to the evidence that will be put before the committee and be honest with ourselves about what type of health service we want and what type of health service the State can support and sustain. The difficulty we have had in the de-

bates on health care in this country for many years, in the case of all political parties and all previous Governments, is over-promising, the simplification of the problems and under-delivery.

We have a health system that is under-resourced, overstretched and lacks capacity. It will require direction in terms of how we fund health care in the years ahead and it will require resourcing. It would be disingenuous of this committee to leave this room six months hence, or whenever the report is published, promising a utopian health system but not being honest about how we would fund it and the requirements and resources that would be necessary. Broadening universality will require extra resources and funding that only comes from a number of sources but primarily from the taxpayer. We cannot look at health care in isolation, without recognising the other consequences it might have on broader society.

However, this is an opportunity for all of us to move our mindset, perhaps, in how we view the provision of health care in this country. I hope the committee uses its time wisely in developing the strategy. That is as opposed to overlapping with Deputy Harty's committee or ending up as a platform for lobbying. What we need is blue-sky thinking and beyond.

We mention a ten-year strategy in the motion, but we should be able to point out that there may be milestones or stepping stones that we should try to achieve as we get to a long-term goal. We can have a ten-year strategy, but how we get there should be marked in some reasonable timeframe. For example, we have the primary care strategy, but the problem is that it has not been enacted in full for the past ten or 11 years. There are many reports and strategies, but if there is a commitment on all sides to ensure they are a priority in developing an overarching strategy, they could make a meaningful impact on people using our health services in the medium term.

I wish the Chairman and committee members well. It will be an onerous task and one we should not take lightly. The public will be looking on and we do not want them just to see another committee promising the sun, moon and, invariably, the stars without highlighting the cost implications, how it is to be funded, and accessibility. We must be realistic in our efforts. Nevertheless, we should have a positive and aspirational view of what we would like our health care system to be in the years ahead. I assume the resourcing of the committee will have to be discussed as well.

Chairman: We can come back to that later.

Deputy Louise O'Reilly: I congratulate Deputy Shortall on her election to the Chair, and we very much look forward to working with her. We have a huge job of work and nobody underestimates that. We must be very mindful of the potential for overlap. We will not get any work done if we spend all our time in here allowing ourselves to be lobbied. Notwithstanding that, we must balance our time, as I do not want anybody to get the impression that somehow we will not listen or we are not available. The work of the other health committee will, I hope, take up some of that lobbying work.

Whatever findings we make must be evidence-based, but there is a substantial body of evidence out there already. I have publicly stated that on a number of occasions. The health service has, to a large extent, been researched to death and there are major volumes of research already available to us. We need to be cognisant that there is much information out there that we can and should be using. Equally, people will want to come and see us and we must be mindful that there are players with a vested interest. They may be strong or powerful people seeking to influence us away from what is certainly Sinn Féin policy with regard to universal

health care, rather than universal health insurance, for example. We must be mindful of that and be careful that whomever we see, there is a balanced view.

We are here to do the work and we are very much looking forward to it. We wish the committee well. However, a substantial amount of work can be done with written submissions and we do not need to have a huge number of hearings. We can learn much from what is out there already.

Deputy Josepha Madigan: I congratulate Deputy Shortall on her appointment and I am looking forward to working on this committee. My background is not in medical health but in law; however, that is not necessarily bad, because one may see the issues on an objective level. We all know how the health system works. I hope to feed this back to the committee.

From an aspirational perspective, members know that universal health care was eventually abandoned. I know approximately 47% of the population has private health insurance and 46% of people have medical cards. We must be careful about what we are promising, as Deputy Kelleher alluded to earlier, from a practical perspective, and take care not to over-reach. I will endeavour to do all I can, but we must watch the budget from that perspective.

From a practical perspective, there are micro- and macro-issues. On a constituency level, I have already been lobbied by particular stakeholders wishing to contribute and have their say. I wonder if the Chairman wishes us to meet such groups by ourselves and feed it back to the committee or should every group be represented in front of all members. One of the issues I have with committees in general is they end up being a talking shop. Will the Chairman assign specific tasks to particular members of the committee in order to bring about movement? That is instead of just talking every week - or whenever we sit - about what we are doing. On a practical level, as this is set up for a finite period, I suggest that we be strategic in how we approach the process. There can be many lofty notions in speaking about health but we must bring that back to the micro level. I am prepared to do whatever it takes from my perspective to help the committee in that regard.

Deputy Jim Daly: On behalf of the Fine Gael Party, I congratulate Deputy Shortall on her election and I wish her every success in the role. It is a daunting task that the Chairman has chosen us to lead and I cannot think of a greater task to be landed on the doorstep of any politician, to be honest, in this day and age, than what all of us have signed up for here, namely, to devise a ten-year strategy for health.

I have never felt so ill-equipped or ill-prepared for anything as landing in a seat here with responsibility to devise a health care policy for the next ten years. With that in mind, there are a couple of points I should make. The first is in regard to lobbying, which will be an issue for all of us. The groups that will not get to appear before the committee will seek us out individually, as we know, and that has started already. They will try to get to us all in that way. Those are the joys of living in a democracy and we must all deal with it. I support Deputy Louise O'Reilly's comments and we should go down the road of written submissions. There is an onus on all of us to take the role seriously and do much of the reading and research ourselves. We do not have to hear from everybody as much can be done through written submissions and us being responsible.

One of the biggest difficulties with the health system in the past has been politics and the flip-flop policymaking of politicians, individual Ministers and party policy. There have been changes and movements with whatever way the wind is blowing. I am not sure that has been

very helpful in many cases and one would wonder about the influence of politics on the health area. Medical politics is involved as well, which is another story.

The first shot in developing a ten-year strategy should be a presentation from somebody on how to devise a strategy. It might have nothing to do with the medical world but how to plan for ten years. Perhaps we could have a presentation on strategic planning from an academic who might give us some guidance. It is just a suggestion as a starting point for the committee to consider and see how we go. Deputy Kelleher referred to resources, which is an important issue. We saw the resources put into the banking inquiry and I would like to think this committee could serve a function that is equal to that if it does as it is supposed to do. Resources should be made available to the committee, noting the short timeframe, so as to equip us to deal with the challenge we have taken and to do it justice. The savings would be immeasurable down the road if we do the job right.

Deputy John Brassil: I congratulate Deputy Shortall on her appointment and I look forward to working with her. I am qualified in the pharmacy area and I have worked in it for the past number of years, so I have a specific interest in primary care. I would probably like to see the committee break up what we should deal with and try to categorise primary care, accident and emergency departments, elective surgery, step-down facilities, community care, etc. Perhaps we should try to categorise each section that we would like to examine in detail so as to see how we can build our strategy around them.

As other speakers have noted, there are numerous reports out there. I have printed what we have been sent by e-mail and I have run out of paper several times. There is a primary care report by Indecon that is quite thick. I think all the reports would have common suggestions on how to tackle the issues in primary care. It would be well worthwhile for the committee to resource people to analyse and come up with the common themes of all these reports. If a team of experts has gone to the trouble of producing a very detailed report with the same suggestions, having taken cognisance of it as a group, we should bring forward the proposals for action, instead of a further report. That is what we should consider.

One hears very good reports of what works in certain hospitals. For example, for many years, one has been hearing very good reports of the accident and emergency unit in St. Luke's Hospital, Kilkenny. If that is the case, why can we not replicate that model in other hospitals? We should look at the elements of the health system that are working and at ways of replicating what works in other areas. That is the model we should look at. Yesterday in the Dáil I spoke about the lack of an acute stroke unit in University Hospital Kerry during the Topical Issues debate. I had read a comparative report on the service in Kilkenny, Waterford and Kerry. The results were startling. It was frightening to compare the results from an acute stroke unit that is working properly with one that does not. The very simple solution is to get an acute stroke unit working in all hospitals which deal with strokes. That does not happen at present. Sometimes we over-complicate the issues instead of following a strategy of simplifying things and replicating models that work.

I agree with Deputy Clare Daly that for me and many others developing a strategy is a new idea, whether it is in the area of health, education or whatever. It would be helpful if we could get advice on formulating strategy, so that we go down the right road from the start instead of finding out that we have spent months on work that did not bring us forward.

Deputy Alan Kelly: I congratulate the Chairperson on her appointment. I know she will be excellent in the Chair because when I served in government with her, she was very passionate

about this topic. It will be a difficult task but I am looking forward to working on this committee. There are a number of points that we need to get out in the open. In our discussions, when the word "we" is used, it should not be a reference to our political parties but to a collective unit greater than politics. We will achieve more. Ultimately, this could be the most important committee of the Oireachtas for many years. There has been no consistency in the thinking on health care for generations. If we are to formulate a plan, and I like the terms of reference, on what we are trying to achieve, we must adopt a completely different approach, one which is open. I am very much taken by what Deputy Daly said. We should start with the basics, what we are trying to achieve, how we should go about achieving it in practice and what is strategy. That is a very important point.

People know that I am a practical person. I think our meetings should take place as much as possible on Tuesdays, Wednesdays and Thursdays. Life in the Oireachtas is busy for everyone but I hope we can meet even if it means early morning meetings.

The next issue is the politics of health. As politicians, we are politically tuned in but the most political issue in Ireland is health care. We need to be alert to the politics of health care and be able to recognise lobbying from witnesses and others. I think the Chair will have to be clinical in her dealings. Obviously, we will be lobbied to death. Perhaps Deputy Harty will have a function to distinguish between what is important on a day-to-day basis. I and others on this committee are on his committee also.

Our role is to put forward a pathway for the future of health care. We also must look at the domain in which we are working. There is no point in meeting for six months with the idea of developing a utopian vision, which is not realistic. We have to create a vision of what can be realised within the realistic constraints in Ireland. We can be expansive and ambitious, cutting through all that has happened in the past in setting out a plan that is robust, but there is no point producing a report that is not practical and implementable. That is critical. If we go the distance in doing that, we will have achieved a great deal.

While six months might seem a long period of time, it is actually short. I understand we will have a separate discussion on resources but the level of resources required will be incredible.

Deputy Mick Barry: It is useful at the start of the work programme of any committee to start with the terms of reference. When we are talking strategy, the terms of reference are particularly important. Our terms of reference include a reorientation from a hospital-based health service to a primary and community care service. Our terms of reference include moving towards a one-tier universal health care system based on need and not on ability to pay. I think we must follow through on the terms of reference in a forensic and laser-like way. Whatever system is the one most likely to deliver on those goals, which have never been delivered in the history of the State, universal health care, a one-tier system based on need and not on ability to pay is what we must do.

Let us remind ourselves of the terms of reference at the very outset. If we do that, there will be no fear of members being at cross-purposes with the health committee. We have very different terms of reference. We are looking at models for the best model of health care in order to deliver on our terms of reference. We need to have a broad vision and, as other speakers have said, an evidence-based approach to our task. The US model is primarily health care for profit. The mainstream European model is primarily based on versions of social insurance. The UK model is a national health service style health provision. The question for this committee is what is the best model for this country. The curse of the Irish health service through the 20th

century into the 21st century has been a short-sighted pragmatism, which at the end of the day is not pragmatic. Working from week to week or month to month without an overall view and strategy is a type of short-sighted pragmatism, which at the end of the day is not pragmatic. The result of this is a health service which is a hybrid. It is actually neither fish nor fowl. We started in the early 20th century with elements of a welfare state, with the reforms implemented by the liberal Government. With the foundation of the State came the role of the voluntary sector and the church in terms of health services, followed in the last decades by a move in the direction of US models. Thus, we have ended up with a bit of everything, which does not deliver particularly well. We need to stand back from the immediate and develop a strategy around the best model for Ireland.

I am not sure about the idea of breaking up into working groups, at least not initially. I think what we need first is an overview of the situation, following which we can get into the detail, rather than the other way around. There are a few other points I could make but I will leave it at that for now.

Deputy Kate O'Connell: I congratulate Deputy Shortall on her election as chairman and wish her the best of luck. We probably all need a bit of luck in terms of our endeavours in this area.

By way of background, I am a community pharmacist. I studied in the UK and my background is in the NHS where I specialised in primary care at undergraduate level. When I qualified, which is approximately 12 years ago, the NHS was in the process of restructuring. When looking to evidence-based solutions we could probably look to the NHS. While it is not a perfect model there are elements of it which we could, possibly, aspire to.

I come from an extended family of public and private medical practitioners. It is difficult when looking at the structural model of the HSE to get what is going on. I have tried in the past to overlap it with the hospital trust structure but I cannot do it. It would be useful to all of us if we could look first at what we have, where it is at and where possibly we might go with it. We cannot have all of these structures working in tandem or going off in different directions. It is important for us as a committee to see in diagram form what we have. I welcome Deputy Jim Daly's comments in regard to strategy in general. While I am not sure if any of us come from that type of background we could all benefit from that. There has been a lack of long-term vision in the health service. I agree that ten years is not that long, but it is a starting point. What has been done by successive Governments is something we need to move on from.

Data from the current structures of the HSE and the hospital trusts, should be mapped with the latest population data, showing disease burden, socioeconomic conditions and so on to enable us to determine why the sickest people in this country for some reason have the least access to health care. In focusing on that information we would not be focusing on any particular profession. I am always surprised when I hear the much used new phrase "the focus should be on the patient". Surely, the patient should always be the focus of any health system.

We are unique in this country in that because of our geographical land mass and population we could probably implement a system that no other country in the world could implement. I believe this committee has the opportunity to come up with a system that will work for the people of Ireland not only for the next ten years but into the future. My focus was preventive medicine in the primary care setting and that feeding into reducing the burden on the acute hospital structure. From the outset, we need to hear about strategy and what we have so that we are educated to some extent in regard to what we have as a country and what we can do with

it. We are spending more per head of population on health services in this country than any other country and we need to question why that is the case. We also need to question why our outcomes are not necessarily ideal.

I look forward to working with all members. I hope we all have the common goal of progressing this issue. Let us get at it.

Deputy Michael Harty: I, too, congratulate Deputy Shortall on her election as Chairman and, even more so, on bringing this topic to the floor of the Dáil and in that regard, the timely establishment of this committee so quickly after the formation of a Government. Apart from the housing and homelessness issue, the health problem is the most critical in political terms.

As stated by Deputy Kate O'Connell, the patient must always come first. In planning a health service, our focus should be on the development of systems that suit the patient rather than, as has been the case down through the years, the patient being accommodated by the system, which results in patients falling through the cracks. It is important the patient remains in our focus as we plan our strategy.

Many people are of the view that primary care is the answer to many of the problems in our health services. Our hospital system is so expensive, it is critical that primary and community care is developed. We have an ageing population and a huge burden of chronic illness. The most appropriate place for the treatment of chronic illness is the primary and community care setting. We need to integrate primary and secondary care. In this regard, the Kilkenny model, which is a pilot system involving the seamless integration of primary and secondary care, which delivers cost effective medicine as close as possible to the patient's home thereby preventing unnecessary admission to hospital, has been very successful. We also need to integrate our public and private systems. There is huge capacity in our private system that the public system, which is bursting at the seams, could tap into. The integration of public and private medicine could start the process of a one-tier system.

We should have common purpose. This is not about politics. It would make no sense to seek political advantage on health issues. We are all here for the same purpose. This issue should be above politics and the committee should aim to keep it so. The task with which we are faced is not an impossible one. Many of our other systems work well. To achieve change, we will need to challenge particular work practices and management structures. Front-line staff are often excluded from decision making. We should seek to ensure front-line staff are involved in all policy decisions because they are the people who are delivering the service.

We need to start moving in the right direction. In this regard, a strategic framework will be important. I agree that the focus of the committee from the outset should be on how to go about strategically changing the system and how to manage that change properly.

Deputy Hildegarde Naughton: I, too, congratulate Deputy Shortall on her appointment as Chairman. I know she will do an excellent job. I look forward to working with her and the committee.

I agree with Deputy Harty and other members that keeping politics out of this issue will be key to the success of this committee. We all want to see the ten-year plan implemented. We are also aware of how politics has curbed progress within the health service. It is important that our ten-year vision is workable and affordable, bearing in mind that resources are limited. We must also be cognisant of this Government's term in office and set out clear targets in terms of

what is achievable within the next year or two. This is an all-party committee and its vision for our health service over the next ten years and beyond should be implemented regardless of who is in government in the future.

I look forward to participating in the work of this committee. We are faced with a huge challenge. I concur with Deputy Daly in regard to the strategic plan, which will be a key part of the success of the committee. I look forward to working with everyone over the next six months.

Deputy James Browne: I congratulate the Chairman on her appointment. I do not think we have personally met yet but her passion in this area over the years has always come across clearly. I know that she will keep this committee focused. We could end up going down all sorts of rabbit holes, so staying focused will be key. It is a serious and significant undertaking but I have a lot of hope for the committee. However, with hope comes expectation. We need to end up with an evidence-based strategy which clearly sets out where we want to end up and how we will get there, including pathways and goal setting. Ultimately, the report will need to be tight. We do not want to end up with a report that states what we feel it should state but which would allow those who are to implement it all sorts of get-out clauses due to broad and perhaps passionate wording but wording which is lacking in specifics.

That, of course, will require us to make decisions and those decisions will upset people. I have no doubt a lot of lobbying will be attempted. We will need to close our ears to it and try to look at what we are doing here with an open mind. Everyone here is here for the right reasons. Everyone wants to see an effective health care system. Access to health care and equality in access to health care is a human right. We need to get that point. We have a very *ad hoc* health care system in this country and there seems to be little rhyme or reason to it. There is a lot of geography lottery and what one can get in one county cannot be got in another. There are also situations in which those in villages on the edge of a county border must travel perhaps 20 miles to their county town when the facility closest to them is only a mile away in the next county. We have that type of carry-on.

If we are modulating this in terms of the different areas and when we are bringing people in, we should consider that the area of mental health is extremely important and can sometimes be forgotten. As spokesperson for mental health, I will try to keep the focus on that area but all the different aspects of our health care will need to be linked in together. I have confidence in the committee and the Chairman's stewardship of it and am looking forward to the next six months.

Chairman: I thank everyone for their contributions. There is a general theme running through all of them and there is a lot of enthusiasm and ambition for the health service in the room. Perhaps our fault as politicians over the years has been that we have been fatalistic about the health service and that there was a sense that it was a hopeless case. However, I very much get a sense that people here want to work very hard to achieve a better health system. We know that most other countries, certainly most other European countries, have good, functioning health services where it is unheard of that a person would have to wait 15 months or two years for an appointment with a specialist. Services are accessible when they are needed, irrespective of means. I think that is the aim for all of us.

There is a strong level of ambition and an open-mindedness in the committee to look at the evidence, leave the politics aside and do what a number of members spoke about, which is putting the focus on the patient. Often within the health service, the patient is forgotten because there are so many other interests. At a ministerial level, in particular, this is something one would be conscious of. There are some powerful lobbying groups within the health service

and sometimes it is hard to get through the fog of all of that and keep the focus on the patient. That is probably the single most important message coming from the contributions this morning, which is the need to keep the focus on the patient and to do what is in best interests of the patient.

The ten-year plan has been mentioned and a few people outside the committee have been commenting on it. We have to make it clear that we are not talking about doing work for something that can be achieved in ten years' time. It is about agreeing the kind of health system that we need in this country, the funding model for it and how we start to transition later this year and early next year over a ten-year period, which is a reasonable perspective in terms of system change, but we have to be clear about the phasing of it.

The problem we have had to date is that every time there is a new Government or a new Minister there is a new plan. With each change of plan, there is huge disruption caused to the health service and a huge lack of certainty about what the future holds. We have to bring that to an end. We can learn a lot from what happened in the UK after the war where the two big parties in the UK, coming from very different places, agreed on the NHS model. Irrespective of which party was in government, everyone supported that model. Notwithstanding some of the problems that have arisen over the years, by and large there is huge buy-in to that approach and the British people are very proud of their health service. We need to get to that point, which is an agreement on the system and the model and, irrespective of what parties are in government, we can support, fund and stick to the model for the future.

The order to take is probably to agree the type of system, then the funding model and then the model of care. There are lots of examples of models of care including the switch to primary care in terms of pharmacists, GPs, allied health professionals and so on providing services locally in the community thereby saving the patients the need to go to acute hospitals and taking the burden off acute services. There are lots of models and all of them have to be considered in the context of the overall system and the funding system, which determines in practical terms the types of models we have.

There have been many good suggestions. On Deputy Daly's point about getting advice on strategy, we probably need to get advice on the project management aspect. We will examine the matter and perhaps we will have a chance to speak about it later. The other suggestion was that we would get an initial presentation on the current system, the different types of health systems, particularly those which are common in Europe, and the different issues in respect of funding models. In that regard, I suggest we bring in representatives from the ESRI to give us that overview at our next meeting. A lot of academic work has been carried out by the ESRI over recent years. Specifically, last year it did the costings for Government on the proposals for universal health insurance, which was subsequently dropped. It has looked at different types of health systems and the funding models involved. I suggest that we get those representatives in at an early stage to give us that kind of overview and context.

We also need to consider the best time and how frequently we should meet. How do members feel about us having weekly meetings until the end of July? Is that possible? Can we do that? Yes.

Deputy Alan Kelly: In correlation with the Dáil.

Chairman: We do not have a definite date for when the Dáil will go into recess.

Deputy Billy Kelleher: Given that there is a duplication of members between the two committees, I imagine that will have to be taken into account on a fairly regular basis. The two health committees will be-----

Deputy Alan Kelly: How many members here are on the other health committee?

Chairman: Five. There is a significant overlap.

Deputy Jim Daly: It is six.

Chairman: Okay. Is there a date set for the other committee to meet yet?

Deputy Alan Kelly: When is it meeting?

Deputy Michael Harty: The Senators have not been nominated yet, so it will probably be next week or the week after.

Chairman: The provisional slot is for us to meet on a Thursday, but that does not suit because it clashes with the Committee of Public Accounts.

Deputy Billy Kelleher: There are also the practicalities of rooms. That is what it comes down to a lot of the time.

Chairman: We will ask the secretariat to work on that, bearing in mind the points made this morning about membership of other committees.

Deputy Alan Kelly: Also bear in mind it is better if it is a Tuesday, Wednesday or Thursday if possible, but Thursdays look difficult now.

Chairman: We will keep that in mind.

Deputy Josepha Madigan: Forgive me for being elementary about this, but some of us are new Deputies as well. I want to be clear on the committee and its approach. I mentioned meeting with other groups, for example in my constituency, which have already approached me about meeting up. First, is there anything to prohibit me doing that? Second, if I do, is it worthwhile bringing that feedback to the committee? What is your guidance on that?

Chairman: I heard your suggestion about the committee breaking up into smaller working groups and dealing with elements of the task. We should hold off on that. It is a good suggestion, but we will start with the overarching presentation and briefing, then look at how we might proceed. A huge number of groups are certainly very keen to come before the committee. We have to be very careful about that. For individual members to meet with groups and bring feedback to the committee entails those groups having access through members. Maybe after the initial presentation we will have some discussion on that and see whether we can put some shape on how we will proceed. In the meantime, I will ask the secretariat to identify some of the representative groups. There are umpteen patient groups, for example; we cannot have them all in, but there are a small number of umbrella groups that represent several different patient groups. We might just look at suggested groupings that we would invite before the committee. I will come back to members at the next meeting on that, if that is all right.

Deputy Louise O'Reilly: I would not favour individual Deputies meeting with groups, because they would put themselves in a position whereby they represent those groups, or their views, back to the committee. It is access by another name. The Chairman pointed out a very

practical way to approach it by talking to the overarching representative groups. This is a personal opinion, but I do not think it is productive for us to have mini-representatives, in ourselves, coming in to represent other groups. I am acutely aware, from my constituency as well as outside it, that we will all be lobbied, but it does not make practical sense for us to come in and speak on behalf of a group. We will all be in that situation, but what makes practical sense to get over that is to facilitate short - God help us, we hope - written submissions to the group.

Deputy Josepha Madigan: I want absolute clarity on this. Somebody said I was not prohibited. Am I prohibited from meeting groups in my constituency who want to meet me in regard to the committee and bringing their views back here?

Chairman: Clearly, any member here is free to meet whoever they wish outside, but we ask you to be mindful that you are not being used as a conduit for different lobby groups to put pressure on you to feed their views back into the committee. I ask you to be conscious of that. Obviously people will meet whoever they wish, but we have a very clear remit with regard to the bigger picture, being objective and sticking to our terms of reference on using the evidence base.

Deputy Michael Harty: On representation, we will all be lobbied. I have been lobbied substantially over the past few days. I suggest that if groups approach us individually we should acknowledge receipt of their lobby but give it to the secretariat to decide whether it is appropriate for the committee to meet them. It is probably not appropriate for us as individuals to decide on who comes before the committee. We could meet them as public representatives but not wearing the hat of a committee member. We should make it clear that the way the system operates is that everything goes through the secretariat. We can meet them but we cannot influence the committee in respect of their lobbying.

Deputy Alan Kelly: To be practical, it is virtually impossible for a public representative to say that we will not end up talking to somebody somewhere. We need to separate our hats and draw a distinction between being public representatives and being on this committee. We are not on the committee to represent them but to express views based on the data that will be before the committee. We should not negate our role as politicians in our daily life, but we are not coming to committee meetings representing those whom we meet in any shape or form.

Since I was appointed spokesperson on health more than two weeks ago, I have been inundated with people who want to meet to talk about this committee. Everybody will be faced with this issue. May I make a practical suggestion? I would like collective agreement on a template for written submissions so that those who wish to communicate with the committee can use the template and send in written submissions directly. We should encourage everybody to use the template in their communications with the committee so that their submissions can be put up online and everybody can read them. We have to have practical strategies on how to get through the volume of work. With a template we would know the structure and size of each document, and it would lead to consistency. I strongly encourage the use of a template.

Chairman: It is clear that we need a structured means of stakeholder consultation. I know the clerk has expertise in that area. I am asking him to bring proposals to the committee on how we might go about doing that.

Initially, if members receive a request for a meeting from a particular group, this should be referred to the secretariat. We need to consider how we can do that in a structured way.

Deputy Alan Kelly: I know the clerk is more knowledgeable about this than the rest of us, but in this unique situation the volume of material will be incredible. If we do not have an actual physical structure so that organisations document what they want in a structured manner, rather than firing in everything in their submission, we will be at naught.

Deputy Louise O'Reilly: A template would work quite well and would keep things consistent so that one would not have a submission of 80 pages from one group and two pages from another. I think the terms of reference are fairly explicit. We will not be stepping outside the terms of reference, so the template can be moulded and guided by them. I think that makes good practical sense.

Deputy Kate O'Connell: I agree with Deputy Kelly's proposal on a *pro forma* approach so that we are not going through stuff. In regard to the structure we have, perhaps we could have someone explain it within the first few sessions so that whoever claims to know what is going on is invited to show us what we have, why there are so many people employed, what they are doing and where they are based. I think we need to know where we are at the minute. Perhaps we could set up a session with the ESRI as soon as possible before we start off.

Chairman: Members will see in their packs a document from the ESRI entitled Challenges in Achieving Universal Healthcare in Ireland, which would be useful for members to read before the groups come before us.

Deputy Jim Daly: I wish to make a point on how we deal with the debate, essentially addressing the question raised by Deputy Madigan. Everybody is free to use his or her judgment on whom to meet, and that is what we do as practising policy makers. This is not an issue exclusive to this committee. We are members of other committees and vested interests seek time with us. It is a capacity issue that we will not be led and used by any particular vested interest. I think we all have the capacity to rise above vested interests and not represent narrow views. In the same vein, I do not know how relevant this is but some of the other members and I visited the College of Physicians yesterday. I know they are doing a ten year health plan strategy which they hope to have completed by the end of this year. I suggest the committee should tie in with them so as to avoid duplication.

I support Deputy Kelly's suggestion. It is a good idea to have a template for submissions so that we are all on the same page.

Chairman: I thank Deputy Daly for his contribution. I suggest we go into private session to discuss our meeting times. I am also keen to have a discussion on the budget available for research work. Is that agreed? Agreed.

The committee went into private session at 11.40 a.m. and adjourned at 12 noon until 9 a.m. on Wednesday, 20 July 2016.